Respite Services
Policy Number: HS-227

Original Effective Date: 2/6/2014
Revised Date(s): 2/5/2015; 2/4/2016; 2/2/2017; 1/4/2018

Application Statement
The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

Disclaimers
The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any. All links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; current LOBs can be found at www.wellcare.com. All guidelines can be found at this site as well but selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

Position Statement
Applicable To:
- Medicaid – Florida (inpatient; outpatient provided through Nursing Home Diversion program)
- Medicaid – Georgia (inpatient only)
- Medicaid – Hawaii (inpatient and outpatient)
- Medicaid – Illinois (inpatient only)
- Medicaid – Kentucky (inpatient and outpatient)
Medicaid – Missouri (inpatient only)
Medicaid – New Jersey (inpatient; outpatient not covered for Plan D only)
Medicaid – New York (inpatient; outpatient provided through Long Term Care) (Healthy Choice)
Medicaid – New York (inpatient and outpatient) (NY Family Health Plus)
Medicaid – South Carolina (inpatient only)

NOTE: Prior authorization is needed except for Outpatient Respite in Florida.
NOTE: Respite Services are not a covered benefit for Medicare members.

**Inpatient Respite Services** are provided in a skilled nursing facility or hospice.

**Outpatient Respite Services** are provided in a member’s place of residence (e.g., in-home, assisted living facility), as well as for those receiving hospice care.

**FLORIDA**

Please refer to HS:280 Florida Downward Substitution Services.

**GEORGIA**

**Inpatient Respite Services** are a covered benefit for Georgia Medicaid members.

**Outpatient Respite Services** are **not** a covered benefit for Georgia Medicaid members.

Respite Care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the hospice patient is residing in a nursing home on a permanent basis. (Georgia DCH, 2014).

There are four levels of care into which each day of care is classified:
1. Routine Home Care
2. Continuous Home Care
3. Inpatient Respite Care
4. General Inpatient Care

Respite Services provide brief periods of support or relief for caregivers of individuals with disabilities. Respite is provided in the following situations:
- When families or the usual caretakers are in need of additional support or relief;
- When the participant needs relief or a break from the caretaker;
- When a participant is experiencing severe behavioral challenges and needing structured, short-term support;
- When relief from care giving is necessitated by unavoidable circumstances, such as a family emergency.

Planned or scheduled respite, or Maintenance Respite, provides brief periods of support or relief for caregivers or participants. Respite Services might also be needed to respond to emergency situations. Emergency Respite is intended to be a short-term service for a participant who requires a period of structured support, or when respite services are necessitated by unavoidable circumstances, such as a family emergency. (Georgia DCH, 2014).

Inpatient Respite Care is short-term inpatient care required to provide relief from care for the individual’s family or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days at a time. (Georgia DCH, 2014).

**Hospice**

Individuals residing in the nursing facility who elect the hospice benefit are ineligible to receive respite care services. Respite care may not be provided when the hospice individual resides in the nursing facility on a permanent basis.
The hospice agency must have a contract with the inpatient facility to provide respite care delineating the roles of each provider in the hospice agency’s Plan of Care. However, the hospice agency is the professional manager of the member’s care, despite the physical setting of that care or the level of care. (Georgia DCH, 2014).

The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. (Georgia DCH, 2014).

NOTE: Inpatient Care (General or Respite) and Nursing Home Room and Board cannot be reimbursed for the same member for the same covered days of service.

HAWAII
Source: ARCH, 2011

Inpatient Respite Services are a covered benefit for Hawaii Medicaid members.

Outpatient Respite Services are a covered benefit for Hawaii Medicaid members.

Respite care services are provided to QExA (Hawaii'1 QUEST Expanded Access) eligible members unable to care for themselves who meet nursing facility level of care (NFLOC) level of care to allow the choice to live in their homes and communities with appropriate quality supports designed to promote health and safety and independence.

Criteria

Respite care services are authorized by the member’s primary care physician (PCP) as part of the member’s care plan and may be:

• Self-directed.
• Identified as an HCBS benefit.

The maximum allowable benefit is 2 weeks per episode.

The following criteria must be met to authorize respite services:

• Requires an approved 1147 with current services already in place; AND,
• Must be on a short term basis. There is a definite plan to return to the original care setting; AND,
• Requires prior authorization via Home and Community Based Services (HCBS) Authorization Request form; AND,
• All other resources have been explored. i.e. family, friends, etc.; AND,
• The rationale is for medical necessity, not convenience (i.e. caregiver ill, potential caregiver burnout). (Going on vacation or on a business trip does not constitute medical necessity); AND,
• Developmentally Delayed / Intellectual Disability (DDID) members must receive respite services through Developmental Division of the State of Hawaii Department of Health.

