Add-on 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*

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Applicability

This reimbursement policy applies to all health care services billed on CMS 1500 forms and 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 all 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

Add-on codes are reimbursable services when reported in addition to the appropriate primary service by the Same Individual Physician or Other Qualified Health Care Professional reporting the same Federal Tax Identification Number on the same date of service unless otherwise specified within the policy. Add-on codes reported as Stand-alone codes are not reimbursable services in accordance with Current Procedural Terminology (*CPT®)* and the Centers for Medicare and Medicaid Services (CMS) guidelines.

For the purpose of this policy, the Same Individual Physician or Other Qualified Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Reimbursement Guidelines

United Behavioral Health operating under the brand Optum
U.S. Behavioral Health Plan, California doing business as OptumHealth Behavioral Solutions of California

In order to appropriately apply pricing and benefits, a specific Health Care Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) codes is required when billed with a non-specific revenue code. Claims for services that are billed without a specific procedural HCPCS and/or CPT code(s) will be denied.

The basis for Add-on codes is to enable physicians or other health care professionals to separately identify a service that is performed in certain situations as an additional service or a commonly performed supplemental service complementary to the primary service/procedure.

Optum follows the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) with respect to the reporting of "Add-on" CPT and HCPCS codes. Per CPT Add-on codes describe additional intra-service work associated with a primary procedure/service, are always reported in addition to the primary service/procedure, and must be performed by the Same Individual Physician or Other Health Care Professional reporting the primary service/procedure. For these code pairs, Optum requires that the Add-on code must be reported with a given primary procedure/service code. In addition, add-on codes are never reimbursed unless a primary procedure code is also reimbursed. Many Add-on codes are designated by the AMA with a "**+**" symbol and are also listed in Appendix D of the CPT book.

In some instances, a Definitive Source specifies the primary procedure/service codes that must be reported in conjunction with a given Add-on code.

In other situations, a primary/add-on code relationship may exist but the guidance from CPT or CMS is not as well-defined. Specifically, the code description does not directly identify the Add-on code or identify any specific primary codes that correspond with that code. In those instances an interpretation is necessary utilizing CPT, CMS and/or specialty society guidelines. Optum will interpret these sources to identify additional primary/add-on relationships. For these code pairs, Optum also requires that the Add-on code must be reported with a given primary procedure/service code. In addition, add-on codes are never reimbursed unless a primary procedure code is also reimbursed. Please see the Definitions section below for further explanations of Definitive and Interpretive Sources.

Key phrases to identify Add-on codes when not specified in the code description, include, but are not limited to, the following:

- list separately in addition to; *and*
- each additional*; and*
- done at time of other major procedure.

Unless otherwise specified within this policy, add-on procedures must be reported with the primary procedure for the same date of service.

Codes (Note: This list of representative codes is not intended as exhaustive of all relevant codes.)

Primary CPT Codes	Add-On Code	Description
90791, 90792, 90832, 90834, 90837, 90853 90833*, 90836*, 90838*	90785	Interactive complexity (List separately in addition to the code for primary procedure)
96158	96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96164	96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167	96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

96170	96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
99202-99205 99211-99215 99221-99223 99231-99236 99238-99239 99304-99310, 99315-99316 99341-99350	90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
99202-99205 99211-99215 99221-99223 99231-99236 99238-99239 99304-99310, 99315-99316	90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
99202-99205 99211-99215 99221-99223 99231-99236 99238-99239 99304-99310, 99315-99316	90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90839	90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
90832, 90834, 90837	90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services can only be perfomed by a Psychologist (List separately in addition to the code for primary procedure)

* *Psychotherapy codes* should not be billed as primary code but billed as secondary code to an evaluation and management service in conjunction with the Interactive complexity code as appropriate.

Prolonged Services Codes that may only be billed for providers who are contracted for Spravato Services please refer to the Spravato Services Reimbursement policy for Guidance Spravato Reimbursement Policy.

Prolonged Services that may be billed with the appropriate E/M codes please refer to the Prolonged Services Reimbursement Policy for guidance. Prolonged Services Reimbursement Policy - Commercial and Medicare

For further information on Health and Behavior Initial Assessment and Re-Assessment please refer to - Health and Behavior Assessment and Intervention Reimbursement Policy Commercial & Medicare

Definitions	
Add-on code	Add-on codes describe additional intra-service work associated with the primary service/procedure.
Stand-alone code	A code reported without another primary service/procedure code by the Same Individual Physician or Other Health Care Professional.
Definitive Source	Definitive Sources contain the exact codes, modifiers or very specific instructions from the given source.

Interpretive Source	An edit source that includes guidelines; however, no exact or specific code or modifier information is listed. Therefore, an interpretation must be made as to what codes correlate to the guidelines. Additionally, an interpretation may be applied to surrounding or similar codes based on related definitively sourced edits.

Questions & Answers

1	**Q:** How has Optum determined which codes are "Add-on" codes that must be reported with a primary service? **A:** The policy follows CPT guidelines for those codes designated with a "+" symbol. These codes are considered to be Add-on codes by Optum
2	**Q:** Does Optum require the Add-on code be submitted on the same claim as the primary code? **A:** No. The Add-on code may be reported on a separate claim submission from the primary code; however it is recommended the Add-on and primary procedure codes be reported on the same claim form.

Resources

American Medical Association, *Current Procedural Terminology* (CPT®) and associated publications and services

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Individual state Medicaid regulations, manuals & fee schedules
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System (HCPCS ®) Level II Manual

History / Updates

June, 2023	Annual Anniversary Review; Added H&B primary and add-on codes
January, 2023	Updated Reimbursement Guidelines Section and Code Section- deleted code range 99334-99337 and 994318 and 99354
May, 2022	Annual Anniversary Review; Reimbursement Guidelines Section updated
May, 2021	Annual Anniversary Review; No Updates
January, 2021	Updated code section descriptions; removed deleted code 99201; Updated code table related to Spravato (99417 commercial) & G2212 (Medicare) based on 2021 AMA guidelines
May, 2020	Annual Anniversary Review Updated Codes table
March, 2019	Annual Anniversary Review
April, 2018	Annual Anniversary Review
January, 2018	Clarified add-on codes are never reimbursed unless a primary procedure code is also reimbursed.
March, 2017	New

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