CMS Proposed Rules:
2024 Medicare Physician Fee Schedule/Hospital Outpatient Prospective Payment System

ASAM Summary of Major Provisions

On July 13, 2024 the Centers for Medicare and Medicaid Services (CMS) issued a Proposed Rule which revises CY 2024 payment policies under the Medicare Physician Fee Schedule (PFS) and makes other policy changes.

CMS has also published a fact sheet on the 2024 Medicare Physician Fee Schedule Proposed Rule, available here.

A summary of the major proposed changes is listed below:

Conversion Factor & Impact on Addiction Medicine Specialty

CMS proposes a CY 2024 Medicare conversion factor (CF) of $32.75, a decrease of $1.14 or 1.25 percent from the current 2023 CF rate of $33.89.

Per an analysis from the American Medical Association (AMA), the Addiction Medicine specialty is expected to see a **2.93% positive adjustment** in allowed Medicare charges in 2024, when the combined impact of the CY 2024 Notice of Proposed Rule Making (NPRM) and reduction of the temporary CF increase from 2.5% to 1.25%.

Visit complexity inherent to evaluation and management (G2211)

CMS is proposing to implement a new add-on code (G2211) designed to better recognize the resource costs associated with evaluation and management visits for primary care and longitudinal care of complex patients. CMS proposes that this code would be used in outpatient office visits, recognizing the inherent costs practitioners may incur when longitudinally treating a patient's single, serious, or complex chronic condition.

Medicare Coverage of Marriage & Family Therapists, and Mental Health Counselors

The Consolidated Appropriations Act of 2023 defines Marriage and Family Therapist (MFT) services as as services furnished by an MFT for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MFT is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

The CAA also defines a as a person who:

- Possesses a master's or doctor's degree which qualifies for licensure or certification as a MFT pursuant to State law of the State in which such individual furnishes marriage and family therapist services;

- Is licensed or certified as a MFT by the State in which such individual furnishes such services;
- After obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and
- Meets such other requirements as specified by the Secretary.

The CAA defines mental health counseling (MHC) services as for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MHC is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service.

The CAA also defines a MFT as an individual who:

- Possesses a master's or doctor's degree which qualifies for licensure or certification as law of the State in which such individual furnishes MHC services;
- Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are furnished;
- After obtaining such degree has performed at least 2 years of clinical supervised experience in mental health counseling; and
- Meets such other requirements as specified by the Secretary.

The CAA also specified that amounts paid to MFT and MHC shall be 80 percent of the lesser of either (1) the actual charge for the services or (2) 75 percent of the amount determined for payment of a psychologist.

MFTs and MHCs were also added to the list of practitioners whose services can only be paid by Medicare on an assignment basis, meaning that MFTs and MHCs agree to charge beneficiaries no more than the amount Medicare has approved for that service.

CMS is proposing to add MFTs and MHCs to the list of practitioners who are eligible to furnish Medicare telehealth services at the distant site. CMS is also proposing to proposing to allow Addiction Counselors who meet all of the applicable requirements (possess a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor; after obtaining such degree have performed at least 2 years (or, as proposed, 3,000 hours) of clinical supervised experience in mental health counseling; and licensed or certified as a MHC, clinical professional counselor, or professional counselor by the State in which the services are furnished) to enroll in Medicare as MHCs.

These practitioners will be eligible to enroll and bill for their services beginning January 1, 2024. Additionally, HCPCS code G0323 is being modified to clarify that MHCs and MFTs can bill for this code (Care management services for behavioral health conditions, at least 20 minutes, per calendar month.)

MFT and MHC services furnished in RHCs and FQHCs would also be eligible for Medicare payment beginning in 2024.

Mobile crisis services

Consistent with the CAA, CMS is establishing two new psychotherapy for crisis services:

GPFC1 (Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes)

GPFC2 (Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting);; each additional 30 minutes (List separately in addition to code for primary service)).

