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New Medicare Coverage of Intensive Outpatient Program (IOP) Services

3/13/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

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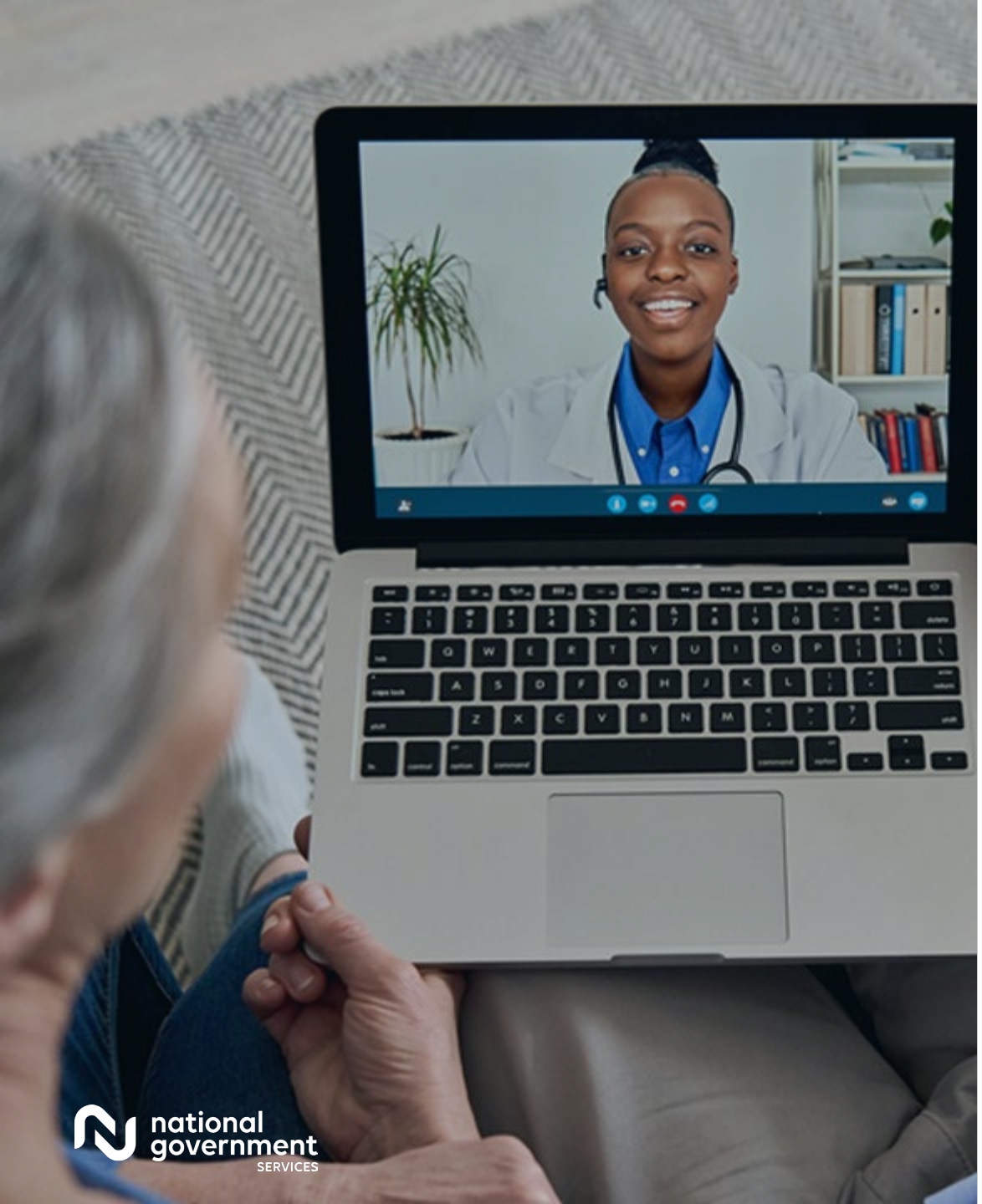

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Objective

Gain an understanding of the new “Intensive Outpatient Program”

Today's Presenter

- Provider Outreach and Education Consultant

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Agenda

- Overview
- Coverage
- Billing
- FQHC/RHC/OTP
- Resources

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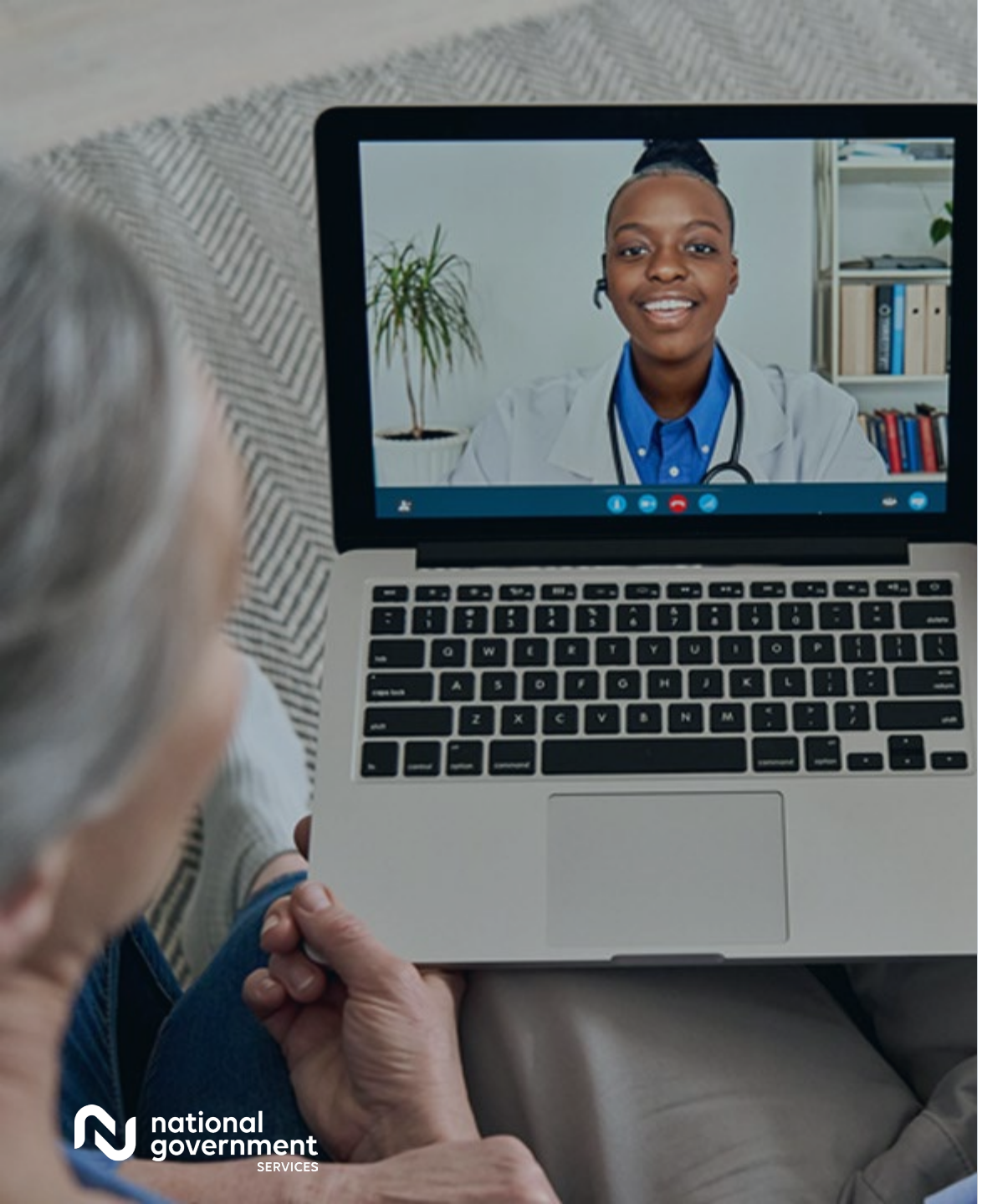
Outpatient Hospital Psychiatric Services

