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1.0 Description of the Service

Respite services provide periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for:

- child or adolescent recipients ages 3-17 with serious emotional disturbance (SED), moderate or severe substance use disorders (SUD), or
- child or adolescent or adult recipients ages 3 and above with intellectual or developmental disability (I/DD) or traumatic brain injury (TBI).

This service enables the primary caregiver(s), when other natural supports are unavailable, to assist with caregiving, to meet or participate in periodic, 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 (caregiver emergency based). The respite provider supplies care that addresses the health, nutrition and daily living needs of the recipient. Respite may be provided in an individual or group setting.

1.1 Definitions

Periodic means occurring at occasional intervals.

Planned is decided on and arranged in advance.

Primary caregiver is the person principally responsible for the care and supervision of the recipient and must maintain their primary residence at the same address as the recipient.

Serious Emotional Disturbance (SED) - As defined by 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.”

Unexpected or **unplanned** needs are unforeseen and respite care should be arranged for as soon as possible.

2.0 Eligibility Criteria

2.1 Provisions

2.1.1 General

An eligible recipient shall be enrolled with the Local Management Entity-Managed Care Organization (LME/MCO) on or prior to the date of service, meet the criteria for SED, or moderate or severe SUD or I/DD state-funded Benefit Plans and shall meet the criteria in Section 3.0 of this policy.

2.1.2 Specific

State funds may cover Respite services for an eligible recipient who is ages 3-17 with SED or moderate or severe SUD, or who is age 3 and above with an intellectual or developmental disability (I/DD) or traumatic brain injury (TBI) and meets the criteria in Section 3.0 of this policy.

3.0 When the Service is Covered

3.1 General Criteria Covered

State funds shall cover the service related to this policy when medically necessary, and

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by State Funds

State funds may cover Respite when ALL of the following criteria are met:

a. The recipient is either
   1. ages 3 through 17 and has a primary diagnosis of a SED as defined above in Section 1.1 or a primary diagnosis of moderate or severe SUD, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or any subsequent editions of this reference material; **OR**,
   2. the recipient is age 3 and up and has a primary diagnosis of I/DD or TBI; **AND**

      To demonstrate meeting a Developmental Disability as defined by G.S. 122-C-3(12a) for an individual with Autism Spectrum Disorder, Intellectual Disability or Traumatic Brain Injury; OR to demonstrate meeting a Traumatic Brain Injury as defined by G.S. 122-C-3(38a):
      - A psychological, neuropsychological, or psychiatric assessment is required that includes:
        - Appropriate psychological / neuropsychological testing (with validated tools) performed by a licensed clinician within their scope.

      To demonstrate meeting a Developmental Disability as defined by G.S. 122-C-3(12a) for an individual without accompanying intellectual disabilities:
      - A physician assessment, substantiating a definitive diagnosis and associated functional limitations consistent with a Developmental Disability, is required. Associated psychological or neuropsychological testing is not required in this situation; **AND** The recipient requires continuous supervision due to their diagnosis; **AND**

b. The primary caregiver(s) need periodic support and relief from the responsibility and stress of caregiving OR the recipient needs periodic support and relief from the primary caregiver(s); **AND**
c. For all of the above there is documentation in the (e.g., PCP, ISP, or other supporting documentation) there are no other natural resources and

supports available to the primary caregiver to provide the necessary relief of substitute care.

3.2.2 Admission Criteria

State funds shall cover Respite services when the following Admission Criteria are met:

The recipient meets the Specific Criteria for this service as outlined in **Subsection 3.2.1**.

Prior authorization by the LME/MCO is required. A service authorization request that indicates the recipient would benefit from Respite must be completed by a Qualified Professional and submitted to the LME/MCO prior to the services being provided.

If an urgent or emergent situation presents the need for a verbal authorization for Respite services, a recipient is allowed up to 192 units (48 hours) of service for an initial 2-day pass-through (calendar days). An authorization from the approved LME/MCO is required after this initial 2-day pass-through. This pass-through is available only once per state fiscal year.

Relevant clinical information must be obtained and documented in the recipient's Person-Center Plan (PCP) or Individual Support Plan (ISP).

3.2.3 Continued Stay Criteria

a. The recipient continues to meet the Specific Criteria for the service. Refer to **Subsection 3.2.1;**
b. The Primary caregiver continues to need temporary relief from caregiving responsibilities for a child or adolescent with SED, or moderate or severe SUD, developmental disabilities, or a Traumatic Brain Injury or for an adult with developmental disabilities or a Traumatic Brain Injury,
c. The adult with I/DD or TBI has limitations in adaptive skills that require supervision in the absence of the primary caregiver.
d. For all of the above, there is documentation that there are no other natural resources and supports available to the primary caregiver to provide the necessary relief of substitute care.

3.2.4 Transition and Discharge Criteria

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

a. The recipient does not meet Admission Criteria for the service. Refer to **Subsection 3.2.1; OR**
b. Respite is no longer identified in the Individual Support Plan or Service Plan; **OR**
c. Sufficient natural family supports have been identified to meet the need of the caregiver; **OR**
d. The child or adult moves to a residential setting that has paid caregivers.

