RESPITE CARE

APPLICABILITY

This policy applies to respite care providers serving members who are unable to care for themselves and who are residing in the home of their family, guardian, or a foster or adoptive home.

PURPOSE

Respite care is a short-term service to provide needed relief to a caregiver or in the absence of a caregiver.

ELIGIBILITY CRITERIA

Respite services are available for members from birth through age 20 who cannot care for themselves.

Members must be unable to care for themselves and reside in one of the following settings to receive this service:

- their family home (biological or kin),
- legal guardian's home,
- pre-adoptive/adoptive home, or
- foster home.

DEFINITIONS

Caregiver - includes biological kin, pre-adoptive parent, adoptive parent, foster parent, and legal guardian.

Electronic Visit Verification (hereafter referred to as "EVV") – means systems which electronically verify, by a phone or computer-based system, that personal care, home health, and other home and community-based services are being provided and the actual provider time in rendering the service.

Home and Community Based Setting (HCBS) - means a member's own home or community location rather than an institution or other isolated setting.

COVERED SERVICES & LIMITS

Member must be present for this service to occur. Respite care may include hourly, daily, and overnight support.

Respite may include:

- Assistance with daily living skills
- Assistance with accessing/transporting to/from community activities
- Assistance with grooming and personal hygiene
- Meal preparation, serving, and cleanup

- Administration of medications
- Supervision
- Recreational and leisure activities

Receipt of respite care does not necessarily prevent a member from receiving other services on the same day. For example, a member may receive supported employment on the same day as they receive respite care.

LIMITS
Monthly maximum of 40 hours (160 units) for this service and an annual maximum of 480 hours per calendar year.

Services cannot exceed thirty (30) consecutive days without service authorization to exceed this limit.

Service authorization requests exceeding the maximum limit which are deemed necessary to prevent the individual's imminent institutionalization, hospitalization, or out of home/out of community placement will be reviewed by ND Medicaid. All requests to exceed limits must be submitted by the member's care coordinator.

NON-COVERED SERVICES

- Respite care furnished at the same time when other services that include care and supervision are provided.
- Routine care and supervision which is expected to be provided by family for activities or supervision for which a payment is made by a source other than Medicaid.
- Care used as day/childcare to allow the caregiver to go to work or school. Respite care services do not include on-going day care or before or after school programs.

DUPLICATIVE SERVICES
Care coordinators are responsible for ensuring there is no duplication of services.

SERVICE REQUIREMENTS
Respite care providers must

- provide a monthly update to the member's care coordinator
- comply with all state and federal standards

ELECTRONIC VISIT VERIFICATION (EVV)
Respite care is subject to Electronic Visit Verification (EVV) regulations. ND HHS has contracted with Therap to provide the EVV system. https://help.therapservices.net/s/nd-idd.

Please review and ensure you are in compliance with our Electronic Visitation Verification policy.

For additional EVV information, please visit https://www.hhs.nd.gov/adults-and-aging/electronic-visit-verification-evv-system.

SERVICE AUTHORIZATIONS

Respite providers must submit service authorizations in Therap. The Therap entry is required due to the EVV requirements.

To learn how to submit service authorizations in Therap, please scroll down to the **Service Authorization Setup** section on this website - https://help.therapservices.net/s/article/3213

DOCUMENTATION

Respite providers must provide monthly case notes to the member's care coordinator. This happens for two reasons:

1) to ensure progress toward the member's goals, and
2) to evaluate service necessity.

The member's progress is discussed at each 1915(i) plan of care meeting and documented in the plan.

Sample progress notes:

> *"Provided respite for Barbara's mother, Debbie, at her home. I served Barbara eggs and bacon for breakfast, assisted her with a shower, getting dressed, brushing her teeth, and combing her hair. Barbara then watched TV and played on her IPad for an hour while I prepped sandwiches for lunch. I cleaned up the kitchen afterward."*

See "Documentation Guidelines" section of Provider Requirements policy for Medicaid documentation requirements.

«Service documentation must occur in Therap using the Supportive Service Case Note beginning January 6, 2025.»

