Nursing Services

Definition: Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of practice in the state Nurse Practice Act. These services are provided to a participant in their home. Continuous and individual skilled care provided by a licensed registered nurse or licensed practical nurse, under the supervision of a registered nurse, licensed in accordance with the State Nurse Practice Act, in accordance with the participant's plan of care as deemed medically necessary by an authorized health care provider. Services are not allowable when a participant is in an institutional setting.

The unit of service for Nursing Services through the waiver is one hour. 1 unit = 1 hour
Procedure code for Nursing Services: S9123

See Nursing Scope of 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.

Conflict Free Case Management
To honor choice and prevent conflicts of interest, providers of Waiver Case Management services must not provide any other waiver service to the same person. When there is a conflict, the WCM will help the participant understand why a conflict exists and offer a choice of either another WCM provider or another waiver service provider. The Case Manager must then transition the participant to the chosen provider within 60 days.

Service Limits:
Nursing Services are limited to 60 hours per week. *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, be institutionalized.

A week is defined as Sunday through Saturday. Unused units from one week cannot be banked (i.e., held in reserve) for use during a later week.

All medically necessary nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit. The service is defined and described in the approved State Plan and will not duplicate any service available to adults aged 21 and older in the State Plan. See the "Medicaid State Plan Services" Section of Chapter 10 for nursing services for children.

Arranging for and Authorizing Services: *The Physician's Order for Nursing Services (DDSN Form 28) must* be completed by a licensed physician. 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.

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

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 (DDSN 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 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 reconsideration, 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 reconsideration/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 WCM. In order to assure that the appropriate amount of Nursing Services is authorized and continues to be authorized, DDSN requires the need for nursing services be evaluated prior to authorization and annually thereafter.

For those determined to need nursing services, the following information must be submitted to SCDDSN as part of plan review.

- Participant name, date of birth, county of residence
- Personal physician assessments/progress notes for the past three (3) months
- All specialized physician summaries/treatment regime for the past three (3) visits
- All hospitalization discharge summaries for the past twelve (12) months
- WCM name and contact information

For those currently receiving nursing, the following information should be gathered prior to the annual plan date and submitted to SCDDSN for review. 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.

- Participant 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 physician assessments/progress notes for the past three (3) months
- All specialized physician summaries/treatment regime for the past three (3) visits
- All hospitalization discharge summaries for the past twelve (12) months
- WCM name and contact information.