APPENDIX A-

MEDICAID HOME AND COMMUNITY-BASED WAIVER
SCOPE OF SERVICES
FOR
NURSING SERVICES

A. Objective

The objective of nursing services is to provide skilled medical monitoring, direct care, and intervention to maintain the participant through home support. This service is necessary to avoid institutionalization.

B. Conditions of Participation

1. Agencies desiring to be a provider of Medicaid Nursing services must have demonstrated experience in providing Nursing services or a similar service. Experience must include at least three (3) years of health care experience, one of which must be in administration.

2. Provider agency must be housed in an office that is in a commercial zone. Office can not be located in a residence/home office. Current providers with residential/home offices must relocate to a commercially zoned office space by July 1, 2012 in order to maintain their contract.

3. Agencies must utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.

4. Providers must accept or decline referrals from SCDHHS or SCDDSN within two (2) working days. Failure to respond will result in the loss of the referral.

5. The provider must verify the participant's Medicaid eligibility when it accepts a referral and monthly thereafter to ensure continued eligibility. Providers should refer to the SCDHHS Services Provider Manual for Community Long Term Care Services for instructions on how to verify Medicaid eligibility.

6. Providers may use paperless filing systems. When using electronic filing systems any documentation requiring signatures must be signed prior to scanning. Electronic records must be made available upon request, and providers must have a reliable back-up system in the event their computer system shuts down.

C. Description of Services to be Provided

1. The unit of service is one (1) hour of direct nursing care provided to the participant in the participant's place of residence. Services are not allowable when the participant is in an institutional setting. The amount of time authorized does not include travel time. Services provided without a current, valid authorization are not reimbursable.

2. The number of units and services provided to each participant are determined by the individual participant's needs as set forth in the Service Plan/Authorization.

3. Nursing services providers will provide skilled nursing services as ordered by the physician performed by a registered nurse (RN) or licensed practical nurse (LPN) in accordance with state law. In addition, providers will assist with/perform ADL's as needed.

D. Staffing

1. The provider must maintain individual records for all employees.

2. The provider must employ an RN or LPN that meets the following requirements:

   a. Supervised by an RN;

   b. Licensed to practice nursing by the State of South Carolina

   c. Has at least one year of experience in public health, hospital, or long term care nursing; and,

   d. Has a minimum of six (6) hours relevant in-service training per calendar year (The annual six-hour requirement will be pro-rated during the nurse's first year of employment with the provider)

   e. Providers must ensure that nurses serving pediatric participants have at least one year of pediatric nursing experience in a clinical setting.

   f. Providers must ensure that nurses serving pediatric participants are additionally trained in caring for children with a tracheostomy, mechanical ventilation, gastric or jejeunostomy tubes, and indwelling catheters.

   g. PPD Tuberculin Test

      Please refer to Department of Health and Environmental Control (DHEC) website, Regulation 61-75 – Standards for Licensing page 11 of 36 section b. 1-6 for PPD Tuberculin test requirements. http://www.scdhec.gov/health/licen/hladcinfo.htm

      Providers needing additional information should contact the Tuberculosis Control Division, Department of Health and Environmental Control, 1751 Calhoun Street, Columbia, S.C. 29201, phone (803) 898-0558.

3. The provider must conduct a criminal background check for all potential employees to include employees who will provide direct care to SCDHHS/SCDDSN participants and all administrative/office employees. All criminal background checks must include all data for the individual with no limit on the timeframe being searched. Criminal background checks that cover a specific time period such as seven or ten year searches are not acceptable. The criminal background check must include statewide (South Carolina) data. Potential employees with felony convictions within the last ten (10) years cannot provide services to SCDHHS/SCDDSN participants or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to SCDHHS/SCDDSN participants under the following circumstances:

   - Participant/responsible party must be notified of the nurse's criminal background
   - Provider must obtain a written statement, signed by the participant/responsible party acknowledging awareness of the nurse's criminal background and agreement to have the nurse provide care; this statement must be placed in the participant record.

   Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the discretion of the provider.

   Hiring of employees with misdemeanor convictions will be at the discretion of the provider.

4. The provider must check the Office of Inspector General (OIG) exclusions list for all staff. A copy of the search results page must be maintained in each employee's personnel file. Anyone appearing on this list is not allowed to provide services to waiver participants or participate in any Medicaid funded programs.
   The website address is:

   OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

   The provider must verify nurse licensure and license status at the State Board of Nursing website. http://www.llr.state.sc.us/pol.asp A copy of the current license must be maintained in the employee's personnel file.

5. Each September the provider must submit a statement certifying that all professional staff are appropriately and currently licensed.