PROVIDER QUALIFICATIONS

Group

North Dakota Medicaid enrolled group provider of 1915(i) Respite Care.

A group provider of this service must:

1. Have one of the following licenses:
   - Child Placing Agency under NDAC 75-03-36;
   - Supervised Independent Living Program under NDAC 75-03-41;
   - Child Care Center under NDAC 75-03-10;
   - Providers licensed by ND HHS, Division of Developmental Disabilities under 75-04-01;

- Qualified Residential Treatment Program Providers licensed by ND HHS, Children and Family Services Division under 75-03-40;
- Psychiatric Residential Treatment Facility Providers licensed by ND HHS, Behavioral Health Division under NDAC 75-03-17;
- Providers licensed by ND HHS under 75-05-00.1 Human Service Center Licensure; or
- Substance Abuse Treatment Program under NDAC 75-09.1.

2. Have a North Dakota Medicaid provider agreement and attest to all the following:
   - individual practitioners meet the required qualifications;
   - services will be provided within their scope of practice;
   - individual practitioners will have the required competencies identified in the service scope;
   - agency conducts training in accordance with state policies and procedures; and
   - agency adheres to all 1915(i) policies and procedures including, but not limited to, individual rights, abuse, neglect, exploitation, use of restraints, and reporting procedures are written and available for ND Medicaid review upon request.

Individual

An individual provider of the service must be:

1. be employed by an enrolled ND Medicaid provider of this service.
2. at least 18 years of age.
3. knowledgeable and competent in person-centered plan implementation

A relative related by blood, marriage, or adoption, who is not the legal guardian, and does not live in the home with the individual, may enroll as a 1915(i) individual respite care provider under the affiliation of a 1915(i) group provider of respite care. **Respite providers may not live in the same home as the member.**

Individual respite care providers are not required to be QSPs or licensed.

BILLING AND REIMBURSEMENT

Respite is a 15-minute rate.

Respite providers will enter claims into the Therap system. The Therap system will merge the claim with MMIS and the claim will be paid through MMIS.

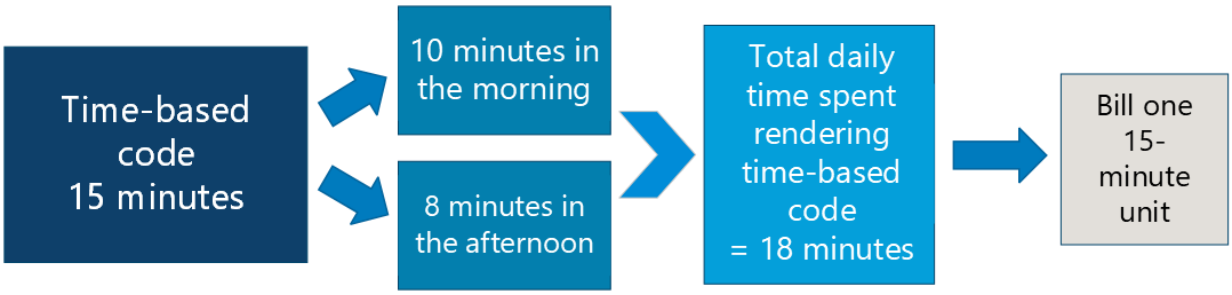
Code	Description
T2027	Respite (per 15 minutes)

15 Minute Units

Providers can bill a single 15-minute unit for services greater than or equal to 8 Minutes. Services performed for less than 8 minutes should not be billed. Minutes from the same day, with the same Place of Service (POS) code, and for the same member can be combined and billed when adding up to at least 8 minutes.

1 unit: ≥ 8 minutes through 22 minutes
2 units: ≥ 23 minutes through 37 minutes
3 units: ≥ 38 minutes through 52 minutes
4 units: ≥ 53 minutes through 67 minutes
5 units: ≥ 68 minutes through 82 minutes
6 units: ≥ 83 minutes through 97 minutes
7 units: ≥ 98 minutes through 112 minutes
8 units: ≥ 113 minutes through 127 minutes

The pattern remains the same for times exceeding 2 hours.



Rates are published here under 1915(i) Services.