Service Definitions: Behavioral Health Respite **Date Created: 06/06/2022** **Last Reviewed: 11/1/2024** **Date Revised: 06/03/2026**	
Clinical Eligibility Criteria	Behavioral health respite services provide short-term, temporary relief for a primary caregiver of a member with behavioral health symptoms or functional impairment. The service requirement is recognized by the Care Coordinator in collaboration with the Child and Family Team (CFT), the member and the member's primary caregiver. Aetna Better Health covers behavioral health respite services provided that the following criteria are met and documented in the child and family-centered care plan (CFCP): • The member resides: o With his or her primary caregiver in a home that is not owned, leased, or controlled by a provider of any health-related treatment or support services o In a foster home licensed by the Ohio department of job and family services (ODJFS); o In the home of kin o In a medically fragile or treatment foster home • The member demonstrates behavioral health needs requiring caregiver relief and does not meet criteria for imminent risk of harm to self or others. • Behavioral health respite is identified on the member's child and family-centered care plan (CFCP) and the CFCP includes supporting documentation indicating that the primary caregiver has a demonstrated need for temporary relief from the care of the member because of the member's health needs. o Supporting documentation must demonstrate that the caregiver's need for respite is directly related to managing the youth's behavioral health symptoms and functional impairments, and is not based solely on supervision, scheduling, or convenience-related needs. ▪ Presence of behavioral health condition(s) that require ongoing supervision and intervention- functional impairments- behavioral health symptoms requiring continuous or intermittent supervision beyond age-appropriate expectations-history of crisis episodes, ED use. ▪ Impact member stability and placement preservation. ▪ Lack of available alternative or existing supports are unable to safely manage the member's behavioral health needs CFCP must contain a detailed description of the amount, scope, and duration of services to be provided, aligning to the documented need. Behavioral health respite services may not be authorized as open-ended or standing support.

Continuing Stay Criteria	○ If the member requires behavioral health respite services beyond 60-day service limit, within the enrollment span, the provider will submit a prior authorization request through the provider-initiated portal. ○ Continued authorization beyond the initial period requires clinical documentation demonstrating that: ○ The member continues to meet clinical eligibility criteria ○ The level of functioning has not been restored, improved, or sustained based on medical necessity. ○ Other interventions have not been effective in managing the level of behavioral health symptoms ○ The clinical or placement risk that would reasonably occur if respite were discontinued. ○ Documentation that alternative supports have been explored and are unavailable, insufficient, or unable to safely meet the youth's behavioral health needs on their own. ○ Aetna may approve subsequent requests in 15-day increments within the enrollment span based on medical necessity and progress.
Service Exclusions	The following exclusions apply to behavioral health respite services: • Reimbursement for behavioral health respite is not allowable when the youth is receiving otherwise available respite services as defined in rules 5160-26-03.4, 5160-44-17, and 5160-59-05.1 of the Administrative Code, or in Chapter 5123-9 of the Administrative Code. • Reimbursement for the behavioral health respite services is not allowable when delivered by the youth's "legally responsible family member" as defined in rule 5160-45-01 of the Administrative Code. • Transportation activities that do not include the provision of behavioral health respite are not reimbursable as behavioral health respite. • Behavioral health respite services are not a substitute for treatment due to imminent risk of harm to self or others. • Behavioral Health Respite is not to be used as placement or alternative living arrangement. See billing limitations for further detail.
Required Components	• Behavioral health respite services are services that provide short-term, temporary relief to the primary caregiver of a member, to support and preserve the primary caregiving relationship. • Behavioral health respite services are medically necessary preventive services when a youth's behavioral health needs create clinically significant caregiver strain that, without temporary relief, would reasonably increase the risk of

	behavioral health symptom escalation, caregiver burnout, or placement disruption, and when the youth does not require a higher level of care.
	
