



Inappropriate Primary Diagnosis Codes Reimbursement Policy

Policy Number	2020RP505A	Annual Approval Date	6/25/2020	Approved By	Optum Behavioral Reimbursement Committee
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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, 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, 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 ensure accurate and appropriate claims processing in accordance with industry standards. This policy identifies diagnosis codes, which should never be billed as primary or billed alone on a CMS-1500 claim form or its electronic equivalent.

Reimbursement Guidelines

Optum Behavioral Health will deny claims where an inappropriate diagnosis is pointed to or linked as primary in box 24E (Diagnosis Pointer) on a CMS-1500 claim form or its electronic equivalent. When a code on the Inappropriate Primary Diagnosis List is pointed to or linked as the primary diagnosis on the claim form, the associated claim line(s) will be denied.

Inappropriate Primary Diagnosis Codes Determination

Optum follows Certificate of Coverage Guidelines. Please refer to the Diagnostics Statistical Manual (DSM) for further clarification to determine appropriate primary diagnosis codes for mental health services and substance-related and addictive disorders.

Claims submitted with either or both of the following will not be reimbursed.

- Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Questions and Answers

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Q: When an inappropriate diagnosis code is pointed to or linked as primary in box 24E on a CMS-1500 claim form or its electronic equivalent and there is more than one claim line, will the entire claim be denied?

A: No. Only the claim line(s) associated with the diagnosis code inappropriately reported as primary in box 24E will be denied by this policy.

Resources

- Diagnostic and Statistical Manual of the American Psychiatric Association
- Centers for Disease Control and Prevention, *International Classification of Diseases, 10th Revision, Clinical Modification*
- UnitedHealthcare Company Generic Certificate of Coverage 2019.

History / Updates

June, 2020

Policy Implementation

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