CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12423	**Date: December 20, 2023**
	Change Request 13222

Transmittal 12125 issued July 13, 2023, is being rescinded and replaced by Transmittal 12423, dated December 20, 2023, to remove sensitive language, add provider education business requirements and to revise Publication (Pub) 100-04 IOM chapters 2, 4, 12, 20, 25, 29 and 30. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated December 20, 2023. This instruction may now be posted to the Internet.

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

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the new condition code 92 for Intensive Outpatient Program (IOP) services and enforce billing requirements.

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
R	2/05/Definition of Provider and Supplier
R	4 - Table of Contents
R	4/10.1/Background
R	4/10.7.1/Outlier Adjustments
R	4/10.9/Updates
R	4/30.1/Coinsurance Election
R	4/120.1/Bill Types Subject to OPPS
R	4/170 - Hospital and CMHC Reporting Requirements for Services Performed on the Same Day
N	4/261/Intensive Outpatient Program Services
N	4/261.1/Special Intensive Outpatient Program Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
N	4/261.1.1/Bill Review for Intensive Outpatient Program Services Received in Community Mental Health Centers (CMHC)
N	4/261.2/Professional Services Related to Intensive Outpatient Program
N	4/261.3/Outpatient Mental Health Treatment Limitation for Intensive Outpatient Program Services
N	4/261.4/Reporting Service Units for Intensive Outpatient Program
N	4/261.5/Line Item Date of Service Reporting for Intensive Outpatient Program
N	4/261.6/Payment for Intensive Outpatient Program Services
R	4/270/Billing for Hospital Outpatient Services Furnished by Clinical Social Workers (CSW) Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)
R	4/270.1/Fee Schedule to be Used for Payment for CSW Services
R	12/190.5/Originating Site Facility Fee Payment Methodology
R	12/210.1/Application of the Limitation
R	20/01/Foreword
R	25/75.5/Form Locators 43-65
R	29/110/Glossary
R	30/500/Glossary

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12423	Date: December 20, 2023	Change Request: 13222

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

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

I. GENERAL INFORMATION

A. Background: The National Uniform Billing committee has approved for usage a new condition code "92" to identify claims where services were provided under an Intensive Outpatient Program (IOP) services care plan. All services for IOP provided and billed by a hospital or Community Mental Health Center (CMHC) must be submitted with condition code "92". IOP services will receive per diem payments under the Outpatient Prospective Payment System (OPPS) when billed by an OPPS provider.

B. Policy: Section 4124 of the Consolidated Appropriations Act of 2023 establishes Medicare coverage and payment for IOP services for individuals with mental health needs when furnished by hospital outpatient departments, Critical Access Hospital (CAH) outpatient departments, and CMHCs. The law establishes this new benefit for services furnished on or after January 1, 2024.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13222 - 04.1	Contractors shall add the new condition code "92" to the global solution screen.	X								
13222 - 04.1.1	HIGLAS shall accept the new condition code "92"									HIGLAS
13222 - 04.2	Contractors shall ensure that IOP claims with a condition code "92" paid with the OPPS payment methodology have an OPPS/Non-OPPS Flag of "1" assigned to the claim.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Note: Intensive Outpatient Program (IOP) services that are paid with the OPPS payment methodology are identified as OPPS hospitals on a bill type 013x with a condition code of 92 or CMHCs on a bill type 076x with a condition code of 92. **Note**: Critical Access Hospitals (CAHs) on a bill type 085x with a condition code of 92 continue to pay under 101% of reasonable costs. Non-OPPS hospitals on a bill type 013x with a condition code 92 are paid under their current methodologies.									
13222 - 04.3	Contractors shall ensure that OPPS IOP claims with a condition code "92" paid with an OPPS/Non-OPPS Flag of "1" are routed correctly to the IOCE and OPPS Pricer.					X				IOCE, OPPS Pricer
13222 - 04.4	Contractors shall ensure that IOP claims with a condition code "92" are processed and follow a similar workflow as Partial Hospitalization Program (PHP) claims, including: • Composite Ambulatory Payment Classifications (APC) Processing • Minimum services provided daily (Edit 30) • Weekly services with more than 9 hours of IOP services per week									IOCE

