

Nursing Services

Definition: Nursing services are continuous or intermittent skilled care provided by a nurse, licensed in accordance with the State's Nurse Practice Act, in accordance with the participant's Support Plan, as deemed medically necessary by a physician. This service will be provided in the home unless deemed medically necessary by the physician and indicated in the Support Plan.

Note: State Plan Medicaid covers Nursing Services for children (under age 21). When a child is enrolled in the ID/RD Waiver, the Waiver Case Manager/Early Interventionist must authorize State Plan funded Private Duty Nursing. See the "Medicaid State Plan Services" section of this chapter for more information.

The unit of service for Nursing Services through the waiver is one hour.

Please see: Scope of Services for Nursing Services-
<https://www.scdhhs.gov/internet/pdf/MEDICAID%20NURSING.pdf>

Providers: Nursing services are provided by agencies or companies contracted with SCDHHS to provide Nursing Services.

ID/RD Waiver Nursing Services are for adults (age 21 and over) – For Children see the "Medicaid State Plan Services" Section of Chapter 10

Service Limits: ID/RD Waiver-funded Nursing Services are limited to a maximum of 56 units per week by a LPN or 42 units per week by a RN, as determined by SCDDSN assessment. A week is defined as Sunday through Saturday. If both a LPN and a RN provide services, the combined cost cannot exceed the cost of the maximum number of units provided by either a LPN or a RN alone. However, the limits may be exceeded if applying the limits would create a substantial risk that the individual would no longer be able to live in the community, but would, because of the limit in services, have to be institutionalized. Unused units from one week cannot be banked (i.e. held in reserve) for use during a later week.

Please refer to the ID/RD Waiver Rate Table for unit costs.

Arranging for and Authorizing Services: A physician's order for Nursing Services (ID/RD Form 28) must be completed by a licensed physician, specifying the skill level required (RN or LPN). **Prior approval of service provision must be obtained from SCDDSN, who will also determine the number of units needed. This approval can be obtained by submitting a packet as required in the "Required Records for Review for DDSN Authorized Nursing Services" at the end of this chapter. This review by SCDDSN is required at least annually thereafter at the time of the annual assessment/plan development (unless otherwise instructed by SCDDSN during the previous review). The packet should be sent as part of plan review to SCDDSN far enough in advance of the plan date (+/- 30 days) to allow for ample time for review.**

The need for the service, as well as its amount, frequency and duration must be documented. Once the amount needed is determined and prior approval obtained, the Waiver Case Manager will authorize Nursing services.

Once the physician orders the services, the Waiver Case Manager should provide the participant/legal guardian with a list of Medicaid-contracted Nursing Services providers and document the offering of a choice of providers. To initiate the service following approval by the Waiver Administration Division, an electronic authorization must be completed and submitted to the chosen. The service must be Direct-billed to SCDHHS. This must be indicated on the authorization.

Services must be authorized annually at the time of the Support Plan, and as changes are made to the service throughout the plan year.

Note: A RN can provide care if the order is written for a LPN; however, the provider can only claim the LPN rate for that participant when billing SCDHHS. A LPN **cannot** provide services when a RN is ordered by the physician.

For those participants who have private insurance, Nursing Service providers must bill the participant's private insurance carrier prior to billing SCDHHS for all nursing services provided. ID/RD Waiver Nursing Services should not be billed to SCDHHS until all other resources, including private insurance coverage, have been exhausted. The Waiver Case Manager/Early Interventionist must first determine if the ID/RD Waiver participant has private insurance and if the insurance policy covers nursing services. In no instance will SCDHHS pay any amount that is the responsibility of a third party resource. The ID/RD Waiver is the payer of last resort and maximum allowable limits as defined above apply.

The following guidelines are to be followed when authorizing Nursing Services:

