



MACOMB COUNTY

COMMUNITY MENTAL HEALTH

Subject: Clinical Practice	Procedure: Respite Care Services When Provided by a RN or LPN	
Last Updated: 3/19/2026	Owner: Managed Care Operations	Pages: 5

I. PURPOSE

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

II. DEFINITIONS

A. Medical Necessity:

Determination that a specific service is medically (clinically) appropriate; necessary to meet needs; consistent with the person's diagnosis, symptomatology, and functional impairments; is the most cost-effective option in the least restrictive environment; and is consistent with clinical standards of care. The medical necessity of a service shall be documented in the individual plan of service (IPOS).

B. Respite Care Services:

Medicaid funded support services provided on a short-term, intermittent basis to relieve the family or other primary unpaid 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.

III. PROCEDURE

A. Respite Care Services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the person's family or other primary unpaid caregiver(s) from the daily stress and care demands during times when they are providing unpaid care.

1. The person served must be on the Healthy Michigan Plan (HMP) or one of the following Medicaid waiver programs: 1915(i) State Plan Amendment (iSPA), Children with Serious Emotional Disturbances Waiver (SED Waiver), Children's Waiver Program (CWP) or the Habilitation Supports (HSW).

2. The person served must meet eligibility standards for MCCMH services as a person with a Serious Emotional Disturbance, a Severe Mental Illness, or a person with an Intellectual/Developmental Disability.
 3. Short-term means the respite service is provided during a limited period such as a few hours, a few days, weekends, or for vacations.
 4. Intermittent means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between.
 5. Unpaid means the respite service may only be provided during portions of the day when no one is being paid to provide care, i.e., not a time when the person is receiving Adult Home Help, CLS, a service through another program (e.g. school), or another support service. The person served must have periods of unpaid care to be eligible for respite care services.
 6. Respite is not to be provided as a part of daily services to enable the unpaid caregiver to work elsewhere.
- B. When a person served notifies their primary case holder of an interest in Respite Care Services the primary case holder shall:
1. Identify if this is a treatment need for the person served, per the Michigan Medicaid Provider Manual, specific to the service and medical necessity.
 2. The primary case holder discusses this service need as a part of the person-centered planning process.
 3. The primary case holder ensures that this service is an identified service in the Individual Plan of Service (IPOS). The goal(s) must address the medical necessity of the service, identify the provider, and the amount, scope, and duration of the service.
- C. When the person's needs are such that respite care services might need to be provided by a RN or LPN additional documentation is required. 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. The goal in the IPOS must identify that the service will be provided by an RN or an LPN and detail 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.

D. 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 cannot complete a Specialized Nursing Assessment.

E. The primary case holder assists the person in identifying a provider for this service.

- 1. A list of all providers can be found in the MCCMH Provider Directory.
- 2. Persons served can hire family members or other natural supports to provide Respite Care Services through the Self-Determination process.
 - a. Respite Care Services may not be provided by the parent of a minor, spouse of the person served, legal guardian of the person served, or the unpaid primary caregiver.

F. The primary clinical provider submits the prior authorization request to Managed Care Operations (MCO) in the FOCUS Electronic Medical Record (EMR). Authorization requests can be submitted up to sixty (60) calendar days, and no less than fourteen (14) calendar days, prior to the effective date of the authorization.

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 an 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.

G. MCO has seven (7) calendar days to make a medical necessity determination on these requests.

1. When it is determined that the individual meets the medical necessity criteria for the authorization of Respite Care Services, the authorization is approved in the Focus EMR, and an electronic notification is sent to the primary clinical provider.

2. When it is determined that the individual does not meet the medical necessity criteria for all or part of the authorization of Respite Care Services, the authorization is denied in the Focus EMR, and an electronic notification is sent to the primary clinical provider. MCO sends a Notice of Adverse Benefit Determination to the person served and/or their legal guardian

IV. REFERENCES

None.

V. RELATED POLICIES

- A. MCCMH MCO Policy 2-001, “Person-Centered Planning Practice Guideline”
- B. MCCMH MCO Policy 4-020, “Medicaid and Non-Medicaid Notice of Adverse Benefit Determination”
- 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
2	3/19/2026	Revision of Procedure	MCCMH MCO Division