

Clinical Policy: Respite Services

Reference Number: HI.CP.MP.504

Date of Last Revision: 08/25

Coding Implications

Revision Log

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy describes the medical necessity requirements for respite services.

Policy/Criteria

- I. It is the policy of Ohana Health Plan that respite services are **medically necessary** when all of the following criteria are met:
 - A. Member is unable to care for themselves;
 - B. Rationale for services is for medical necessity not convenience (e.g., caregiver ill, potential caregiver burnout, going on vacation or on a business trip);
 - C. All other resources have been explored (e.g., family, friends, etc.);
 - D. Member meets nursing facility level of care (NFLOC) to allow the choice to live in their homes and communities with appropriate quality supports designed to promote health, safety and independence;
 - E. Services are authorized by the member's primary care physician (PCP) as part of the member's care plan;
 - F. An approved 1147 form has been obtained and includes current services already in place;
 - G. Services are on a short term basis with a definite plan to return to the original care setting;
 - H. Services are furnished on a short-term basis due to the absence of, or need for, relief for those persons normally providing the care;
 - I. Services are to be provided at one of the three (3) levels:
 1. Hourly;
 2. Daily;
 3. Overnight.
 - J. Place of Service (POS) is provided in one of the following locations when at the same level of care:
 1. Individual's home or place of residence;
 2. Private residence of a respite care worker;
 3. Licensed Day Care Facility;
 4. Medicaid Certified Nursing Facility;
 5. Foster home/ARCH, Expanded ARCH;
 6. Licensed respite day care facility;
 7. Other community care residential facility approved by the State.

Note: The maximum allowable benefit is two weeks per episode.

Background

Respite care is short-term care provided to an individual to relieve their caregivers at home.

Although, it is one of the most frequently requested support services by caregivers, respite care

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services are often underused, primarily due to a lack of service flexibility and accessibility among respite care services capable of meeting the unique needs of different families.²

Inpatient respite services are provided in a skilled nursing facility or hospice facility. Outpatient respite services are provided in a member's place of residence (e.g., in-home, assisted living facility), as well as for those receiving hospice care.¹

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. 25 minutes must be met or exceeded.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. 35 minutes must be met or exceeded.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. 50 minutes must be met or exceeded.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 10 minutes must be met or exceeded.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. 20 minutes must be met or exceeded.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. 30 minutes must be met or exceeded.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. 45 minutes must be met or exceeded.

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HCPCS* Codes	Description
H0045	Respite care services, not in the home, per diem
S9125	Respite care, in the home, per diem
T1005	Respite care services, up to 15 minutes

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		02/14
Annual review, no changes		02/15
Annual review, no changes		02/16
Annual review, no changes		02/17
Annual review, no changes		01/18
Updated lines of business		12/18
Annual review, no changes		11/19
Transitioned policy to new state specific template and sent to market for ownership, Policy number changed from HS-227 to HI.CP.MP.504	9/2020	
Policy template and references updated-sent to market for ownership.	08/23	
Annual review. Minor grammatical edits with no impact to criteria. Added CPT codes 99304 through 99310. References reviewed and updated.	08/24	
Annual review. Minor grammatical edits with no impact to criteria. References reviewed and updated.	08/25	

References

1. State of Hawaii Department of Human Services Med-QUEST Division. Administrative Rules and DHS Policies. Hawaii Administrative Rules: Title 17 (subtitle 9; chapter 1427 respite services). <https://humanservices.hawaii.gov/wp-content/uploads/2014/01/17-1427-Respite-Services2.pdf> Published June 29, 1992. Accessed July 10, 2025.
2. Castro AR, Ould Brahim L, Chen Q, et al. Information and Communication Technologies to Support the Provision of Respite Care Services: Scoping Review. *JMIR Nurs*. 2023;6:e44750. Published 2023 May 30. doi:10.2196/44750
3. State of Hawaii Department of Human Services. Med-QUEST Division. Level of Care (LOC) and at risk evaluation-DHS Form 1147. https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-forms/1147-level-of-care---at-risk-evaluation/DHS_1147_Form_Rev_06_2023-PRINT.pdf Revised June 2023. Accessed July 10, 2025.
4. State of Hawaii Department of Human Services. Med-Quest Division: covered benefits. QUEST integration benefits; home and community-based services-respite care. <https://medquest.hawaii.gov/en/members-applicants/quest-integration-coverage/medical-benefits.html>. Accessed July 10, 2025.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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