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New Condition Code 92: Billing Requirements for Intensive Outpatient Program Services

Related CR Release Date: December 20, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13222

Related Change Request (CR) Number: CR 13222 & CR 13496

Related CR Transmittal Number: R12423CP, R12425GI, & R12425BP

Related CR Title: Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92

Affected Providers

- Hospital outpatient departments
- Critical access hospitals (CAHs)
- Community mental health centers (CMHCs)
- Other providers billing Medicare Administrative Contractors (MACs) for IOP services they provide to Medicare patients

Action Needed

Make sure your billing staff knows that effective January 1, 2024:

- New condition code "92" identifies claims for IOP services
- 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 pay 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 CAH outpatient departments
  - CMHCs

Background

Starting January 1, 2024, the National Uniform Billing Committee approved a new condition code 92 identifying claims for services you provide under an IOP services care plan. Hospitals and CMHCs must use condition code 92 on all claims for IOP services. CMS will pay for IOP

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services with per diem payments under the OPPS when billed by an OPPS provider. Section 4124 of the Consolidated Appropriations Act of 2023 creates Medicare coverage and payment for IOP services for people with mental health needs provided by HOPDs, CAH outpatient departments, and CMHCs.

An IOP provides treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a partial hospitalization program (PHP). We don't consider programs providing primarily social, recreational, or diversionary activities to be intensive outpatient programs.

Patients you admit to an IOP must be all of these:

- Under the care of a physician who certifies the need for IOP services
- Need a minimum of 9 hours of services per week, as shown by their plan of care
- Requires a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder, including substance use disorder, which severely interferes with multiple areas of daily life, including social, vocational, and educational functioning
- Be able to cognitively and emotionally participate in the active treatment process and tolerate the intensity of an IOP program

We make payment for IOP services you bill with condition code 92 based on:

- OPPS for OPPS hospitals submitting claims on type of bill (TOB) 013x
- OPPS for CMHCs using TOB 076X
- 101% of reasonable cost for CAHs using TOB 085x
- Current payment methods for non-OPPS hospitals using TOB 013x

MACs will return the claim to the provider (RTP) when:

- An IOP service claim overlaps partial hospitalization program (PHP) claims with condition code 41
- An IOP services claim in Medicare's history files has a line item date of service within 7 days prior to the "from date" for an incoming claim for the same patient and provider

Claims on TOB 076x with condition code 41 will process as PHP claims.

CR 13222 also makes numerous revisions to the Medicare Claims Processing Manual to include condition code 92 and IOP services. Manual revisions include:

- New Section 261 in Chapter 4 includes details on IOP services, including:
  - Revenue codes
  - HCPCS codes
  - Service units reporting
  - Claim examples
- Other revised sections to add IOP information

CR 13496 makes changes to the Medicare Benefit Policy Manual, especially the addition of Section 70.4, Intensive Outpatient Services, to Chapter 6. Section 70.4 gives more details on IOP about:

- Program criteria
- Patient eligibility criteria
- Covered services
- Reasonable and necessary services
- Reasons for denials
- Documentation and physician supervision requirements

Other revisions to the manuals are primarily to add IOPs to covered services, where appropriate.

More Information

We issued CR 13222 & CR 13496 to your MAC as the official instructions for this change. These CRs include 3 transmittals:

1. Transmittal R12423CP updates the Medicare Claims Processing Manual
2. Transmittal R12425BP updates the Medicare Benefit Policy Manual
3. Transmittal R12425GI updates the Medicare General Information, Eligibility, and Entitlement Manual

For more information, find your MAC's website.

Document History

Date of Change	Description
December 26, 2023	Initial article released.