Outpatient Services Outside A Program Reimbursement Policy					
Policy Number	2018RP502A	**Annual Approval Date**	8/15/18	**Approved By**	Optum Behavioral Reimbursement Committee

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, clinical rationale, industry standard reimbursement logic, regulatory issues, business issues and other input in developing reimbursement policy may apply.*

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.

Optum uses a customized version of the Claim Editing System known as iCES Clearinghouse to process claims in accordance with our reimbursement policies.

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

Applicability

This reimbursement policy applies to:

- Behavioral health services billed on CMS 1500 forms and, when specified, to services billed on UB04 forms when mandated, as well as equivalent electronic and successor forms
- All products when Optum manages the behavioral health benefit plan
- All network and non-network physicians and other qualified behavioral health care providers

Policy

Overview

The purpose of this reimbursement policy is to ensure accurate and appropriate claims processing in accordance with industry standards by Optum Behavioral Health on behalf of UnitedHealthcare/Optum members whose behavioral health benefit plans are managed by Optum.

Reimbursement Guidelines
Consistent with CMS and Optum level of care guidelines, Optum will not reimburse individual services of an unlicensed provider, unless that provider is part of a contracted facility/group/program with an established supervisory protocol. Individual services provided under an established supervisory protocol will be reimbursed according to Optum's Network Manual; otherwise, individual services must be billed under the rendering provider's TIN. All services, including Evaluation and Management (E&M), must be provided by practitioners who are able to demonstrate, by virtue of their training and State-specific licensure or certification, that they are professionally qualified to provide medically necessary services. All services must be within the scope of practice for the relevant provider type in the State in which they are performed.

CPT codes listed below represent outpatient services and are not intended as exhaustive of all relevant codes and do not guarantee reimbursement.

CPT Code	Description
90791	Psychiatric Diagnostic Evaluation
90792	Psychiatric Diagnostic Evaluation with medical services
90832	Psychotherapy with patient, 30 minutes
90833	Psychotherapy with patient, 30 minutes, with E/M services
90834	Psychotherapy with patient, 45 minutes
90836	Psychotherapy with patient, 45 minutes, with E/M services
90837	Psychotherapy with patient, 60 minutes
90838	Psychotherapy with patient, 60 minutes, with E/M services
90846	Family Psychotherapy (without the patient present), 50 minutes
90847	Family Psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)

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
- Optum Level of Care Guidelines

History / Updates	
August, 2018	New