



Therapy Services Documentation Requirements Reimbursement Policy

Policy Number	2019RP502A	Annual Approval Date	3/27/2019	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 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

In order to ensure accurate and appropriate claims processing, Optum may request access to treatment record documentation. You are required to maintain high quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request. Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its Payors, Customers, Clinicians, and Facilities.

Reimbursement Guidelines

Documentation Guidelines for Group Therapy;

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
 - Full name of member on each page
 - Date of Service
 - Date and legible identity of the provider with credentials
 - Start and stop times or total time of session for time based codes
 - Subject covered in group
 - Therapy Intervention Techniques
 - Patients progress, response to treatment
3. Changes in treatment and revision of diagnosis, if applicable.
4. The procedure code and ICD-10 codes reported on the health insurance claim should be supported by the documentation in the medical record.

Documentation Guidelines for Family Therapy;

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
 - Full name of member
 - Date of Service
 - Date and legible identity of the provider with credentials
 - Start and stop times or total time of session for time based codes
 - Relationship Identification as to who in the family attended
 - Therapy Intervention Techniques
3. The Patients progress, response to and changes in treatment and revision of diagnosis, if applicable.
4. The procedure code and ICD-10 codes reported on the health insurance claim should be supported by the documentation in the medical record.



Documentation Guidelines for Individual Psychotherapy;

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
 - Full name of member on each page
 - Date of Service
 - Date and legible identity of the provider with credentials
 - Start and stop times or total time of session for time based codes
 - Therapy Intervention Techniques
3. The Patients progress, response to and changes in treatment and revision of diagnosis, if applicable.
4. The procedure code and ICD-10 codes reported on the health insurance claim should be supported by the documentation in the medical record.

Resources

- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Provider Express Network Manual

History / Updates

March, 2019	New policy
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