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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.

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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
-1915 (i) Clinical Coverage Policies

1.0 Description of the Procedure, Product, or Service

Respite services provide periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for or adolescent beneficiaries ages 3-20 with mental health or substance use disorders, and for adolescent and adult beneficiaries with I/DD or 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

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.

Periodic means occurring at occasional intervals.

Planned is decided on and arranged in advance.

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

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.

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 become obvious 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:

a. Self-care
b. Receptive and expressive language
c. Learning
d. Mobility
e. Self-direction
f. Capacity for independent living
g. Economic self-sufficiency

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."

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC 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.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

a. Medicaid

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 who meets the criteria in **Section 3.0** of this policy.

b. NCHC

NCHC beneficiaries are not eligible for Respite.

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

   EPSDT provider page: https://medicaid.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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 both Medicaid and NCHC

None Apply

3.2.2 Medicaid Additional Criteria Covered

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Medicaid shall cover Respite when ALL following criteria are met:

a. the beneficiary has a primary diagnosis of SED, IDD, TBI or SUD as defined by the DSM V; AND

b. the beneficiary requires continuous supervision due to their diagnosis.

3.2.3 NCHC Additional Criteria Covered

None Apply

3.2.4 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. A Child Assessment of Needs and Strengths (CANS) (for beneficiary with mental health or substance use disorder) or a NC Support Needs Assessment Profile (SNAP) or Supports Intensity Evaluation (SIS Evaluation) (for beneficiary with I/DD) completed by a care management agency that indicates the beneficiary would benefit from Respite.

3.2.5 Continued Stay Criteria

Medicaid shall cover continued stay if:

a. The beneficiary continues to meet Admission Criteria for service. Refer to **Subsection 3.2.4**.

b. The Primary caregiver continued to need temporary relief from caregiving responsibilities of the child with mental health, substance abuse or developmental disabilities or an adult with developmental disabilities.

c. The adult with IDD or TBI has limitation in adaptive skills that require supervision in the absence of the primary caregiver.

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.

3.2.6 Transition and Discharge Criteria

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

a. The beneficiary continues to meet Admission Criteria for service. Refer to Subsection 3.2.4; OR

b. Respite is no longer identified within 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 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 and NCHC 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 both Medicaid and NCHC

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 for the beneficiary or family members;
b. Any habilitation activities;
c. Time spent doing, attending or participating in recreational activities unless tied to specific planned social skill assistance;
d. Covered services that have not been rendered;
e. Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision;
f. Services provided to teach academic subjects or as a substitute for education personnel;
g. Interventions not identified on the beneficiary's care plan or PCP;
h. Services provided without prior authorization;
i. 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 PCP;

j. Respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports and;

k. Payment for room and board.

4.2.3 NCHC Additional Criteria Not Covered

a. None apply.
b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

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 1915(i) 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.

5.2.1 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 beneficiary.

For periodic respite, no more than 1,536 units (384 hours) can be provided to an individual in a calendar year unless specific authorization for exceeding this limit is approved.

For 24-hour respite, no more than 24 days, or 24 units/per diems, can be provided to an individual in a calendar year unless specific authorization for exceeding this limit is approved.

5.3 Additional Limitations or Requirements

a. Respite may not be provided by relatives or legal guardians if they live in the same home as the beneficiary
b. Persons receiving this service must live in a non-licensed setting, with non-paid caregiver(s).
c. Medicaid shall not cover staff sleep time.

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 revisited, 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 written entry. The signature must include credentials for the staff member who provided the service.

Contents of a Service Note

For this service, a full service note for each date of service, written and signed by the person who provided the service is required.

A service note must document ALL following elements:

a. Beneficiary's name;
b. Medicaid identification number;
c. Date of the service provision;
d. Name of service provided;

i. Duration of service, amount of time spent providing respite;
j. Brief summary of the respite care activities and any concerns or highlights to note
k. Date and signature and credentials or job title of the staff member who provided the service.

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 PHIP 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\

10A N.C.A.C. 27G and NC G.S. 122 C;

6.2 Provider Certifications

For Facility Based Crisis NC G.S. 122 C license and certification is required

6.2.1 Staff Requirements

Agency staff that work with beneficiaries:

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 beneficiary
d. Not listed in the North Carolina Health Care Abuse Registry
e. Qualified in CPR and First Aid
f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP, and receive supervision from a 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. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
i. Trauma-Informed Care training

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.

8.0 Policy Implementation and History

Original Effective Date: December 1, 2022
History:

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

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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 and NCHC. 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

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

H0045 HB U4- Individual Adult
H0045 HQ HB U4- Group Adult

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Provider will follow the PIHP billing guidelines for Community Transition services. Federally recognized tribal or IHS providers may be entitled to alternate reimbursement methodologies under Federal Law.

F. Place of Service
Not Applicable

G. Co-payments
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

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