Consistent with the CAA, 2023, CMS will pay for these services when provided in non-facility settings, other than the office setting. Additionally and further consistent with the CAA, 2023, CMS is proposing to pay for GPFC1 and GPCF2 at 150% of the RVUs for CPT codes *90839 (Psychotherapy for crisis; first 60 minutes) and 90840 (Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)), respectively.*

CMS will also be required to use existing communication mechanisms to provide education and outreach to providers of services, physicians, and practitioners with respect to the ability of auxiliary personnel, including peer support specialists, to participate, consistent with applicable requirements for auxiliary personnel, in the furnishing of psychotherapy for crisis services billed under the PFS, behavioral health integration services, as well as other services that can be furnished to a Medicare beneficiary experiencing a mental or behavioral crisis.

Health and Behavior Assessment and Intervention

CMS is proposing to allow MHCs and MFTs to bill CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, and 96171 which describe health and behavior assessment and intervention. These codes apply to services that address psychological, behavioral, emotional, cognitive, and interpersonal factors in the treatment/management of people diagnosed with physical health issues.

Adjustments to Payment for Timed Behavioral Health Services

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CMS is proposing to adjust the work RVUs for the following services over a four-year transition period as part of the agency's effort to address distortions that may occur within the valuation process that may otherwise result in understated estimates of the relative resources involved in furnishing psychotherapy services. The work RVUs will be adjusted for the following services:

- CPT code 90832 (Psychotherapy, 30 minutes with patient)
- CPT code 90834 (Psychotherapy, 45 minutes with patient); CPT code 90837 (Psychotherapy, 60 minutes with patient)
- 90839 (Psychotherapy for crisis; first 60 minutes)
- CPT code 90840 (Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
- CPT code 90845 (Psychoanalysis)
- 90846 (Family psychotherapy (without the patient present), 50 minutes)
- CPT code 90847 (Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes)
- CPT code 90849 (Multiple-family group psychotherapy)
- CPT code 90853 (Group psychotherapy (other than of a multiple-family group)
- HCPCS codes GPFC1 and GPFC2 ((Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting)

CMS proposes to adjust the work RVUs for these services by calculating the difference between the total RVUs for evaluation and management office visits (99202-99205 & 99211-99215) billed with the visit complexity code (G2211) and evaluation and management office visits billed without the visit complexity code. If finalized, this would represent a nearly 19% upward adjustment, notwithstanding the impact of the proposed decrease in the Medicare Conversion Factor.

Updates to the Payment Rate for the PFS Substance Use Disorder (SUD) bundle (HCPCS codes G2086-G2088)

In the FY 2023 MPFS, CMS finalized a change to the payment rate for the non-drug component of the bundled payment for episodes of care under the Opioid Treatment Program (OTP) benefit to base the rate for individual therapy on a crosswalk to CPT code 90834 (Psychotherapy, 45 minutes with patient), which reflects a 45-minute psychotherapy session, instead of a crosswalk to CPT code 90832 (Psychotherapy, 30 minutes with patient), as was the policy at the time.

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CMS notes in the proposed rule that they are persuaded by comments in previous rulemaking that noted that patients who are prescribed buprenorphine in non-OTP settings will have similarly complex care needs requiring more intensive therapeutic care, and that CMS should recognize the appropriate complexity and intensity of the services in those settings.

In response, CMS is proposing to increase the payment made for *HCPCS codes G2086 (Office-based treatment for a substance use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month)* and *G2087 (Office-based treatment for a substance use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month)* to reflect two individual psychotherapy sessions per month, based on a crosswalk to the work RVUs assigned to CPT code 90834 (Psychotherapy, 45 minutes with patient), rather than CPT code 90832 (Psychotherapy, 30 minutes with patient).

Accordingly, the total non-facility RVUs for G2086 and G2087 would be 13.89 and 12.83, respectively for the 2024 payment year. That represents a 21% increase in total RVUs for G2086 and a 23% increase in total RVUs for G2087.