- Hospitals provide wide range of psychiatric services to outpatients needing psychiatric care
  - One or more individual services up to comprehensive, full-day programs (e.g., PHP)
  - May be intensive or primarily supportive
- General coverage
  - Reasonable and necessary for diagnosis or treatment of patient's condition
  - Physician supervision and evaluation
  - Services provided incident to physician's service
  - Individualized treatment plan
  - Beneficiary must have Medicare Part B coverage



Medicare Coverage of Outpatient Psychiatric Services

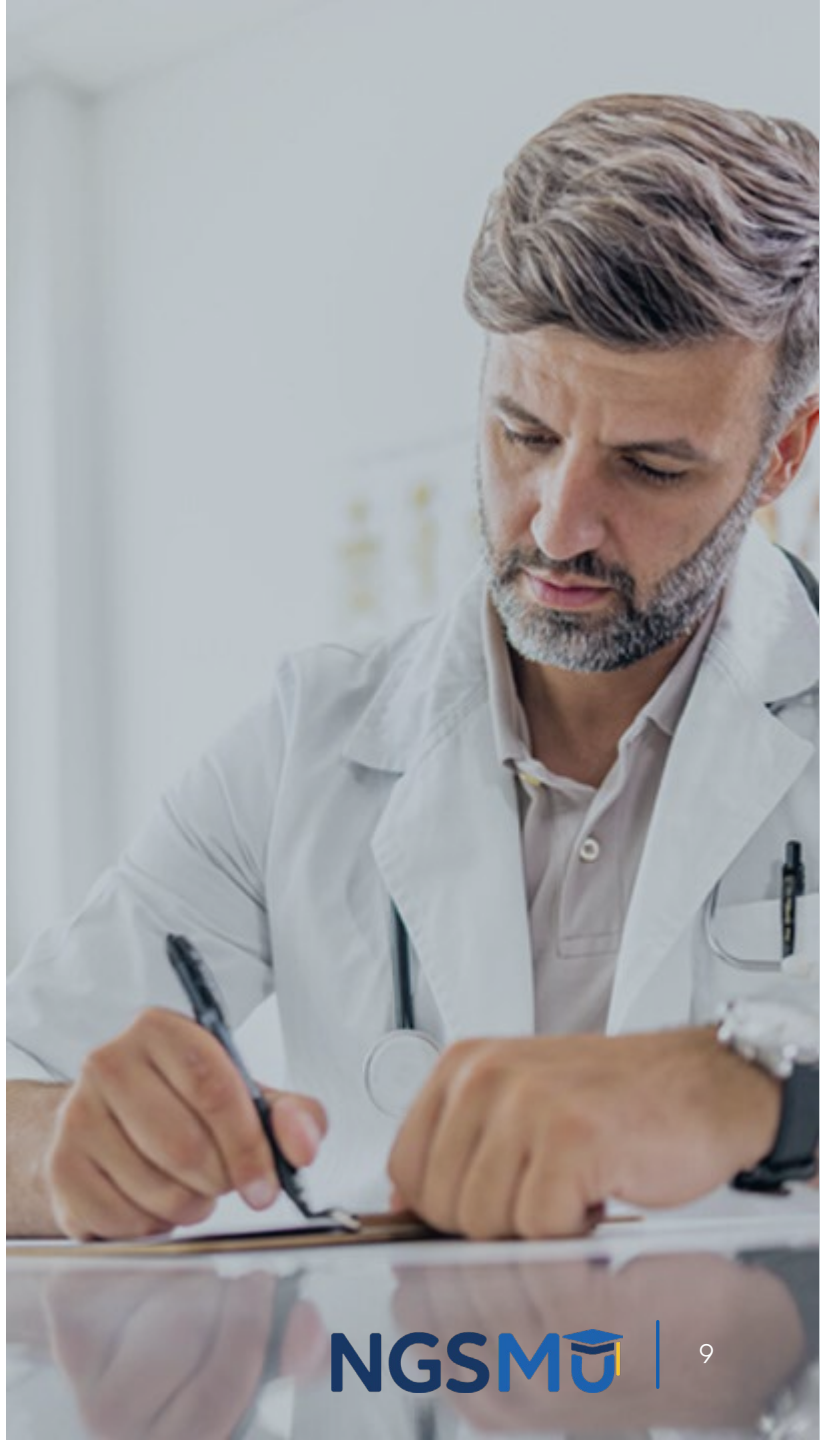
- Medicare covers
  - Inpatient psychiatric services
  - PHP services
  - Outpatient therapy for behavioral health conditions
- Effective 1/1/2024, Medicare covers Intensive Outpatient Program (IOP)
  - Closes coverage gap for patients requiring more intense services than traditional outpatient therapy but less than inpatient-level care or PHP would provide

Community Continuum

- IOP works best as part of community continuum of care ranging from the most restrictive (inpatient hospital) to less restrictive outpatient care and support
- IOP objectives should focus on ensuring important community ties and closely resemble real-life experiences of the patients served