	• Behavioral health respite services may be provided either during normal awake hours or overnight. The provider of the behavioral health services will be awake when the youth is awake during the provision of behavioral health respite services. The CFCP will document when a provider will need to be awake during overnight hours dependent on a youth's assessed needs.
	• The behavioral health respite service may be provided on a planned or emergency basis. An emergency behavioral health respite service may be provided to address either a primary caregiver's unexpected need for behavioral health respite or to address an urgent need related to the youth's behavioral health diagnosis.
	  ○ Any use of emergency health behavioral respite will require a Care Plan update during the next Child and Family Team meeting.
	• Behavioral health respite may include the following activities and components:
	  − Assistance with activities of daily living;
	  − Transportation; and
	  − Supports in home and community-based settings.
	• The legal guardian is responsible for providing written consent via CFCP or CSP, and thorough care instructions. Respite services delivery may occur in the following locations:
	  − The primary caregiver's home that is not owned, leased, or controlled by a provider of any health-related treatment or support services;
	  − A qualifying provider's place of residence when approved by the youth's legal guardian;
	  − A foster home licensed by ODJFS;
	  − In the home of kin;
	  − In a treatment foster home certified by ODJFS;
	  − A community setting in which the general public has access.

Staffing Requirements	Behavioral health respite services can be provided by the following individuals or organizations: • Behavioral health entities operating in accordance with paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code. Rendering practitioners will meet the criteria to be an eligible provider of behavioral health services in accordance with rule 5160-27-01 of the Administrative Code. • Department of developmental disabilities (DODD)-certified providers of community respite as set forth in rule 5123-9-22 of the Administrative Code; • DODD-certified providers of informal respite as set forth in rule 5123-9-21 of the Administrative Code; • Family, who do not also meet the definition of "legally responsible family member" as defined in rule 5160-45-01 of the Administrative Code, and who do not reside in the home with the youth; • Natural supports; or

	• Foster care settings as described in rule 5101:2-47-16 of the Administrative Code are excluded from being eligible providers of behavioral health respite services when these settings are currently fostering youth, unless the foster home: – Has an established relationship with the youth who will receive respite services in the foster home; – Is fostering siblings or kin of the youth who will receive respite services in the foster home; or – Is fostering the child of a parenting youth who will receive respite services in the foster home.
Clinical Operations	Behavioral health respite services do not require prior authorization unless sixty (60) days of behavioral health respite services have been used within an enrollment span Care coordination monitors respite service use and informs the provider when the CFT supports the continuation of service beyond 60 days within the enrollment period. The prior authorization request should be submitted no later than 7 days prior to a clinical request review period. Behavioral health respite services are authorized in an amount, scope, and duration consistent with the youth's needs and behavioral health history. • The amount, scope, and duration of behavioral health respite services as defined by the Child and Family Team must be time-limited and matched to the youth's assessed behavioral health needs. Behavioral health respite services may not be authorized as open-ended or standing support. If additional behavioral health respite services are necessary beyond sixty (60) days within an enrollment span, the behavioral health respite provider (or designee) submits the prior authorization request. Instances where there are multiple behavioral health respite providers, the care coordinator is responsible for coordinating and submitting the prior authorization request. • For urgent preservice requests, the health plan will complete a clinical review within forty-eight (48) hours of Aetna Better Health's receipt of request. • For non-urgent pre-service requests, the health plan will complete a clinical review within seven (calendar) days of Aetna Better Health receipt of request. • The authorization request is submitted through the provider-initiated portal • The request must include the following clinical and non-clinical information: – Current, applicable codes, which may include: o Revenue Codes o Current Procedural Terminology (CPT) o International Classification of Diseases, 10th Edition (ICD-10) o CMS Common Procedure Coding System (HCPCS) codes o National Drug Code (NDC)

- Name, date of birth, sex, and identification number of the member
- Treating practitioner/provider
-
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the acute facility
- Requestor's name, phone, and fax number
- Reason for the request
- Presentation of supporting objective clinical information, such as clinical notes, comorbidities, complications, progress of treatment, psychosocial situation, home environment, as applicable for the request

Clinical Review

An urgent request is defined as a request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:

- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Aetna Better Health notifies practitioners, providers and/or members of utilization decisions within forty-eight (48) hours of receipt of the request for an urgent pre-service request and within ten (10) calendar days for a non-urgent preservice request.