Behavioral Health Request for Information

CMS is also seeking feedback on the following topics:

- Ways to increase access to behavioral health integration (BHI) services, including the psychiatric collaborative care model;
- Whether CMS could consider new coding to allow interprofessional consultation to be billed by practitioners who are authorized by statute for the diagnosis and treatment of mental illness;
- Intensive outpatient (IOP) services furnished in settings other than those addressed in the CY 2024 OPPS proposed rule;
- How to increase psychiatrist participation in Medicare given their low rate of participation relative to other physician specialties;
- Whether there is a need for potential separate coding and payment for interventions initiated or furnished in the emergency department or other crisis setting for patients with suicidality or at risk of suicide, such as safety planning interventions and/or telephonic post-discharge follow-up contacts after an emergency department visit or crisis encounter, or whether existing payment mechanisms are sufficient to support furnishing such interventions when indicated; and
- Other ways CMS might consider expanding access to behavioral health services for Medicare beneficiaries.

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Digital Therapies

CMS is seeking a wide variety of information on digital therapeutics. Please see the proposed rule for more information.

Community Health Integration Services

CMS is proposing two new HCPCS codes to describe community health integration (CHI) services. Specifically, these services would be performed by certified or trained auxiliary personnel, which may include a Community Health Worker (CHW), incident to the professional services and under the general supervision of the billing practitioner. CMS is proposing that CHI services could be furnished monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) in which the practitioner identifies the presence of a social determinants of health (SDOH) need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit. Under the proposal, CHI services could be furnished under general supervision of the billing practitioner. Auxiliary personnel who provide CHI services must be certified or trained to perform all included service elements, and authorized to perform them under applicable State laws and regulations. In states where there are no applicable licensure or other laws or regulations relating to providing CHI services to be trained to provide them.

CMS is seeking comment on several items related to the provision of CHI services, including:

1. Whether the agency should consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite initiating visit for CHI services:
2. Whether these services can be provided via telehealth or solely in-person; and
3. Whether patient consent should be required as with other care management services.

The specific code descriptors are:

GXXX1 Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit.

GXXX2 – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to GXXX1).

CMS proposes to assign the RVUs of *CPT code 99490 (Chronic care management services, first 20 minutes of clinical staff time per calendar month)* to GXXX1 and the RVUs of CPT code *99439 (Chronic care management services, each addition 20 minutes of clinical staff time per calendar month)* to code

GXXX2, noting their belief that these values reflect the resource costs incurred when the billing practitioner furnishes CHI services.

Social Determinants of Health

CMS is proposing to create a new G code described by *GXXX5, Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.*

The valuation for GXXX5 would be directly cross-walked to *G0444 (Screening for depression in adults, 5-15 minutes).* CMS is also proposing to add this service to the list of Medicare Telehealth services.

CMS proposes that a SDOH risk assessment be furnished by the practitioner on the same date they furnish an E/M visit, as the SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis, and treatment plan established during the visit. Required elements would include the administration of a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.

CMS is seeking comment on whether the agency should require as a condition of payment for SDOH risk assessment that the billing practitioner also have the capacity to furnish CHI, PIN, or other care management services, or have partnerships with community-based organizations (CBO) to address identified SDOH needs.

The SDOH needs identified through the risk assessment must be documented in the medical record, and may be documented using a set of ICD-10-CM codes known as "Z codes"22 (Z55-Z65) which are used to document SDOH data to facilitate high-quality communication between providers. CMS is proposing that GXXX5 billed no more often than once every 6 months, noting the belief that there are generally not significant, measurable changes to health outcomes impacted by a patient's SDOH in intervals shorter than 6 months.

Annual Wellness Visit (AWV)

CMS is also proposing to add the new SDOH Risk Assessment service as an optional element within the AWV. CMS is proposing that the SDOH Risk Assessment service be paid at 100 percent of the Medicare fee schedule amount. Additionally, under the CMS proposal, the SDOH Risk Assessment service would be separately payable with no beneficiary cost sharing when furnished as part of the same visit with the same date of service as the AWV.