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• IOP claims submitting a claim with a code first diagnosis in the principal diagnosis position without a mental health diagnosis in the first secondary diagnosis position (Edits 28 & 109). • For Type of Bill (TOB) 076x, IOP providers are subject to outlier payment caps. • For TOB 076x, Mental health services that are not approved for IOP are submitted on an IOP claim (excluding hospital 13x with cc 92) (Edit 80) • For TOB 076x, Remote Mental Health (RMH) services are not permitted (edit 55)									
13222 - 04.5	Contractors shall ensure that IOP claims TOB 076x with condition code "92" are included in charges for logic that caps outliers for CMHC providers (TOB 076x).					X				
13222 - 04.6	Contractors shall bypass duplicate editing with repetitive services when a claim with condition code "92" is billed and overlaps a repetitive service claim without condition code 92. Note: This applies to TOB 013x and 085x.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13222 - 04.7	Contractors shall create a new edit to ensure that IOP claims (TOB 013x, 076x, and 085x) with condition code "92", do not overlap PHP claims with condition code "41". Additionally, the new edit should include, a CMHC provider (TOB 076x) cannot bill an IOP claim with condition code "92" and a separate PHP claim with or without condition code "41" for overlapping periods of time. This edit shall be set to Return to Provider (RTP).					X				
13222 - 04.8	Contractors shall create a new edit to ensure that IOP claims with condition code "92", do not also contain condition code "41". This edit shall be set to RTP.					X				
13222 - 04.9	Contractors shall accept condition code "41" on TOB 076x claims.					X				
13222 - 04.10	Contractors shall ensure that TOB 076x claims with condition code "41" are processed as partial hospitalization claims.					X				
13222 - 04.11	Contractors shall enforce consistency editing for interim claims billing for IOP services submitted by hospitals on a bill type 013x with a condition code of "92", Critical Access Hospitals (CAHs) on a bill type 085x with a condition code of "92", or Community Mental Health Centers on a bill type 076x with a condition code of "92" for the same beneficiary and provider.					X				
13222 - 04.11.1	Contractors shall validate that an incoming claim for IOP services with a bill type of					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	0131 and condition code "92", 0851 and a condition code "92", or 0761 and a condition code 92 does not have a history IOP services claim with a line item date of service within 7 days prior to the from date for the incoming claim for the same beneficiary and provider. If a history IOP services claim contains a line item date of service within 7 days prior to the from date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.									
13222 - 04.11.2	Contractors shall validate that an incoming claim for IOP services with a bill type of 0132 and condition code "92", 0852 and a condition code "92", or 0762 and a condition code 92 does not have a history IOP services claim with a line item date of service within 7 days prior to the from date for the incoming claim for the same beneficiary and provider. The patient status should be 30 for IOP services billed on an 0XX2 If a history IOP services claim contains a line item date of service within 7 days prior to the from date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.					X				
13222 - 04.11.3	Contractors shall validate that an incoming claim for IOP services with a bill type of 0133 and condition code "92", 0853 and a condition code "92", or 0763 and a condition code "92" has a prior history claim with a line item date of					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	service within 7 days of the from date and a corresponding claim with a bill type of 0132, 0133, 0137 or contractor adjustment claim and condition code "92"; 0852, 0853, 0857 or contractor adjustment claim and a condition code "92"; or 0762, 0763, 0767 or contractor adjustment and condition code "92" claim in history for the same beneficiary and provider. The patient status should be 30 for IOP services billed on an 0XX3. If there is no history IOP claim that contains a line item date of service within 7 days prior to the from date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.									
13222 - 04.11.4	Contractors shall validate that an incoming claim for IOP services with a bill type of 0134 and condition code "92", 0854 and a condition code "92", or 0764 and a condition code "92" has a prior history claim with a line item date of service within 7 days of the from date and a corresponding claim with a bill type of 0132, 0133, 0137 or contractor adjustment claim and condition code "92"; 0852, 0853, 0857 or contractor adjustment claim and a condition code "92"; or 0762, 0763, 0767 or contractor adjustment and a condition code "92" claim in history for the same beneficiary and provider. If there is no history IOP services claim that contains a line item date of service within					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	7 days prior to the from date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.									
13222 - 04.12	Contractors shall enforce sequential billing requirements for IOP claims.					X				
13222 - 04.12.1	Contractors shall validate that an incoming claim for IOP services with a bill type of 0131 and condition code "92", 0851 and a condition code "92", or 0761 and a condition code "92" does not have a history IOP services claim with a line item date of service within 7 days after the through date for the incoming claim for the same beneficiary and provider. If a history IOP services claim contains a line item date of service within 7 days after the through date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.					X				
13222 - 04.12.2	Contractors shall validate that an incoming claim for IOP services with a bill type of 0132 and condition code "92", 0852 and a condition code "92", or 0762 and a condition code "92" does not have a history claim with a line item date of service within 7 days after the through date for the incoming claim with a bill type of 0131 or 0132 and condition code "92", 0851 or 0852 and a condition code "92", or 0761 or 0762 and a condition code "92" on the history claim for the same beneficiary and provider. The patient status should be 30 for					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	IOP services billed on an 0XX2. If a history claim with a bill type of 0131 or 0132 and condition code "92", 0851 or 0852 and a condition code "92", or 0761 or 0762 and a condition code "92" contains a line item date of service within 7 days after the through date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.									
13222 - 04.12.3	Contractors shall validate that an incoming claim for IOP services with a bill type of 0133 and condition code "92", 0853 and a condition code "92", or 0763 and a condition code "92" does not have a history claim with a line item date of service within 7 days after the through date for the incoming claim with a bill type of 0131 or 0132 and condition code "92", 0851 or 0852 and a condition code "92", or 0761 or 0762 and a condition code "92" on the history claim for the same beneficiary and provider. The patient status should be 30 for IOP services billed on an 0XX3. If a history claim with a bill type of 0131 or 0132 and condition code "92", 0851 or 0852 and a condition code "92", or 0761 or 0762 and a condition code "92" contains a line item date of service within 7 days after the through date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13222 - 04.12.4	Contractors shall validate that an incoming claim for IOP services with a bill type of 0134 and condition code "92", 0854 and a condition code "92", or 0764 and a condition code "92" does not have a history claim with a line item date of service within 7 days after the through date for the incoming claim with a bill type of 0131, 0132 or 0133 and condition code "92"; 0851, 0852 or 0853 and a condition code "92"; or 0761, 0762 or 0763 and a condition code "92" on the history claim for the same beneficiary and provider. If a history claim with a bill type of 0131, 0132 or 0133 and condition code "92"; 0851, 0852 or 0853 and a condition code "92"; or 0761, 0762 or 0763 and a condition code "92" contains a line item date of service within 7 days after the through date for the incoming claim, Medicare systems shall Return To Provider the incoming claim.					X				
13222 - 04.13	Contractors shall educate IOP providers on how to appropriate bill interim claims including proper usage of the following: • Sequential Billing • Type of Bill Frequency • Discharge Status Codes	X				X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13222 - 04.14	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X				

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): Fred Rooke, fred.rooke@cms.hhs.gov (for Hospital and CMHC billing questions), Nicolas Brock, nicolas.brock@cms.hhs.gov (for Hospital and CMHC policy questions)

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: 0