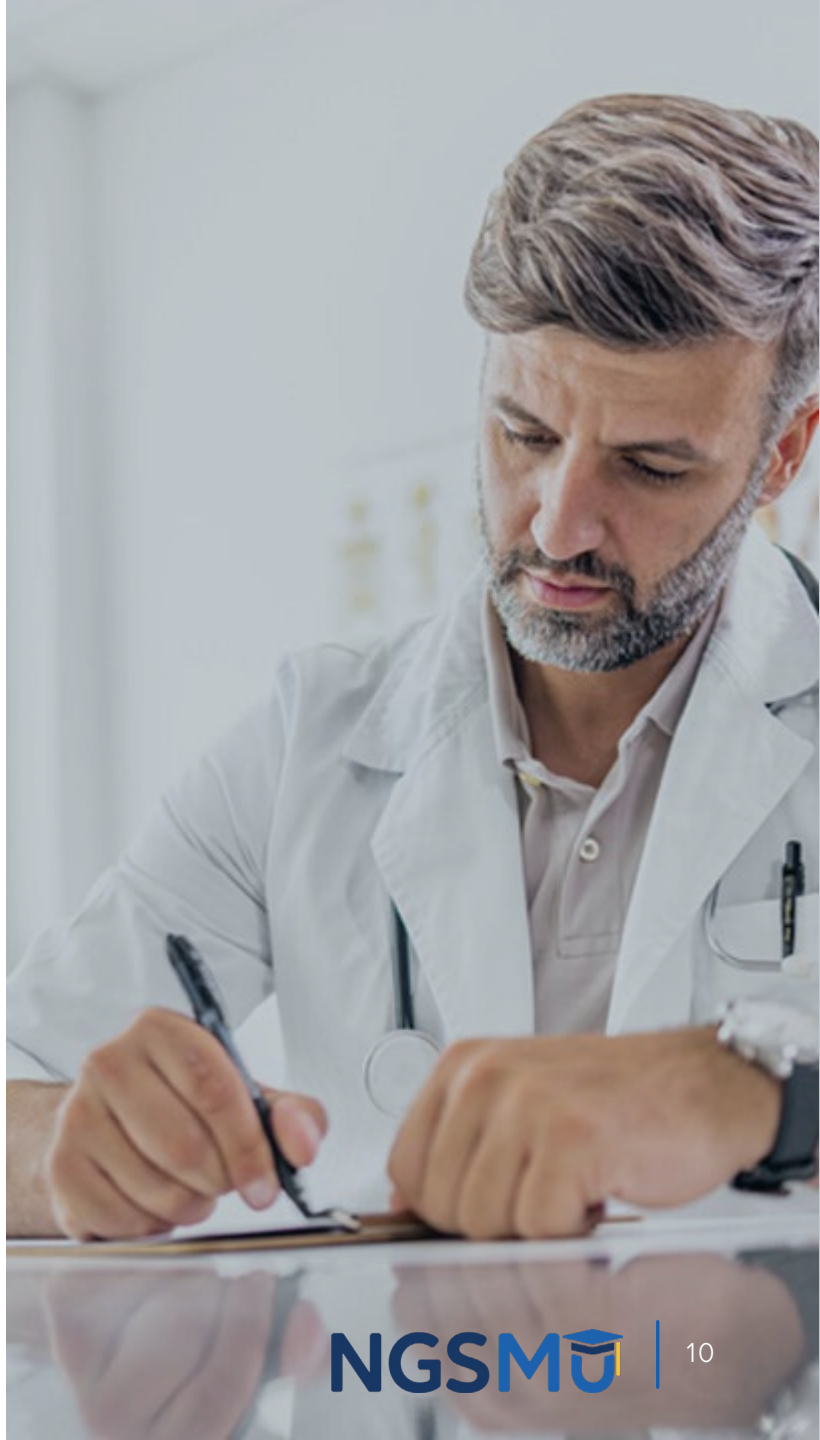
Intensive Outpatient Program

- Distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness
  - Includes/not limited to conditions such as depression, schizophrenia, and substance use disorders
- Consists of specified group of behavioral health services paid on per diem basis under the OPPS or other payment system, as applicable
- Services are defined in SSA Section 1861



Intensive Outpatient Program

- Structured
- Active treatment
- Individualized treatment plan and treatment goals
- Multidisciplinary team approach
- High degree of structure and scheduling
- Use combination of clinically recognized items and services Treatment level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than PHP
- Reminder: Programs providing primarily social, recreational, or diversionary activities are not IOP



Coverage

IOP Providers

- Consolidated Appropriations Act of 2023 (CAA, 2023). Section 4124: Effective 1/1/2024, Medicare coverage and payment provided for IOP services for individuals with mental health needs when furnished by:
  - Hospital outpatient departments (HOPD): 013X TOB
  - Critical Access Hospital (CAH) outpatient department: 085X TOB
  - Community Mental Health Centers (CMHCs): 076X TOB
  - Federally Qualified Health Centers (FQHCs): 77X TOB
  - Rural Health Clinics (RHCs): 071X TOB
  - Opioid Treatment Programs (OTPs) for the treatment of opioid use disorder (OUD): 013X (HOPD), 085X (CAH), TOB 087X (Free-Standing Opioid Treatment Program Facility

Intent of IOP

- Diagnosis and active, intensive treatment of individual's serious presenting psychiatric and/or substance use disorder (SUD) symptoms
- IOP services should reasonably be expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization
  - **Note:** Medicare requires evidence (medical record documentation) when continued IOP treatment is necessary to maintain a stable psychiatric condition or functional level where less intensive treatment options cannot provide the level of support necessary to maintain the patient and to prevent relapse or hospitalization

Criteria for IOP 1

- IOP patient must
  - Have acute dysfunction or decompensation due to mental disorder, including SUD, that severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning.
    - ✓ Impairment severe enough to require comprehensive, structured, multimodal treatment requiring medical supervision and coordination
    - ✓ Be able to benefit from participating in active treatment program
  - Not require supervision 24-hours per day nor inpatient care
    - ✓ Must require fewer hours of services per week than PHP
  - Have adequate support system to sustain/maintain themselves outside the IOP, and must not be an imminent danger to themselves or others
  - Be able to tolerate the intensity of an IOP program and be cognitively and emotionally able to participate in active treatment

Criteria for IOP 2

- Physician must certify/recertify beneficiary's need for IOP
- Physician recertification must address continuing serious nature of the patients' psychiatric condition requiring active treatment in an IOP
- Individualized treatment plan must be completed
  - Structured, multimodal active treatment program effective on/after 1/2024
- Diagnosis: Acute onset or decompensation of covered Axis I mental disorder which severely interferes with multiple areas of daily life

Criteria for IOP 3

- IOP active treatment must be vigorous and proactive; not passive and/or custodial
  - Must be evidenced in individual treatment plan and progress notes

