REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Intensive Outpatient Program-Behavioral Health-MP-PY-1477	09/01/2024
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.
CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Intensive Outpatient Program – Behavioral Health

B. Background

The Consolidated Appropriations Act of 2023 (CAA, 2023) established Medicare coverage and payment for Intensive Outpatient Program (IOP) services provided on or after January 1, 2024 for individuals with mental health conditions and/or substance use disorder (SUD) needs provided in hospital outpatient departments (HOPD), critical access hospital (CAH) outpatient departments, community mental health centers (CMHC), rural health clinics (RHCs), and federally qualified health centers (FQHCs). IOP services may also be furnished in opioid treatment programs (OTPs) for the treatment of opioid use disorder (OUD).

Per federal guidelines, IOPs incorporate items and services prescribed by a physician for an individual determined, not less frequently than once every other month, to need services for a minimum of 9 hours per week. An IOP is active treatment provided under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician in consultation with appropriate staff participating in the program. In addition to documenting the physician's diagnosis, type, amount, frequency, and duration of the items and services provided to the member, the treatment plan describes a coordination of services wrapped around the needs of the member and includes a multidisciplinary team approach to care. Treatment goals will be measurable, functional, time-framed, directly related to admission reason, and medically necessary.

Items and services provided can include the following:

- individual and group therapy with physicians, psychologists, other mental health professionals to the extent authorized under state law
- occupational therapy requiring the skills of a qualified occupational therapist
- services of social workers, trained psychiatric nurses, and other staff trained to work with members with psychiatric diagnoses
- drugs and biologicals furnished for therapeutic purposes, which cannot, as determined in accordance with regulations, be self-administered
- individualized activity therapies that are not primarily recreational or diversionary
- family counseling with a primary purpose for treatment of the individual's diagnosis, including counseling services for caregivers
- patient training and education to the extent that activities are closely and clearly related to individual's care and treatment
- diagnostic services
- other items and services, in no event to include meals and transportation, that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level, to prevent relapse or hospitalization, and furnished pursuant to guidelines relating to frequency and duration of services established by regulations

(taking into account accepted norms of medical practice and the reasonable expectation of patient improvement)

IOPs for substance use disorders (SUDs) offer services to members seeking primary treatment, step-down care from inpatient, residential, and withdrawal management settings, or step-up treatment from individual or group outpatient treatment. To assist members with fulfilling individualized treatment plan goals, IOP services may incorporate other in-house treatment and peer services, encourage attendance at mutual-support groups, and collaborate with local community providers to secure needed services (eg, medication-assisted treatment, psychological assessments, vocational rehabilitation services, and trauma-specific treatment).

Advantages of IOP treatment have been thoroughly documented in peer-reviewed literature. Day, evening, and weekend programming offers flexibility in treatment delivery and allows clients to maintain responsibilities outside treatment, including work, caregiving, parenting, and education. Less restrictive, comprehensive treatment offers more intensive services than traditional outpatient while avoiding the restrictions of residential treatment. Services are provided over a longer period than most residential treatment programs, and most are available in local communities, creating less disruption for clients managing day-to-day responsibilities. Continuity of care and support are increased as well, as members engaged in IOP treatment often use local community services and mutual-support groups outside the program that remain intact after completing treatment. IOP programs provide opportunities to practice recovery skills in real time, allowing members to apply newly acquired skills with family and friends and in other circumstances while still engaged in treatment.

C. Definitions

- **American Society of Addiction Medicine (ASAM)** – A professional medical society dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.
- **ASAM Intensive Outpatient Level of Care (LOC**) **2.1** – 9 or more hours of SUD treatment services a week (adults) or 6 or more hours (adolescents) to treat multidimensional instability, particularly services meeting complex needs of members with addiction and co-occurring conditions.
- **Concurrent Review** – A request for prior authorization or a predetermination that is submitted before or during the course of receiving a health care service.
- **Intensive Outpatient Program (IOP)** – Behavioral health (BH) services provided by facilities, group practices or clinics at least 3 hours a day, 2 to 3 days a week and usually as a step down from acute inpatient care, partial hospitalization care, or residential care but a step up from traditional outpatient services.
- **Partial Hospitalization** – Structured, multimodal, active treatment for BH needs with a treatment period of less than 24 hours, including individual, group and/or family psychotherapy, member education and training, and diagnostic services focusing on member reintegration into society.