Principal Illness Navigation (PIN) Services

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CMS is proposing to create two new G codes described by *GXXX3 Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month* and *GXXX4 – Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to GXXX3).*

The valuation for GXXX3 would be directly cross-walked to *CPT code 99490 (Chronic care management services, first 20 mins of clinical staff time directed by a physician or other qualified health care professional, per calendar month)* and the valuation for GXXX4 would be directly cross-walked to *CPT code 99439 (Chronic care management service ; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month).*

CMS proposes that PIN services could be furnished following an initiating E/M visit addressing a serious high-risk condition/illness/disease, with the following characteristics:

- One serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation/decompensation, functional decline, or death; and
- The condition requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver.

Similar to the proposal for CHI services, CMS proposes that in order to bill for PIN services, there must first be an E/M initiating visit in which the billing practitioner would identify the medical necessity of PIN services and establish an appropriate treatment plan. The subsequent PIN services would be performed by auxiliary personnel incident to the professional services of the practitioner who bills the PIN initiating visit under the general supervision of the billing practitioner. Auxiliary personnel who provide PIN services must be certified or trained to perform all included service elements and authorized to perform them under applicable State laws and regulations. In states where there are no applicable licensure or other laws or regulations relating to providing PIN services, auxiliary personnel must be trained to provide them.

CMS is seeking comment on whether we should consider any professional services other than an E/M visit performed by the billing practitioner as the prerequisite for the initiating visit for PIN services.

Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

Audio-only flexibilities for periodic assessments

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CMS is proposing to extend the audio-only flexibilities for periodic assessments (HCPCS code G2077) furnished by OTPs through the end of CY 2024, consistent with flexibilities allowed under the CAA, 2023. Under this proposal, CMS proposes to allow periodic assessments to be furnished via audio-only when video is not available to the extent that use of audio-only communications technology is permitted under the applicable SAMHSA and DEA requirements at the time the service is furnished and all other applicable requirements are met.

Direct Supervision

CMS proposed in the proposed rule to continue to allow the presence and "immediate availability" of the supervising practitioner to be through "real-time audio and visual interactive telecommunications" through the end of 2024.

In the case of the supervision of teaching residents, teaching physician can continue to have a virtual presence in all teaching settings but only in clinical instances when the service is furnished virtually. This may continue through to December 31, 2024. Audio-only is not permitted.

Telehealth

As a reminder, Medicare pays for covered telehealth services included on the Medicare telehealth list when furnished by an interactive telecommunications system if the following conditions are met:

- The practitioner is a Medicare provider under statute and licensed under state law to provide the service
- The service is furnished at an originating site as defined in statute, which includes, but not limited to a:
    - Physician office
    - RHC or FQHC
    - Hospital
    - Community Mental Health Center
    - Home of a patient (for the purposes of the treatment of a SU)
    - Home of a patient (for the purposes of the treatment of a mental health disorder under certain circumstances)
- Provided under certain geographic requirements, except that the requirements do not apply to services to treat a SUD or mental health condition

Payment

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For the duration of 2024, for telehealth services provided to patients in their homes, CMS will continue to pay the non-facility rate for these claims. Telehealth services provided in locations other than a patients home will be paid at the facility rate.

Implementation of Provisions of the CAA, 2023

In-person Requirements for Mental Health Telehealth

CMS proposes to implement through regulatory revision the requirements under CAA, 2023 that delays the requirement for an in-person visit with the physician or practitioner within 6 months prior to the initial mental health telehealth service, and again at subsequent intervals as the Secretary determines appropriate. Therefore, the in-person requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder will again be effective on January 1, 2025. Specifically, the implementing regulations will allow a patient's home to serve as an originating site for mental health telehealth services until December 31, 2024. Beginning in 2025, for Medicare mental health telehealth services, patients must have an in-person visit at least 6 months prior to the telehealth visit and within 6 months after any subsequent telehealth visit. This extension also applies to FQHCs and RHCs.