6. In addition, services must also adhere to the following:

   a. The RN supervisor must be accessible via beeper/phone at all times the RN or LPN is on duty; and,

   b. The RN supervisor must decide the frequency of supervisory visits based on his/her professional knowledge of the participant's situation and health status; however, this may be no less frequently than every 90 days for LPNs and every 180 days for RNs. In the event the participant is inaccessible during the time the visit would have normally been made, the visit must be completed within five (5) working days of the resumption of Nursing services. These visits will include a re-evaluation of the participant's condition as well as updating of the plan of care.

E. Conduct of Service

The provider must maintain documentation showing that it has complied with the requirements of this section. An individual participant record must be maintained.

1. The provider must obtain the Plan of Service/Authorization from the SCDHHS/SCDDSN prior to the provision of services. The authorization will designate the amount, frequency, and duration of service for participants in accordance with the participant's Plan of Service. This documentation must be maintained in the participant's file.

2. Prior to the initiation of nursing services, the provider must conduct an assessment and develop a plan of care. This must be done by an RN. If services are to be provided by an LPN, the plan of care must be developed by the RN supervisor. The provider must maintain the initial and subsequent care plans in the participant's record. If applicable, recommendations to change the service schedule from the initial authorization may be sent to SCDHHS/SCDDSN. **For SCDHHS Participants:** this visit must be recorded in Care Call.

3. If there is a break in service which lasts more than sixty (60) days, the supervisor is required to conduct a new initial visit and subsequent visits as indicated above.

4. The provider is responsible for procuring the direct care skilled nursing orders from the physician. The orders must specify the skilled needs of the participant and include the medication administration record (MAR). The provider must communicate with the participant's physician(s) in order to maintain current physician orders. The physician's orders must be updated no less than every 90 days. Participant records must be maintained by the provider and made available to the nurse providing care.

5. Nursing services must begin on the date negotiated by SCDHHS/SCDDSN and the Nursing services provider. Payment will not be made for nursing services provided prior to the authorized start date.

6. The provider must notify SCDHHS/SCDDSN within two (2) working days of the following participant changes:

   a. Participant's condition has changed, and the Plan of Service no longer meets the participant's needs, or the participant no longer needs nursing services;

   b. Participant is institutionalized, dies or moves out of the service area;

   c. Participant no longer wishes to receive the Nursing services; or

   d. Knowledge of the participant's Medicaid ineligibility or potential ineligibility.

7. The provider must maintain a record keeping system which documents:

   a. **For SCDHHS participants:** The delivery of services in accordance with the SCDHHS Service Plan. The provider will maintain daily notes including MAR that reflect the nursing services provided to the participants. The provider shall not ask the participant/responsible party to sign any nursing notes. The nurse's note must be reviewed, signed, with original signature (rubber signature stamps are not acceptable), and dated every two weeks by the supervisor. Nursing notes must be filed in the participant's record within 30 days of service delivery

   b. **For SCDDSN participants:** The delivery of services and units provided in accordance with the service authorization. The provider will maintain daily notes reflecting the Nursing services provided by the nurse for the participants and the actual amount of time expended for the service. The daily logs must be signed weekly by the participant or family member. The nurse's note must be reviewed, signed with original signature (rubber signature stamps are not acceptable) and dated every two weeks by the Supervisor. Nursing notes must be filed in the participant's record within 30 days of service delivery.

   c. All active participant records must contain at least two (2) years of documentation to include nurse's notes, service plans, authorizations, supervisory visit documentation, etc. Per Medicaid policy, all records must be retained for a period of at least five (5) years. Daily logs must be made available to SCDHHS/SCDDSN upon request.

8. A summary of services provided must be sent to SCDHHS/SCDDSN monthly. This summary must be documented on the monthly summary form. Documentation of supervisory visits must be sent to SCDHHS/SCDDSN quarterly on the supervisory visit form and maintained in the participant record. Providers serving pediatric participants must document on the Pediatric Monthly Summary and Pediatric Supervisory Visit forms. All of these forms can be obtained on the SCDHHS website:

   http://www.scdhhs.gov/insidedhhs/bureaus/BureauofLongTermCareServices/nursing.asp

F. Overview of compliance review process

The Division of Long Term Care Waiver Management, Provider Compliance Department has developed this policy for clarification of the provider compliance process. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider will receive a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

Following is a chart that outlines how reviews are scored:

**Sanction Level**

- Provider compliance review questions in the Scope of Services are classified into three classes, based on (1) the significance of the question regarding to the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

**Severity level: 1=less serious, 2 = serious, 3 = very serious**

| **Client Service Questions** | Possible Answers | Severity level |
|---|---|---|
| Was supervisory visit made within 30 days after PC II services initiated? | Y,N,NA | 3 |
| Was the initial supervisory visit documented in Care Call? | Y,N,NA | 3 |
| Does provider maintain individual client records? | Y,N | 2 |
| Did provider give participant written information regarding advanced directives? | Y,N,NA | 1 |

There are five types of sanctions:

- Correction Plan – This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a corrective action plan outlining how and when deficiencies will be corrected (or have been corrected) and outline a plan of how they will avoid future deficiencies

- 30-day suspension – At this level, new referrals are suspended for 30 days. The provider will also be required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 30-day period; indicates moderate deficiencies.
- 60-day suspension – At this level, new referrals are suspended for 60 days. The provider will also be required to submit a corrective action plan. If the corrective action plan is approved, the suspension is automatically lifted at the end of the 60-day period; indicates substantial deficiencies.