Aetna Better Health authorizes covered and medically necessary behavioral health respite services provided the service definition criteria are met.

Authorization requests that do not meet criteria for behavioral health respite services are presented to the medical director for review. The medical director reviews the request, the member's need, and the clinical information presented. Using the approved criteria and the medical director's clinical judgment, a determination to approve or deny coverage for the stay is made. Only a medical director can reduce or deny a request for coverage.

Medical Necessity Criteria

Aetna Better Health uses clinical eligibility criteria listed in this document to determine behavioral health respite services.

Requests for criteria/guidelines can be made via email, phone, or mail. Staff fulfills requests for clinical criteria/guidelines by:

- Distributing the clinical eligibility criteria specific to a member coverage determination

- Including a “Response to Request for Decision Making Criteria” letter that details the request and identifies the specific criteria used in making the determination

Health plan staff document the following in the Utilization Management business application system by the end of the current business day:

- Name of the person requesting the guideline
- Contact information of the requestor
- Date request received
- Date information provided
- Method of delivery of information
- Guideline name and number provided

Approval, Denial or Reduction in Services

For urgent pre-service requests, Aetna Better Health notifies the behavioral health respite provider orally within forty-eight (48) hours of receipt of the request and provides written notification to the provider and member within forty-eight (48) hours of receipt of the request. Provider and member notifications communicate utilization management decisions including approvals, denials and reductions in services. Written notifications to members must be at a sixth grade reading level.

For non-urgent pre-service requests, Aetna Better Health notifies the behavioral health respite provider orally within seven (7) calendar days of receipt of the request and provides written notification to the provider and member within seven (7) calendar days of the receipt of the request. Provider and member notifications communicate utilization management decisions including approvals, denials and reduction(s) in services. Written notifications to members must be at a sixth grade reading level.

When there is a denial or reduction in service, the written notification includes:

- The action the health plan has taken or plans to take and the effective date
- The specific reason for the action
- Notification that upon request, that the provider or member may obtain a copy of the guideline that was used for the denial
- Notification that practitioners/providers have the opportunity to discuss UM denials with a physician or other appropriate reviewer
- Appeal information
- Translation service information

Peer to Peer

Practitioners/providers are notified in the written notification that they may request a peer-to-peer consultation to discuss behavioral health respite services denied authorizations with the medical director reviewer by calling Aetna Better Health. When the denial of authorization is for a service on a member's established child and family-centered care plan, the peer-to-peer consultation is offered to the appropriate clinical representative at the assigned Care Management Entity (CME) who shall serve as the

	liaison to the member's Child and Family Team if one has been established. If the requesting provider for the service is not the CME, peer-to-peer consultation is offered to the provider and to the CME who is responsible for the comprehensive child and family-centered care plan developed by the care plan team in addition to the CME. **Appeal** Providers and members are notified in the denial letter of appeal rights, including the right to submit written comments, documents, or other information related to the appeal. The denial letter also explains: • The appeal process includes the right to member representation and the timeframes for deciding appeals • A description of the next level of appeal, either within the organization or to an independent external organization • The right of the member or provider (with written permission of the member) to request a Medicaid Fair Hearing and instructions about how to request a Medicaid Fair Hearing • A description of the expedited appeals process for concurrent denials • Notification that expedited external reviews can occur concurrently with the internal appeals process • The circumstances under which expedited resolution is available and how to request • The member's right to request continued benefits pending resolution of the appeal, or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services
Additional Requirements	Additional requirements for behavioral health respite providers include the following: • Behavioral health respite providers will adhere to the criminal records check criteria set forth in rule 5160-43-09 of the Administrative Code. • All eligible providers of behavioral health respite will obtain and maintain first aid certification from instruction which includes hands-on training by a certified first aid instructor. At its discretion, ODM may accept training conducted by a solely internet-based class as sufficient for the purposes of first aid certification. • All eligible providers of behavioral health respite will complete training in trauma-informed care practices as set forth in rule 5101:2-9-42 of the Administrative Code. • Behavioral health respite providers serving an OhioRISE youth with behaviors that pose safety concerns for the youth or others, will be trained in de-escalation strategies that can be used to support the youth and prevent the use of restrictive interventions. • Behavioral health respite providers are responsible for ensuring the health, safety, and welfare of the youth during service delivery, consistent with Ohio

