Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Clinical program requirements

For behavioral health adult intensive and child intensive services

For Blue Cross commercial, Medicare Plus Blue^{SM}, Blue Care Network commercial and BCN Advantage^{SM}

November 2024

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This document describes the clinical program requirements for adult intensive services, or AIS, and children's intensive services, or CIS. These are wraparound support services that are included in mental health and substance use disorder specialty treatment programming for Blue Cross Blue Shield of Michigan and Blue Care Network.

Purpose of supportive outpatient provider-delivered care management

Blue Cross and BCN members sometimes need significant support and coordination of services to successfully achieve full remission of their illness.

This type of support offered through outpatient provider-delivered care management programs must:

- Coordinate care
- Address the barriers to health care that are often insurmountable for members due to the behavioral, physiological, social and emotional consequences of their conditions

Programs providing outpatient provider-delivered care management that have a successful track record in addressing these needs assist in moving the member from response to remission and support the member's stability over the longer term.

Outpatient care management requires a treatment and support team that is coordinated and that has staffing adequate for a level of outpatient intensity that would typically be provided by an outpatient psychiatric care, or OPC, program or a health care system.

However, it is less likely that a group practice or a single provider would be able to support this level of activity and have access to all the providers needed to perform the required program tasks.

For providers able to offer the treatment and support services involved in outpatient provider-delivered care management, this document outlines the requirements for these adult intensive services and children's intensive services.

Procedure codes and prior authorization requirements

For outpatient provider-delivered care management services offered in the form of AIS or CIS, these procedures codes and prior authorization requirements apply:

- For members without an autism diagnosis: Use complex chronic care management codes *99487 and *99489. These codes don't require prior authorization.
- For members with an autism diagnosis: Autism spectrum disorder codes *97151 through *97158 may apply. These codes require prior authorization.

  Note: These services can be used to focus on autism-related care management issues and coordination of complex treatment protocols for targeting autism behaviors. Two separate licensed behavior analysts, or LBAs, (the primary outside referring LBA and the CIS program's specialist LBA) **may** be involved in the treatment of neurobehavioral symptoms during the same interval for a month or two until the escalated behavior is addressed by the specialist LBA and the member returns to a new baseline. However, the two LBAs may not treat the member during the same session.

Any services **not** covered by the codes shown above can be billed in line with the behavioral health fee schedule — for example, for crisis psychotherapy, psychiatric time, individual or group psychotherapies, or individual therapy with prolonged service codes for extended sessions.

Members' eligibility and benefits

Health care coverage varies for different contracts and for different groups. If there's a difference between the services described in this document and the services available under a member's Blue Cross or BCN contract, the contract applies.

Providers offering AIS or CIS programs should check each member's eligibility and benefits. To do that, complete these steps:

1. Log in to our provider portal (availity.com**)
2. On the Patient Registration menu, select *Eligibility and Benefits Inquiry*.
3. Follow the prompts.

Staffing model: Roles and tasks

To be eligible for reimbursement, AIS and CIS programs must have the following provider types available:

- Psychiatrist (MD or DO): Orders AIS or CIS and signs off on the orders for each case

  Note: Services are billed by the ordering psychiatrist.
- Program supervisor: Does community outreach, leads the care coordination huddles, coordinates community outreach, supports incoming referrals and requests prior authorization for services
- Team lead / behavioral health clinician (licensed Master's-level clinician): Completes intake assessments and therapy services (direct and indirect) and directs the behavioral health care managers
- Behavioral health care manager (limited-license Master's-level social worker, qualified behavioral health professional or Bachelor's-level social worker): Provides a broad range of care management activities (direct and indirect) under the direction of the team lead or behavioral health clinician, as outlined in the member's individual service plan
- Community health worker (certified peer support specialist or recovery coach or community health worker: Provides outreach and coordinates support services assigned as directed by a behavioral health care manager

Key components of the interventions

For all intervention types, face-to-face community-based services are preferred. In special circumstances, some services for members could be delivered through audiovisual telemedicine.

