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Provider Notice

To:	**All IBHS Providers and Prescribers**
From:	**PerformCare**
Date:	**April 18, 2022**
Subject:	**IBHS 22-103 IBHS Group and ABA Group (formerly Summer Therapeutic Activities Program - STAP)**

This Provider Notice serves to inform Individual and ABA IBHS providers and IBHS prescribers of changes made to the program formerly known as the Summer Therapeutic Activities Program (STAP). With the implementation of IBHS, STAP is categorized as a group service and must be prescribed as such. Below is the specific terminology to be used in Written Orders as well as the new procedure codes for each group type, noted parenthetically:

- IBHS Group (H2021 HQ)
- IBHS ABA Group (97154)

These services will follow PerformCare's IBHS group process, and Written Orders prescribing IBHS Group or IBHS ABA Group should be sent to that provider. A complete request for this service consists of:

- Submission Sheet
- Written Order/Best Practice Evaluation
- Proposed Treatment Plan

Attached to this memo is an updated copy of the IBHS Written Order that reflects these changes for use by prescribers. Specific information regarding providers who will be offering this service, dates, etc. is forthcoming. Contact your Account Executive with any questions.

cc: Lisa Hanzel, PerformCare
Scott Suhring, Capital Area Behavioral Health Collaborative
Missy Reisinger, Tuscarora Managed Care Alliance
PerformCare Account Executives

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Intensive Behavioral Health Services (IBHS) Written Order Form

Today's Date: _____

Member's Name: _____ MAID#: _____ DOB: _____

Member's Current Address:_____ Foster Care Placement? ☐ Yes ☐ No

Current Member/Family/Guardian phone #: _____ Alternate phone #: _____

Member County: ☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Fulton ☐ Lancaster ☐ Lebanon ☐ Perry

Following my recent face-to-face appointment and/or evaluation with _____ , and after considering less restrictive, less intrusive levels of care such as _____, I am prescribing the service listed below per this IBHS Order.

It is medically necessary that _____ receive a comprehensive face-to-face assessment for Intensive Behavioral Health Services (IBHS).

Along with this written order, I have included clinical documentation to support the medical necessity of the services ordered, including a behavioral health disorder diagnosis (listed in the most recent edition of the DSM or ICD), and measurable improvements in the identified therapeutic needs that indicate when services may be reduced, changed, or terminated, as per regulations.

I. Current Behavioral Health Diagnoses: _____

Current Medical Diagnoses: _____

II. Recommendations:

Intensive Behavioral Health Service Type	Specific Level of Care	Maximum number of hours per month	Setting(s) in which IBHS is necessary
☐ IBHS Individual Services	☐ Behavior Consultant (BC) ☐ Behavioral Health Technician (BHT) ☐ Mobile Therapist (MT)	Up to ____ hours per month Up to ____ hours per month Up to ____ hours per month	☐ Home ☐ Center-based ☐ School ☐ Community, specify: _____
☐ IBHS Individual Services, Other	☐ Flexible Outpatient - Mobile Therapy (Flex-MT) ☐ Functional Family Therapy (FFT)	Up to ____ hours per month Up to 90 hours per month	☐ If applicable, specify setting(s) other than the individual service site:

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	☐ Juvenile Fire setter Assessment Consultation Treatment Services (JFACTS) ☐ Multi-systemic Therapy (MST) ☐ Specialized In-Home Treatment Services (SPIN)	Up to _20_ hours per month Up to _50_ hours per month Up to _50_ hours per month	_____
☐ IBHS ABA Services	☐ Behavior Analytic ☐ Behavior Consultant-ABA (BC-ABA) ☐ Assistant Behavior Consultant-ABA (Assistant BC-ABA) ☐ Behavioral Health Technician (BHT-ABA)	Up to ____ hours per month Up to ____ hours per month Up to ____ hours per month Up to ____ hours per month	☐ Home ☐ Center-based ☐ School ☐ Community, specify: _____
☐ IBHS Group Services (Non-ABA)	☐ After School Program (ASP) ☐ Intensive Day Treatment (IDT) ☐ IBHS Group	Up to _115_ hours per month Up to _200_ hours per month Up to ____ hours per month	☐ If applicable, specify setting(s) other than the group service site: _____
☐ IBHS ABA Group Services	☐ Early Intensive Behavioral Intervention (EIBI) ☐ Enhanced Intensive Behavioral Services (EIBS) ☐ Stepping Stones ☐ IBHS ABA Group	Up to _161_ hours per month Up to _110_ hours per month Up to 115 hours per month Up to____ hours per month	☐ If applicable, specify setting(s) other than the group service site: _____

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III. Please provide clinical information to support your recommendation and medical necessity for all services selected above: Clinical information should include the frequency, intensity, and duration of each specific behavior noted.

IV. Please detail all measurable improvements in targeted behaviors described above that will indicate when the services recommended may be reduced, changed, or terminated.

V. Signature of Prescriber: _____ Date: _____

Printed Name of Prescriber: _____

Please indicate professional title:

☐ Licensed Physician ☐ Licensed Psychologist ☐ CRNP ☐ Physician Assistant ☐ LPC ☐ LCSW ☐ LMFT

MA Provider ID: _____ Provider NPI#: _____
(Please enter the 9-digit MA Provider #)

Note: All aspects of this form need to be completed or the request will not be valid.