	and Federal law, applicable Ohio Administrative Code requirements and trauma-informed care standards.
Provider Documentation Requirements	Service documentation for behavioral health respite will include each of the following to validate reimbursement for Medicaid services: • Date of service; • Place of service; • Name of youth receiving services; • Medicaid identification number of youth receiving services; • Name of provider; • Provider identifier; • Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider; and • A summary of the amount, scope, duration, and frequency of services delivered that directly relate to the services specified in the approved child and family-centered care plan to be provided. • A summary of when restrictive interventions were used including a date, time, the de-escalation techniques used to prevent the restrictive intervention, and whether or not the use of restrictive intervention was included in the individual crisis and safety plan.
Billing Limitations	• A provider or organization may not bill for BH Respite services and Title XX services for a member on the same day • An independent provider and organization may not provide BH Respite services to more than three (3) members at any time except in the case of a family unit. • If an independent provider or organization offers BH Respite services to more than one member at a time the maximum age difference between the youngest and oldest member cannot exceed three (3) years except in the case of a family unit. • An independent provider or organization that provides 5 consecutive days of home-based would be subject to post-pay review. BH Respite home based is defined as follows: o The primary caregiver's home that is not owned, leased, or controlled by a provider of any health-related treatment or support services; o A qualifying provider's residential setting when approved by the youth's legal guardian; o A foster home licensed by ODJFS. o In the home of kin; o In a treatment foster home certified by ODJFS • An independent provider or organization that provides 7 consecutive days of community-based BH Respite would be subject to post-pay review. • Community based BH Respite is defined as follows: o A community setting in which the general public has access.

	• Reimbursement for behavioral health respite is not allowable when the youth is receiving otherwise available respites services as defined in rules 5160-26-03.2, 5160-44-17, and 5160-59-05.1 of the Administrative Code, or in Chapter 5123-9 of the Administrative Code.
Billing and Reporting Requirements	Behavioral health respite includes the following codes: S5150: unit value=15 minutes, up to three hours S5151: unit value: Per Diem, three plus hours For more information about billing for behavioral health respite services in OhioRISE, please refer to the OhioRISE Provider Enrollment and Billing Guidance. Valid Ohio Medicaid Billing Provider Types: • Community Mental Health Agency (PT 84) • SUD Agency (PT 95) • Waivered Services Organization (PT 45) with DODD Community Respite certification • Waivered Services Individual (PT 55) with DODD informal respite provider certification • Non-Agency Personal Care Aid (PT 25) with DODD informal respite provider certification, family and natural supports or foster care, as described in OAC 5160-59-03.4 Requirements for billing: • May be provided for up to Sixty (60) days without prior authorization. • Must be planned in the CFCP • Cannot be provided on the same DOS as another Respite service • Addition of the “BHR” specialty to the primary Ohio Medicaid billing provider type • The rendering provider must have an NPI, be enrolled in Medicaid and be affiliated with the billing provider • Diagnosis code is required – any valid ICD-10 diagnosis code may be used, including “Z-codes”