

Respite Care

Definition

Respite Care is assistance and supervision provided to a HASCI Waiver participant due to a short-term absence of or need for relief by those normally providing unpaid care. It can be provided on a periodic and/or emergency basis to relieve one or more unpaid caregivers.

The service may include hands-on assistance or direction/cueing for personal care and/or general supervision to assure safety. It may include skilled nursing procedures only if these are specifically delegated by a licensed nurse or as otherwise permitted by State law.

Respite Care may be provided in a variety of community or institutional settings. Federal Financial Participation (FFP) will not be claimed for cost of room and board except if Respite Care is provided in a facility approved by the State that is not a private residence.

Service Unit

Non-Institutional Respite Care: one unit equals one (1) hour

Institutional Respite Care: one unit equals one (1) day when the participant is present at midnight

Refer to the current HASCI Waiver rate table for reimbursement amounts. *This can be accessed via the SCDDSN Application Portal >R2D2 >View Reports >Waiver >Service Rates >HASCI.*

Service Limit / Restrictions

Non-Institutional Respite Care on an hourly basis may be provided in the following locations:

- Participant's home or other private residence
- Group home:
 - SCDDSN licensed residence (CTH-I or CTH-II)
 - SCDHEC licensed Community Residential Care Facility (CRCF) operated by an agency contracted with SCDDSN

Institutional Respite Care on a daily basis may be provided in the following locations:

- Medicaid-certified hospital
- Medicaid-certified nursing facility (NF)
- Medicaid-certified Intermediate Care Facility for the Intellectually Disabled (ICF-ID); this may be a SCDDSN Regional Center or a community ICF-ID

Respite Care cannot substitute for or be an ongoing supplement to a participant's authorized Attendant Care/Personal Assistance or Medicaid Waiver Nursing funded by the HASCI Waiver. There must be one or more identified unpaid caregivers to be relieved.

Within the designated service limits, Respite Care may be authorized on the same days that Attendant Care/Personal Assistance and/or Medicaid Waiver Nursing is received, but must be provided at different hours.

All requests for new or increased units of Respite Care are subject to prior approval by the SCDDSN Head and Spinal Cord Injury (HASCI) Division.

Except in extreme circumstances, Non-Institutional (Hourly) Respite Care may not exceed 68 units per calendar month if the participant also receives any amount of Attendant Care/Personal Assistance and/or Medicaid Waiver Nursing through the HASCI Waiver. To exceed 68 units per month, prior approval for a service limit exception must be obtained from the HASCI Division. If granted, approval will be time-limited for up to 3 months.

Except in extreme circumstances, Non-Institutional (Hourly) Respite Care may not exceed 240 units per calendar month if the participant does not receive any Attendant Care/Personal Assistance and/or Medicaid Waiver Nursing through the HASCI Waiver. To exceed 240 units per month, prior approval for a service limit exception must be obtained from the HASCI Division. If granted, approval will be time-limited for up to 3 months.

In addition to monthly limits above, Non-Institutional (Hourly) Respite Care may not exceed 16 units per calendar day. Unless there is clear justification, Respite Care does not include time when the participant/Respite Care worker is sleeping. To exceed 16 units per day, prior approval must be obtained from the HASCI Division.

Providers

Non-Institutional (Hourly) Respite Care may be provided by the following:

- An agency or company directly enrolled with SCDHHS as a Respite Care provider for HASCI Waiver participants

- A DSN Board or other qualified provider agency contracted by SCDDSN for Respite Care or Home Supports

The DSN Board or provider agency is responsible to ensure that Respite Care workers meet minimum qualifications as stipulated in SCDDSN Respite Program Standards.

This can be accessed on the SCDDSN website: www.ddsn.sc.gov >About DDSN >Directives and Standards >Current DDSN Standards.

The DSN Board or provider agency must also comply with SCDDSN Directives 567-01-DD, Employee Orientation, Pre-Service and Annual Training Requirements and 735-02-DD, Relatives/Family Members Serving as Paid Caregivers of Respite Services. *These can be accessed on the SCDDSN website: www.ddsn.sc.gov >About DDSN >Directives and Standards >Current DDSN Directives.*

If Respite Care will be provided in a participant's home or other private residence, the DSN Board or provider agency must certify Respite Care workers using SCDDSN's *Home Supports Caregiver Certification*. *This can be accessed via the SCDDSN Application Portal >Business Tools >Forms >HASCI Waiver.*

Institutional (Daily) Respite Care may be provided by the following:

- SC Medicaid-certified hospital
- SC Medicaid-certified nursing facility (NF)
- SC Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disability(ICF-IID). This may be a SCDDSN Regional Center or a community ICF-IID.

Arranging and Authorizing the Service

When it is determined Respite Care is needed and desired on a periodic, occasional, or emergency basis to provide relief to one or more identified unpaid caregivers, the need must be clearly documented in the participant's Support Plan.

For new or increased units of Respite Care or to exceed service limits, a request with justification must be submitted to the HASCI Division by fax or e-mail. Notification of approval or denial of the request by the HASCI Division will be made by fax or e-mail. Receipt of this notification must be documented in a Service Note and a copy of the fax or e-mail must be maintained in the participant's file.

The participant or representative must be offered choice among types of Respite Care available through the HASCI Waiver and must be offered choice of available providers.

It must be clearly documented in Service Notes that these options and choices were offered, as well as the selection(s) made by the participant or representative.

For Institutional Respite Care, admissions are often restricted due to bed availability and appropriateness/capability of a hospital, NF, or ICF-ID to accept a particular individual. Additional referral procedures/forms may be required by the hospital, NF, or ICF-ID. The Service Coordinator must inquire about any Respite Care referral procedures required by that facility and follow-up as necessary.