Outpatient provider-delivered care management services delivered through AIS or CIS programs must:

- Be carried out by a community health worker or a peer support specialist, or both, and supervised by a Master's-level provider or team lead
- Be facilitated by and coordinated with all involved, as applicable — for example, by the member's primary care provider, therapist, psychiatrist, parents or caregiver, emergent assessment facility or others
- Include the development of a treatment plan
- Coordinate all appliable resources to address the social determinants of health, which includes but is not limited to:
  - School or other family or caregiver needs, including coordination of care between providers for consultation, education, training, and collaboration according to best practices, to meet the complex needs of the member
  - Legal needs related to managing involuntary treatment on a continuing basis under assisted outpatient treatment laws, as applicable
- Provide supervision or coordination of interventions for these member needs:
  - Peer support partner or parent support partner or both
  - In-home services, including the potential of in-home respite care
  - Programming and close coordination of all treatment and support providers, for members with an autism diagnosis

Levels of care

See the information below for the AIS and CIS levels of care related to:

- Procedure code *99487, for complex chronic care management services, first hour — one unit billed monthly
- Procedure code *99489, for complex chronic care management, subsequent 30 minutes — total units billed monthly

For each level of care, the information includes:

- The caregivers and services to be provided
- The member needs and identified concerns to be addressed, including the associated scores on the Preschool And Early Childhood Functional Assessment Scale, or PECFAS, and the Child And Adolescent Functional Assessment Scale, or CAFAS

Level 1

The typical length of stay for Level 1 is two to three months.

Note: If the member needs only medication management, Level 1 may or may not include all the services listed below. It may include case management, as needed, in consultation with the Blue Cross or BCN case manager.

Level 1: Caregivers and services	Level 1: Member needs and identified concerns

Based on the member's individualized treatment plan and the family's service needs, the following services will be offered in Level 1 by the caregivers identified below:
• Case manager (support coordinator) — Up to 18 hours per month of provider-delivered care management:
  o Facilitates and coordinates with all parties involved as needed, including the primary care provider, therapist, psychiatrist, parents/caregiver, emergent assessment facility and others
  o Develops the treatment plan
	The behavioral health or autism services needs are based on the following:
	• Member shows regression in behavior or baseline functioning with change in family dynamics related to changes in home, social or school environment. See note below.
	• Provider should consider medication re-evaluation needs.
	• Parent/child is concerned about or struggles with issues related to new medications.
	• Parent is engaged but has limited skills and requires further treatment and/or support.
	• Parent is in need of assistance in developing further identified resources.
	• Parent/child needs support with developmental transitions or school issues. See note below.

<table>
<tr><th>Level 1: Caregivers and services</th><th>Level 1: Member needs and identified concerns</th></tr>
<tr><td>
<li style="list-style:none">
Links resources related to the social determinants of health — for example, connects with school, other family members and caregivers to coordinate care among providers, including consultation, education, training, and collaboration on best practices to address the complex needs of the member
Supervises or coordinates interventions in the pertinent areas of the member’s need, including parent support partners (peer)

Parent support partners (peer)
Note: State-certified partners are preferred.
Complement the coordination and implementation of the management issues for a particular member’s support system and caregivers

</td><td>

Post-crises support is needed for family and child.
Parent/caregiver is highly motivated and engaged in applied behavioral analysis or other behavioral health services.
A refresher is needed to assist in stabilizing a crisis.
Child is near baseline.
Regression is less severe related to developmental milestones or environmental changes.
Coordination with current interventions by treating board-certified behavioral analyst and other community supports is needed to transition out of crisis programming.

Note: PECFAS / CAFAS scores are 50-80. (This does not apply to autism spectrum disorder because this is not normed.) A score of 49 or lower may indicate readiness for discharge to outpatient treatment; a score of 81 or more may indicate a need to transition to a higher level of care.
</td></tr>
</table>

Level 2

The typical length of stay for Level 2 is one to two months.

<table>
<tr><th>Level 2: Caregivers and services</th><th>Level 2: Member needs and identified concerns</th></tr>
<tr><td>
Based on the member’s individualized treatment plan and the family’s service needs, the following services will be offered in Level 2 by the caregivers identified below:
Case manager (support coordinator) — Up to 50 hours per month of provider-delivered care management
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The behavioral health or autism services needs are based on the following:
The family is verbalizing or experiencing stressors related to managing care for the family and/or member’s needs and those stressors are overwhelming the family. See note below.
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<table>
<tr><th>Level 2: Caregivers and services</th><th>Level 2: Member needs and identified concerns</th></tr>
<tr><td>

