Intensive Outpatient Program Guidelines

Medicare Advantage Medical Policy #073
Original Effective Date: 03/01/2025
Current Effective Date: 03/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Preauthorization by the Plan is required.

Based on review of available data, the Health Plan may consider the Intensive Outpatient Program (IOP) **eligible for coverage**** when **ALL** the following patient selection criteria are met.

Patient Selection Criteria:

- Services must be reasonable and necessary for the diagnosis and treatment of the patient's condition.
- Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals.
- Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.
- Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.
- Patients admitted to an IOP must be under the care of a physician who certifies the need for intensive outpatient services, including the need for a minimum of 9 hours per week of services, as evidenced by their plan of care.

- Patients require 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/or educational functioning. Such dysfunction generally is of an acute nature.
- Patients must be able to cognitively and emotionally participate in the active treatment process and be capable of tolerating the intensity of an IOP program.
- Recertification must address the continuing serious nature of the patients' psychiatric condition requiring active treatment in an IOP.

When Services Are Not Covered

Based on review of available data, the Health Plan considers the following services to be **not covered.****

Services that are not covered include but are not limited to the following:

- Meals and transportation.
- Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.
- "Geriatric day care" programs are available in both medical and nonmedical settings. Administration of routine oral medication, eye drops, and ointments,
- Psychosocial programs. These are generally community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction. Outpatient programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they are covered. However, if an individual's outpatient hospital program consists entirely of psychosocial activities, it is not covered.
- Vocational training. While occupational therapy may include vocational and prevocational assessment and training, when the services are related solely to specific employment opportunities, work skills or work settings, they are not covered.
- A program that only monitors the management of medication for patients whose psychiatric condition is otherwise stable.
- Programs attempting to maintain psychiatric wellness, where there is no risk of relapse or hospitalization, e.g., day care programs for the chronically mentally ill.
- Patients who cannot, or refuse, to participate (due to their behavioral or cognitive status) with active treatment of their mental disorder (except for a brief admission necessary for diagnostic purposes), or who cannot tolerate the intensity of an IOP.

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Policy Guidelines

Intensive outpatient services that make up a program of active treatment must be vigorous and proactive (as evidenced in the individual treatment plan and progress notes) as opposed to passive and custodial. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued. Covered services are listed and defined in the Medicare Benefits Policy Manual, 70.4, B., 2.

Intensive outpatient services must be reasonable and necessary as defined in the Medicare Benefits Policy Manual, 70.4, B. 3.

When intensive outpatient services are no longer necessary for treatment of a psychiatric condition (including substance use disorder), patients in IOP may be discharged by either stepping down to a less intensive level of outpatient care when the patient's clinical condition improves or stabilizes and the patient no longer requires structured, intensive, multimodal treatment, or by stepping up to a more intensive level of care.

Basic Requirements for Clinical Appropriateness:
1.Patients must meet patient eligibility criteria defined in the Medicare Benefits Policy Manual, Chapter 6, 70.4, B., 1, 2, 3.
2.Providers and Programs must deliver services that meet criteria defined in the Medicare Benefits Policy Manual, Chapter 6, 70.4.

Background/Overview

Intensive Outpatient Program Guidelines
Instruction for Use: Intensive Outpatient Programs are covered under Medicare in approved settings for the treatment of patients who have an acute mental illness, including substance use disorder when medical criteria and guidelines are met. Intensive Outpatient Program (IOP) services are to be provided in accordance with the guidelines established by Medicare.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

References

1.Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap 6 – Hospital Services Covered Under Part B, (Rev. 12425; Issued: 12/21/2023: Effective 01/01/2024; Implementation: 01/02/2024). https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c06.pdf2.
2.InterQual Solution. https://www.changehealthcare.com/clinical-decision-support

Policy History

Original Effective Date: 03/01/2025
Current Effective Date: 03/01/2025
11/19/2024 Utilization Management Committee review/approval. New policy.
Next Scheduled Review Date: 02/2026

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan's Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-benehelp.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.

InterQual®

Interqual® is utilized as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. InterQual® criteria are clinically based on best practice, clinical data, and medical literature. The criteria are updated continually and released annually. InterQual® criteria are a first-level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. The utilization review staff does the first-level screening. If the criteria are met, the case is approved; if the criteria are not met, the case is referred to the medical director.