

Clinical Policy: Intensive Behavioral Supportive Supervision

Reference Number: WA.CP.BH.528

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[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy describes the authorization guidelines for Intensive Behavioral Supportive Supervision (IBSS) services, which are Health-Related Social Needs (HRSN) services that may be provided in lieu of a service or setting (ILOS) as defined in 42 CFR 438.3(3)(2). An ILOS can be used as an immediate or longer-term substitute for a service or setting that is covered under Apple Health, or when the ILOS can be expedited to reduce or prevent the future need to utilization the covered service or setting. Services likely to be avoided with the provision of ILOS include: inpatient and outpatient hospital services, emergency hospital services, crisis intervention and crisis stabilization.

IBSS services are defined as direct, in-person monitoring, redirection, diversion, and cueing of the member to prevent at-risk behavior that may result in harm to the member or others. It provides individuals with person-centered assistance to build skills and resiliency to support stabilized living and integration.¹ These services may be habilitative or rehabilitative to support individuals to remain stable in the community. Supportive supervision should include integration of behavior support and/or crisis plans to help ensure community stability and an escalation process for collaborative care.²

The target population includes

- members who are at risk of hospitalization or institutionalization where previous institutionalization may have negatively impacted the members' quality of life due to frequent provider movements and hospitalization.
- Members who have exceptional behavioral care needs requiring additional supports in the community due to being unable to remain stable outside of hospital or institutional settings without behavioral supports.
- All members in IMC, IFC or BHSO are potentially eligible.

The coverage period is determined by the client's care needs, such as 3 months, 6 months or 12 months depending on client stability. No authorization period may exceed 12 months.

Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority guidance, that IBSS may be **medically appropriate** when ALL the following conditions are met:

¹ *Health-Related Social Needs (HRSN) Services & In Lieu of Services (ILOS) Policy Guide*. Page 12.

² *Health-Related Social Needs (HRSN) Services & In Lieu of Services (ILOS) Policy Guide*. Page 13.

- A. Member is 18 years of age or older,
- B. Member has had a medically necessary hospital admission (not including emergency department or hospital observation stays, unless visit is longer than 72 hours with a barrier to discharge related to IBSS behaviors) within 12 months prior to initial authorization of IBSS,
- C. Clinical documentation to support the Member is part of the IBSS target population, as demonstrated by
 - i. Member has been diagnosed with severe cognitive impairment, such as
 - 1. Traumatic brain injury,
 - 2. Autism spectrum disorders,
 - 3. Developmental delay,
 - 4. Dementia,
 - 5. Encephalopathy,
 - 6. Substance use disorder impacting cognitive functioning chronically (over 3 months),
 - 7. Other diagnosis/conditions that that chronically (>3 months) impact cognitive function and ability to perform **ADLs** independently,
 - ii. At risk for hospitalization or institutionalization where history of institutionalization or other life events or experiences may negatively impact quality of life due to frequent changes in placements, movements, hospitalization, and admissions to other therapeutic settings,
 - iii. Presence of exceptional behavioral care needs requiring additional supports in the community due to inability to remain stable outside of hospital or institutional settings without behavioral supports,
- D. All other appropriate service options have been exhausted. The member must have care needs met through IBSS that cannot be serviced by other existing Apple Health programs. Member's who may be eligible for other programs must have a determination by the other service prior to IBSS authorization.
- E. Member has clinical complexity that requires the level of supplementary or specialized services and staffing available only under the IBSS services, as evidenced by at least one or more of the following with the past year:
 - i. Two or more assaultive incidents related to a health condition during inpatient or long-term care that can only be prevented with a high level of staffing and/or skilled staff intervention. Self-endangering behaviors related to a health condition that would result in bodily harm if not prevented with a high level of staffing and/or skilled staff intervention.
 - ii. Intrusiveness (e.g., rummaging, unawareness of personal boundaries) related to a health condition that places the individual at risk of assault by others if not prevented with a high level of staffing and/or skilled staff intervention.
 - iii. Symptoms that cause distress to and escalate the individual and/or other residents to crisis if not monitored and redirected by staff. Without intervention, this could result in institutional care.