Place of Service. Care may be furnished on a short-term basis due to the absence of, or need for, relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations when at the same level of care:

• Individual’s home or place of residence; OR,
• Private residence of a respite care worker; OR,
• Licensed Day Care Facility; OR,
• Medicaid Certified Nursing Facility
• Foster home/ARCH, Expanded ARCH; OR,
• Licensed respite day care facility; OR,
• Other community care residential facility approved by the State.
Process:
- Service Coordinator (SC) to assess validity of the request using criteria identified above.
- SC to explore all potential support systems available and document such.
- SC to obtain SC manager and UM manager approval. Approval will be documented in case notes and/or on the original authorization request.
- SC to obtain medical director and Vice President approval for any services not at the same level and/or admission to foster home or certified nursing facility. Member must utilize a participating facility, if this is the only option available after all options have been explored. Approval should be documented in Case notes and/or directly on the authorization request.
- SC to submit the completed HCBS request form to the Care Management Coordinator (CMC) for processing via fax.
- Annual report on respite services will be submitted to Health Services Leadership team for oversight review/trending. A designee shall be assigned to maintain a tracking tool that will be used as a listing for all members who have had respite services. This list will be stored in an identified shared folder for access by designated associates.

ILLINOIS

Inpatient Respite Services are a covered benefit for Illinois Medicaid members.

Outpatient Respite Services are not a covered benefit for Illinois Medicaid members.

The Department covers the four types of hospice care: routine home care, continuous home care, general inpatient care, and respite care.

Inpatient respite care is applicable for each day in which the patient is in an approved inpatient facility and is receiving respite care. Respite care is short-term inpatient care provided to the patient when, in the opinion of the attending physician, it is necessary to relieve the family members or other persons caring for the patient at home. This must be documented in the patient’s medical record.

Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating facility. Under 42 CFR Part 418, services for pain control and symptom management can be provided in:
- A hospital meeting the requirements of Part 418.100 (a) and (e)
- A skilled nursing facility meeting the requirements of Part 418.100 (a) and (e)
- A hospice that can provide inpatient care directly, in compliance with all standards under Part 418.100

Services for Hospice Members

In addition, the Department covers physician services and nursing home room and board charges related to the hospice patient. To be covered, hospice services must meet the following requirements:
- They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.
- The individual must elect hospice care in accordance with topic K-211 and a plan of care must be established as set forth in topic K-211.3 before services are provided.
- The services must be consistent with the plan of care.
- A certification that the individual is terminally ill must be completed as set forth in Topic K-211.1.

Reimbursement

Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days at a time including the date of admission but not counting the date of discharge. Charges for the
sixth (6th) and any subsequent days are to be made at the routine home care rate. On the day of discharge from an inpatient unit, the appropriate home care rate is to be billed unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient respite rate is to be billed for the discharge date.

Contracting for hospital general inpatient services and reimbursing the hospital for these services is the responsibility of the hospice provider if the hospitalization is related to the terminal illness of the patient. When a hospice patient is placed in a hospital, the hospital must send a bill to the hospice. If the hospitalization was not related to the terminal illness, the hospice will return the bill to the hospital with a written statement explaining the bill is being denied because the hospitalization was not related to the terminal illness of the patient. The hospital will then submit an inpatient claim to the Department with the denial letter attached. The Department cannot pay the hospital’s claim without the denial letter from the hospice. Under 42 CFR Part 418, services for respite care can be provided in:

- A hospital meeting the requirements of Part 418.100 (a) and (e)
- A skilled nursing facility meeting the requirements of Part 418.100 (a) and (e)
- A hospice that can provide inpatient care directly, in compliance with all standards under Part 418.100

**KENTUCKY**

Source: Kentucky Cabinet for Health Services, 2006

**Inpatient Respite Services** are a covered benefit for Kentucky Medicaid members.

**Outpatient Respite Services** are a covered benefit for Kentucky Medicaid members.

Respite shall be defined as short term care which is provided to a Home and Community Based (HCB) Waiver member due to the absence or need for relief of the primary caregiver. The need for relief may be caused by a hospital stay of the caregiver, other family problems affecting the caregiver, vacation for the caregiver or a need for relief of the caregiver on a more regular basis (such as every two (2) weeks).

