CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12392	**Date: December 5, 2023**
	Change Request 13264

Transmittal 12263, dated September 26, 2023 is being rescinded and replaced by Transmittal 12392, dated December 5, 2023, to remove the Sensitive/Controversial disclaimer; in addition, to update the Policy Section to reflect the CY 2024 OPPS Final Rule, adding the final rate for Business Requirement (BR) 13264.2.1, updating BR 13264.3, BR 13264.7, and BR 13264.14 for IOCE/FQHC Pricer, deleting BR 13264.3.1 – BR 13264.3.2 , and updating Primary Services A/B and updates the Attachment A: IOP Codes and Services file. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being recommunicated on December 5, 2023. This may now be posted to the internet.

SUBJECT: Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with Revenue Code 0905 for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the Intensive Outpatient Program (IOP) billing requirements for FQHC and RHCs.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Effective January 1, 2024, section 4124 of the Consolidated Appropriations Act of 2023 (CAA, 2023) establishes Medicare coverage and payment for Intensive Outpatient Program (IOP) services for individuals with mental health needs when furnished by hospital outpatient departments, Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). An IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to conditions such as depression, schizophrenia, and substance use disorders.

Section 4124(c) of the CAA, 2023 requires payment for IOP services furnished by RHCs and FQHCs to be made at the same payment rate as if it were furnished by a hospital. Section 4124(c) of the CAA, 2023 also requires that costs associated with IOP services furnished by RHCs and FQHCs to not be used to determine payment amounts under the RHC all-inclusive rate (AIR) methodology or FQHC prospective payment system (PPS).

Section 1833(a)(3)(B)(i)(II) of the Social Security Act (The Act) requires that FQHCs that contract with MA organizations be paid at least the same amount they would have received for the same service under the FQHC PPS. This provision ensures FQHCs are paid at least the Medicare amount for FQHC services. Therefore, if the MA organization contract rate is lower than the amount Medicare would otherwise pay for FQHC services, FQHCs that contract with MA organizations would receive a wrap-around payment from Medicare to cover the difference. Since section 4124 of the CAA, 2023 defines IOP services as FQHC services, IOP services are included as part of the wrap-around payment policy.

Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations that met the conditions of section 413.65(m) on or before April 7, 2000, and have a change in their status on or after April 7, 2000 from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the Conditions of Participation requirements, could seek to become certified as grandfathered tribal FQHCs. These grandfathered tribal FQHCs are required to meet all FQHC certification and payment requirements. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

The new provisions mandated under section 4124 of the CAA, 2023 requires several changes to the RHC and FQHC policies, including scope of benefits and services, certification and plan of care requirements, and special payment rules for IOP services in RHCs and FQHCs.

B. Policy:
We're implementing the following for RHCs and FQHCs, for services furnished on or after January 1, 2024:

IOP Scope of Benefits

Items and services available under the IOP benefit include the following:

* Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law);

* Occupational therapy with a qualified occupational therapist provided by an 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 furnished for therapeutic purposes, which cannot be self-administered;

* Individualized activity therapies that are not primarily recreational or diversionary;

* Family counseling (the primary purpose of which is treatment of the individual's condition);

* Patient training and beneficiary education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); and

* Diagnostic services.

For a list of IOP services, see Attachment A for both List A Primary Services and List B Services.

Note: There are certain IOP services that are not payable as RHC or FQHC services. For example, group therapy is considered an IOP service and payable via the IOP payment amount but would not be paid if billed as a RHC or FQHC service.

IOP Certification and Plan of Care Requirements

IOP services must be provided pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan. Specifically, 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 9 hours per week of therapeutic services as evidenced in their plan of care. The certification would require documentation to include that the individual requires such services for a minimum of 9 hours per week. This determination must occur no less frequently than every other month.

IOP Payment Rate:

The IOP payment rate is based on the 3-services per day hospital-based per diem payment amount which is $259.40.

For IOP services furnished in FQHCs, the payment is based on the lesser of an FQHC's actual charges or the 3-services per day payment amount.