- iv. Sexual inappropriateness related to a health condition that requires skilled staff intervention to redirect to maintain safety of the individual and other vulnerable adults.
 - v. A history of any of the above behaviors, which are currently only prevented by additional skilled staff intervention.
 - vi. For currently hospitalized clients, subspecialties must have consulted as medically necessary to assess care needs (e.g., psychiatry).
- F. The provider's Plan of Care addresses all the following elements updated for the authorization period under review:
- i. Care specific to the member/enrollee's needs,
 - ii. Staffing plan to demonstrate the amount of staffing support for IBSS is medically appropriate for the covered diagnosis and behaviors,
 - iii. Proactive crisis response planning,
 - iv. Staffing readiness to support individual's behaviors and support needs while maintaining safety in the shared environment, and
 - v. Re-evaluation plan specific to member/enrollee's presentation to ensure the appropriate level of support for community stability. Proactively determined plan specifically designed to respond to the individual's behavioral stability to evaluate need to adjust IBSS hours to ensure the appropriate level of support for community stability. Example(s): trial period reduction or wean from supportive supervision after one month of stability without need of caregiver intervention. Due to client's frequency in escalation pattern, evaluation to determine if adjusting hours per day warranted to support reduced crisis/de-escalation.

NOTE: Funding for IBSS services comes from General Fund State (GFS). When GFS funding for the year has expired, services may be administratively denied.

- II.** It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority guidance, that IBSS does not include:
- A. The provision of personal care, though that can be provided concurrently.
 - B. The provision of room and board.

DDA/ALTSA

For member/enrollees served by the Department of Social and Health Services through Developmental Disabilities Administration (DDA) or Aging and Long-Term Support Administration's (ALTSA) Home and Community Services (HCS):

- The DDA or HCA case manager performs the assessment and updates the client's record in the Comprehensive Assessment Reporting Evaluation (CARE) tool to include the member's individual care needs. The ILOS care is best informed when the HCA or DDA case manager provides this information to the provider and the MCO prior to the ILOS authorization submission, which supports the provider in developing the plan of Care for the ILOS submission.
- For approved ILOS, the MCO shall submit a copy of the Plan of Care to the member/enrollee's HCS or DDA case manager.

Tiering Guidelines

When determining the appropriate level of support needed for an individual, consider the frequency and timing of behaviors (i.e., difficulty with transitions in activities, wakefulness at night, behaviors at mealtimes, etc.).

Source data or information to utilize:

- Comprehensive Assessment Reporting Evaluation (CARE) assessment, recent discharge records from inpatient setting(s), claims data, Predictive Risk Intelligence System (PRISM), clinical data repository, etc.
- Direct consultation with the discharge social worker, managed care liaison, Home and Community Services (HCS) or Area Agency on Aging (AAA) case manager, etc.
- Outpatient, inpatient and other medical records.

Initial authorization for IBSS requires meeting the threshold for Tier 4 or higher. Authorization may be subsequently given for Tier3 as behaviors stabilize.

Rate Tier	Guidance	Examples
Tier 3 6.1-10 hours per day	The member demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 6.1-10 hours per day of 1:1 staffing to redirect, engage, de-escalate, and cue to promote community stability and to ensure the safety of the individual and other residents OR The member has demonstrated multiple qualifying behaviors requiring an average of 6.1-10 hours per day of 1:1 staffing within the past month. Behaviors may be well-managed in a highly structured setting but are at risk of recurring in a community setting if not met with the appropriate level of Supportive Supervision OR For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.	• May include behavioral examples from previous Tier(s) and • Irritability and agitation often expressed through intimidating behavior or posturing • Requires close monitoring to prevent intentional self-injury • Engages in wandering but redirectable if closely monitored • Sexually inappropriate comments • If awakens during night to toilet, able to return to bed without excessive prompting
Tier 4 10.1-15 hours per day	The member demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 10.1-15 hours per day of 1:1 staffing to redirect, engage, de-escalate, and cue to promote	• May include behavioral examples from previous Tier(s) and • Assault on staff or other residents within the past 6 months

