

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.

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Application

This reimbursement policy applies to all health care services billed on CMS 1500 forms and to electronic claim submissions (i.e., 837p) and for claims submitted online through provider portals. This policy applies to all commercial, Medicare and Individual Exchange benefit plan 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

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 listed below are not intended as exhaustive of all relevant codes. Please refer to the Reimbursement Policy links within the policy for further guidance regarding add-on codes

Primary CPT Codes	Add-On Code
90791, 90792, 90832, 90833*, 90834, 90836*, 90837, 90838*, 90853,	90785
96158	96159
96164	96165
96167	96168

96170	96171
99202-99205 99211-99215 99221-99223 99231-99236 99238-99239 99304-99310, 99315-99316 99341-99350	90833
99202-99205 99211-99215 99221-99223 99231-99236 99238-99239 99304-99310, 99315-99316 99341-99350	90836
99202-99205 99211-99215 99221-99223 99231-99236 99238-99239 99304-99310, 99315-99316 99341-99350	90838
90839	90840
90832, 90834, 90837	90863

* *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](#)

For further information regarding OTP services and Add-On Codes please refer to the [Opioid Treatment Program Reimbursement Policy](#)

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.
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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 and when the description of the code has key phrases such as "list separately in addition to", "each additional" and "done at the time of other major procedure". 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.
3	Q: Why does Optum have some Add-on codes listed as primary in the Add-On to Primary Code Relationship List? A: CPT® indicates in the parentheses of some Add-on codes, that those codes must be reported in conjunction with other codes that can include Add-on codes. Optum will indicate an Add-on code that must be reported as primary to another by adding it to the primary column. An appropriate primary code would still be required when reporting both Add-on codes.

Resources
American Medical Association, <i>Current Procedural Terminology</i> (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, 2025	Annual Anniversary Review; Added link to OTP Reimbursement Policy for reference regarding Add-On Codes; Updated Application Section added IFP LOB; Updated Q&A 1 & added Q&A 3; Archived History/Updates March 2017- May 2022
June, 2024	Annual Anniversary Review; Updated reimbursement guidelines section
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

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