<li style="list-style-type:circle">Facilitates and coordinates with all parties involved as needed, including the primary care provider, therapist, psychiatrist, parents/caregiver, emergent assessment facility and others
<li style="list-style-type:circle">Develops the treatment plan
<li style="list-style-type:circle">Links resources related to the social determinants of health — for example, connects with school, other family members and caregivers to coordinate care among providers, including consultation, education, training, and collaboration on best practices to address the complex needs of the member
<li style="list-style-type:circle">Supervises or coordinates interventions in the pertinent areas of the member's need, including intensive home-based treatment, peer support partners and parent support partners

Intensive home-based treatment with child and family, as clinically appropriate
Peer support partners (behavioral health)
Note: State-certified partners are preferred.
<li style="list-style-type:circle">Complement the coordination and implementation of the management issues for a particular member's support system and caregivers
Parent support partners (autism spectrum disorder)
Note: State-certified partners are preferred.
<li style="list-style-type:circle">Complement the coordination and implementation of the management issues for a particular member's support system and caregivers

</td><td>

There is a decrease in the number of physical/verbal outbursts, but the member has not returned to baseline. See note below.
There are a limited number of attempts at self-injurious behavior.
Medication adjustments and monitoring continue.
Interventions are focused on specific behaviors addressed in the environment in which they occur — for example, at home, in school or at play.
The frequency of redirection is increased.
There is the potential to step down from a higher level of care or to step up due to escalation of symptoms and behaviors.
There is regression in the member's behavior of with changes in the family dynamics related to home, social, environmental or developmental transition.
Parent is engaged but has limited skill and requires additional support in developing and/or identifying community resources.

Note: PECFAS / CAFAS scores are 80-100. (This does not apply to autism spectrum disorder because this is not normed.) A score of 80 or lower may indicate readiness for transition to a lower level of care; a score of 011 or more may indicate a need to transition to a higher level of care.
</td></tr>
</table>

Level 3

The typical length of stay for Level 3 is one month or more, with one of the following goals:

- Stabilization and step-down
- Urgent assessment, to evaluate for a higher level of care

Level 3: Caregivers and services	Level 3: Member needs and identified concerns

Based on the member's individualized treatment plan and the family's service needs, the following services will be offered in Level 3 by the caregivers identified below:
• **Case manager (support coordinator)** — Up to 90 hours per month of provider-delivered care management
  ○ Facilitates and coordinates with all parties involved as needed, including the primary care provider, therapist, psychiatrist, parents/caregiver, emergent assessment facility and others; this includes coordination of services provided in the member's home
  ○ Develops the treatment plan
  ○ Links resources related to the social determinants of health — for example, connects with school, other family members and caregivers to coordinate care among providers, including consultation, education, training, and collaboration on best practices to address the complex needs of the member
	The behavioral health or autism services needs are based on the following:
	• The member requires a high frequency of redirection/supervision at home, at school and/or in the community.
	• The member exhibits severe behavioral problems involving regression of behaviors at home or school; these may include assaultive/escalating physical aggression, destructive behavior, self-injurious behaviors, unstable mood dysregulation and/or reported suicidality.
	• The member's medication regime requires modification or change.
	• The member engages in redirectable self-injurious behaviors.
	• The family requires intensive support and improvement of parent/caregiver skills. See note below.
	• There's a need to assess parent/family needs in the interests of their own well-being.
	• A brief respite from the living environment appears likely to stabilize.
	• The social/family supports are poor. See note below.
	• The family/caregiver is nonadherent or exhibits limited adherence to the treatment plan and/or interventions.
	• The member is severely agitated and exhibits behavior that is poorly controlled at home, at school or socially. See note below.

<table>
<tr><th>Level 3: Caregivers and services</th><th>Level 3: Member needs and identified concerns</th></tr>
<tr><td>
<li style="list-style:none">
Supervises or coordinates interventions in the pertinent areas of the member’s need, including parent support partners (peer) and in-home respite
Parent support partners (peer)
Note: State-certified partners are preferred.
In-home respite
Complements the coordination and implementation of the management issues for a particular individual’s support system and caregivers
</td><td>
The member may have psychotic symptoms and the caregivers are out of options.
The member’s risk level for suicide or homicide may be escalated; there’s a need to assess the risk level.
The parent/caregiver is “out of options” for caregiving.
Note: PECFAS / CAFAS scores are 101 or more. (This does not apply to autism spectrum disorder because this is not normed.) A score of 100 or lower may indicate readiness for transition to a lower level of care.
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</table>

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