Optum

Quick Reference Guide

Network Intensive Outpatient Program (IOP) Services

Overview

The Centers for Medicare and Medicaid Services (CMS) requires national, in-network providers delivering services to members covered by Optum-managed Medicare plans for Intensive Outpatient Program (IOP) Services to bill using certain revenue codes to avoid claim denial beginning Nov. 1, 2025.

On Sept. 15 and Sept. 30, Optum Behavioral Health sent the following letters to providers whose Participation Agreements were amended to align with these CMS and Consolidated Appropriations Act of 2023 billing requirements:

Letter to Hospital Outpatient Departments (HODs), Critical Access Hospitals (CAHs) and Community Mental Health Centers (CMHCs)

Optum

[Date]

[Provider Name]
[Facility Name]
[Address]
[City, State, Zip code]

RE: Notice of amendment to your Optum Participation Agreement for Medicare IOP and PHP billing

Dear [Provider Name]:

To align with CMS billing requirements, Optum Behavioral Health is amending your Participation Agreement for Intensive Outpatient Program (IOP) and/or Partial Hospitalization Program (PHP) services.*

Beginning Nov. 1, 2025, you are required to bill using the following primary and secondary codes based on your facility type. Claims submitted with other billing codes or without condition codes will be denied.

Codes for Hospital Outpatient Departments (HODs), Critical Access Hospitals (CAHs) and Community Mental Health Centers (CMHCs)

Condition codes	Revenue codes	Allowable primary codes considered for reimbursement (List A)		Allowable secondary codes (Encounter codes only – not separately reimbursable)	
92 (IOP) 41 (PHP)	914	90832 90834 90837	90845 90880	90785 90833 90836 90838 90839 90840 90899	
	915	G0410 G0411	90853	N/A	
	916	90846 or 90847		90849	
	918	96112 96116 96130	96132 96136 96138	96131 96133 96137 96139 96146 96156	96158 96161 96164 96167 97151 97152
Note: IOP & PHP services can **not** be provided via telehealth due to current statutory limitation under 1861(ff)(3)(A) of the Consolidated Appropriations Act of 2023.					

All other terms and conditions of your Agreement, including reimbursement, for any other contracted Optum network(s) will remain unchanged and in full force and effect.

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Why billing requirements are changing
These changes are a result of the Consolidated Appropriations Act of 2023 (Section 4124). Section 4124 outlines CMS-mandated billing requirements based on provider type. The billing requirements were changed to offer much-needed Medicare coverage and payment for IOP services for people with mental health needs. Specifically, it offers coverage for those patients that require more intense services than traditional outpatient therapy, but less than inpatient or partial hospitalization.

For more information on Section 4124, see the CMS guidance on Medicare and Mental Health Coverage.

Additional billing and coding notes

Revenue Code	Additional Information
905	Can only be used by Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)
906	Can no longer be used to bill IOP
912 and 913	Can no longer be used – CMS has indicated 914, 915, 916 and 918 should be used instead, as outlined in the table above.

- **Condition codes must be used**
  All IOP and PHP service claims must now include a condition code indicating service type 92 (IOP) or 41 (PHP)
  - These condition codes must be included with the appropriate revenue code and at least 1 encounter code
  - Condition codes 92 and 41 cannot be billed on the same claim
- **Contract includes old codes**
  If your current contract includes Revenue codes 914, 915, 916 and/or 918 and you do not bill using the correct condition code, your claim will be paid as a non-IOP/PHP service. For example, if you are contracted for outpatient services under Revenue codes 914, 915, 916 and 918, and bill without a condition code, you'll be paid the outpatient rate for Individual Therapy for Revenue code 914 or Family Therapy for 915, etc.
- **Bill using at least 1 allowable primary service code**
  Claims must include at least 1 allowable IOP service code from Primary Service Code List A. Allowable secondary codes, from List B Services, for multiple services provided that day are optional.
- **Critical Access Hospitals**
  Are not required to report encounter codes

Questions?
Should you have any questions, please contact your Provider Relations Advocate or Facility Contract Manager directly. Thank you for your continued participation in our network.