IOP Treatment Program Covered Services 1

- Medically necessary diagnostic services related to mental health treatment (including SUD)
- Drugs and biologicals furnished for therapeutic purposes
  - Not covered: Drug that can be self-administered
- Individual or group psychotherapy
  - Physicians, psychologists, or other mental health professionals authorized/licensed by state (e.g., licensed clinical social workers, mental health counselors, marriage and family therapists, clinical nurse specialists, certified alcohol and drug counselors)
- Occupational therapy (OT) requiring skills of qualified OT therapist
  - OT, if required, must be component of physician's treatment plan for specific patient

IOP Treatment Program Covered Services 2

- Services rendered by social workers, trained psychiatric nurses, and other staff trained to work with psychiatric or SUD patients
  - ✓ Includes principal illness navigation services provided by auxiliary staff, including peer support specialists
- Family counseling when primary purpose is treatment of the patient's condition
  - ✓ Includes counseling services for caregivers
- Training and education when activities are closely and clearly related to patient's care and treatment of his/her diagnosed psychiatric condition
  - ✓ Includes caregiver training services when furnished for patient's benefit
- Individualized activity therapies that are not primarily recreational or diversionary
  - ✓ Must be individualized and essential for treatment of patient's diagnosed condition and for progress toward treatment goals

Not Covered as IOP 1

- Services to hospital inpatients
- Patient cannot, or refuses, to participate (due to behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate IOP intensity
- Treatment of chronic conditions without acute exacerbation of symptoms that would place the individual at risk of relapse or hospitalization
- Social, vocational training, recreational, or diversionary activities such as day care, custodial, respite care, or programs that maintain psychiatric wellness where there is no risk of relapse or hospitalization

Not Covered as IOP 2

- Meals, self-administered medications, transportation; including psychiatrically stable or require only medication management
- Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature
- Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered
- FYI: Patient not requiring an IOP, PHP, or inpatient level of care may be candidates for medically necessary psychiatric/SUD individual psychiatric professional services such as those by a psychiatrist or psychologist

Initial IOP Physician Certification

- Physician must certify need for IOP, including signature, upon admission
  - Signature must be by physician treating patient and has knowledge of patient's response to treatment
  - Patient requires minimum of nine hours of IOP services per week
  - Need for intensive, structured combination of services provided by IOP that constitutes active treatment necessary to appropriately treat patient's presenting psychiatric/SUD condition
  - Identify diagnosis and clinical need for IOP

Physician Recertification of IOP

- Required at intervals established by provider
  - Recertification is **required at least every 60 days** after initial IOP certification
- Must be signed by treating physician with knowledge of patient's response to treatment
- Must specify patient:
  - Requires a minimum of nine hours of mental health treatment services per week
  - Has continuing serious nature of psychiatric and/or SUD symptoms requiring continued active treatment in IOP
  - Response to therapeutic interventions provided by IOP
  - Treatment goals for coordination of services to facilitate discharge from the IOP

Treatment Plan

- Must be individualized, written, and periodically reviewed by physician
- Include
  - Services must be established, prescribed and signed by physician
    - ✓ Diagnoses specified
    - ✓ Provided under an individualized written treatment plan established by a physician after any needed consultation with appropriate staff members
  - Reflect active treatment
    - ✓ Provided via a combination of structured, intensive services that are reasonable and necessary to treat the serious presenting psychiatric and/or SUD symptoms and prevent relapse or hospitalization
  - Include a multidisciplinary team approach

Treatment Plan 2

- Describes coordination of structured services to meet individual patient's needs
  - ✓ Must state type, amount, frequency, and duration of items and services to be furnished
  - ✓ Include anticipated treatment goals
  - ✓ Directly address presenting symptoms and are basis for evaluating patient's response to active treatment
- Include documentation of ongoing efforts to restore individual to higher level of functioning with goal of
  - ✓ Permitting discharge from IOP or reflect continued need for intensity of active therapy to maintain the individual's condition and functional level and to prevent relapse or hospitalization

- Services not qualified as IOP services
  - Activities that are primarily recreational and diversionary, or provide only a level of functional support that does not treat the serious presenting psychiatric and/or SUD symptoms placing the patient at risk

Progress Notes

- Progress notes must include
  - Signed and dated by person rendering service
  - Description should include nature of the treatment service
  - Patient's response to the therapeutic intervention and its relation to the goals indicated in the treatment plan
- Ensure documentation supports medically necessary covered services were rendered (SSA Section 1833 (e))

Discharge and Discharge Planning

- Discharge may be by either
  - Stepping down to less intensive level of outpatient care when clinical condition improves or stabilizes and IOP is no longer required
  - Stepping up to more intensive level of care such as PHP or an inpatient level of care
- IOP discharge planning should ensure coordination of needed services and follow-up care
  - Promote patient's return to higher level of functioning in least restrictive environment
  - Provide linkages to community resources, supports, and providers

Billing & Reimbursement

IOP Requires Condition Code (CC) 92

- CC 92 identifies a claim for services under an Intensive Outpatient Program (IOP) treatment plan for DOS on/after 1/1/2024
  - Applies to OPPS/non-OPPS hospitals (13X), CAH (85X), RHC (71X), FQHC (77X), or CMHC (76X) claims for IOP services
  - CC 92 entered in FL 18-28, or electronic equivalent

Reporting HCPCS/CPT/Revenue Codes

- Hospitals and CAHS must report revenue codes and charges for each individual service furnished
- Hospital Outpatient departments (HOPDs) & CMHCs are required to report HCPCS/CPT codes
  - Hospitals and CMHCs report the number of times the service or procedure, as defined by the HCPCS code, was performed
  - Line-Item DOS (LIDOS) required
- CAHs report the number of times the revenue code visit was performed
  - CAHs are not required to report HCPCS/CPT codes; LIDOS not required

HCPCS/CPT Code Reporting/Documentation

- OPPS, CAH, and CMHC claims must report a revenue code and charge for each service billed
  - Revenue code 0250 does not require HCPCS/CPT codes
    - ✓ Service units not required
- Providers must retain documentation to support the medical necessity of each service provided
  - Include documentation of beginning and ending time for each service
- When HCPCS/CPT code definition does not include any reference to time (no minutes, hours, or days)
  - Do not bill for sessions of less than 45 minutes

Revenue Code Descriptions

Revenue Code	Description	Revenue Code	Description
0250	Drugs & Biologicals	0914	Individual psychotherapy
043X	Occupational therapy	0915	Group therapy
0900	Behavioral/mental health treatment/services	0916	Family psychotherapy
0904	Activity therapy	0918	Behavioral health/Testing
0905	Intensive outpatient psychiatric services (CMHC/FQHC/RHC)	0942	Education/Training
0906	Chemical dependency - Intensive outpatient services (OTP)		

