Authorization Guide for Respite Services

Respite services are provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis due to the absence or need for relief of the nonmedical caregiver. These services are distinct from medical respite/recuperative care and provide rest for the caregiver only.

Members must meet the following criteria to qualify for Respite Services:

Program overview	Required documentation

• Services are provided to the member in his or her own home or another location being used as the home.
• Services that attend to the member's basic self-help needs and other activities of daily living.
• Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout.
• Respite services include:
  – Service by the hour on an episodic basis.
  – Service by the day/overnight on a short-term basis.
	Community Supports (CS) Referral Form that includes the member's needs and the reason for the caregiver's absence.

Eligibility

- Members who live in the community and are compromised in their activities of daily living (ADL) and dependent on a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.
- Other subsets may include:
  - Children who previously were covered for respite services under the Pediatrics Palliative Care Waiver.
  - Foster care program beneficiaries.
  - Members enrolled in California Children's Services or Genetically Handicapped Persons Program (CHPP).
  - Members with complex care needs.

Authorization

Initial authorization

Hourly and varies based on the caregiver absence. The service is limited to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. **Exceptions** to the limit of 336 hour per calendar year can be made when the caregiver experiences an episode that leaves the member without their caregiver.

Authorization Extension

If an extension is needed, a re-assessment of need is required. Reauthorizations are hourly and vary based on the caregiver's absence.

Restrictions	State services to be avoided
Member is participating in a duplicative state, local, or federal funded programs.	State Plan services to be avoided include, but are not limited to, inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

Codes

- H0045 respite care services, not in the home, U6
- S5151 unskilled respite care, not hospice, U6
- S9125 respite care, in the home, U6

Unit of service: Per diem

Total lifetime maximum

Total lifetime maximum: The service limit is up to 336 hours per calendar year. The service is inclusive of all in home and in-facility services.

Exceptions to the limit of 336 hours per calendar can be made, when the caregiver experiences an episode that leaves the member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

Eligible providers

Allowable CS providers must have experience and expertise with providing respite-related services and supports in a culturally and linguistically appropriate manner. Provider must use best practices in rendering services.[i]

[i] **Examples of provider** home health or respite agencies to provide services in: private residence; residential facility approved by the state, such as congregate living health facilities (CLHFs); providers contracted by county behavioral health.