After a Respite Care provider is chosen and accepts the participant, the participant's Support Plan must be updated to clearly reflect the name of the service and payer, the amount, frequency, and duration of the service, and service provider type. Budget information for the service must then be entered in the Waiver Tracking System (WTS) and service information must be entered into the Service Tracking System (STS).

To initiate services following WTS processing, Respite Care must be authorized to the provider using *Authorization for Respite Care* (HASCI Form 12-RC). *This can be accessed via the SCDDSN Application Portal >Business Tools >Forms >HASCI Waiver.* A copy must be maintained in the participant's file.

- If Institutional Respite Care will be provided in a hospital or NF, both HASCI Form 12-RC and *Community Long Term Care Adult Day Health Care/Respite* (DHHS Form 122) must be submitted to the facility. *This can be accessed via the SCDDSN Application Portal >Business Tools >Forms >HASCI Waiver.*
- If Institutional Respite Care will be provided in a SCDDSN Regional Center ICF/ID, HASCI Form 12-RC must be sent to the Claims and Collections Officer at the designated Regional Center. If Institutional Respite Care will be provided in a community ICF/ID, HASCI Form 12-RC must be sent to the Finance Director of the provider agency.

Billing

Non-Institutional (Hourly) Respite Care provided by a DSN Board or qualified provider agency must be Board-billed to the participant's Financial Manager agency. This includes Respite Care provided in a participant's home or other private residence or in a licensed group home. Billing to the Financial Manager agency must be checked on *HASCI Form 12-RC*; no prior authorization number is required.

- The DSN Board or provider agency is responsible for maintaining documentation that service was rendered for each unit billed.

- The Financial Manager agency must follow *Procedures to Report and Bill for Board-Based Services Provided to HASCI Waiver Recipients* to receive reimbursement from SCDDSN. *This can be accessed via the SCDDSN Application Portal >Business Tools >Forms >Finance Manual Chapter 10 >Section 10-14.*

Non-Institutional (Hourly) Respite Care provided by an agency or company enrolled with SCDHHS as a Respite Care provider for the HASCI Waiver must be Direct-billed to Medicaid. Billing to South Carolina Department of Health and Human Services must be checked on *HASCI Form 12-RC*; a prior authorization number must be assigned.

Institutional (Daily) Respite Care in a hospital or nursing facility must be Direct-billed to Medicaid. Billing to South Carolina Department of Health and Human Services must be checked on *HASCI Form 12-RC*; a prior authorization number must be assigned.

Institutional (Daily) Respite Care in a SCDDSN Regional Center or community ICF-ID must be Board-billed to the participant's Financial Manager agency. Billing to the Financial Manager agency must be checked on *HASCI Form 12-RC*; no prior authorization number is required.

- The facility is responsible for maintaining documentation that service was rendered for each unit billed.
- The Financial Manager agency must follow *Procedures to Report and Bill for Board-Based Services Provided to HASCI Waiver Recipients* to receive reimbursement from SCDDSN. *This can be accessed via the SCDDSN Application Portal >BusinessTools >Forms >Finance Manual Chapter 10 >Section 10-14.*

Monitorship

The Service Coordinator must monitor provision of each HASCI Waiver service received by a participant to:

- verify the service is being provided as authorized,
- assure the usefulness and effectiveness of the service,
- determine the participant's and/or representative's satisfaction with the service and service provider(s), and
- confirm health status and safety of the participant.

Monitorship includes:

- Contact with the participant and/or representative within two (2) weeks after beginning the service or beginning with a new provider of the service,

- Contact with the participant and/or representative at least bi-monthly (every other month),
- Contact with service providers as necessary to confirm health status and safety of the participant and appropriate provision of authorized services,
- Face-to-face visit with the participant at least every six (6) months (180 days), and
- Review of the participant's Support Plan as often as needed, but at least every six (6) months (180 days).

Monitoring contacts, face-to-face visits, and review of the participant's Support Plan must be documented in Service Notes.

Information obtained during monitoring may lead to changes in authorized HASCI Waiver services, such as increased/decreased units, change of provider, or change to a more appropriate service.

Service Denial, Reduction, Suspension, and Termination

If a HASCI Waiver participant is denied a service that was requested or denied an increase in units of a service already authorized, the Service Coordinator must provide written notification to the participant or legal guardian, including reason for denial. Information concerning SCDDSN Reconsideration and SCDHHS Appeal must also be provided.

If a participant's authorized units of a HASCI Waiver service must be reduced, temporarily suspended, or indefinitely terminated, the Service Coordinator must provide written notification to the participant or legal guardian, including reason for the action. Information concerning SCDDSN Reconsideration and SCDHHS Appeal must also be provided.

Except when the action was requested by the participant or legal guardian or if the action is due to the participant's death, admission to a hospital or nursing facility, or loss of Medicaid and/or HASCI Waiver eligibility, there must be at least 10 calendar days between the date of notification and effective date of the action.

Written notification to the participant or legal guardian is made using the following forms, which are also used to notify each affected service provider of the action:

- *Notice of Denial of Service* (HASCI Form 11C)
- *Notice of Reduction of Service* (HASCI Form 11A)
- *Notice of Suspension of Service* (HASCI Form 11B)
- *Notice of Termination of Service* (HASCI Form 11)

These can be accessed via the SCDDSN Application Portal >Business Tools >Forms >HASCI Waiver.

When the action becomes effective, the participant's Support Plan must be updated and budget information in the Waiver Tracking System (WTS) must be adjusted accordingly. For service reduction or termination, excess or unused units must be deleted from the budget. Service information must be entered into the Service Tracking System (STS).