- 90-day suspension – Indicates serious and widespread deficiencies; the 90-day suspension of new referrals will only be lifted after an accepted corrective action plan is received. In addition, an acceptable follow-up review visit will be conducted if warranted.

- Termination – Indicates very serious and widespread deficiencies, generally coupled with a history of bad reviews. Termination is a last resort.

We have developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. Following is an outline of how reviews will be scored:

**Calculating process**

- The level of sanction will be decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.

- Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

- Since each level has different severity, multiple points will be added on each class's score. Final score = level 3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

**Example:**

| Level | Deficiency percentage | Basic points | Final points |
|---|---|---|---|
| Level 1 (less serious) | 28% | 5 | 5x1=5 |
| Level 2 (serious) | 20% | 4 | 4x2=8 |
| Level3 (major) | 35% | 7 | 7x3=21 |
| Final score | | | 34 |

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

**Score scale & Sanction Level**

| Sanction Type | Final score | With Good History* |
|---|---|---|
| Correction Plans | 0-99 | 0-149 |
| 30 Days Suspension | 100-199 | 150-249 |
| 60 Days Suspension | 200-299 | 250-349 |
| 90 Days Suspension | 300-399 | 350-449 |
| Termination | >400 | >450 |

Good History is determined based on previous review scores. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than 30-day suspension based on the previous review score.

Scores are automatically calculated using a computer generated compliance review program.

Provider records will be reviewed periodically at the provider's office. Onsite visits are un-announced. If the reviewer arrives at the provider's office to conduct a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals
- Third time – contract termination.

G. Administrative Requirements

1. The provider must inform SCDHHS of the provider's organizational structure, including the provider personnel with authority and responsibility for employing qualified personnel, ensuring adequate staff education, in-service training, and employee evaluations. The provider shall notify SCDHHS within three (3) working days in the event of a change in or the extended absence of the personnel with the above listed authority.

2. The provider must provide SCDHHS with a written document showing the organization, administrative control and lines of authority for the delegation of responsibility down to the hands-on participant care level staff at contract implementation. The document shall include an organizational chart including names of those currently in the positions. Revisions or modifications to this organizational document must be provided to SCDHHS. It is recommended that this document be readily accessible to all staff.

3. Administrative and supervisory functions shall not be delegated to another agency or organization.

4. The provider agency must acquire and maintain for the duration of the contract liability insurance and worker's compensation insurance as provided in Article IX, Section D of the Contract. The provider is required to list – SCDHHS as a Certificate Holder for informational purposes only on all insurance policies using the following address: Post Office Box 8206, Columbia, SC 29202-8206.

5. The provider will ensure that its office is staffed by qualified personnel during the hours of 10:00 am to 4:00 pm. Outside of these hours, the provider agency must be available by telephone during normal business hours, 8:30 am to 5:00 pm, Monday through Friday. Failure to maintain an open and staffed office as indicated will result in sanctions as outlined in section F, last paragraph. The provider must also have a number for emergencies outside of normal business hours. Participant and personnel records must be maintained at the address indicated in the contract and must be made available, upon request, for review by SCDHHS.

6. The provider must develop and maintain a policy and procedure manual which describes how it will perform its activities in accordance with the terms of the contract. The Policy and Procedure Manual shall be available during office hours for the guidance of the governing body, personnel and will be made available to SCDHHS upon request.

7. The provider must have an effective written back-up service provision plan in place to ensure that the participant receives the nursing services as authorized. Whenever the provider determines that services cannot be provided as authorized, the SCDHHS/SCDDSN must be notified by telephone immediately.

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ADDENDUM

Nursing Services to High Risk/High Tech Children:

The Department of Health and Human Services has established a separate classification and compensation plan for Registered Nurses (RN) and Licensed Practical Nurses (LPN) who provide services to medically fragile children under the age of 21 who are ventilator dependent, respirator dependent, intubated and require parental feeding or any combination of these conditions.

In addition to the staffing requirements outlined in Section D.1, the RN or LPN must have documented experience to care for these children that is over and above normal home care or school based nurses.

If the above requirements are met, the provider will be paid an enhanced rate for High Risk/High Tech RN and LPN services as indicated on the rate sheet included in the contract

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