- When private insurance covers **all** Nursing Services
 - The Waiver Case Manager/Early Interventionist will follow all the steps listed above including obtaining approval from the SCDDSN and will indicate the needed amount of Nursing Services and that the private insurance carrier is the funding source in the participant's Support Plan. No authorization is necessary for the services.
- When private insurance covers **a portion** of the Nursing Services
 - The Waiver Case Manager/Early Interventionist will indicate the needed amount of Nursing Services that the private insurance carrier will provide and will indicate the private insurance carrier as the funding source in the participant's Support Plan.
 - For those additional hours not covered by the private insurance carrier, but deemed medically necessary, the Waiver Case Manager/Early Interventionist will indicate the needed amount and will indicate ID/RD Waiver as the funding source in the participant's Support Plan.
 - The Waiver Case Manager/Early Interventionist will follow all the steps listed above including obtaining approval from the SCDDSN and will issue an Authorization for Nursing Services for the amount not covered by private insurance. Providers of Nursing Services must only bill SCDHHS for that amount.
- When private insurance covers **none** of the Nursing Services or the participant does not have private insurance
 - The Waiver Case Manager/Early Interventionist will follow all the steps listed above including obtaining approval from the SCDDSN and will indicate the needed amount of Nursing Services and that the ID/RD Waiver is the funding source in the participant's Support Plan. He/she will complete the Authorization for Nursing Services for the amount needed, not to exceed the service limits.

When sending the Authorization for Nursing Services to the selected Nursing provider, the Waiver Case Manager/Early Interventionist must attach a copy of the Physician's Order for Nursing Services (ID/RD Form 28).

The Nursing Services provider must notify the Waiver Case Manager within two (2) working days of any significant changes in the participant's condition or status. The Waiver Case Manager must respond to requests

from the provider to modify the participant's Support Plan within three (3) days of receipt by notifying SCDDSN. **SCDDSN will determine any needed changes prior to the participant's Support Plan being revised.** Once SCDDSN approves the update, a new authorization can be sent to the provider, reflecting the new number of units and start date.

Monitoring the Services: The Waiver Case Manager must monitor **waiver funded Nursing Services** for effectiveness, usefulness and participant satisfaction. Monitoring may be completed with the participant, representative, service providers, or other relevant entities. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. DDSN recommends that the Waiver Case Manager monitors this service when it begins and as changes are made.

- Monitoring must be conducted on-site at least once annually (i.e. within 365 days of the previous on-site monitoring).

Monitoring must be conducted as frequently as necessary in order to ensure:

- the health, safety and well-being of the participant;
- the service adequately addresses the needs of the participant;
- the service is being furnished by the chosen provider in accordance with the authorization, relevant policies and quality expectations;
- the participant/representative is satisfied with their chosen provider/s.

Some questions to consider during monitoring include:

- ❖ Is the participant receiving Nursing Services as authorized?
- ❖ Does the provider show up on time and stay the scheduled length of time? If the provider does not show up to provide care to the individual, who is providing back-up care in the provider's absence?
- ❖ Does the provider show the participant courtesy and respect?
- ❖ Has the participant's health status changed since the last monitoring? If so, does the service need to continue at the level at which it has been authorized? If the individual is receiving the service for an acute condition, has the physician been consulted about the continuation of Nursing Services and the skill level required?
- ❖ Have there been any changes to the participant's specific nursing plan developed by the provider? If so, is a copy of the current nursing plan present in the participant's Case Management record?
- ❖ Is the participant pleased with the service being provided, or is assistance needed in obtaining a new provider?
- ❖ What is the expected duration of services at the current level?

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

Required Records for Review for DDSN Authorized Nursing Services

For those enrolled in the ID/RD or HASCI Waiver, Nursing Services [*both* State Plan funded (for those under 21) *and* HCB Waiver funded] are authorized by the person's Waiver Case Manager or Early Interventionist. In order to assure that the appropriate amount of Nursing Services are authorized and continue to be authorized, DDSN is requiring that the need for nursing services be evaluated prior to authorization and annually thereafter.

For those determined for the first time to need nursing services, the following information must be submitted to SCDDSN for review prior to issuing an authorization to the chosen provider.

The following information must be submitted as part of plan review.

- Consumer Name, Date of Birth , County of Residence
- Personal Physicians assessments/progress notes for the past three (3) months
- All Specialized Physicians summaries/treatment regime for the past three (3) visits
- All Hospitalization Discharge summaries for the past twelve (12) months
- CM/EI name and contact information

For those currently receiving, the following information should be gathered prior to the annual plan date and submitted to SCDDSN. If the review requires that adjustments be made to the authorization, those changes must be discussed with the family at the time of annual planning.

The following information must be submitted as part of plan review.

- Consumer Name, Date of Birth , County of Residence
- If currently receiving nursing services, nursing assessments/notes/flow charts (if applicable) for the past three (3) months
- Personal Physicians assessments/progress notes for the past three (3) months
- All Specialized Physicians summaries/treatment regime for the past three (3) visits
- All Hospitalization Discharge summaries for the past twelve (12) months
- CM/EI name and contact information.