For grandfathered tribal FQHCs, payment will be the Medicare outpatient per visit rate as established by the IHS when furnishing IOP services. That is, payment is based on the lesser of a grandfathered tribal FQHC's actual charges or the Medicare outpatient per visit rate.

Coding and Billing Requirements

The coding and billing requirements for IOP services furnished in RHCs and FQHCs are as follows:

* RHCs and FQHCs are required to report condition code 92 to identify intensive outpatient claims and revenue code 0905 when billing for IOP services. The HCPCS codes describing IOP services are listed in Appendix A as List A Primary Services and List B Services.

* RHCs must also report the CG modifier on the line for payment along with the charges so coinsurance is calculated.

* FQHCs must report charges on the primary service line for all IOP services furnished that day to be included in the calculation for coinsurance.

* At least one IOP service from List A Primary Services must be included on the claim for payment. Additional IOP services from List B Services listed on the claim will be bundled for that specific day.

FQHC Supplemental Payments

If the MA organization contract rate for services is lower than the amount Medicare would otherwise pay for IOP services, FQHCs that contract with MA organizations would receive a wrap-around payment from Medicare that covers the difference. If the MA contract rate is higher than the amount Medicare would otherwise pay for IOP services, there is no additional payment from Medicare. Therefore, to receive the wrap-around payment, FQHCs that contract with MA organizations must report condition code 92, revenue code 0519 and a HCPCS code from the Primary List A and any services from List B, if applicable.

Multiple Visits

Currently, encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and a single location constitute a single visit, except when a patient has a medical visit and a mental health visit on the same day or when a patient has an initial preventive physical exam and a separate medical or mental health visit on the same day. When IOP services are furnished on the same day as a mental health visit or on the same day as a medical visit, all services are covered under Medicare Part B. However, in the event IOP services are furnished on the same day as a mental health visit, CMS will make one payment at the IOP rate. That is, payment for the mental health visit will be included under the IOP rate. In the event IOP services are furnished as a medical visit, CMS will make one payment for the medical visit under the FQHC PPS and one payment for IOP services at the IOP rate.

Note: Mental health services should continue to be reported with revenue code 0900. Do not report IOP services with revenue code 0900.

Costs Associated with IOP Services

Section 4124(c)(1) of the CAA, 2023 amended section 1834(o) of the Act to add a new paragraph (5)(B) to require that costs associated with intensive outpatient services not be used to determine the amount of payment for FQHC services under the FQHC PPS. Likewise, section 4124(c)(2) of the CAA, 2023 amended section 1834(y) of the Act to add a new paragraph (3)(B) to require that costs associated with intensive

