Facility-Based Behavioral Health Program Reimbursement Policy					
Policy Number	2016RP503A	**Annual Approval Date**	03/15/2016	**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, 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.

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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 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

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 purposes of this reimbursement policy "facility-based behavioral health program" refers to the following:

- **Inpatient:** A structured hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services; active behavioral health treatment; and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.
- **Residential Treatment:** A sub-acute facility which delivers 24-hour/7-day assessment and diagnosis services, and active behavioral health treatment to members who do not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient.
- **Partial Hospital Program:** A structured program provided in an ambulatory setting that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues.
- **Intensive Outpatient Program:** A structured program provided in an ambulatory setting that maintains hours of service for at least 9 hours per week for adults and 6 hours per week for children/adolescents (and up to a maximum/ceiling of 19 hours per week) during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues.
- **Ambulatory Detoxification** - Outpatient Detoxification is comprised of services that are provided in an ambulatory setting for the purpose of completing a medically safe withdrawal from alcohol or drugs. Outpatient Detoxification is typically indicated when the factors that precipitated admission indicate that there is little risk of moderate or severe withdrawal and co-occurring mental health and/or medical conditions – if present – can be safely managed in an ambulatory setting.

Reimbursement Guidelines

As defined in our Coverage Determination and Level of Care Guidelines, 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 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. Such payment does not include attending physician charges billed by a single daily E&M code as clinically appropriate. (See list of codes below.) Separate payments are not made for additional ancillary services itemized on a claim when billed with the primary independent program service.

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

- Diagnostic evaluation and assessment including psychological and neuropsychological testing
- Clinical diagnostic laboratory tests including drug testing
- Treatment planning
- Procedures described by add-on codes
- 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**
Inpatient	
• Mental Health or Substance Abuse	100, 113, 114, 120, 124, 134, 136, 144, 146, 154, 204
• Substance Abuse Detoxification	116, 126, 136, 146, 156
• Substance Abuse Rehabilitation	128
• Substance Abuse Low Intensity Rehabilitation (for contracts that utilize the ASAM Criteria)	148
Residential Treatment	
• BH Accommodations	1000
• Mental Health	1001
• Substance Abuse	1002
• Substance Abuse Detoxification	126 with bill type 86x 126 with H0010 or H0011
• Supervised Living	1003
• Halfway House	1004
• Group Home	1005
Partial Hospital Program	
• Mental Health or Substance Abuse	912, 913
Intensive Outpatient Program	
• Mental Health	905
• Substance Abuse	906

Ambulatory / Outpatient Codes preferably billed on CMS1500 with accompanying CPT/HCPCS Codes	
• Psychiatric Outpatient	513 (OP Clinic); 900-9xx 900 (OP Clinic); 911 (MH or SA Rehab); 914 (Individual Therapy); 915 (Group Therapy); 916 (Family Therapy); 944 (Drug Rehab); 945 (Alcohol Rehab)
Professional Fees	
• Attending Physician and E&M Codes	99201 – E&M of new patients (10 minutes) 99202 – E&M of new patients (20 minutes) 99203 - E&M of new patient, Presenting problem(s) are moderate severity (30 minutes) 99204 - E&M of new patient, Presenting problem(s) are moderate to high severity (45 minutes) 99205 – E&M of new patient, Presenting problem(s) are moderate to high severity (60 minutes) 99211 – Medication Monitoring (10 minutes) for ongoing patient-RN check in 99212 – E&M of an established patient (10 minutes) 99213 – E&M of an established patient (15 minutes) 99214 – E&M of an established patient. Presenting problem(s) are moderate to high severity (25 minutes) 99215 – E&M of an established patient. Presenting problem(s) are moderate to high severity (40 minutes) 99217 – Observation care discharge day management 99218 – Initial observation care, per day (30 minutes) 99219 – Initial observation care, per day (50 minutes) 99220 – Initial observation care, per day (70 minutes) 99221 – Initial Hospital Care (30 minutes) 99222 – Initial Hospital Care (50 minutes) 99223 – Initial Hospital Care (70 minutes) 99224 – Subsequent observation care, per day (15 minutes) 99225 – Subsequent observation care, per day (25 minutes) 99226 – Subsequent observation care, per day (35 minutes) 99231 – Subsequent Hospital Care (15 minutes) 99232 – Subsequent Hospital Care (25 minutes) 99233 – Subsequent Hospital Care (35 minutes) 99234 – Observation of I/P hospital care including admission and discharge on the same day low severity (40 minutes) 99235 - Observation of I/P hospital care including admission and discharge on the same day moderate severity (50 minutes) 99236 - Observation of I/P hospital care including admission and discharge on the same date (55 minutes)