Sincerely,

Victoria Bogatyrenko
Senior Vice President, Network Contracting and Provider Relations
Optum Behavioral Health

*This guidance does not address IOP services billed by Opioid Treatment Programs for opioid use disorders: 013X (HOPD), 085X (CAH), TOB 087X (Free-Standing Opioid Treatment Program Facility).

**Hospital outpatient departments (HOPD), Critical Access Hospital (CAH) outpatient department, Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs).

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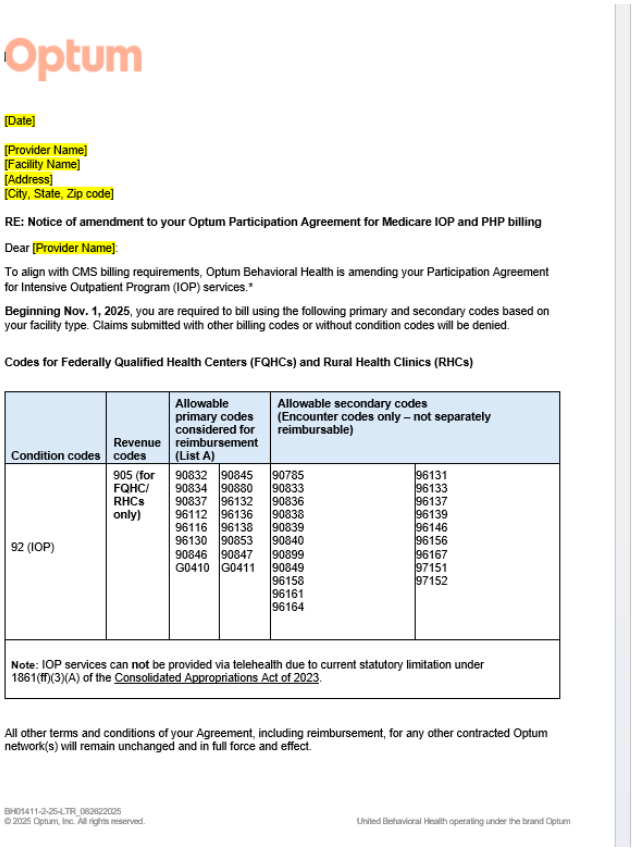
Letter to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)



Optum

[Date]

[Provider Name]
[Facility Name]
[Address]
[City, State, Zip code]

RE: Notice of amendment to your Optum Participation Agreement for Medicare IOP and PHP billing

Dear [Provider Name]:

To align with CMS billing requirements, Optum Behavioral Health is amending your Participation Agreement for Intensive Outpatient Program (IOP) services.*

Beginning Nov. 1, 2025, you are required to bill using the following primary and secondary codes based on your facility type. Claims submitted with other billing codes or without condition codes will be denied.

Codes for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Condition codes	Revenue codes	Allowable primary codes considered for reimbursement (List A)		Allowable secondary codes (Encounter codes only – not separately reimbursable)	
92 (IOP)	905 (for FQHC/ RHCs only)	90832 90834 90837 96112 96116 96130 90846 G0410	90845 90880 96132 96136 96138 90853 90847 G0411	90785 90833 90836 90838 90839 90840 90899 90849 96158 96161 96164	96131 96133 96137 96139 96146 96156 96167 97151 97152

Note: IOP services can **not** be provided via telehealth due to current statutory limitation under 1861(ff)(3)(A) of the Consolidated Appropriations Act of 2023.

All other terms and conditions of your Agreement, including reimbursement, for any other contracted Optum network(s) will remain unchanged and in full force and effect.

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Why billing requirements are changing
These changes are a result of the Consolidated Appropriations Act of 2023 (Section 4124). Section 4124 outlines CMS-mandated billing requirements based on provider type. The billing requirements were changed to offer much-needed Medicare coverage and payment for IOP services for people with mental health needs. Specifically, it offers coverage for those patients that require more intense services than traditional outpatient therapy, but less than inpatient or partial hospitalization.

For more information on Section 4124, see the CMS guidance on Medicare and Mental Health Coverage.

Additional billing and coding notes

Revenue Code	Additional Information
905	Can only be used by Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)
906	Can no longer be used to bill IOP

- **Condition codes must be used**
  All IOP service claims must now include a condition code indicating service type 92 (IOP). This condition code must be included with the appropriate revenue code and at least 1 encounter code.
- **Bill using at least 1 allowable primary service code**
  Claims must include at least 1 allowable IOP service code from Primary Service Code List A. Allowable secondary codes, from List B Services, for multiple services provided that day are optional.

