Facility-Based Behavioral Health Program Reimbursement Policy

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: member's benefit coverage, provider contracts and/or legislative mandates. Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT® is a registered trademark of the American Medical Association*

Applicability

This reimbursement policy applies for services reported using the UB-04 Claim Form (a/k/a CMS-or its electronic equivalent or for claims submitted online through provider portals. This policy applies to Commercial products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

This reimbursement policy describes how Optum aligns with CMS in paying facility-based behavioral health services on a per diem basis. Payment represents the expected daily cost of facility-based behavioral health services. Consistent with CMS policy and reimbursement guidelines, separate payment is not made for certain services which are considered an integral part of the prevailing program.

For the Purpose of this reimbursement policy "facility-based behavioral health program" refers to the following levels of care:

Mental Health:

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum
U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

Inpatient Acute,Residential,Partial Hospitalization, Intensive Outpatient Services

Substance Abuse:

ASAM Level of Care: 4.0,3.7,3.5,3.2,3.1,2.5,2.1:

Inpatient Acute,Residential,Partial Hospitalization, Intensive Outpatient Services

Please note ASAM level of care **3.2 WM** and **3.1** are also listed in this policy however, this only pertains specifically to **CA state Only- Commercial Fully Insured**

See below for further ASAM Level of Care descriptions.

Reimbursement Guidelines

As defined in our Optum Clinical Criteria, the course of treatment is focused on addressing factors that precipitated admission such as changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning.

Treatment consists of clinically recognized therapeutic interventions such as group, individual and family psychotherapies pertinent to the member's behavioral health condition. Medical and psychiatric diagnostic evaluation and medication management are also integral to treatment. If the member is diagnosed as having a Substance-Related Disorder in addition to a mental health condition, the program must be prepared to appropriately treat the co-morbid Substance-Related Disorder.

Consistent with CMS, for treatment to be considered "active" services must be as follows:

- Supervised and evaluated by the attending/rendering provider;
- Provided under an individualized treatment plan that is focused on addressing the factors that precipitated admission, and make use of clinical best practices; and
- Are reasonably expected to improve the member's presenting problems within a reasonable period of time.

Optum has adopted clinical guidelines outlining the type of treatment that should be provided by level of care. Effective March 1, 2016, Optum will reimburse the expected cost of a day of facility-based behavioral health services using a single day rate for all expected components of an active treatment program. The single day rate will incorporate payment for all dependent, ancillary, supportive, and therapeutic services into payment for the primary independent program service. Separate payments are not made for additional ancillary services itemized on a claim when billed with the primary independent program service.

Such payment does not include attending professional charges billed with cpt code 90792 or single daily E&M code as clinically appropriate.

The following services are considered an integral part of the program services that will be reimbursed under the single day rate paid by Optum and therefore are not separately eligible for reimbursement:

- All supplies
- Ancillary services
- Psychological and neuropsychological testing
- Clinical diagnostic laboratory tests including drug testing
- Treatment planning
- Individual therapy

- Group therapy
- Family therapy
- Crisis intervention

Codes (Note: This list of representative codes and levels of care is not intended as exhaustive of all relevant codes.)	
Level of Care	**Revenue Code & HCPCS Code**
Mental Health	
○ Inpatient (IP) Acute	114,124,134, 144,154, 204
○ Residential	1001
○ Partial Hospitalization	912,913
○ Intensive Outpatient (IOP)	905

Substance Use Disorder (SUD)	
Level of Care	**Revenue Code**
ASAM 4.0 ○ Medically Managed Intensive Inpatient Withdrawal Management (WM)	116,126,136,146,156 * With required CPT/HCPCS based on State Medicaid plan rules
ASAM 3.7 WM ○ Medically Monitored Inpatient Withdrawal Management (WM) Services	116,126,136,146,156 * With required H0010, H0011, H0012, or H0013
ASAM 3.7 ○ Medically Monitored Intensive Inpatient Services	118, 128, 138, 148, 158 * With required CPT/HCPCS based on State Medicaid plan rules
ASAM 3.5 ○ Clinically Managed High – Intensity Residential Services	1002 *H0019 (Use this code for Medicaid only if no other code is specified by the State Medicaid plan)

	* With required CPT/HCPCS based on State Medicaid plan rules
ASAM 3.2 WM (Medicaid only) ○ Clinically Managed Residential withdrawal Management	*H0008, H0010,H0012 (Use this code for Medicaid only if no other code is specified by the State Medicaid plan) * With required CPT/HCPCS based on State Medicaid plan rules
ASAM 3.2 WM (CA Commercial Only – Fully Insured) ○ Clinically Managed Residential withdrawal management	1002 *With required HCPC H0010
ASAM 3.1 (CA Commercial Only – Fully Insured) ○ Clinically Managed Low-intensity Residential Services	1004 *With required HCPC H2034
ASAM 3.1 (Medicaid only) ○ Clinically Managed Low-intensity Residential Services	1003 and/or *H2034 * With required CPT/HCPCS based on State Medicaid plan rules
ASAM 2.5 ○ Partial Hospitalization (PHP)	912 or 913 *H0035 (Use this code for Medicaid only if no other code is specified by the State Medicaid plan) * With required CPT/HCPCS based on State Medicaid plan rules
ASAM 2.1 ○ Intensive Outpatient Services (IOP)	906 *H0015 (Use this code for Medicaid only if no other code is specified by the State Medicaid plan) * With required CPT/HCPCS based on State Medicaid plan rules
Reimbursable Professional Services (not subject to bundled services)	

○ Attending Professional and E&M Codes	99202 – 99205 99211 – 99215 99221 – 99223 99231 – 99236 99238 – 99239 99281 – 99285 99304 – 99310 99315 – 99316 99408 – 99409

Resources
American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services
Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) Edits

History / Updates	
March 2023	Updated Reimbursement Guidelines Section
February, 2023	Anniversary review; No updates
January, 2023	Removed E/M deleted codes 99217-99226 and 99318 effective 1/1/2023
January, 2022	Anniversary Review; no updates
December, 2021	Updated ASAM Level 3.2 WM Revenue code from 900 to 1002 for CA state Only; Added ASAM Level 3.1 CA only per state requirement
September, 2021	Added ASAM Level 3.2 WM for CA state ONLY
August, 2021	Updated ASAM Level 3.7 WM
March, 2021	Maintenance update for further clarification related to reimbursement guidelines section
January, 2021	Updated Overview section and Level of Care codes and reimbursement guidelines; removed cpt 99201 deleted code
June, 2020	Removed definitions
February, 2020	Annual review
March, 2019	Annual review
September, 2018	Clarifying eligible charges
April, 2018	Annual review
March, 2016	New