Revenue Code to HCPCS/CPT Code

Revenue Code	HCPCS/CPT Code	Revenue Code	HCPCS/CPT Code
043X	G0129	0915	G0410, G0411, 90853
0900	90791 or 90792, 97153, 97154, 97155, 97156, 97157, 97158	0916	90846, 90847, 90849
0904	G0176	0918	96112, 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96156, 96158, 96161, 96164, 96167, 97151, 97152
0914	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90865, 90880, 90899	0942	G0023, G0024, G0140, G0146, G0177, G0451, 96202, 96203, 97550, 97551, 97552

- CAH: Not required to report HCPCS/CPT codes

Line-Item DOS (LIDOS) Requirement

- LIDOS required when IOP services are provided on more than one day in billing period
  - Identify DOS for each CPT/HCPCS code (Exception: CAH)
    - ✓ Report in FL 45 “Service Date” (or electronic equivalent) Format: MMDDYY
    - ✓ Repeat each service (revenue code) on a separate line item with date service was provided for every occurrence
  - Example: Group therapy services provided twice during a billing period

Revenue Code	CPT/ HCPCS Code	DOS	Units	Total Charges
0915	G0410	20240105	1	$80
0915	G0410	20240129	2	$160

Sequential (Interim) Billing 1

- Medicare enforces consistency editing for sequential (interim) billing of claims for IOP services
- Sequential billing requires claims submission in DOS order
  - Applies to TOBs:
    - ✓ 13X (hospital outpatient); 85X (CAH); 76X (CMHC)
- Prior claim must finalize before next claim submitted in sequential order
- Patient status code should be 30 (still a patient) for interim IOP claims
- Final claim in series will include appropriate discharge status code applicable to discharge

Sequential (Interim) Billing 2

- Must bill appropriate frequency digit in TOB
  - TOB XX1 = Admit though discharge claim
    - ✓ Examples: 0131, 0851, 0711, 0761, 0771, 0871
  - TOB XX2 = First in a series of claims
    - ✓ Examples: 0132, 0852, 0712, 0762, 0772, 0872
  - TOB XX3 = Claim for continuing course of treatment
    - ✓ Not admission or discharge claim
    - ✓ Examples: 0133, 0853, 0713, 0763, 0773, 0873
  - TOB XX4 = Last claim in a series/discharge claim
    - ✓ No additional IOP services are anticipated
    - ✓ Examples: 0134, 0854, 0714, 0764, 0774, 0874

Sequential (Interim) Billing 3

- Claims submitted out of sequence will be returned to the provider (RTP) for correction
  - Submit claim(s) for earlier DOS first
  - When that claim is finalized, then resubmit the out of sequence claim
- Claim for IOP services (CC 92) RTP when Medicare's history files include claim with CC 92 and LIDOS within seven days prior to "from date" for incoming claim for same patient and provider
- Medicare validates initial IOP claim is submitted as
  - TOB 131 or 132 (outpatient hospital)
  - TOB 851 or 852 (CAH)
  - TOB 761 or 762 (CMHC)

Same Day Services

- Hospital (13X; 85X) rendering non-IOP mental health services to an IOP patient
  - All IOP and non-IOP mental health services must be reported on same claim with CC 92
- Hospital rendering electroconvulsive therapy (ECT) on same day as IOP, report on one IOP claim (with CC 92)
  - All charges/supplies associated supplies for ECT and IOP furnished on same date on same claim

Prevent Processing Issues

- IOP claim must not include both CC 92 and CC 41
- IOP claims (examples: TOB 013x, 076x, and 085x) with CC 92 must not overlap PHP claims with CC 41
- CMHC provider (TOB 076x) must not bill IOP claim with CC 92 and separate PHP claim with/without CC 41 for overlapping periods of time (RTP)
  - CMHC (076X) claim billed with CC 41 processes as PHP
  - CMHC (076X) claim billed with CC 92 processes as IOP

Reminder: Off-Campus PBD Billing Requirement 1

- IOP services rendered at off-campus provider-based hospital outpatient department and CMHC
  - PO modifier: Grandfathered/excepted off-campus practice location (location effective date prior to 11/2/2015)
    - ✓ Required on each claim line for excepted off-campus provider-based departments
  - PN modifier: Non-grandfathered/non-excepted off-campus practice location (location effective date on/after 11/2/2015)
    - ✓ Required on each claim line for non-excepted off-campus provider-based departments
- SE19007 specifies for the 837 institutional claim transaction:
  - Report the billing provider address only in the billing provider loop 2010AA
  - When services are rendered at for an off-campus, outpatient, provider-based department of a hospital

Reminder: Off-Campus PBD Billing Requirement

- Address reporting
  - Report the billing provider address only in the billing provider loop 2010AA
  - When services are rendered at for an off-campus, outpatient, provider-based department of a hospital
    - ✓ Report off-campus service facility address in 2310E loop
    - ✓ DDE submitters report off-campus service facility address in MAP 171F screen
  - CMS Resource
    - ✓ Centers for Medicare and Medicaid Services Internet-Only Manual Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Sections 20.6.11, 20.6.12, 20.6.18, 26
  - NGS articles:
    - ✓ Attention All OPPS Providers: Provider-Based Department Edits Being Implemented on/after 8/1/2023
    - ✓ URGENT: Billing Reminders for OPPS Providers with Multiple Service Locations

IOP Payment Methodology

- Claims containing CC 92 (IOP) are processed similarly to PHP claims including: APC payment, minimum daily number of services rendered and at least nine hours/week reimbursed
  - Hospitals and CMHCs: OPPS payment methodology
    - ✓ IOP services: Per diem (APC) payment under OPPS when billed by OPPS provider
  - CY 2024: Non-excepted off-campus hospital-based IOPs
    - ✓ Payment per MPFS at CMHC per diem rate for APC 5851 or APC 5852 depending on number of IOP services per day
  - Non-OPPS hospitals: Current payment methodology
  - CAH: 101% of reasonable cost basis
  - Part B deductible, if any, and coinsurance apply

IOP Primary HCPCS Codes - 2024 Additions

- 90832
- 90847
- 90853
- 90880
- 96112
- 96116
- G0411
- 90846
- 96136
- 90834
- G0410
- 90845
- 96138
- 96130
- 90837

Source: Final Summary of Data Changes IOCE v25.0.0 January 2024 or DataHCPCS table (in 2024 I/OCE files)

1/2024 I/OCE: IOP APCs

APC	Description	Payment
5851	CMHC: Intensive Outpatient (up to 3 services/day)	$87.57
5852	CMHC: Intensive Outpatient (4 or more services per day)	$157.42
5861	Hospital-based IOP: Intensive Outpatient (up to 3 services per day)	$259.13
5862	Hospital-based IOP: Intensive Outpatient (4 or more services per day)	$357.83

