Professional/Technical Component Reimbursement Policy					
Policy Number	2018RP501A	**Annual Approval Date**	8/15/18	**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, clinical rationale, industry standard reimbursement logic, regulatory issues, business issues and other input in developing reimbursement policy may apply.*

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.

Optum uses a customized version of the Claim Editing System known as iCES Clearinghouse to process claims in accordance with our reimbursement policies.

**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 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

The purpose of this reimbursement policy is to ensure accurate and appropriate claims processing in accordance with industry standards. This policy describes the reimbursement methodology for Current Procedural Terminology (CPT®) and Healthcare Common Procedural Coding System (HCPCS) codes based on the Centers for Medicare and Medicaid Services (CMS) Professional Component (PC)/Technical Component (TC) indicators and place of service (POS).

Reimbursement Guidelines

Many procedure codes are POS comprised of a technical and/or professional component. For the purposes of this policy, a facility place of service reported on a CMS-1500 claim is considered 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 and 61. All other POS are considered non-facility.

For Services furnished in a Facility POS 19, 21, 22, 23, 26, 34, 51, 52, 55, 56, 57 or 61
Any services that are provided in a facility POS and have both a Professional Component and a Technical Component according to the CMS PC/TC indicators shall be considered for reimbursement. Optum will reimburse the interpreting physician or other qualified health care professional only the Professional Component. For example, charges billed by a single daily E/M code as clinically appropriate, as the facility is reimbursed for the Technical Component of the service.

It is never appropriate for the technical and professional components to be unbundled and reported separately under the same TIN number (whether on separate line items of a single claim or on separate claims). When determining if the technical and professional components were performed by the "same provider" or by different providers, if both components will be billed under the same tax ID number (TIN) then both components were performed by the same provider and are not eligible to be reported as separate components.

When the service is furnished to a facility, the facility bills the technical component, which includes the cost of equipment, supplies, technician salaries, etc. The facility must bill for the technical component portion of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory or other provider. Therefore, if a specimen (e.g., tissue, blood, urine) is taken from a facility, the facility or technical component (TC) of the diagnostic test must be billed by the facility. Only in cases where the patient leaves the hospital and obtains the service elsewhere is the facility not required to bill for the service.

For services furnished to a facility, the physician may bill only for the professional component. This requirement applies even if the service for a hospital patient is performed in a physician's office. If the attending physician is not paid by the facility for services but will instead be submitting a claim separately, the physician may bill only for the E/M code (professional component).

Facility Place of Service Codes (The following list of POS codes is provided for reference purposes only and may not be all inclusive)

POS Code	Description
19	Off Campus-Outpatient Hospital
21	Inpatient Hospital
22	On Campus-Outpatient Hospital
23	Emergency Room – Hospital
26	Military Treatment Facility
34	Hospice
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility

61	Comprehensive Inpatient Rehabilitation Facility

Resources
American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Centers for Medicare and Medicaid Services, Place of Service Code Set

History / Updates	
May, 2022	Anniversary Review; No Updates
May,2021	Anniversary Review; Reimbursement guidelines updates
May, 2020	Anniversary Review
August, 2018	New