• Attending Physician and E&M Codes (cont.)	99238 – Hospital Discharge Services (up to 30 minutes) 99239 – Hospital Discharge Services (greater than 30 minutes) 99241 – Office/Other Outpatient Consultation (15 minutes) 99242 - Office/Other Outpatient Consultation (30 minutes) 99243 – Office/Other Outpatient Consultation (40 minutes) 99244 – Office/Other Outpatient Consultation (60 minutes) 99245 – Office/Other Outpatient Consultation (80 minutes) 99251 – Initial Inpatient Consultation (20 minutes) 99252 – Initial Inpatient Consultation (40 minutes) 99253 – Initial Inpatient Consultation (55 minutes) 99254 – Initial Inpatient Consultation (80 minutes) 99255 – Initial Inpatient Consultation (110 minutes) 99281 – Emergency Room Visit – straightforward problem focused examination 99282 – Emergency Room Visit – expanded problem focus – low severity 99283 – Emergency Room Visit – expanded problem focus – moderate severity 99284 – Emergency Room Visit – detailed examination – moderate complexity/high severity 99285 – Emergency Room Visit – detailed examination – urgent and comprehensive 99304 – Nursing Facility Assessment Low (30 minutes) 99305 – Nursing Facility Assessment Moderate (40 minutes) 99306 – Nursing Facility Assessment High (50 minutes) 99307 – Subsequent Nursing Facility Care (10 minutes) 99308 – Subsequent Nursing Facility Care (15 minutes) 99309 – Subsequent Nursing Facility Care (25 minutes) 99310 – Subsequent Nursing Facility Care (35 minutes) 99315 – Nursing Facility discharge day management (up to 30 minutes) 99316 – Nursing Facility discharge day management (greater than 30 minutes) 99318 – E&M N/E Annual Nursing Facility (30 minutes) 99324 – Domiciliary or rest home visit for the evaluation and management of a new patient (20 minutes) 99325 – Domiciliary or rest home visit for the evaluation and management of a new patient (30 minutes) 99326 – Domiciliary or rest home visit for the evaluation and management of a new patient (45 minutes) 99327 – Domiciliary or rest home visit for the evaluation and management of a new patient (60 minutes) 99328 – Domiciliary or rest home visit for the evaluation and management of a new patient (75 minutes)

• Attending Physician and E&M Codes (cont.)	99334 – Domiciliary or rest home visit for the evaluation and management of an established patient (15 minutes) 99335 – Domiciliary or rest home visit for the evaluation and management of an established patient (25 minutes) 99336 – Domiciliary or rest home visit for the evaluation and management of an established patient (40 minutes) 99337 – Domiciliary or rest home visit for the evaluation and management of an established patient (60 minutes) 99341 – Home visit, new patient; low severity (20 minutes) 99342 – Home visit, new patient; moderate severity (30 minutes) 99343 – Home visit, new patient; moderate to high severity (45 minutes) 99344 – Home visit, new patient; high severity (60 minutes) 99345 – Home visit, new patient; high severity (75 minutes) 99347 – Home visit, established patient; stable (15 minutes) 99348 – Home visit, established patient; low severity (25 minutes) 99349 – Home visit, established patient; moderate severity (40 minutes) 99350 – Home visit, established patient; high severity (60 minutes) 99383 – Inpatient History and Physical – initial (5-11 years) 99384 – Inpatient History and Physical – initial (12-17 years) 99385 – Inpatient History and Physical – initial (18-39 years) 99386 – Inpatient History and Physical – initial (40-64 years) 99408 – Alcohol/substance abuse (other than tobacco) screening & brief intervention (15-30 minutes) 99409 - Alcohol/substance abuse (other than tobacco) screening & brief intervention (greater than 30 minutes)

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, 2019	Annual review
September, 2018	Clarifying eligible charges
April, 2018	Annual review
March, 2016	New