Inappropriate Primary Diagnosis 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.

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

Applicability

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 commercial, Medicare, and all Individual Exchange benefit plan, 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 *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5)* 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 Mental Disorders 5th Edition (DSM-5).*

Please refer to CMS applicable ICD-10 Official Guidelines for Coding and Reporting such as Code First or Chapter 15, Pregnancy, Childbirth, and the Puerperium for appropriate exceptions.

Questions and Answers

1	**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.
2	**Q:** What does Optum consider for reimbursement during an initial assessment for CPT code 90791 or 90792? **A:** Optum would consider reimbursement for an initial assessment for any valid and appropriate ICD-10 Diagnosis. For any additional mental health services after the initial assessment Optum requires a covered behavioral health ICD-10 diagnosis.

Resources

- Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5).
- Centers for Disease Control and Prevention, *International Classification of Diseases, 10th Revision, Clinical Modification*
- UnitedHealthcare Company Generic Certificate of Coverage 2021.

History / Updates	
December, 2024	Anniversary Review; Updated applicability Section
December, 2023	Anniversary Review; No updates
July, 2023	Add Q&A 2
December, 2022	Anniversary Review; No Updates
November, 2021	Anniversary Review; added additional source lCD-10 Official Guidelines for Coding and Reporting ink for “code first” exceptions
June, 2020	Policy Implementation