Note: Part B and any unmet deductible applies

Status Indicator = P for each APC

- P = PHP or IOP - per diem payment under OPPS

ICD-10 Diagnosis

- Claim must include diagnosis code(s) reflecting acute mental illness
- Code first rule applies to IOP
  - When code first applies, Medicare requires mental health diagnosis in first secondary diagnosis position
  - Code first information: 2024 ICD-10-CM Coding Guidelines

Discharge Status Codes 1

- Ensure that the correct patient discharge status code is billed
  - Report patient status code 30 (still a patient) for IOP services billed on a TOB XX2 and XX3 (interim claims)
  - Otherwise, report the patient discharge status code appropriate for the discharge

- Note: Codes used for Medicare claims are available from the National Uniform Billing Committee (NUBC) via the NUBC's Official UB-04 Data Specifications Manual
  - Refer to the NUBC for coding updates

Discharge Status Codes

Value	Description	Value	Description
01	Discharged to home or self-care (routine discharge)	07	Left against medical advice or discontinued care
02	Discharged or transferred to a short-term general hospital for inpatient care	09	Discharged from outpatient care to be admitted to same hospital where patient received outpatient services
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care	20	Expired
04	Discharged/transferred to a facility providing custodial or supportive care (intermediate care facility [ICF])	21	Discharged and transferred to court or law enforcement
05	Discharged/transferred to another type of institution	30	Still a patient
06	Discharged/transferred to home under care of organized home health service organization		

Note: Discharge Status Codes continue on next slide

Discharge Status Codes

Value	Description	Value	Description
41	Expired in a medical facility, i.e., hospital, SNF, ICF or freestanding hospice	62	Discharged/transferred to inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
43	Discharged or transferred to federal health care facility	63	Discharged/transferred to Medicare-certified long term care hospital (LTCH)
50	Hospice – home	64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
51	Hospice – medical facility providing hospice level of care	65	Discharged or transferred to psychiatric hospital or psychiatric distinct part of a hospital (effective for discharges on/after 4/1/2004)
61	Discharged/transferred to a hospital-based Medicare approved swing bed	66	Discharged or transferred to a CAH

FYI: Professional IOP Services 1

- Certain professional services in HOPD are separately covered/paid as professional services and are billed to Part B MAC on 1500/electronic equivalent claim
  - Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis
  - Physician assistant (PA) services as defined in SSA section 1861(s)(2)(K)(i)
  - Nurse practitioner and clinical nurse specialist services, as defined in SSA section 1861(s)(2)(K)(ii)
  - Clinical psychologist services as defined in SSA section 1861(ii)

FYI: Professional IOP Services 2

- Other practitioners' services are bundled (included in the IOP per diem) when furnished to IOP patients
  - Includes: Clinical social workers (CSW), marriage and family therapists (MFT), mental health counselors (MHC), and occupational therapists (OT)
- OPPS hospital must bill Part A MAC for such nonphysician practitioner services as IOP to Part A MAC on 1450/electronic equivalent claim
- CAH Method II facilities bill certain professional services to Part A on 1450/electronic equivalent claim

FYI: IOP and Telehealth

- Originating site facility fee (Q3014): Not an IOP service
  - Does not count toward number of services required for IOP payment
- CMHC: Remote mental health services not allowed

FQHC/RHC/OTP

FQHC/RHC: IOP Scope of Benefits 1

- Individual and group therapy with physicians, psychologists or other mental health professionals to the extent authorized under state law
- Occupational therapy by a qualified occupational therapist or under appropriate supervision of a qualified occupational therapist by an occupational therapy assistant
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients
- Drugs and biologicals provided for therapeutic purposes, which can't be self-administered

FQHC/RHC: IOP Scope of Benefits 2

- Individualized activity therapies that aren't primarily recreational or diversionary
- Family counseling, the primary purpose of which is treatment of the patient's condition
- Patient training and education to the extent that training and educational activities are closely and clearly related to the patient's care and treatment
- Diagnostic services
- Note: Certain IOP services are not payable as RHC or FQHC services
  - Example: Group therapy is an IOP covered service,; however, group therapy is not covered when billed as FQHC or RHC service

FQHC/RHC: List of HCPCS/CPT codes for IOP

- At least one IOP service from List A Primary Services must be included on the claim for payment
  - Refer to Change Request 13264 , Attachment A “IOP Codes and Services” for HCPCS/CPT codes and short descriptors
    - ✓ List A Primary Services
    - ✓ List B Services
  - At least one IOP primary service (List A) must be billed
  - Services on List B are bundled into payment for the primary service

FQHC and RHC

- IOP requirements are the same including (not limited to)
  - Physician certification and plan of care requirements required for IOP furnished in the RHC/FQHC setting require physicians to certify that an individual needs IOP services for a minimum of nine hours per week of therapeutic services as evidenced in their plan of care
  - Certification must include documentation that individual requires such services for a minimum of nine hours per week
- Specific to FQHC/RHC:
  - Physician recertification must occur no less frequently than every other month

FQHC/RHC IOP Billing

- FQHC and RHC must
  - Report condition code 92 for IOP services
  - Bill IOP services with revenue code 0905
  - Report at least one primary IOP service per day (List A Primary Service)
    - ✓ RTP without one primary IOP service/day
  - Report charges on primary service line for all IOP services furnished that day to be included in the calculation for coinsurance
- RHC must report CG modifier on payment line along with charges
  - Ensures coinsurance is calculated
- FQHC payment code and qualifying visit code is not required for IOP

FQHC: Multiple Visits on Same Day 1

- Currently, encounters with more than one health professional and multiple encounters with the same health professional on the same day and same location constitute a single visit, except when a patient has:
  - A medical visit and a mental health visit on the same day
  - An initial preventive physical exam and a separate medical or mental health visit on the same day

FQHC: Multiple Visits on Same Day 2

- IOP services furnished on same day as mental health visit
  - FQHC receives one payment at IOP rate
    - ✓ Mental health visit is included in IOP payment
- IOP services furnished on same day as medical visit
  - FQHC receives two payments
    - ✓ One payment is for the medical visit under the FQHC PPS
    - ✓ One payment is for the IOP services at the IOP rate.
- Note:
  - Bill IOP services with revenue code 0905
  - Do **not** report IOP services with revenue code 0900; continue to report mental health services with revenue code 0900