4.0 When the Service is Not Covered

4.1 General Criteria Not Covered

State funds shall not cover the service related to this policy when:

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

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

State funded Respite shall require prior approval. Refer to **Subsection 5.3** for additional limitations. The provider shall obtain prior approval before rendering the service.

A service order must be signed prior to or on the first day Respite is provided. Refer to **Subsection 5.4** of this policy.

Prior authorization is not a guarantee of claim payment.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the LME/MCO both of the following:

a. the prior approval request; and
b. all health records and any other records that support the recipient has met the specific criteria in **Subsection 3.2** of this policy; and
c. Units for Respite services are 15-minute increments.

5.2.2 Specific

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible recipient.

No more than 1,536 units (384 hours) can be provided to a recipient in a plan year. This service is a periodic service.

For 24-hour respite, providers shall bill for the time staff were awake providing supports.

Initial Authorization

Services are based upon a finding of medical necessity, must be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the addresses the health, nutrition and daily living needs of the recipient to the degree detailed in the recipient's PCP or ISP.

Medical necessity is determined by North Carolina community practice standards, as verified by the LME/MCO who evaluates the request to determine if medical necessity supports intensive services. Medically necessary services are authorized in the most cost-effective manner, (i.e., when the treatment that is made available is similarly efficacious as services requested by the recipient's physician, therapist, or another licensed qualified professional). The medically necessary service must be recognized as an accepted method of treatment.

To request an initial authorization for a recipient with a mental health diagnosis or substance use disorder, the service order for medical necessity, PCP and the required LME/MCO authorization request form must be submitted to the LME/MCO.

To request an initial authorization for a recipient with an I/DD or TBI, the psychological evaluation or physician assessment, service order for medical necessity, PCP or ISP. and the required LME/MCO authorization request form must be submitted to the LME/MCO. Refer to **Subsection 5.4** for Service Order requirements.

Reauthorization

Reauthorization requests must be submitted to the LME/MCO 14-days prior to the end date of the recipient's active authorization. Reauthorization is based on medical necessity documented in the updated PCP or ISP, the authorization request form.

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient, legally responsible person or both about the recipient's appeal rights pursuant to G.S. 143B-147(a)(9) and Rules10A NCAC 27I .0601-.0609.

5.3 Limitations or Requirements

a. Transportation to/from school or 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 recipient's care plan or PCP;
g. Services provided without prior authorization;
h. Services provided to children, spouse, parents or siblings of the recipient under treatment or others in the recipient's life to address problems not directly related to the recipient's needs and not listed on the care plan or PCP;
i. Payment for room and board;

j. Respite may not be provided by relatives, legal guardians or individuals if they live in the same home as the recipient;
k. Recipients receiving this service must live in a non-licensed setting, with non-paid caregiver(s). The only exception is recipients' who reside in licensed or Unlicensed Alternative Family Living (AFL) settings may utilize respite; however, respite shall not be billed on the same day as Residential Supports if utilized for more than 8 hours per day;
l. Individuals receiving this service may not be eligible for NC Medicaid-funded Respite service benefit, or have exhausted the NC Medicaid-funded Respite service benefit;
m. This service is a periodic service.

5.4 Service Orders

Service orders are a mechanism to demonstrate medical necessity for a service and are based upon an assessment of the recipient's needs. A signed service order must be completed by a physician, licensed psychologist, physician assistant, nurse practitioner, and for the I/DD population also a qualified professional per the individual's scope of practice.

ALL the following apply to a service order:

a. Backdating 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;
c. A service order must be in place prior to or on the first day that the service is provided to bill state funds for the service; and
d. Service orders are valid for one calendar year. Medical necessity must be reviewed, and service must be ordered at least annually, based on the date of the original PCP or ISP service order.

If an urgent or emergent situation presents the need for a verbal order, standard procedures must be followed for the verbal order to be valid. Treatment may proceed based on a verbal order by the appropriate professional as long as the verbal order is documented in the recipient's service record on the date that the verbal order is given. The documentation must specify the following:

a. Date of the order;
b. Who gave the order;
c. Who received the order;
d. Identify the service that was ordered;
e. The documentation should reflect why a verbal order was obtained in lieu of a written order;
f. The appropriate professional must countersign the order with a dated signature within seventy-two (72) hours of the date of the verbal order.

5.5 Documentation Requirements

Documentation is required as specified in the Records Management and Documentation Manual and service definition.

The service record documents the nature and course of a recipient's progress in treatment. To bill state funds, 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 with state funds. The staff person who provides the service shall sign and date the written entry. A Service Note or a Service Grid, as outlined in the Records Management and Documentation Manual, may be utilized for this service.

