Payment Policy: Respite Care: LTSS

Reference Number:DE.PP.004

Revision Log | Coding Implications

Date of Last Revision: 01/2024

See Important Reminder at the end of this policy for important regulatory and legal information.

Disclaimer

Delaware First Health payment policy is intended to service only as a general reference resource regarding coverage for services described. The policy does not constitute medical advice or intended to govern or otherwise influence medical advice.

Purpose

This policy outlines Delaware First Health payment policy for **respite care for LTSS** members.

Definitions

Delaware First Health (DFH)-Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Delaware First Health members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Delaware First Health currently services Delaware Medicaid: Diamond State Health Plan (DSHP), Delaware Healthy Children Program (DHCP), and Diamond State Health Plan Plus (DSHP)LTSS members.

Respite Services- Services provided on a short-term basis to allow temporary relief from caretaking duties for a member's primary caregiver.

Respite care includes services provided to members unable to care for themselves furnished on a short-term basis because of the absence or need for relief for the member's caregiver. Noted below are types of respite services.

Respite Care Services

Respite care can cover a wide range of services. Respite care services can include:

- Light personal care, such as bathing and grooming.
- Socialization, like conversation and companionship
- Meal preparation and cooking
- Running errands
- Transportation
- Nursing and medical care
- Dementia care
- Medication management
- Participation in facility activities

Types of Respite Care

- In-Home Respite Care
- Assisted Living Facility
- Nursing Home

Prior Authorization

- Prior authorization is not required.

Limitations

- Limited to 14 days (or 336 hours) per calendar year based on needs.
- The Contractor's case manager may authorize service request exceptions above this limit when it determines that:
    - no other service options are available to the member, including services provided through an informal support network;
    - the absence of the service would present a significant health and welfare risk to the member; or
    - respite service provided in a nursing facility or assisted living facility is not utilized to replace or relocate an individual's primary residence.
    - Caregiver hospitalization or doctor appointments
    - Illness of a loved one
    - Funeral or wake
    - Drug or alcohol abuse counseling or support
    - Care recipient transitions (i.e., living arrangements)
    - Loss of employment or work-related situations
    - Declining mental health

Place of Service

Inpatient/Outpatient

Reimbursement

DFH will reimburse participating providers per their Delaware First Health contract. The provider will be paid according to the fee schedule for the equivalent HCPCS, and modifiers noted below.

Coding and Modifier Information

CPT/HCPCS Codes	Descriptor
S5150	Unskilled respite care, not hospice; per 15 minutes
S5150 U2	Unskilled respite care – self-directed, not hospice; per 15 minutes
S5150 U2 TU	Overtime unskilled respite care – self-directed, not hospice; per 15 minutes
*T1005	Respite care services; per 15 minutes
T1005 U1	Respite - PASA agency
T1005 PC	Respite - HH agency

***Based on specific provider contracted terms.**

Post-payment Audit Statement

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Delaware First Health at any time pursuant to the terms of your provider agreement.

References

State of Delaware Masters Service Agreement (page 60)
https://dhss.delaware.gov/dhss/dmma/files/mco_msa_2020.pdf

Revision History	
1/26/2024	Initial Policy Draft

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

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

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

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

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.