FQHC/RHC Payment for IOP

- Costs associated with IOP services furnished by RHCs and FQHCs is not be used to determine payment amounts under the RHC all-inclusive rate (AIR) methodology or FQHC prospective payment system (PPS)
- FQHC payment for IOP: Based on the lesser of actual charges or the three-services per day payment amount
  - Payment based on three services per day; hospital based per diem is $259.13
  - FQHC coinsurance is based on the lessor of the IOP rate or the submitted charges
- RHC payment for IOP services: Payment rate is $259.13
  - Payment based on three services per day; hospital based per diem is $259.13

FQHC Supplemental Payment for IOP

- FQHC supplemental payment
  - FQHCs that contract with MA organizations must be paid at least the same amount as would have received for the same service under FQHC PPS (SSA Section 1833(a)(3)(B)(i)(II))
    - ✓ Medicare provides wrap-around payment to cover any difference in payment when MAO contract rate is less than wat Medicare would pay for FQHC services
    - ✓ IOP services are FQHC services; therefore, IOP services are included as part of the wrap-around payment policy

Medicare Enrolled OTPs offering IOP

- CY 2024 OPPS Final Rule establishes weekly payment adjustment for IOP provided by an OTP for opioid use disorder treatment
  - OTPs reimbursed via bundled payments for OUD treatment services
  - OTPs billing IOP must furnish services as part of distinct and organized intensive ambulatory treatment program for the treatment of OUD
    - ✓ Part of a program offering less than 24-hour daily care that is not in patient's home, residential setting, or inpatient
  - G0137 (add-on code) describes IOP services when episode of care lasts seven continuous days
    - ✓ Physician/NPP must certify that patient requires minimum of nine hours of services per week and requires a higher level of care intensity compared to other non-OTP services
    - ✓ Must also meet requirements for certification, plan of treatment, and recertification requirements

Medicare Enrolled OTPs offering IOP: Billing Threshold

- Threshold to bill HCPCS code G0137 (once per week) for OTP services: Minimum of nine services furnished over seven-continuous day period
  - Regardless of the length or time duration of these services
  - Must be medically reasonable and necessary
  - Must not be duplicative of any service paid for under any bundled payments billed for an episode of care in a given week
  - Do not count an IOP service for the purposes of the nine-service threshold if that same service is being used to qualify for billing other weekly bundles and add-on codes under the OTP benefit
  - IOP care must be provided in person
  - Not reimbursed: Services furnished by audio-video/audio-only communication

Resources

Resources 2

- Section 4124 of Division FF of the Consolidated Appropriations Act (CAA) 2023
- CMS Fact Sheet: CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1786-FC)
- CY 2024 OPPS Final Rule (CMS-1786-FC)
- CY 2024 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System final rule

Resources 3

- NGS article, 1/5/2024, "Intensive Outpatient Program"
- L33632: LCD for Psychiatry and Psychology Services
  - A56937: Billing and Coding: Psychiatry and Psychology Services
- Change Request (CR) 13496, effective 1/1/2024: "Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92 - Additional Publication Update"
  - CMS IOM Pub. 100-02, *Medicare Benefit Policy Manual*, Chapters 6, 7, 15
  - CMS IOM Pub. 100-01, *Medicare General Information, Eligibility, and Entitlement*, Chapters 1, 4, 5

Resources

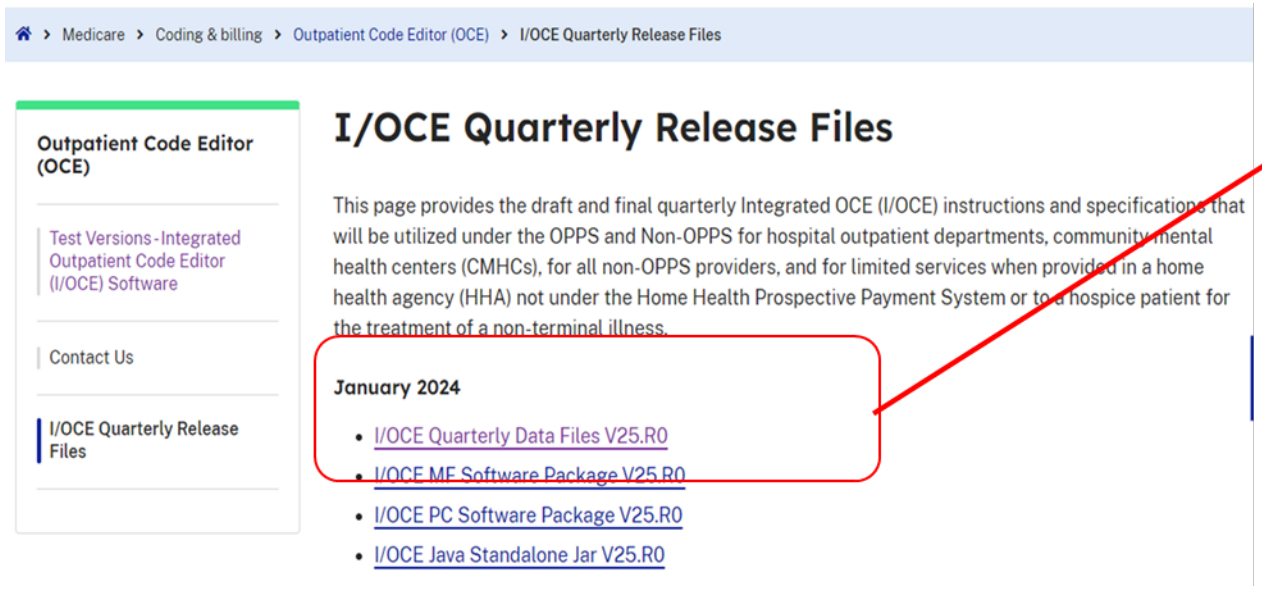
- CR 13264, effective 1/1/2024: "Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with Revenue Code 0905 for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)"
  - MLN Matters MM13264
- CR 13222, effective 1/1/2024: "Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92"
  - MLN Matters MM13222
- CMS OTP website
- CMS MLN Booklet, *MLN1986542: Medicare & Mental Health Coverage*

Resources 5

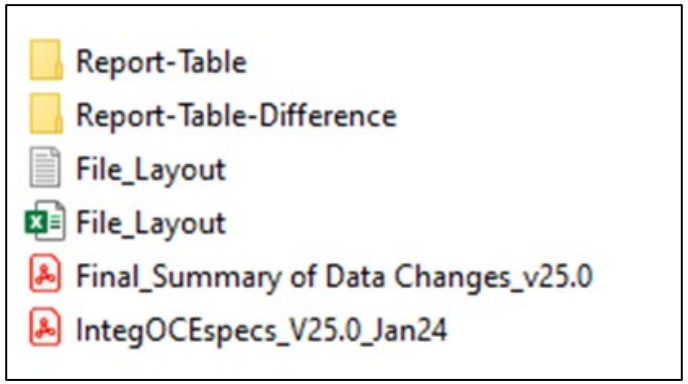
- CR13470, effective 1/1/2024, "Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Opioid Treatment Programs (OTPs)"
  - CMS IOM Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 17
  - CMS IOM Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 39
- CR 13488 "January 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)"
  - CR 13488: CMS IOM Pub. 100-04, *Medicare Claims Processing Manual*
- CR 13456 "January 2024 Integrated Outpatient Code Editor (I/OCE) Specifications Version 25.0"