Respite care service may be provided in the HCB Waiver member’s place of residence, which may be his own home or the home where he is staying at the time the service is provided. The HCB Waiver Provider shall be responsible for the arrangement and monitoring of the respite care services. The HCB Waiver Provider shall be responsible for ensuring that the respite care is provided at a level to appropriately and safely meet the medical needs of the HCB Waiver member and that the caregiver has the appropriate training and qualifications. This may require that the respite care provider be a licensed nurse (RN or LPN). Respite provided to children shall be required to be of a skill level beyond normal baby-sitting. The HCB Waiver Provider shall also be responsible for ensuring adequate supervision of the respite care providers. The respite care provider shall not be a member of the HCB Waiver member’s family.

Respite care services may also be provided by the ADHC. In this instance, it shall be ADHC’s responsibility to assure that respite care is at a level to appropriately and safely meet the medical needs of the HCB Waiver member.

**Respite Qualifications and Requirements**

The respite care provider shall:

- Be free of communicable disease; AND,
- Demonstrate the ability to read and write, understand and carry out instructions, record messages, keep simple records, and interact with the HCB Waiver member when providing the service; AND,
- Be emotionally and mentally mature; AND,
- Be interested in providing respite care services to elderly or disabled individuals in a home setting or ADHC.

**MISSOURI**

Source: State of Missouri, 2013

**Inpatient Respite Services** are a covered benefit for Missouri Medicaid members.
Outpatient Respite Services are not a covered benefit for Missouri Medicaid members.

Respite Care provides relief to a caregiver for periods of time from a few hours to several days. Respite care includes assistance with personal care needs. Short-term inpatient respite care furnished as a means of providing respite for the member’s family or other persons caring for the individual at home. The participating hospice inpatient unit, or a participating hospital or nursing facility must meet the special state hospice standards regarding staffing and patient areas.

Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days per calendar month. Payment for respite care may be made for a maximum of five (5) days at a time including the date of admission but not counting the date of discharge.

Respite care may be provided in a MO HealthNet certified nursing facility or an acute care hospital. The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient or nursing facility and is receiving respite care. Respite care may not be provided when the hospice patient is a nursing home resident. Hospice may provide short term inpatient respite care. Aged and disabled waiver respite services are provided in the home or in a nursing facility. The waiver respite service cannot be authorized during times when inpatient respite care under the hospice benefit is used. Respite care is appropriate for the hospice participant who has a caregiver (other than the hospice provider) who needs to be away from the home for periods of time (two (2) to 12 hour periods, for up to several days at a time).

NEW JERSEY

Inpatient Respite Services are a covered benefit for New Jersey Medicaid members.

Outpatient Respite Services are a covered benefit for New Jersey Medicaid members except those enrolled in Part D.

"Respite" or "respite care" means the provision of temporary, short-term care for, or the supervision of, an eligible person on behalf of the caregiver in emergencies or on an intermittent basis to relieve the daily stress and demands of caring for the functionally impaired adult.

Respite may be provided hourly, daily, overnight or on weekends and may be provided by paid or volunteer staff.

The term includes, but is not limited to, companion or sitter services; homemaker and personal care services; adult day health services; short-term inpatient care in a licensed nursing facility, residential health care facility or assisted living residence; adult family care arrangement or overnight camp program; private duty nursing; and peer support and training for caregivers.

"Caregiver" means a spouse, parent, child, relative or other person who:
1. Is 18 years of age or older;
2. Has the primary responsibility of providing daily care for the eligible person; and
3. Does not receive financial remuneration for the care.

(Source: N.J.A.C. § 8:82-1.4, 2013)

Assisted living facilities are permitted to accept short-term residents whose regular caregivers are participating in a respite care program (N.J.A.C. § 8:36-20.1, 2013).

Long-term care facilities are authorized by law to accept short-term residents whose regular caregivers are participating in a respite care program. A caregiver is defined as any individual, paid or unpaid, who provides regular in-home care for an elderly, disabled, or cognitively impaired person. (N.J.A.C. § 8:39-44.1, 2013).

Coverage and Criteria

Respite Services are covered up to $ 4,500 in a calendar year (N.J.A.C. § 8:82-6.1, 2013).
In addition, placement in a licensed nursing facility, a licensed residential health care facility, a camphership, an assisted living residence or an adult family care arrangement shall not exceed 21 days in a calendar year (N.J.A.C. § 8:82-6.1, 2013).