outpatient services not be used to determine the amount of payment for RHC services under the methodology for all-inclusive rates (established by the Secretary) under section 1833(a)(3) of the Act. In accordance with the CAA, 2023 provisions, CMS will issue revisions to the cost reporting instructions in future guidance.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13264.1	Contractors shall identify IOP RHC and FQHC claims as: • TOB is 71X or 77X; • dates of service on or after January 1, 2024; • condition code is 92; • revenue code 0905 or 0519 (MA claims); • and HCPCS code from attachment A.					X				FQHC Pricer, IOCE, PS&R
13264.1.1	Contractors shall bypass current IOCE edits and allow revenue code 0905 to be submitted on TOBs 71X and 77X for dates of service on or after January 1, 2024, when a claim is submitted with a HCPCS code from attachment A.									IOCE
13264.2	Contractors shall create a user controlled field to house the IOP rate for TOB 71X. This rate will be used for RHCs billing IOP services with revenue code 0905 and condition code 92. This field should be updated by the MACs. The rate for FQHCs will be housed in the FQHC Pricer.	X				X				
13264.2.1	Contractors shall update the IOP rate field with the following amount: $259.40.	X								
13264.3	Contractors shall package mental health services and pay at the IOP rate when the TOB is 77X and the claim contains IOP services (revenue code 0905) and mental health services (revenue code 0900) with the same line item date of service (LIDOS). IOP and mental health services cannot be performed on the same day.									IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: IOP and mental health services are allowed on the same day but paid a single payment based on the IOP rate									
13264.3.1	This requirement has been deleted.					X				
13264.3.2	This requirement has been deleted.	X								
13264.4	Contractors shall create an edit to assign when condition code 92 is present and the TOB is 71X or 77X and the claim does not contain a HCPCS code from the attachment A, list A primary services.									IOCE
13264.4.1	FISS shall accept the claim level edit from the IOCE.					X				
13264.4.2	Contractors shall return the claim to the provider (RTP).	X								
13264.5	Contractors shall pass condition code 92 to the IOCE.					X				IOCE
13264.6	This requirement has been deleted.					X				FQHC Pricer
13264.7	The IOCE shall identify the IOP service that will receive the IOP rate and return the following to FISS: • payment indicator flag '15' and • composite adjustment flag “04 - FQHC Intensive Outpatient Program visit”. The IOP payment line is identified by revenue code 0905 with a HCPCS code from attachment A, list A primary services. Only one service will be paid per day. An FQHC payment code and qualifying visit code is not required.									FQHC Pricer, IOCE
13264.8	The IOCE shall identify the MA service line that will receive the IOP wrap-around payment and return payment indicator flag '16' to the FISS. The IOP payment line is identified by revenue code 0519 (MA claims), condition code 92 with a HCPCS code from attachment A, list A primary services.									FQHC Pricer, IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Only one service will be paid per day. An FQHC payment code and qualifying visit is not required.									
13264.9	The IOCE shall return a flag to FISS to identify all service lines that are bundled and not eligible for a separate IOP payment. The IOCE will determine which service line from attachment A, list A primary services will receive the payment indicator flag, when present, other services lines with revenue code 0905 or 0519 (MA claims) with HCPCS codes from attachment A will be packaged/bundled.					X				IOCE
13264.9.1	FISS shall accept the new IOCE flags (13264.7-13264.9) and pass the new IOCE flags to the FQHC Pricer.					X				FQHC Pricer
13264.10	The IOCE shall continue to assign payment indicator (PI) 14 to Grandfathered Tribal FQHC claims when payer only condition code 'MG' is present on the claim with IOP services. Grandfathered Tribal FQHCs will be paid their PPS rate, not the IOP rate.									IOCE
13264.11	The FQHC PRICER shall utilize the IOCE flags to apply payment.									FQHC Pricer
13264.12	The FQHC PRICER shall continue to apply the Grandfathered Tribal FQHC PPS payment for IOP services when the payment indicator is 14.									FQHC Pricer
13264.13	The FQHC Pricer shall pay the lessor of the IOP rate or the submitted charges for revenue line 0905 when the IOCE payment indicator flag is '15'.									FQHC Pricer
13264.14	For IOP services with revenue code 0519, the FQHC Pricer shall make a wrap-around payment when the IOCE payment indicator flag is '16'.									FQHC Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	The current wrap-around methodology should be used.									
13264.15	The FQHC Pricer shall apply coinsurance based on the lessor of the IOP rate or the submitted charges.									FQHC Pricer
13264.16	The contractor shall display the PRICER output for IOP claims in the current fields: (Pricer payment amount, Pricer return codes, and coinsurance at the service line and (total coinsurance (value code A2), total payment amount, labor adjusted factor) at the claim level. **NOTE**: IOP claims are identified by condition code 92, revenue code 905 or 519 with a HCPCS code from attachment A.					X				FQHC Pricer, PS&R
13264.17	Contractors shall ensure an IOP services (revenue code 0905) and a medical services (revenue code 052X) can both bill modifier CG with the same LIDOS on TOB 71X.					X				
13264.18	Contractors shall create an edit to assign when modifier CG is billed with revenue code 0905 on TOB 71X, and the HCPCS code is not from attachment A, list A primary services.									IOCE
13264.18.1	FISS shall accept the claim level edit from the IOCE.					X				
13264.18.2	Contractors shall return the claim to the provider (RTP).	X								
13264.19	Contractors shall pay the IOP rate on RHCs claims when, the TOB is 71X, the revenue code is 0905 and modifier CG is present with a HCPCS code from attachment A, list A primary services. Only one IOP payment is made per day.					X				PS&R
13264.20	Contractors shall apply coinsurance and deductible based on the submitted charges for RHCs, TOB 71X.					X				
13264.21	Contractors shall ensure any service line (s) that do not receive an IOP rate are shown as covered with the following ANSI information: Group code CO- Contractual obligation					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CARC 97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC M15 Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. MSN 16.34 - You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'You May Be Billed' column.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, Tracey.Mackey@CMS.HHS.GOV , Cindy Pitts, Cindy.Pitts@CMS.HHS.GOV