1/2024 I/OCE Quarterly Release – IOP Details

- 1/2024 I/OCE Quarterly Release Files



Select "I/OCE Quarterly Data Files V25.RO" to download files:



Choose file named: "IntegOCEspecs_V25.0_Jan24"; "Final_Summary of Data Changes_v25.0"

Resources 6

- CMS IOM 100-02, *Medicare Benefit Policy Manual*
  - Chapter 6 – Hospital Services Covered Under Part B
  - Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
  - Chapter 17 - Opioid Treatment Programs (OTPs)
- CMS IOM 100-04, *Medicare Claims Processing Manual*
  - Chapter 1 - General Billing Requirements
  - Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)
  - Chapter 9 - Rural Health Clinics/Federally Qualified Health Centers
  - Chapter 12 - Physicians/Nonphysician Practitioners
  - Chapter 39 - Opioid Treatment Programs (OTPs)

1/4/2024: CMS MLN Connects

- New Condition Code 92: Billing Requirements for Intensive Outpatient Program Services
- Learn about this new condition code (PDF) effective 1/1/2024:
  - Intensive Outpatient Program (IOP) services will get per diem payments under the Outpatient Prospective Payment System (OPPS) when billed by an OPPS provider
  - Medicare covers and pays for these services for people with mental health needs who require this level of care
  - These billing requirements apply when IOP is provided by:
    - ✓ Hospital and critical access hospital outpatient departments
    - ✓ Community mental health centers
- Medicare Administrative Contractors will return your IOP service claim if it:
  - Overlaps partial hospitalization program claims with condition code 41
  - Has a line-item date of service within seven days prior to the “from date” for an incoming claim for the same patient and provider

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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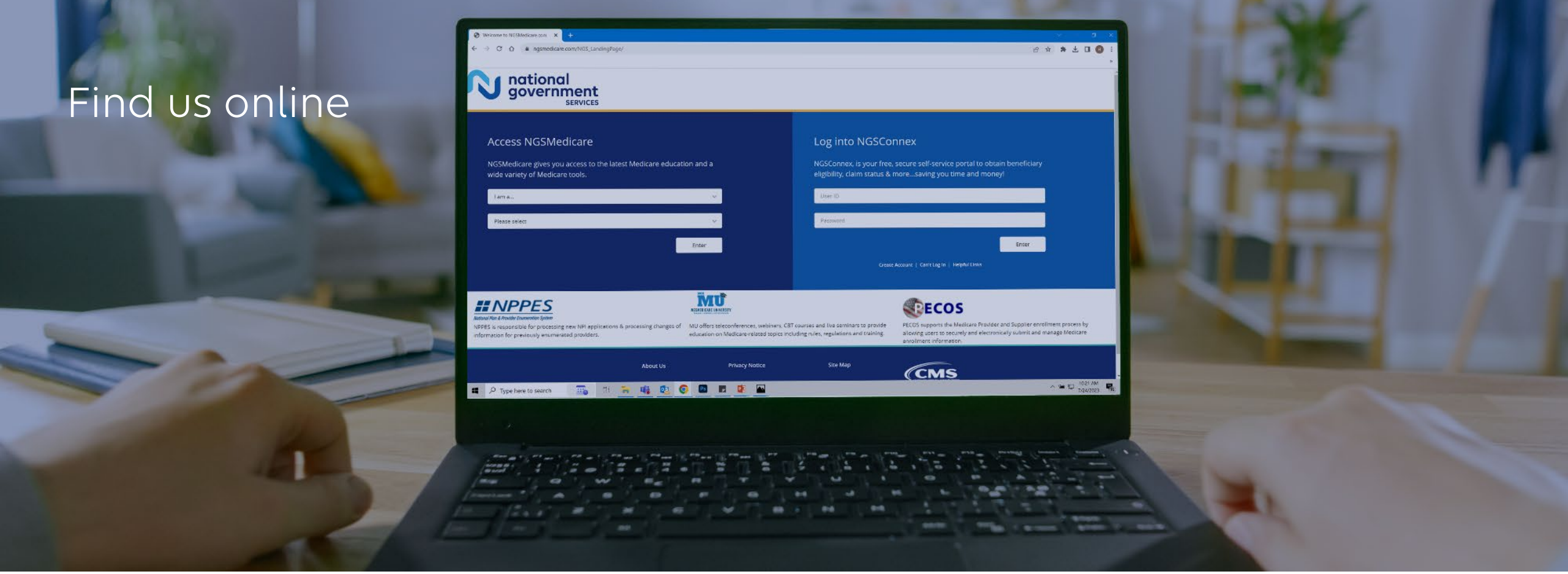

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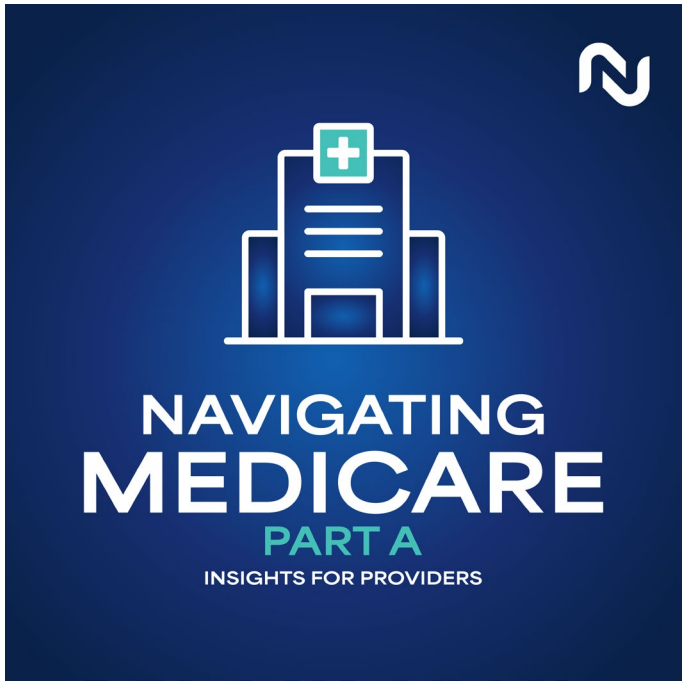

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