Originating Site Requirements

CMS proposes to implement additional sections of the CAA, 2023 which expands the telehealth originating sites for any service on the Medicare Telehealth Services List to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home, beginning on the first day after the end of the PHE for COVID-19 through December 31, 2024.

Adding Services to the Telehealth List

CMS is proposing to revise the process of adding, revising, and removing codes from the approved list of Medicare telehealth services. Under the proposal, CMS will would approve services as approved, provisional, or rejected, under a revised process.

Remote Monitoring Services

CMS made the following clarifications in the proposed rule:

- Remote physiologic monitoring (RPM) services can only be provided to established patients after the end of PHE.
- The 16-day monitoring requirement is reinstated after the PHE. Monitoring must occur over at least 16 days of a 30-day period.

- CMS notes that although multiple devices can be provided to a patient, "the services associated with all of the medical devices can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected."
- Practitioners may bill RPM or RTM, but not both, concurrently with the following services:
  - Chronic Care Management (CCM)
  - Transitional Care Management (TCM)
  - Behavioral Health Integration (BHI)
  - Principle Care Management (PCM)
  - Chronic Pain Management (CPM)
- RTM and RPM cannot be billed together.

Implementation of Intensive Outpatient Services Benefit

Proposed definition of IOP Services

"Intensive outpatient services means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.44. Intensive outpatient services are not required to be provided in lieu of inpatient hospitalization."

CMS proposes new regulation at *§ 410.44(a)* that defines that *IOP services are services that:*

(1) are reasonable and necessary for the diagnosis or active treatment of the individual's condition; (2) are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; (3) are furnished in accordance with a physician certification and plan of care as specified under new regulations at § 424.24(d); and include any of the services listed in § 410.44(a)(4).

Scope of Benefits (410.44(a)(4))

- Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law);
- Occupational therapy requiring the skills of a qualified occupational therapist;
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients;
- Drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered);
- Individualized activity therapies that are not primarily recreational or diversionary;

- Family counseling (the primary purpose of which is treatment of the individual's
- condition);
- Patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment);
- Diagnostic services; and
- such other items and services as the Secretary may provide (excluding meals and transportation) that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish, taking into account accepted norms of medical practice and the reasonable expectation of patient improvement

CMS also notes in the proposed OPPS rule that it is clarifying that partial hospitalization (PHP) services can be provided to patients with a SUD, in response to concerns from stakeholders.

CMS also proposes under § 410.44(b) that the following services are separately covered and not paid as intensive outpatient services: (1) physician services; (2) physician assistant services; (3) nurse practitioner and clinical nurse specialist services; (4) qualified psychologist services; and (5) services furnished to residents of a skilled nursing facility (SNF).

Patient Eligibility for Services (§ 410.44(c))

CMS proposes to establish that intensive outpatient services are intended for patients who: (1) require a minimum of 9 hours per week of therapeutic services as evidenced in their plan of care; (2) are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment; (3) do not require 24-hour care; (4) have an adequate support system while not actively engaged in the program; (5) have a mental health diagnosis; (6) are not judged to be dangerous to self or others; and (7) have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the intensive outpatient program.

CMS also explicitly notes that the term "mental health diagnosis" would include SUD and behavioral health diagnoses generally.

Coding and Billing

Currently, CMS makes payment on a per diem base to hospital-based and Community Mental Health Centers (CMHC)-based PHP programs based on those programs offering at least 3 services from an approved list of procedures per day.

