MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Subject: **Clinical Practice**	Procedure: **Respite Care Services Provided by a RN or LPN**	
Last Updated: **6/5/2023**	Owner: **Managed Care Operations**	Pages: **3**

I. PURPOSE

To define and describe operational guidelines for direct and contract providers requesting respite care services provided by a RN or LPN.

II. DEFINITIONS

Medically Necessary Services:
Services necessary for the diagnosis or treatment of disease, illness, or injury and without which the person served can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services should not be a duplication of a service that the individual may be receiving from another provider.

Respite Care Services:
Services provided on a short-term, intermittent basis to relieve the person's served family or other primary caregiver(s) from the daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is part of the daily services that would enable an unpaid caregiver to work full-time.

III. PROCEDURE

A. A primary clinical provider completes documentation in a person's record to request respite care services provided by a RN or LPN. This includes, but is not limited to:

1. Specialized Nursing Assessment (SNA), with yearly follow up after completing an initial SNA. This may be required sooner due to clinical concerns or changes in the individual's health status.
2. A goal specific to the service in the Individual Plan of Service (IPOS). There must be measurable objectives that supports medical necessity for respite services; indicate the amount, scope, and duration of the service; identify if the service will be provided by an RN or an LPN; and details the qualifying medical criteria from the following:

a. Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;

b. Mechanical ventilation rate-dependent by ventilator or Bi-PAP;

c. Deep oral (past the tonsils) or tracheostomy suctioning to remove obstruction from the airway;

d. Nasogastric (NG) tube feedings or medications when removal and insertion of the NG tube is required or if emergency medications need to be delivered via the NG tube;

e. Total Parenteral Nutrition (TPN) delivered via a central line;

f. Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required;

g. Injections or infusions when there is a regular or predicted schedule, or PRN injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);

h. Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment, or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

~~C.~~B. An assessment by a PIHP RN can be requested if the primary clinical provider is not able to complete either of the following requirements:

1. The individual has a medical condition not indicated above;

2. The primary provider is not able to complete a Specialized Nursing Assessment.

~~D.~~C. The primary clinical provider submits the request for authorization to Managed Care Operations (MCO) in the EMR.

1. Respite care services are requested via the HCPCS code T1005. The following modifiers added to this code signify that the service will be provided by a nurse:

a. TE: Service to be provided by a LPN.

b. TD: Service to be provided by a RN.

c. The modifiers are determined by the license of the staff providing respite care. If the individual served has an RN and an LPN that split hours, the request for authorization must be requested based on the nursing provider's breakdown of nursing staff availability.

2. MCO has fourteen (14) calendar days to make a medical necessity determination on these requests.

IV. REFERENCES

None.

V. RELATED POLICIES

A. MCCMH MCO Policy 2-001, "Person-Centered Planning Practice Guideline"

B. MCCMH MCO Policy 12-001, "Access, Eligibility, Admission, Discharge"

C. MCCMH MCO Policy 12-004, "Service Authorizations"

VI. EXHIBITS

None.

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	6/5/2023	Implementation of Procedure.	MCCMH MCO Division