Medical Necessity Guidelines:
Respite for Children for Tufts Health RITogether

Effective: October 21, 2020

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☒ No ☐**

Applies to:
COMMERCIAL Products
☐Tufts Health Plan Commercial products; Fax: 617.972.9409
☐Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☐Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☐Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☐Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW

Respite Services are temporary caregiving services given to an individual unable to care for himself/herself. Services are furnished on a short-term basis, because of the absence or need for relief of those persons normally providing the care for the participant.

Respite services are family directed caregiving supports available for families of children (under 21 years of age) that meet an institutional level of care criteria. Families who are eligible receive an annual allotment of at least 200 hours of respite services. Additional hours may be utilized with prior authorization to prevent the need for more intensive services and supports[1].

Respite Services allow parents or guardians caring for a child with disability, to have time off for themselves. To be eligible for the Respite for Children Program, a child must need an institutional level of care that can best be described as the type of care typically provided in a hospital, nursing home or Intermediate Care Facility for the Mentally Retarded (ICF/MR). Other factors used in determining eligibility include, but are not limited to: the severity of the child's condition, the intensity of services required, the child's functional daily living skills, safety and safety awareness and the needs of the family. Parents or guardians are required to find their own respite worker, but assistance is available from certified Respite agencies and a free online resource[2].

CLINICAL COVERAGE CRITERIA

Admission Coverage Criteria
All of the following criteria must be met:
1. Member is a Medicaid-eligible child, less than 21 years of age.

[1] State of Rhode Island, Executive Office of Health and Human Services, Model Contract for Medicaid Managed Care Services, winter 2017, page 325.
[2] www.rewardingwork.org

2. Without Respite services the Member would require an institutional level of care.
3. Member has a DSM or corresponding ICD psychiatric, medical, or developmental diagnosis causing significant impairment of functioning and negatively impacting Member's home environment; the diagnosis is made by a licensed health care professional with experience in child psychology child psychiatry, or child development.
4. Member does not meet criteria for a more intensive LOC.
5. Member lives with parent/guardian in the community; and the parent/guardian is capable and willing to participate and cooperate with the program requirements.
6. Respite can be provided in the home or community without compromising the Member's or respite worker's health and safety.
7. Parent or guardian requires support to stabilize family functioning and successfully care for the Member in the home/community.

Exclusions

Any of the following criteria are sufficient for exclusion from this level of care:

1. The Member requires a level of structure and supervision beyond the scope of Respite services.
2. The Member has medical conditions or impairments that would prevent beneficial utilization of services.
3. The Member is receiving respite services through the Department of Children Youth and Families (DCYF).

Continuation Coverage Criteria

All of the following criteria must be met**:**

1. There is an emergent need for respite services for crisis or crisis prevention without the need for a higher level of care.
2. Member continues to meet admission criteria.
3. Evidence suggests that the defined problems are likely to respond to current service and safety plan.
4. Parent or guardian continues to need support to stabilize family functioning and successfully care for the Member in the home/community.

Discharge Coverage Criteria

Any one of the following criteria is suitable:

1. Member no longer meets admission criteria and/or meets criteria for another LOC.
2. The Member's degree of risk or harm to self or others cannot be safely managed in this setting.
3. The Member's home environment presents safety risks to the respite worker.
4. Parent or guardian no longer needs this level of support and is actively utilizing other formal and/or informal support networks.
5. The Member, family, or guardian is no longer participating to the extent required and agreed upon.
6. Parent or guardian withdraws consent for the service.
7. The Member is admitted to an institutional care setting for long-term care.

The following codes require prior authorization after 200 hours of respite services annually:

Code	Description
T1005	Respite care services, up to 15 minutes
S9125	Respite care, in the home, per diem

REFERENCES

1. State of Rhode Island Executive Office of Health & Human Services, Respite for Children Fact Sheet, 3/1/2016.
2. State of Rhode Island Medicaid Programs for Children with Special Health Care Needs guide for Respite providers, January 2017.
3. State of Rhode Island, Executive Office of Health and Human Services, Model Contract for Medicaid Managed Care Services, Winter 2017
4. State of Rhode Island Executive Office of Health & Human Services, Respite for Children Service Providers, Respite Hour Extension letter, 3/16/2020.

APPROVAL HISTORY

February 8, 2017: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC) for effective date of August 1, 2017.

Subsequent endorsement date(s) and changes made:

- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- April 8, 2020: Respite hours updated from 100 to 200 as per EOHHS Mandate in response to Covid-19 considerations, effective March 16, 2020
- April 10, 2020: Fax number for Unify updated
- October 21, 2020: Reviewed by IMPAC, renewed without changes

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.