Questions?
Should you have any questions, please contact your Provider Relations Advocate or Facility Contract Manager directly. Thank you for your continued participation in our network.

Sincerely,

Victoria Bogatyrenko
Senior Vice President, Network Contracting and Provider Relations
Optum Behavioral Health

*This guidance does not address IOP services billed by Opioid Treatment Programs for opioid use disorders: 013X (HOPD), 085X (CAH), TOB 087X (Free-Standing Opioid Treatment Program Facility).

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Besides the information contained in the above letters, the following information may be helpful as you field questions from providers.

Additional coding and billing notes

- For additional billing guidance, review
  - FQHCs and RHCs: CMS Change Request 13264
  - HODs, CAHs and CMHCs: CMS Change Request 13222
- If an IOP service claim overlaps partial hospitalization program (PHP) on TOB 076x with condition code 41 will process as PHP claims.
- CAHs are not required to report HCPCS code for this benefit.

The difference between IOP and PHP services

Effective 1/1/2024, Medicare covers IOP services for those with a psychiatric or substance use disorder. However, IOP and PHP services are different services. IOP services are more intensive than outpatient day treatment or psychosocial rehabilitation services, but less intensive than services rendered in a PHP.

Criteria for Intensive Outpatient Program Services

To be considered an Intensive Outpatient Program Service:

Patient must:

- Have a behavioral health disorder (including a substance use disorder) that
  - Causes acute dysfunction or decompensation that severely interferes with social, vocational, and/or educational functioning during daily life
  - Is severe enough to require medically supervised, coordinated care and comprehensive, structured, multi-modal treatment
- Not require 24-hour/day supervision, inpatient care and must require fewer hours of services per week than PHP
- Have an adequate support system to sustain/maintain themselves outside the IOP and must not be an imminent danger to themselves or others
- Complete an Individual Treatment Plan
- Be able to cognitively and emotionally tolerate the intensity of active treatment in an IOP program

Physician must:

- Address the continuing serious nature of the patient's psychiatric condition and certify/recertify the need for active treatment in an IOP
- Determine the patient would benefit from participating in an active treatment program

Diagnosis and treatment must be:

- Acute onset or decompensation of covered Axis I mental disorder that severely interferes with multiple areas of daily life
- Vigorous, proactive, active treatment that is detailed in the patient's Individual Treatment Plan and Progress Notes

Is Prior Authorization required for IOP services?

Prior Authorization may be required for IOP services.

Note: Optum will **not** use American Society of Addiction Medicine (ASAM) or Level of Care Utilization System (LOCUS) criteria for IOP. We will only cite the Medicare Benefit Manual as outlined in the Managed Care System (MCS).

IOP Services in an Opioid Treatment Program (OTP) Setting

Opioid Treatment Programs are **not** included in the Consolidated Appropriations Act of 2023 (Section 4124). Instead, credentialing, contracting and billing requirements for Medicare-Certified Opioid Treatment Programs when delivering IOP Services is part of CMS 1786-FC.

Additional resources

CMS IOP billing guidance

- New Condition Code 92: Billing Requirements for Intensive Outpatient Program Services
  - MM13222
  - MM13496
- CMS Medicare Claims Processing Manual (Pub. 100-04), Chapter 1, Section 50.2.3
- RHCs/FQHCs: CMS Medicare Claims Processing Manual (Pub. 100-04), Chapter 9

- OTPs
  - CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 39
  - CMS 1786-FC
  - Quick Reference Guide: Medicare IOP billing requirements for OTPs

Other resources

- Medicare Benefit Policy Manual
- IOP MCS (5.2024)
- 2024 Medicare Changes
- New Medicare Coverage of Intensive Outpatient Program (IOP) Services
- Handling a Medicare OTP IOP Service - National IOP
- OBH Shared Knowledge - National IOP Workflow (optum.com)

Questions? We're here to help.

If you have additional questions, please contact your Provider Relations Advocate or Facility Contract Manager directly.

To find your Provider Relations Advocate, please call the Provider Services Line (PSL) at **1-877-614-0484**.