Rate Tier	Guidance	Examples
	community stability and to ensure the safety of the individual and other residents OR The member has demonstrated multiple qualifying behaviors requiring an average of 10.1-15 hours per day of 1:1 staffing within the past month. Behaviors require at least 1:1 intervention even in a structured setting but may be at risk of increasing in frequency and/or severity in a community setting if not met with the appropriate level of Supportive Supervision OR For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.	- Requires close monitoring during most awake hours to prevent and redirect elopement attempts - Routinely engages in property damage which may include breaking/throwing items - Engages in sexually inappropriate behavior (e.g., exposure, public masturbation, groping, etc.)
Tier 5 15.1-20 hours per day	The member demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 15.1-20 hours per day of 1:1 staffing to redirect, engage, de-escalate, and cue to promote community stability and to ensure the safety of the individual and other residents OR Behaviors require daily 1:1 intervention even in the context of a structured setting and there would be an imminent risk of harm should the member not receive an average of 15.1-20 hours per day of at least 1:1 staffing in a community setting. OR For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.	- May include behavioral examples from previous Tier(s) and - Regularly engages in assaultive behavior toward staff or other residents - Has an irregular sleep schedule or frequent awakening and requires 1:1 whenever awake to address disruption to other residents - Elopement attempts and/or wandering that place the individual's safety as risk may occur multiple times per month - Safety concerns include recent or historical pattern of fire-setting behavior - Disorganized behavior places the individual at risk of harm if unaccompanied in the community - There is a very recent or prolonged history of sexually aggressive behavior
Tier 6 20.1-24 hours per day	The member demonstrates multiple qualifying behaviors at a frequency and intensity that requires an average of 20.1-24 hours per day of 1:1 staffing and/or regular	May include behavioral examples from previous Tier(s) and

Rate Tier	Guidance	Examples
	episodes that require multiple staff to redirect, engage, de-escalate, and cue to promote community stability and to ensure the safety of the individual and other residents OR Behaviors require constant 1:1 monitoring and intervention even in the context of a structured setting and there would be an imminent risk of harm should the member not receive an average of 20.1-24 hours per day of at least 1:1 staffing in a community setting. OR For renewal or re-assessment, the individual has a history of behavior(s) meeting the guidelines above, which are currently only prevented by additional skilled staff intervention at this tier level.	- Consistently engages in assaultive behavior toward staff or other residents at baseline - Demonstrates a consistent pattern of self-harming behavior that is only prevented with line-of-sight supervision - Is consistently awake at night engaging in behavior that causes a significant threat to safety, such as those that could lead to fire or predatory behavior toward other residents - Elopement attempts may occur multiple times per week and elopement could lead to an imminent threat to individual or community safety - Demonstrates current sexually aggressive behavior that is directed toward a specific target

Billing Instructions

Attendant care services (S5126) must be pre-authorized. The unit for billing is day. One unit equals one day. The code, S5126, must be billed with modifier -SE and an additional modifier based on time:

Hours per Day	ILOS Modifier	Tier Modifier
0.5-2	SE	None
2.1-6	SE	TF
6.1-10	SE	HE
10.1-15	SE	TG
15.1-20	SE	HK
20.1-24	SE	HI

Taxonomy code of the provider submitted on the claim must be one of the following:

Taxonomy	Description
311ZA0620X	Adult Family Home (AFH)
3104A0625X	Enhanced Services Facility (ESF)
310400000X	Assisted Living Facility (ALF)
310400000X	Adult Residential Care (ARC) Facility

310400000X	Enhanced Adult Residential Care (EARC) Facility
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Background

This policy is based on the Washington State Health Care Authority (HCA) *HRSN Services Policy Guide*.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HPCS Codes	Description
S5126	Attendant Care Services

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	01/24	02/24
Added Tiering Guidelines. Changed “IBSS Modifier” to “ILOS Modifier”. Changed policy number to include Behavioral Health (BH).	05/24	05/24
Annual review. Updated description: added “services likely to be avoided”, added “Qualifying Population”, clarified duration of authorization. Updated references.	03/25	03/25
Corrected time limit from 16 to 15 for tier 4. Corrected Tier 6 modifier to HI.	03/25	04/25
Added GFS Funding qualification.	07/25	08/25
Revised, added new authorization Tier requirement	11/25	11/25
Added recent hospitalization requirement; removed Tiers 1 and 2.	08/26	01/27

References

1. Washington State Health Care Authority. [*Health-Related Social Needs \(HRSN\) Services & In Lieu of Services \(ILOS\) Policy Guide*](#). Accessed July 1, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, treatment or care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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