Payment Policy: Respite Care: Non-LTSS Pediatric

Reference Number:DE.PP.002

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 pediatric members, age 20 and younger.

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 child's primary unpaid caregiver, parent, court-appointed guardian, or foster parent.

Medically Complex Conditions-is one or more chronic conditions related to three or more organ systems. The condition impairs cognitive or physical functions and demands treatment including but not limited to medication, therapy, or surgery. Chronic condition is defined as "a serious, long-term physical, mental or developmental disability or disease," including the following medical conditions:

- Cerebral palsy.
- Cystic fibrosis;
- HIV/AIDS;
- Blood disease, such as anemia or sickle cell disease;
- Muscular dystrophy;
- Spina bifida;
- Epilepsy;
- Severe autism spectrum disorder; and/or
- Individuals up to age 21 who are not already receiving respite through DSHP Plus, PROMISE, or the Lifespan 1915 (c) waiver.

Emergency Respite Care-the immediate placement of a trained, in-home respite care worker in the home during an emergency or unplanned event, or during a temporary placement outside the home, to substitute for the primary caregiver. Crisis situations that may qualify for emergency respite program include, but are not limited to the following scenarios:

- Caregiver illness (physical, mental and/or emotional)
- 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

Limitations

- **Respite**-Limited to 15 days or 285 hours per waiver year. Additional hours may be available based on medical necessity.
- **Emergency Respite Care**-Emergency respite is limited to 72 hours per episode, with a maximum of six 72-hour episodes per waiver year. Emergency respite is not included in the benefit limit.
- The child and/or child's representative gives final approval of where the respite is provided.
- Respite services are not intended to supplant routine care, including before and after school care.
- Medicaid will not pay for respite provided for the purpose of oversight of additional minor children in the home.
- Delaware Diamond State Health Plan DRAFT 1115 Waiver Amendment 8 - The cost of transportation is included in the rate paid to providers of these services.
- Federal financial participation is not available for the cost of room and board except when provided as part of services furnished in a facility approved by the State that is not a private residence.

Policy/Criteria

Prior Authorization

- Prior authorization is required.

Procedures

Coverage of a pediatric respite benefit as a Section 9817 HCBS Spending Plan initiative for individuals up to age 21 who are not receiving respite through DSHP Plus, PROMISE or the Lifespan 1915(c) waiver.

- This new pediatric respite benefit will be provided for children with a physical health or behavioral health condition affecting their ability to care for themselves and are furnished on a short-term basis to allow temporary relief from caretaking duties for the child's primary unpaid caregiver, parent, court-appointed guardian, or foster parent.
- Respite services may be available up to 24 hours/7 days a week and include support in the home, after school, or at night, as well as transportation to and from school, medical appointments, or other community-based activities, or any combination of the above.

The following types of respite are available:

- **In-home unskilled respite** – Provided in a child's place of residence, home of respite provider, or home of a friend or family member for children with unskilled care needs (i.e., supervision or assistance with ADLs and IADLs, supervision to assure health and welfare, implementing a pre-existing behavior plan to support behavioral needs) who do not require skilled care such as a G-tube feeding. Services provided to children with behavioral health needs are provided by a trained paraprofessional who is supervised by a licensed clinician.

- **In-home skilled respite** – Provided in a child's place of residence or home of a friend or family member for children with ongoing skilled medical and behavioral health needs that can only be provided by an RN/LPN. (e.g., suctioning, G-tube feeding). No FFP is available for the cost of room and board.
- **Out of home respite** – Skilled and unskilled support provided in a community setting or licensed facility, including but not limited to school, nursing facility, hospital, residential treatment facility, foster home, Prescribed Pediatric Extended Care (PPEC), and group home.
- **Emergency respite** – a short-term service for children necessitated by an unplanned and unavoidable circumstance, such as a family emergency. Emergency respite can be provided in the home or in an out of home location.

Permitted Places of Pediatric Respite Services:

Agencies/Facilities

- Community Mental Health Agencies
- Community Mental Health Facilities
- Community Foster Care Agencies
- Home Health Agencies
- Licensed Residential Treatment Facilities
- Nursing Facilities
- Hospitals
- Home Health Agencies
- Camps
- Residential Care Facilities
- Child Care Centers
- Child Development Centers
- Group Homes
- Day Care Centers
- Licensed Foster Home
- Prescribed Pediatric Extended Care (PPEC)

Provider Qualifications for Delivery of Pediatric Respite Services:

Individual Providers:

- At least 18 years of age
- First aid certification - CPR certification
- Training specific to address the child's needs.
- Valid driver license (as needed)
- Criminal Background Check

Licensed/Certified Providers:

- RN, LPN
- Board Certified Behavior Analyst
- Board Certified Assistant Behavior Analyst
- Registered Behavior Technician

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 (based on the methodology below) for the equivalent HCPCS, and modifiers noted below.

Payment Methodology:

Maximum rates are established according to the following methodology:

- One individual: Rate for One = 100% of established baseline rate
- Two individuals: Rate for Each = 50% of 143% of baseline rate
- Three individuals: Rate for Each = 33% of 214% of baseline rate

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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
S5150 U3	Unskilled respite care, not hospice; per 15 minutes; two members
S5150 U3 TU	Overtime unskilled respite care, not hospice; per 15 minutes; two members
S5150 U4	Unskilled respite care, not hospice; per 15 minutes; three members
S5150 U4 TU	Overtime unskilled respite care, not hospice; per 15 minutes; three members
T1005 U1	Respite - PASA agency
T1005 PC	Respite - HH agency

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

Delaware Health and Social Services. 2022. Delaware Section 1115 Waiver Services
https://dhss.delaware.gov/dmma/files/de_dshp_waiver_amend_july2022.pdf

Children with Medical Complexity
https://dhss.delaware.gov/dmma/children_with_medical_complexity.html

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.