- **Residential Treatment** – Services for BH needs that can include individual, family and group therapy, nursing services, medication assisted treatment, detoxification (ambulatory or subacute), and pharmacological therapy in a congregate living community with 24-hour support.
- **Retrospective Review** – A request for medical review that is submitted after the health care service has been received.

D. Policy

I. Prior authorization is required after 5 days per calendar year. CareSource follows MCG criteria for reviews of medical necessity for mental health requests and ASAM criteria for review of substance use disorder requests.

II. Billing

A. Some professional services are separately covered and unbundled. See section 261 of Chapter 4 of the *Medicare Claims Processing Manual* for additional instructions.

B. Under component billing for IOP services, providers must include the following components for service claims:

1. IOP ambulatory payment classifications (APCs) for each provider type
   a. days with 3 services a day
   b. days with 4 or more services a day
2. Type of bills (TOB) for institutional billing
   a. TOB 13X – outpatient hospital
   b. TOB 85X – critical access hospital (CAH)
   c. TOB 76X – community mental health center (CMHC)
3. Claims must be submitted in sequence for a continuing course of treatment. Consistency editing will be enforced for interim billing of IOP claims.

Definition	TOB	Setting
Admit through discharge	131	13X
	851	85X
	761	76X
Interim – First	132	13X
	852	85X
	762	76X
Interim - Continuing	133	13X
	853	85X
	763	76X
Interim – Last	134	13X
	854	85X
	764	76X

4. Hospitals are required to report a revenue code and the charge for each individual covered service furnished under an IOP, including required Healthcare Common Procedure Coding System (HCPCS) or CPT codes.

Revenue codes can be found in Chapter 4 of the *Medicare Claims Processing Manual, 100-04*.

5. IOP services are identified on claims using condition code 92.
6. When applicable, add on codes may be used following an appropriate initial code.
7. Modifiers, including the following, must be reported:

Modifier	Description
PN	Services provided in non-excepted, off-campus, provider-based departments of a hospital. Use will trigger a payment rate under the Medicare Physician Fee Schedule. PN should be reported with each non-excepted item and service, including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.
PO	Services provided in excepted, off-campus, provider-based departments of a hospital (services, procedures and surgeries provided at off-campus provider-based outpatient departments for all excepted items and services furnished).

8. Providers must report service units, dates of service, and patient status. Discharge status codes can located in Chapter 25 of the *Medicare Claims Processing Manual, 100-04.*

III. The following activities and/or programs are considered not medically necessary:
   A. day care programs providing primarily social, recreational, or diversionary activities, custodial or respite care
   B. programs that maintain psychiatric wellness, in which there is no risk of relapse of hospitalization of member
   C. services for members otherwise psychiatrically stable or requiring medication management only
   D. services to inpatient members at a hospital, including meals, self-administration of medication, transportation, and/or vocational training
   E. members who cannot or refuse to participate in treatment (eg, low cognitive status, volatile behavioral issues) or cannot tolerate the intensity of an IOP
   F. treatment of chronic conditions without acute exacerbation of symptoms that place the member at risk of relapse or hospitalization

E. State-Specific Information

West Virginia - Benefits for the first 5 days of IOP will be provided without any retrospective review of medical necessity. Benefits beginning day 6, and every 6 days thereafter, are subject to concurrent review of medical necessity.

F. Conditions of Coverage

In the event of any conflict between this policy and a provider's agreement with CareSource, the provider's agreement will be the governing document.

G. Related Policies/Rules

Medical Necessity Determinations
Behavioral Health Service Record Documentation Standards

H. Review/Revision History

	DATE	ACTION
Date Issued	05/22/2024	Merged AD-1262 and AD-1261. Converted to PY policy.
Date Revised		
Date Effective	09/01/2024	
Date Archived		

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