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CMS is proposing that beginning in 2024, to qualify for payment, PHP and IOP programs (hospital or CMHC-based) would be required to provide at least 3 services from an approved list of services to bill for a per diem. Specifically, CMS proposes to establish 4 separate codes and payment rates for PHP and IOP programs beginning in 2024. Those would be described and valued as follows:

TABLE 45: PROPOSED CY 2024 PHP AND IOP APC GEOMETRIC MEAN PER DIEM COSTS

CY 2024 APC	Group Title	Proposed PHP and IOP APC Geometric Mean Per Diem Costs
5851	Intensive Outpatient (3 services per day) for CMHCs	$97.59
5852	Intensive Outpatient (4 or more services per day) for CMHCs	$153.09
5853	Partial Hospitalization (3 services per day) for CMHCs	$97.59
5854	Partial Hospitalization (4 or more services per day) for CMHCs	$153.09
5861	Intensive Outpatient (3 services per day) for hospital-based IOPs	$284.00
5862	Intensive Outpatient (4 or more services per day) for hospital-based IOPs	$368.18
5863	Partial Hospitalization (3 services per day) for hospital-based PHPs	$284.00
5864	Partial Hospitalization (4 or more services per day) for hospital-based PHPs	$368.18

CMS states in the proposed rule that "since IOPs furnish the same types of services as PHP, just at a lower intensity, we believe it is appropriate to use the same data and methodology for calculating payment rates for both PHP and IOP for CY 2024."

CMS also notes that "we believe setting the IOP payment rates equal to the PHP payments would be appropriate because IOP is a newly established benefit, and we do not have definitive data on utilization. However, both programs utilize the same services, but furnish them at different levels of intensity, with different numbers of services furnished per day and per week depending on the program. Therefore, we believe it is appropriate to pay the same per diem rates for IOP and PHP services unless future data analysis supports calculating rates independently."

CMS also provided an alternative, simplified payment methodology that it is considering implementing for PHP/IOP services that does not take into account whether the service is furnished in a CMHC or hospital. That proposal is listed below:

TABLE 46: ALTERNATIVE CY 2024 PHP AND IOP APC GEOMETRIC MEAN PER DIEM COSTS

Group Title	Alternative PHP and IOP APC Geometric Mean Per Diem Costs
Partial Hospitalization (three services per day)	$281.48
Partial Hospitalization (four services per day)	$316.63
Intensive Outpatient (three services per day)	$281.48
Intensive Outpatient (four services per day)	$316.63

OTPs

CMS proposes to define OTP intensive outpatient services as those services specified in proposed 42 CFR § 410.44(a)(4) when furnished by an OTP as part of a distinct and organized intensive ambulatory treatment program for the treatment of Opioid Use Disorder and that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting.

OTP intensive outpatient services would be services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition; are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; and are furnished in accordance with a physician certification and plan of care. We propose that in order to qualify as "OTP intensive outpatient services," a physician must certify that the individual has a need for such services for a minimum of 9 hours per week and requires a higher level of care intensity compared to existing OTP services.

CMS proposed to establish a new HCPCS add-code that could be billed in addition to the HCPCS code for the primary weekly bundle. The proposed code would be ***GOTP1 (Intensive outpatient services; minimum of nine services over a 7-contiguous day period****, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; individualized activity therapies that are not primarily recreational or diversionary; family counseling (the primary purpose of which is treatment of the individual's condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); diagnostic services; List separately in addition to code for primary procedure.*

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CMS proposes to value HCPCS code GOTP1 based on an assumption of a typical case of three IOP services furnished per day for approximately 3 days per week. After adjustments, the valuation for this code in 2024 would be **$719.67.**

FQHCs/RHCs (389)

CMS proposed to maintain the same patient eligibility, physician certification, and scope of benefits related to IOP services that are provided under the IOP benefit established by the CAA, 2023.

The CAA, 2023 required that IOP services provided in FQHCs/RHCs be the same rate as if they had been covered outpatient department services furnished by a hospital. Therefore, CMS proposes that the rate determined for APC 5861 (Intensive Outpatient (3 services per day) for hospital-based IOPs): $284 would be the payment rate for IOP services furnished in an RHC. For IOP services furnished in FQHCs, CMS proposes that that payment is based on the lesser of a FQHC's actual charges or the rate determined for APC 5861.