5.5.1 Contents of a Service Record

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. More than one intervention, activity, or goal may be reported in a service note, if applicable. The minimum requirements must include ALL of the following elements:

a. Name of the recipient on each page;
b. The service record number or unique identifier on each page;
c. Date [month/day/year] that the service was provided;
d. Name of the service being provided on each page [e.g., Respite];
e. Intervention, activity, or goal addressed;
f. A number or letter as specified in the appropriate key that reflects the intervention, activities, and/or tasks performed;
g. A number/letter/symbol as specified in the appropriate key that reflects the assessment of the recipient's progress toward activities and/or tasks;
h. Duration;
i. Initials of the recipient receiving the service – the initials shall correspond to a full signature and initials on the signature log section of the note/grid; and
j. A comment section for entering additional or clarifying information, e.g., to further explain the interventions/activities provided, or to further describe the recipient's response to the interventions activities or goals. Each entry in the comment section must be dated.

6.0 Provider(s) Eligible to Bill for the Service

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

a. meet LME/MCO qualifications for participation; and
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for services that are within the scope of their clinical practice, as defined by the appropriate licensing entity, as applicable.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Respite must be delivered by qualified professionals employed by organizations that:

a. meet the provider qualification policies, procedures, and standards established by the NC Division of MH/DD/SUS;
b. meet the requirements of 10A N.C.A.C. 27G and NC G.S. 122 C.

6.2 Provider Certifications

Respite services must be provided by a legally constituted entity that meets all of the requirements of the LME-MCO and is contracted with the LME-MCO to serve individuals with SED, moderate or severe SUD or I/DD or TBI.

6.2.1 Staffing Requirements

Agency staff that work with recipients:

a. Are 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 person/s
d. Not listed in the North Carolina Health Care Personnel Registry
e. Qualified in CPR and First Aid
f. Staff that work with person/s must be qualified in the customized needs of the beneficiary as described in the PCP or ISP
g. Staff that work with recipients who are responsible for medication administration must be trained in medication administration in accordance to 10A NCAC 27G .0209, as applicable.
h. Staff that work with recipients must be trained in alternatives to restrictive intervention and restrictive intervention training (as appropriate)
i. High school diploma or high school equivalency (GED).

The Respite paraprofessional must meet the requirements according to 10A NCAC 27G .0104 (15).

Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to the supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

The maximum program staff ratios must meet the paraprofessional to recipient ratio according to 10A NCAC 27G. 5102, as long as the health and safety of the recipients can be maintained.

6.2.2 Staff Training Requirements

In addition to any recipient-specific training necessary to care for a recipient's unique support needs, the provider shall ensure that staff who are providing Respite have completed and documented the following staff

training requirements prior to working with recipients and updated as recipients' needs change:

1. Depending on the specific recipient condition(s) that the staff is serving, training on specific needs and considerations, including co-occurring conditions, related to child/adolescent mental health diagnoses, substance use disorder, intellectual and developmental disabilities, and/or traumatic brain injuries.
2. Person Centered Thinking
3. Trauma Informed Care
4. Crisis Intervention
5. For staff serving recipients taking opioid medications or who have substance use disorder, training in opioid antagonist administration (Administering Naloxone or other federal Food and Drug Administration approved opioid antagonist for drug overdose)

7.0 Additional Requirements

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), 42 CFR Part 2 and record retention requirements; and
b. All NC Division of MH/DD/SUS's service definitions, guidelines, policies, provider manuals, implementation updates, and bulletins, DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation and History

Original Effective Date:

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	

Attachment A: Claims-Related Information

Provider(s) shall comply with the, NCTRACKS Provider Claims and Billing Assistance Guide, DMH/DD/SUS bulletins, fee schedules, NC Division of MH/DD/SUS service definitions and any other relevant documents for specific coverage and reimbursement for state funds:

A. Claim Type

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

Provider(s) shall report the ICD-10-CM and Procedure 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), Healthcare Common 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. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)	
YP014	Individual - Child
YP015	Group - Child
YP012	Individual - Adult
YP013	Group - Adult

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow the applicable modifiers.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Units are billed in 15-minute increments.

LME/MCOs and provider agencies shall monitor utilization of service by conducting record reviews and internal audits of units of service billed. LME/MCOs shall assess their Respite network providers' adherence to service guidelines to assure quality services for recipients served.

F. Place of Service

For a recipient with a mental health diagnosis or substance use disorder, Respite may be provided in:

(a) homes licensed to provide therapeutic foster care, private home services under 131D,

(b) a center-based or private home Respite service licensed under 10A NCAC 27G .5100.,

(c) the recipient's own home or other location not subject to licensure;

OR

For a recipient with an I/DD or TBI, Respite may be provided in:

(a) licensed AFLs (for children or if the AFL serves 2 or more adults), and

(b) unlicensed AFL (if serving 1 adult), or

(c) the recipient's own home or other location not subject to licensure.

Respite service for individuals with I/DD and TBI may be provided in a hotel, shelter, church, or alternative facility-based setting or the home of a direct care worker due to COVID-19 related issues, as long as ALL the following criteria are met:

(a) health and safety of the recipient can be maintained; and

(b) the individual's ISP or PCP plan has been updated indicating service delivery needed in an alternative location due to COVID-19 related issue; and

(c) documentation provided confirming a COVID-19 diagnosis.

This service is not Medicaid billable.

G. Co-payments

Not applicable

H. Reimbursement

Provider(s) shall bill their usual and customary charge.

Note: DMH/DD/SUS will not reimburse for conversion therapy.