Reimbursement Policy
Policy Number 2016RP505A

Facility-Based Behavioral Health Program Professional Fees 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*

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Applicability

This reimbursement policy applies to all health care services billed on CMS 1500 forms, for services billed on the 1500 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

This reimbursement policy describes how Optum aligns with CMS in the reimbursement of professional services billed for facility based behavioral health programs.

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

Mental Health:

Inpatient Acute,Residential,Partial Hospitalization, Intensive Outpatient Services

Substance Use Disorder:

ASAM Level of Care:

Inpatient - 4.0

Residential - 3.7,3.5,3.1

Intensive Outpatient - 2.7,2.5,2.1

Outpatient - 1.7, 1.5,1.0

See below for further ASAM Level of Care descriptions.

Reimbursement Guidelines

Consistent with CMS, for a facility-based program service 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 guidelines outlining the type of treatment that should be provided by level of care. Optum reimburses 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 incorporates payment for all dependent, ancillary, supportive, and therapeutic services into payment for the primary independent program service. Therapeutic services include individual therapy, group therapy and family therapy.

Professional Services are defined as attending, physician or rendering provider charges for supervision and evaluation during active facility-based programs. Unless specified within a provider contract, the single rate for a facility-based treatment program does not include attending physician charges.

Attending physician charges are to be billed by a **single** daily Evaluation and Management (E/M) code as clinically appropriate.

Effective January 2023 E/M services are based on either time or medical decision making.

- Physicians may report only one “new patient” code or “established” patient code on a single date of service;
- Physicians may report only one code from a range of codes describing an initial E/M service on a single date;
- Physician may report only one “per diem” E/M service from a range of per diem codes on a single date of service on the same date of service.

CPT codes 99234-99236 should not be reported the same date of service as initial hospital care per diem codes 99221-99223, subsequent hospital care per diem codes 99231-99233, or hospital discharge day management codes 99238-99239.

Commercial Mental Health 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**
Inpatient (IP) Acute	0114,0124,0134, 0144,0154, 0204
Residential	1001
Partial Hospitalization	0912,0913
Intensive Outpatient (IOP)	0905

Commercial Substance Use Disorder (SUD)		
Level of Care	**Adult – ASAM 4th Edition Billing Code**	**Adolescent – ASAM 3rd Edition Billing Code**
ASAM 4.0 – Medically Managed Intensive Inpatient Services	0116,0118,0126,0128,0136,0138,0146,0148, 0156, and 0158 * With required CPT/HCPCS based on State Medicaid plan rules	0116,0126,0136,0146 and 0156
ASAM 3.7 - Medically Monitored Intensive Residential Services	1000 * With required CPT/HCPCS based on State Medicaid plan rules	N/A
ASAM 3.7 - Medically Monitored High Intensity Inpatient Services	N/A	0126 * With required H0010, H0011, H0012, or H0013
ASAM 3.7 WM - Medically Monitored Inpatient Services with Withdrawal Management (WM) Services	N/A	0128 * 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	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 3.1 - Clinically Managed Low-Intensity Residential Services	1003 * With required CPT/HCPCS based on State Medicaid plan rules	N/A
ASAM 2.7 - Medically Managed Intensive Outpatient Services	0944, 0945 * With required CPT/HCPCS based on State Medicaid plan rules	N/A
ASAM 2.5 - High Intensity Outpatient Services **- Adult**	0907 * With required CPT/HCPCS based on State Medicaid plan rules	N/A

ASAM 2.5 – Partial Hospitalization - **Adolescent**	N/A	0912,0913 * With required CPT/HCPCS based on State Medicaid plan rules
ASAM 2.1 - Intensive Outpatient Services – **Adult & Adolescent**	0906	0906
ASAM 1.7 - Medically Managed Outpatient Services (OTP, OBOT, MDs perform withdrawal management in office setting) - **Adult**	Commercial OTP - H0020, H0033, H0047 Commercial OBOT - H0047 Medicare OTP: G1028, G2067, G2068, G2073-G2080, G2215 Medicare OBOT: G2086-G2088 MD - provider express policy	N/A
ASAM 1.5 - Outpatient Therapy Services – **Adult & Adolescent**	Please refer to your outpatient contract	Please refer to your outpatient contract
ASAM 1 - Long Term Remission Monitory Services – **Adult & Adolescent**	Please refer to your outpatient contract	Please refer to your outpatient contract

CA Commercial Only – Fully Insured		
ASAM 3.2 WM (CA Commercial Only – Fully Insured) ○ Clinically Managed Residential withdrawal management Services	1002 *With required HCPC H0010	
ASAM 3.1 (CA Commercial Only – Fully Insured) ○ Clinically Managed Low-intensity Residential Services	1004 *With required HCPC H2034	

Reimbursable Professional Services (not subject to bundled services)	
• Attending Physician 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) publications

History / Updates	
April, 2024	Updated Reimbursement Guidelines Section – ASAM_4th Edition; archived history section 2016-2021
May, 2023	Updated Reimbursement Guidelines Section related to E/M services
February, 2023	Anniversary review; no updates
January, 2023	Removed E/M deleted codes 99217-99226 and 99318 effective 1/1/2023
February, 2022	Anniversary review; no updates

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