Optum®

Reimbursement Policy
Policy Number 2017RP506A

Non-Covered HCPCS Codes 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 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. 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

The purpose of this reimbursement policy is to define services that do not meet the definition of a covered health service.

Reimbursement Guidelines

Benefit Document Language
Before using this guideline, please check the member specific benefit plan document and any federal or state mandates, if applicable.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state-by-state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

Benefit Limitations and Exclusions

For additional information, please see the member specific benefit plan document

- Services that do not meet the definition of a Covered Health Service are excluded.
- Services that are not listed in the member specific benefit plan document as a Covered Health Service and do not meet the definition of a Covered Health Service are excluded.
- The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered.

Covered Health Service(s) 2001: Those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, mental illness, substance abuse, or their symptoms. A Covered Health Service is a health care service or supply described in *Section 1: What's Covered – Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered – Exclusions.*

Covered Health Service(s) 2007: Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate of Coverage under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered
Persons on Live and Work Well or by calling Customer Care at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Health Service(s) 2011: Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary
- Described as a Covered Health Service in this Certificate under Section 1: Covered Health Services *and in the* Schedule of Benefits.

- Not otherwise excluded in this Certificate under *Section 2: Exclusions and Limitations*.

The following are examples of services that may be inconsistent with benefit coverage.

Non-covered HCPC Codes List attachment: To open an attachment, download the policy document, save it as a pdf, open the pdf in acrobat reader software, right-click on the icon to open the attachment. Note: Due to security protocols, attachments cannot be opened directly from the reimbursement policy.	
📎	Non-covered HCPC Codes

History / Updates	
March, 2024	Updated Non-covered Code list; Added G2211
July, 2023	Anniversary review; Updated Non Covered HCPC Codes list; added code list attachment
July, 2022	Anniversary review; Updated Overview Section and Reimbursement Guidelines Section
June, 2021	Anniversary review; No recommended updates
June, 2020	Clarification on H0033; Removed G0469 & G0470
March, 2020	Added G2067-G2080
July, 2019	Language review and annual review
March, 2019	Annual review
April, 2018	Annual review
March 15, 2017	New