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Attachment A: IOP Codes and Services

List A Primary Services

HCPCS/CPT	Short Descriptor
90832	Psytx pt&/family 30 minutes
90834	Psytx pt&/family 45 minutes
90837	Psytx pt&/family 60 minutes
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient
90853	Group psychotherapy
90880	Hypnotherapy
96112	Devel tst phys/qhp 1st hr
96116	Neurobehavioral status exam
96130	Psychological testing evaluation by physician/qualified health care professional; first hour
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes
96138	Psychological/neuropsychological testing by technician; first 30 minutes
G0410	Grp psych partial hosp/IOP 45-50
G0411	Inter active grp psych PHP/IOP

List B Services

HCPCS/CPT	Short Descriptor
90785	Psytx complex interactive
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90833	Psytx pt&/fam w/e&m 30 min
90834	Psytx pt&/family 45 minutes
90836	Psytx pt&/fam w/e&m 45 min
90837	Psytx pt&/family 60 minutes
90838	Psytx pt&/fam w/e&m 60 min
90839	Psytx crisis initial 60 min
90840	Psytx crisis ea addl 30 min
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient
90849	Multiple family group psytx
90853	Group psychotherapy
90880	Hypnotherapy
90899	Psychiatric service/therapy
96112	Devel tst phys/qhp 1st hr
96116	Neurobehavioral status exam
96130	Psychological testing evaluation by physician/qualified health care professional; first hour
96131	Psychological testing evaluation by physician/qualified health care professional; each additional hour
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour
96133	Neuropsychological testing evaluation by physician/qualified health care professional; each additional hour
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes
96137	Psychological/neuropsychological testing by physician/qualified health care professional; each additional 30 minutes
96138	Psychological/neuropsychological testing by technician; first 30 minutes
96139	Psychological/neuropsychological testing by technician; each additional 30 minutes
96146	Psychological/neuropsychological testing; automated result only
96156	Hlth bhv assmt/reassessment
96158	Hlth bhv ivntj indiv 1st 30
96161	Admin of caregiver – focused hlth risk assmt for ben of patient

HCPCS/CPT	Short Descriptor
96164	Hlth bhv ivntj grp 1st 30
96167	Hlth bhv ivntj fam 1st 30
96202	Multiple-family group behavior management/modification training for parent(s) guardian(s) caregiver(s) with a mental or physical health diagnosis up to 60 minutes
96203	Multiple-family group behavior management/modification training for parent(s) guardian(s) caregiver(s) with a mental or physical health diagnosis each addtl 15 minutes
97151	Bhv id assmt by phys/qhp
97152	Bhv id suprt assmt by 1 tech
97153	Adaptive behavior tx by tech
97154	Grp adapt bhv tx by tech
97155	Adapt behavior tx phys/qhp
97156	Fam adapt bhv tx gdn phy/qhp
97157	Mult fam adapt bhv tx gdn
97158	Grp adapt bhv tx by phy/qhp
97550	Caregiver training 1st 30 min
97551	Caregiver training ea addl 15
97552	Grp caregiver training
G0023	Navigate srv 60 min per m
G0024	Navigate srv add 30 min per m
G0129	PHP/IOP service
G0140	Nav srv peer sup 60 min pr m
G0146	Nav srv peer sup add 30 pr m
G0176	Opps/php/IOP; activity thrpy
G0177	Opps/php/IOP; train & educ
G0410	Grp psych PHP/IOP 45-50
G0411	Interactive grp psyc PHP/IOP
G0451	Development test interpt&rep