DRAFT

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

Table of Contents

DRAFT

Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

1.0 Description of the Procedure, Product, or Service

Respite services provide periodic support and temporary relief to the primary caregiver(s) from the responsibility and stress of caring for a child or adolescent beneficiary ages 3-20 with mental health or substance use disorders, or for child, adolescent, or adult beneficiary with an Intellectual or Developmental Disability (I/DD) or Traumatic Brain Injury (TBI). This service enables the primary caregiver(s) to meet or participate in planned or emergency events, and to have planned breaks in caregiving. Respite may include in and out-of-home services, inclusive of overnight, weekend care, or emergency care (family emergency based, not to include out of home crisis). Respite may be provided in an individual or group setting.

1.1 Definitions

1.1.1 Primary caregiver:

Is the person principally responsible for the care and supervision of the beneficiary and must maintain their primary residence at the same address as the beneficiary.

1.1.2 Periodic:

Means occurring at occasional intervals.

1.1.3 Planned:

Is decided on and arranged in advance.

1.1.4 Unexpected or unplanned:

Needs are unforeseen and respite care should be arranged for as soon as possible.

1.1.5 Traumatic Brain Injury (TBI):

An injury to the brain caused by an external physical force resulting in total or partial functional disability, psychosocial impairment, or both, and meets all the following criteria:

a. involves an open or closed head injury;
b. resulted from a single event or resulted from a series of events which many include multiple concussions;
c. occurs with or without a loss of consciousness at the time of injury;
d. results in impairments in one or more areas of the following functions: cognition, language, memory, attention, reasoning, abstract thinking, judgement, problem-solving, sensory, perceptual, and motor abilities, psychosocial behavior, physical functions, information processing, and speech; and
e. does not include brain injuries that are congenital or degenerative.

1.1.6 Intellectual or Developmental Disability (I/DD):

A severe, chronic disability attributed to a cognitive or physical impairment, or a combination of cognitive and physical impairments diagnosed or that manifests before 22 years of age. The condition is likely to continue indefinitely and substantially impacts the beneficiary's functioning in three or more of the following areas of major life activity:

a. self-care;
b. receptive and expressive language;
c. learning;
d. mobility;
e. self-direction;
f. capacity for independent living; or
g. economic self-sufficiency.

1.1.7 Serious Emotional Disturbance (SED):

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), "for people under the age of 18 years of age, the term Serious Emotional Disturbance refers to a diagnosable mental, behavioral, or emotional disorder in the past year which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities."

1.1.8 Functional Impairment:

As defined by SAMHSA is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>

An applicant may be approved for Medicaid if the applicant meets all eligibility requirements. A beneficiary may become retroactively eligible for Medicaid while receiving covered services.

Retroactively eligible beneficiaries are entitled to receive Medicaid covered services and to be reimbursed by the provider for all money paid during the retroactive period except for any third-party payments or cost-sharing amounts. The qualified provider may file for reimbursement with Medicaid for these services.

Medicaid shall cover Respite services for an eligible beneficiary who meets the criteria in **Section 3.0** of this policy.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health

problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover Respite when ALL following criteria are met:

a. The beneficiary is either:
   1. ages 3 through 17 and has a documented primary diagnosis of a serious emotional disturbance (SED) as defined above in **Section 1.1**, or a primary diagnosis of substance use disorder (SUD), severe, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or any subsequent editions of this reference material; OR,
   2. ages 3 and older has a documented primary diagnosis of IDD or TBI
      A. as defined above in **Section 1.1**; or
      B. A DSM - 5 (or later) diagnosis of ID, Unspecified ID, or ASD; or

C. A genetically diagnosed syndrome that is typically associated with I/DD (e.g., Down Syndrome); or
D. TBI as defined currently in **section 1.1**.

b. The beneficiary requires continuous supervision due to their diagnosis; AND
c. One of the following is met:
   1. the primary caregiver(s) needs periodic support and relief from the responsibility and stress of caregiving; OR,
   2. the beneficiary needs periodic support and relief from the primary caregiver(s).
d. There are no other natural resources and supports available to the primary caregiver to provide the necessary relief of substitute care.

3.2.3 Admission Criteria

a. A standardized independent evaluation completed by a Tailored Plan (TP) or Prepaid Inpatient Health Plan (PIHP) to determine beneficiary eligibility for 1915(i) benefit based on the needs-based criteria; AND
b. An Independent Assessment completed by a care management agency that indicates the beneficiary is eligible for respite.

3.2.4 Continued Stay Criteria

Medicaid shall cover continued stay when the following criteria are met:

a. The beneficiary continues to meet Admission Criteria for service. Refer to **Subsection 3.2.4**.
b. The primary caregiver continues to need temporary relief from caregiving responsibilities of the child with:
   1. mental health,
   2. severe substance abuse,
   3. a developmental disability,
   4. a Traumatic Brain Injury;
   5. Or an adult with a developmental disability or
   6. an adult with a Traumatic Brain Injury.
c. The adult with IDD or TBI has limitation in adaptive skills that require supervision in the absence of the primary caregiver; and
d. For all of the above there are no other natural resources and supports available to the primary caregiver to provide the necessary relief of substitute care.

3.2.5 Transition and Discharge Criteria

The beneficiary meets the criteria for discharge if any ONE of the following applies:

a. The beneficiary does not meet Admission Criteria for service. Refer to **Subsection 3.2.4**;
b. Respite is no longer identified within the Individual Support Plan or Service Plan.;
c. sufficient natural family supports have been identified to meet the need of the caregiver; or
d. The child, adolescent or adult moves to a residential setting that has paid caregivers.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None apply.