Per N.J.A.C. § 8:82-4.1 (2013) An eligible member shall meet the following eligibility standards:

- An eligible person shall be 18 years of age or older; functionally impaired; cared for at home by a caregiver who is not remunerated for his or her services; and at risk of long-term institutional placement if his or her regular caregiver could not continue in that role; **AND**,  
  - The maximum income level shall be 300 percent of the Federal Supplemental Security Income standard for an individual living alone, in effect under section 1611(a)(1)(A) of the Social Security Act (42 U.S.C. § 1382) (as increased pursuant to section 1617 of the Act (42 U.S.C. § 1382f)).  
    - In the case of an individual and spouse, one of whom is an applicant for respite care, 50 percent of the couple's combined income shall be subject to this same income standard.  
      - Clients determined eligible prior to June 1, 1998 will not lose their eligibility upon redetermination for reasons set forth at (a)2i above; **OR,**  
      - In the case of an individual and spouse, both of whom are applicants for respite care, 50 percent of the couple's combined income shall be subject to this same income standard.  
      - Clients determined eligible prior to the June 1, 1998 will not lose their eligibility upon redetermination for reasons set forth at (a)2ii above; **AND,**  
  - An eligible person shall be a resident of the State of New Jersey;  
  - An eligible person shall have liquid resources (as declared by that individual) that do not exceed $40,000.  
    - In the case of an individual and a spouse who are both dependent on the caregiver, the couple's combined liquid resources shall not exceed $60,000.

**NEW YORK**

*Source: New York State Department of Health, 2008; 2011*

**Inpatient Respite Services** are a covered benefit for New York Medicaid members.

**Outpatient Respite Services** are a covered benefit for New York Medicaid members through the Managed Long Term Care program only.

Respite is a temporary relocation of a person with developmental disabilities from his or her home for the purpose of providing short term relief for care givers in a family setting. Respite can be provided in the home by bringing qualified individuals into the home to care for the participant for a period of hours or overnight, (not to exceed thirty (30) days, for each participant each year). Respite can also be provided outside the home (in a "free standing" respite program or in a supervised setting such as a certified congregate care setting where space and staff have been designated for that purpose).

Respite Services is an individually designed service intended to provide relief to natural (informal), non-paid supports who provide primary care and support to a waiver participant. This is usually provided for participants who are in need of oversight and supervision as a discrete task. The primary location for the provision of this service is in the waiver participant's home. Respite Services are provided in a 24-hour block of time.

Services may be provided in another home in the community if this is acceptable to the waiver participant and the people living in the other dwelling. If a waiver participant is interested in seeking a brief respite in a nursing home, this can be accomplished through a Scheduled Short Term Admission, and is not considered a Waiver Service.

Providers of Respite Services must meet the same standards and qualifications as the direct care providers of...
HCSS. If the services needed by the waiver participant exceed the type of care and support provided by the HCSS, then other appropriate providers must be included in the plan for Respite Services and will be reimbursed separately from Respite Services. Respite Services are provided in blocks of 24 consecutive hours, billed on a daily-rate basis. Since Respite Services is provided on an intermittent basis, the SC must determine when participation in Team Meetings is appropriate.

**SOUTH CAROLINA**
(Source: South Carolina Health Connections Medicaid, 2012).

Inpatient Respite Services are a covered benefit for South Carolina Medicaid members.

Outpatient Respite Services are not a covered benefit for South Carolina Medicaid members.

There are four levels of care into which each day of care is classified:

1. **Routine Home Care**
2. **Continuous Home Care**
3. **Inpatient Respite Care**. The hospice will be paid at the inpatient respite care rate for each day that the beneficiary is in an approved inpatient facility and is receiving respite care. Inpatient care may also be furnished to provide respite for the individual’s family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a nursing home.
4. **General Inpatient Care**. Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home.

Services provided in the facility must conform to the hospice’s POC. Payment for respite care may be made for a maximum of five consecutive days at a time including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. Documentation in the beneficiary’s record should reflect why the respite care was necessary. If there is more than one respite care admission in a short amount of time, documentation should indicate why multiple admissions were necessary.

Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the hospice patient is residing in a nursing home on a permanent basis.

**Non-Covered**: Respite care and continuous care are only reimbursed within certain limits. These are discussed in detail under Levels of Care.

**CODING**

 Covered CPT© Codes – No applicable codes.

**HCPCS © Codes**

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<th>Code</th>
<th>Description</th>
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<td>H0045</td>
<td>Respite care services, not in the home, per diem</td>
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<tr>
<td>S9125</td>
<td>Respite care in the home per diem</td>
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<tr>
<td>T1005</td>
<td>Respite care services, up to 15 minutes</td>
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**REV CODES**

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<tr>
<td>0655</td>
<td>Inpatient Respite Care</td>
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Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member’s benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.
REFERENCES


MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

<table>
<thead>
<tr>
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<td>2/6/2014</td>
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Clinical Coverage Guideline

Original Effective Date: 2/6/2014 - Revised: 2/5/2015, 2/4/2016, 2/2/2017, 1/4/2018