CareSource

REIMBURSEMENT POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Intensive Outpatient Program-Behavioral Health-NV MP-PY-1631	09/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies 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 agreements, 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan 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 or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we 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.

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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 active treatment prescribed by a qualified provider for an individual determined, not less frequently than once every other month, to need services for a minimum of 9 hours per week. Services are provided under the supervision of a qualified staff based on an individualized treatment plan established and periodically reviewed by a multidisciplinary team with goals that are measurable, time-framed, directly related to an admission reason and medically necessary.

IOPs for SUDs serve members seeking primary treatment, step-down care from higher levels of care, or step-up treatment from outpatient services, which may include in-house therapies, peer support, mutual-help group participation, and collaboration with community providers to address needs such as medication-assisted treatment, psychological assessments, vocational rehab, and trauma-specific care.

C. Definitions

- **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.
- **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 3 or more hours per day or evening available 5 days per week, where the intensity of services are similar to inpatient settings with skilled nursing care and daily psychiatric care.
- **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.

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 American Society of Addiction Medicine (ASAM) criteria for review of SUD requests.

II. Billing

A. Some professional services are separately covered and unbundled. Chapter 4 of the *Medicare Claims Processing Manual* contains 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. Providers must report service units, dates of service, and patient status. Discharge status codes can be located in the *Medicare Claims Processing Manual, 100-04*.

8. 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).

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. Conditions of Coverage

I. 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.

II. The inclusion of codes in this policy does not guarantee coverage, authorization or reimbursement. This may not be an all-inclusive list:

Intensive Outpatient Program	
Code	**Code Description**
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
S9480	Intensive outpatient psychiatric services, per diem

F. Related Policies/Rules

Behavioral Health Rates
Behavioral Health Service Record Documentation Standards

G. Review/Revision History

	DATE	ACTION
Date Issued	07/16/2025	New policy. Approved at Committee
Date Revised	05/20/2026	Annual review. Simplified background. Matched definitions to 2026 EOC. Added E.II. Updated references. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

H. References

1. About the ASAM criteria. American Society of Addiction Medicine. Accessed April 27, 2026. www.asam.org
2. Centers for Medicare and Medicaid Services. *CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule.* Centers for Medicare and Medicaid Services; 2023. CMS Fact Sheet CMS 1786-FC. Accessed April 27, 2026. www.cms.gov
3. Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, 136 Stat. 4459.
4. Definitions. 42 U.S.C. 1395 (2025).
5. *Diagnostic and Statistical Manual of Mental Disorders (5th ed, Text Revised)*. American Psychiatric Association; 2022. Accessed April 27, 2026. doi:10.1176/appi.books.9780890425787
6. Further Additional Continuing Appropriations and Other Extensions Act, 2024, Pub. L. No. 118-35, 138 Stat. 3.
7. Medical Insurance (SMI) Benefits, 42 C.F.R. §§ 410.42, 410.71, 410.73 to 76, and 410.78 (2023).
8. *Medicare Claims Processing Manual, 100-04*. Centers for Medicare and Medicaid Services. Accessed April 27, 2026. www.cms.gov
9. *Medicare Learning Network. Billing Requirements for Intensive Outpatient Program Services with New Condition Code 92*. Centers for Medicaid and Medicare Services; 2023. MLN Matters Number MM13496. Accessed April 27, 2026. www.cms.gov
10. *Nevada Marketplace Evidence of Coverage*. CareSource; 2026. Accessed April 27, 2026. www.caresource.com
11. Substance Abuse and Mental Health Services Administration. *Clinical Issues in Intensive Outpatient Treatment for Substance Use Disorders: Advisory*. U.S. Dept. of Health and Human Services; 2021. Publication # PEP20-02-01-021. Accessed April 27, 2026. www.samhsa.gov