4.2.2 Medicaid Additional Criteria Not Covered

In addition to the Specific Criteria Not Covered in **Subsection 4.2.1** of this policy, Medicaid shall not cover:

a. Transportation to and from school; to medical appointments or transportation of family members;
b. This service does not cover the cost of transportation;
c. Any formal habilitation goals;
d. Covered services that have not been rendered;
e. Services provided to teach academic subjects or as a substitute for education personnel;
f. Interventions not identified on the beneficiary's care plan or person-centered plan;
g. Services provided without prior authorization;
h. Services provided to children, spouse, parents or siblings of the beneficiary under treatment or others in the beneficiary's life to address problems not directly related to the beneficiary's needs and not listed on the care plan or person-centered plan;
i. Respite may be used to provide temporary relief to a beneficiary who resides in Licensed and Unlicensed Alternative Family Living Situations (AFLs); and must not be billed on the same day as Residential Supports;
j. Payment for room and board; and
k. Staff sleep time is not billable.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for Respite. The provider shall obtain prior approval before rendering service.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2 of this policy.

5.2.2 Specific

a. No more than 1,536 units (384 hours) can be provided to a beneficiary in a plan year.
b. For 24-hour respite, providers shall bill for the time staff were awake providing supports.
c. Units for 1915(i) respite are 15-minute increments.

5.3 Additional Limitations or Requirements

a. Respite must not be provided by relatives or legal guardians if they live in the same home as the beneficiary; and
b. the beneficiary receiving this service must live in a non-licensed setting, with non-paid caregiver(s). (The only exception is a beneficiary who resides in a licensed or Unlicensed Alternative Family Living (AFL) situations can utilize respite and, respite must not be billed on the same day as Residential Supports).

Note: Respite is intended for the relief of the primary caregiver that resides within the primary residence with the beneficiary. The individual providing the relief through respite must not be provided by relatives or legal guardians or person residing with the beneficiary.

5.4 Service Order

Service order is a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the beneficiary's needs. A signed service order must be completed by one of the following;

a. qualified professional,
b. licensed behavioral health clinician,
c. licensed psychologist,
d. physician,
e. nurse practitioner, or
f. physician assistant per his or her scope of practice.

Service order is valid for one calendar year. Medical necessity must be reassessed, and service must be ordered at least annually, based on the date of the original service order.

ALL the following apply to a service order:

a. Backdating of the service order is not allowed;
b. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered; and
c. A service order must be in place prior to or on the first day that the service is initially provided, to bill Medicaid for the service. Even if the beneficiary is retroactively eligible for Medicaid, the provider cannot bill Medicaid without a valid service order.

5.5 Documentation Requirements

To bill Medicaid, providers must ensure that their documentation is consistent with the requirements contained in this policy. The staff member who provides the service is responsible for documenting the services billed to and reimbursed by Medicaid. The staff person who provides the service shall sign and date the service note or grid. The signature must contain credentials for the staff member who provided the service. 1915(i) Respite must be provided in person.

5.5.1 Contents of a Service Note or Grid

For this service, a full service note or grid for each date of service, written and signed by the person who provided the service is required. A service note or grid must document ALL following elements:

a. beneficiary's name;
b. NC Medicaid identification number;
c. date of the service provision;
d. name of service provided;
e. duration of service, amount of time spent providing respite;
f. brief summary of the respite care activities and any concerns or highlights to note; and
g. signature with credentials or job title of the staff member who provided the service.
h. date service note or grid is completed

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or qualifications for participation;
b. Be a part of the PIHP or PHP network; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Providers of Respite services are subject to 10A NCAC 27G .5100 and NC GS 122c and 131D

6.2 Provider Certifications

For Facility Based Crisis under NC G.S. 122 C shall be licensed and certification is required unless provided by a Indian Health Service (his) or 635 compact operated by a Federally Recognized Tribe according to 25 USC §1621t Licensing and 25 USC § 1647a

6.2.1 Staff Requirements

Agency staff shall meet the following requirements who work with a beneficiary:

a. At least 18 years of age;
b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance;
c. Criminal background check presents no health and safety risk to beneficiary;
d. Not listed in the North Carolina Health Care Personnel Registry;
e. Qualified in CPR and First Aid;
f. shall be qualified in the customized needs of the beneficiary as described in the Person-Centered Plan (PCP) or Individual Support Plan (ISP) and receive supervision from a Qualified Professional (QP) with at least 2 years' experience working with the population served focused on the provision of respite services;
g. High school diploma or high school equivalency (GED);
h. Trauma-Informed Care training;
i. Crisis intervention training;
j. For staff serving recipients taking opioid medications or who have substance use disorders, shall have training in opioid antagonist administration (Administering Naloxone or other federal Food and Drug Administration approved opioid antagonist for drug overdose).

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s). Federally recognized tribal and IHS providers may be exempt to one or more of these items in accordance with Federal law and regulations.

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8.0 Policy Implementation and History

Original Effective Date:
History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	New policy 1915(i) Respite.

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Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid. Federally recognized tribal and Indian Health Service providers may be exempt from one or more of these items in accordance with Federal law and regulations:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

HCPCS Code(s)
H0045

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

HCPCS Code(s)
H0045 U4- Individual
H0045 HQ U4- Group Child
H0045 HQ HB U4- Group Adult

E. Billing Units

Units for 1915(i) respite are 15-minute increments.

F. Place of Service

Beneficiary's home or community.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov//