FY 2023 IN-HOME SERVICES PROVIDER PROVISIONS

A 1.1 PURPOSE: The South Dakota Department of Human Services (“State” or “DHS”), Division of Long Term Services and Supports (LTSS), provides home and community based service options to individuals 60 and older and to individuals 18 years of age and older with disabilities. State services enable these South Dakotans to live independent, meaningful lives while maintaining close family and community ties. The State provides home and community-based services, as specified in the Individual Support Plan (ISP), to prevent or delay premature or inappropriate nursing facility placement.

A 1.2 PROVISION: In addition to the requirements outlined in the SD Medicaid Provider Agreement, the Provider agrees to comply with all the requirements in this document.

STANDARD PROGRAM DEFINITIONS

B 2.1 “Adult Companion service” is the performance, by an in-home aide, of non-medical care, assistance, and socialization. Companions perform tasks that are incidental to the care and supervision of the consumer, as opposed to completing the tasks for the consumer. The adult companion service to be performed and the frequency will be specified in the Therap Service Auth and accompanying documents.

B 2.2 “Case Management” includes reassessing the consumer’s needs and eligibility at least annually, facilitating the development of the ISP, convening annual and as-needed person-centered planning meetings to develop and approve changes to the ISP, authorizing additional services by the Provider and/or third parties, and resolving any consumer concerns and other consumer-related issues. The State will provide on-going case management for each consumer.

B 2.3 “Chore service” are services needed to maintain the consumer’s home in a healthy and safe environment. Chore services are lawn mowing, snow and ice removal from sidewalks and driveways, or other services which the homeowner is required to complete by city or county ordinance. Chore services to be performed and the frequency will be specified in the Therap Service Auth and accompanying documents.

B 2.4 “Critical Service Need Consumer” is a consumer who needs service(s) (i.e., oxygen, injection, medication, wound care, therapy) provided on each assigned day without which the consumer’s health condition would decline. The LTSS Case Management Specialist will communicate with the Provider (through the ISP) when a consumer has been identified as a critical service need consumer. When a critical

service need consumer is identified, the LTSS Case Management Specialist will work with the consumer and the Provider to develop a critical service back-up plan to coordinate service provision during an emergency and when the usual caregiver(s) are not available to provide service(s) i.e., personal care, nursing services to the consumer. The Provider must notify the State immediately of any change in scheduled visits and/or when a critical service need consumer cannot be provided necessary services for any reason.

B 2.5 “Eligible Consumer” is any person in need of services who has been determined eligible by DHS.

B 2.6 “Electronic Visit Verification (EVV)” is a required tracking system that provides electronic verification of when a person receives services. The electronic verification must include the type of service performed, the consumer receiving the service, the date of service, the location of service delivery, the individual providing the service and the time the service begins and ends.

B 2.7 "Homemaker services" consist of the performance of general household tasks provided by an in-home aide, when the consumer is unable to manage the home and care for him or herself, or others in the home. The homemaker service to be performed and the frequency will be specified in the Therap Service Auth and accompanying documents.

B 2.8 “In-home aide” is an individual who performs homemaker, personal care, respite, adult companion, and chore as identified on the Therap Service Auth and accompanying documents.

B 2.9 “Individual Support Plan (ISP)” is an electronic document within each consumer’s record in the Therap case management system. The ISP is developed by the LTSS Case Management Specialist with the consumer, as well as any individuals the consumer chooses. The ISP must be finalized with the agreement and informed consent of the consumer in writing and signed by all individuals and providers responsible for its implementation.

The ISP reflects the services and supports that are important for the individual to meet the needs identified through an assessment of need, as well as what is important to the consumer regarding preferences for the delivery of such services and supports.

B 2.10 “Nurse (RN or LPN)” is an individual who provides nursing services as identified on the Therap Service Auth that fall within the scope of practice of a licensed nurse and is licensed by the SD Board of Nursing.

B. 2.11 “Person-Centered Philosophy” encompasses values, concepts and tools that are used to promote a person’s positive control over the life they have chosen for themselves. The core concept of what is important to (happy, content, satisfied) and

important for (healthy, safe, and seen as a valued member of their community) a person is the core concept and is foundational during care planning process.

B 2.12 “Personal Care Service” is assistance provided to a consumer living at home, by an in-home aide, to perform his or her activities of daily living. The personal care services to be performed will be specified in the Therap Service Auth and accompanying documents.

B 2.13 “Respite service” is the performance, by an in-home aide of temporary substitute supports or living arrangements for consumers to provide a period of relief or rest for the primary caregiver. The respite service to be performed and the frequency will be specified in the Therap Service Auth and accompanying documents.

B 2.14 “Significant Change” is a major decline or improvement in a consumer’s status that results in an increase or decrease in aggression, cognition, activities of daily living, change in chronic diagnosis, or change in treatments received (for example, dialysis, chemotherapy, tracheotomy, IV medication) that is anticipated to last longer than 30 days.

B 2.15 “Therap” is the online case management documenting and billing software.

B 2.16 “Therap Service Auth” is the electronic document in Therap which details the services authorized for the consumer. The Therap Service Auth must be acknowledged by the Provider within seven (7) business days of receipt. Failure to acknowledge the Therap Service Auth within the designated time frame may negatively affect reimbursement for services provided. Any permanent change to the Therap Service Auth must be reviewed and authorized by the State.

If a Provider is concerned that there is an error on the Therap Service Auth, the Provider should not acknowledge the Therap Service Auth. The Provider should contact the LTSS Case Management Specialist assigned as the consumer’s case manager to resolve any potential discrepancies.

STANDARD PROGRAM REQUIREMENTS

C 3.1 RULES AND REGULATIONS: The Provider shall comply with all South Dakota Codified Laws and Administrative Rules of South Dakota applicable to the services provided. The Provider also agrees to comply in full with all licensing requirements and other standards required by federal, state, county, city or tribal statute, regulation or ordinance in which the service and/or care is provided. Liability resulting from noncompliance with regulations, licensing and/or other standards required by federal, state, county, city or tribal statute, regulation, or ordinance or through the Provider’s failure to ensure the safety of all consumers served is assumed entirely by the Provider.

C 3.2 VERIFICATION AND DOCUMENTATION: The Provider is required to maintain documentation and verification demonstrating compliance with these Provider Provisions. This documentation must be readily available upon request.

C 3.3 REFERRALS AND GEOGRAPHIC AREA: Any LTSS consumer living within the Provider's identified geographic area may be referred to the Provider. The Provider is expected to consider all referrals but may turn down a referral due to safety concerns, unavailability of staff, or inability to serve consumer need. The consumer will be offered the choice of available Providers and select the Provider of his/her choice.

The Provider is bound to serve the geographical area specified in the In-Home Services Schedule. Any LTSS consumer living within the identified geographic area may be referred to the Provider. The Provider is expected to consider all referrals; however, may turn down a referral due to safety concerns, unavailability of staff, or inability to serve a consumer's needs.

C 3.4 INTERPRETERS: If Interpreter services are necessary, the Providers must utilize DHS approved interpreters. Interpreter services must be authorized by the LTSS Case Management Specialist prior to Interpreter services being utilized. LTSS Case Management Specialist and Provider will cooperatively arrange for interpreter services as necessary for service provision.

The State may not reimburse for interpreter services when the in-home aide or nurse is not available for a scheduled visit requiring interpreter services. If an in-home aide or nurse is not available for a scheduled visit requiring interpreter services, the Provider must contact the Interpreter Service Agency to cancel the visit within 4 hours of the scheduled visit. If the Provider does not cancel the scheduled visit, the Provider will be responsible for reimbursing the Interpreter Agency for the duration of the scheduled visit.

C 3.5 REIMBURSEMENT: The rate(s) for services are specified in the In-Home Services Fee Schedule. All services authorized and delivered by the Provider to eligible consumers will be reimbursed at the stated rates. The State will only consider rate changes during the contract year in extraordinary circumstances. If a Provider wishes to update/change their established rate during the contract year, the Provider must receive approval from the State prior to implementation of their new rate.

The State's reimbursement rate for services must not exceed the Provider's private pay rate(s). If the State's rate(s) of reimbursement exceeds the Provider's private pay rate(s), the State's reimbursement will be adjusted to match the private pay rate(s).

Approved claim forms, including all required information (e.g., Provider's National Provider Identifier), consumer's primary diagnosis code, etc., will be submitted by the Provider to the State for payment of services authorized and provided.

It is the responsibility of the Provider to review the Therap Service Auth to ensure the details (including the rate, units and frequency, recipient ID and referring provider information) are correct prior to acknowledging the Therap Service Auth. If any of the Therap Service Auth information is incorrect, the Provider must contact the LTSS Case Management Specialist to mitigate potential claims error(s).

If the Provider is reimbursed at the incorrect rate resulting in an overpayment, necessary action to resolve this overpayment will be initiated by the State, including voiding of Medicaid claims and ACH recoupment for State-funded services. If the Provider is reimbursed at the incorrect rate resulting in an underpayment, the Provider will be required to initiate the necessary action(s) to correct the underpayment, including voiding of Medicaid claims and initiation of an ACH return for State-funded services. The Provider must resubmit the claims at the correct rate to receive appropriate reimbursement.

For assistance with claim denials and billing issues, Providers must notify the State within the 6-month time limits outlined in ARSD 67:16:35:04. For all claims inquiries, Providers must submit a Claims Resolution Template to ltsstherap@state.sd.us for further review and technical assistance. Providers are encouraged to resubmit all previously denied claims every 90 days for SD Medicaid and SD DHS/LTSS claims compliance. Claims inquiries will be reviewed by LTSS staff in the order in which they are received.

LTSS will not address or review SD Medicaid or LTSS State-funded claims issues that are not in alignment with ARSD 67:16:35:04. LTSS staff will not review and research claims if there is not a claim submitted to Medicaid or LTSS within 6 months of the date of service and every 3 months thereafter per Medicaid billing requirements. It is ultimately the responsibility of the Provider to submit a request for reimbursement for services provided within established guidelines.

LTSS will assist Providers with claims resolution if there is a Claims Resolution Template submitted within 3 months of the date of service. This will ensure there is still time to resolve the issue prior to the timely filing deadline.

The Provider must only bill for services authorized and acknowledged in Therap and delivered by the Provider. Total units authorized are a maximum for the entire duration of the Therap Service Auth. The scheduled frequency and duration of each service is included in the Therap Service Auth and must be followed. Reimbursement received for units above and beyond the total units, frequency, and/or duration specified in the Therap Service Auth will be recouped by the State and the Provider will be responsible to continue to provide services at the scheduled frequency and/or duration as indicated on the Therap Service Auth. If overutilization occurs, the Provider must provide care logs for services rendered during the affected timeframe upon request.

The Provider must contact the LTSS Case Management Specialist if the authorized services routinely take more or less time to complete than indicated in the Therap Service Auth, or if additional services are being requested.

If a situation arises in which unanticipated services must be provided in order to assure the well-being of the consumer, the Provider must notify the LTSS Case Management Specialist by the next business day in order to receive approval for the services. If the Provider does not notify the LTSS Case Management Specialist, the additional units will not be approved and may not be billed.

Due to federal requirements associated with the 21st Century CURES Act and Electronic Visit Verification (EVV), the Provider may only bill for time spent completing authorized services. The Provider may not bill for units not delivered. The Provider may not bill for "not home" visits.

Additional units for mileage will not be authorized and must not be billed. Travel time is included in the non-billable time reported in the cost reports and is used to calculate the rate(s) for services.

The Consumer must be present when services are being performed unless an exception is specified in the Therap Service Auth. If the Provider encounters a situation where an exception is needed, the Provider must contact the LTSS Case Management Specialist for authorization.

If staffing shortages occur, the Provider must provide adequate coverage to serve the assigned consumers. "Clustering" visits to consumers should be employed to more efficiently manage personnel resources during staffing shortages. No additional units will be authorized to cover the Provider's staffing shortages.

The State's reimbursement for services rendered shall be considered payment in full. Except for the cost-share for waiver services, the Provider may not bill the consumer for any additional fees. The Provider will be advised of the consumer's cost-share, if any, and will be responsible for collecting the cost-share from the consumer.

The State will not reimburse or otherwise be made liable for purchases or transactions made by the Provider on behalf of the consumer.

C 3.6 BACKGROUND CHECK: The Provider must, at a minimum, conduct a State fingerprint background check of all employees hired to work in the homes of consumers to screen for disqualifying criminal convictions.

The Provider may request the State's approval for an alternative background check by completing and submitting a Provider Request for Approval of Alternative Background Check form, along with a description of the alternative background check (produced by the company that processes the alternative background checks).

To receive approval, the alternative background check results for employees hired by the provider must be readily accessible to the State upon request and the description of the alternative background check must include verification that the following threshold criteria are met:

- The alternative background check verifies the identity of the individual hired utilizing at least two unique types of identification (must include a government issued photo ID and an additional document that meets I-9 standards);
- The alternative background check identifies the criminal history of the individual hired; and
- The alternative background check creates a report of the criminal history of the individual hired which is readily accessible to the Provider.

An employee hired to work in the homes of consumers must meet the following minimum standards:

1. Be 16 years of age or older.
2. Be employed by an enrolled Medicaid Provider
3. Pass a State fingerprint (or State approved) background check.
   a. The following are a list of fitness criteria that would automatically preclude an individual from being hired/contracted:
      i. Conviction of a crime of violence as defined by SDCL 22-1-2 or a similar statute from another state;
      ii. Conviction of a sex crime pursuant to SDCL 22-22 or SDCL 22-24A or SDCL 22-22A-3 or similar statutes from another state;
      iii. Class A and/or B felony convictions.
   b. The following are a list of fitness criteria that may preclude an individual from being hired/contracted at the discretion of the provider:
      i. Convictions of other felony not described in 3.a.iii.
      ii. Misdemeanor convictions related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
      iii. Any convictions, including any form of suspended sentence, which are determined to be detrimental to the best interests of SD Medicaid. This includes convictions related to a person’s character such as perjury and fraud related charges as individuals determined to be dishonest with any party should not be assumed to be honest with SD Medicaid;
      iv. Any conviction related to obstruction of a criminal investigation.

C 3.7 OIG LEIE AND SAM EXCLUSION LIST(S): The Office of the Inspector General (OIG) has the authority to exclude individuals and entities from federally funded health care programs and maintains a list of all currently excluded individuals. The Provider must check the OIG List of Excluded Individuals and Entities (LEIE) a minimum of once every month to ensure that new hires and current employees are not on the excluded list. The OIG exclusions database can be searched online at: https://exclusions.oig.hhs.gov/.

The System for Award Management (SAM) lists individuals and entities who are suspended or debarred from receive federal funding, contracts, subcontracts, financial and non-financial assistance and benefits. The Provider must screen staff through the SAM system, a minimum of once every month, to ensure that new hires and current employees are not on the excluded list. The SAM exclusion database can be searched online at: https://sam.gov/content/exclusions.

Any payments made for services provided by an employee found on the OIG Exclusionary list or SAM list of individuals who are suspended or debarred must be reported to DHS staff. Participating providers receiving state and federal Medicaid or Medicare dollars have an obligation to report any payments received in error to DHS.

C 3.8 DRIVER'S LICENSE: The Provider is responsible for maintaining proof of a valid driver's license for any employees transporting consumers.

C 3.9 DHS COST REPORT: The Provider must submit a cost report in the format required by the State within four months following the end of the Provider's fiscal year. Failure to submit the report will result in the termination of the Provider's contract with the State. For further information regarding the DHS annual cost report, please visit DHS Budget and Finance webpage, link: https://dhs.sd.gov/budgetandfinance.aspx .

C 3.10 RELATIVES AND LEGAL GUARDIANS: The Provider may hire a relative/legal guardian of a consumer to provide his/her services. The relative/guardian must meet all the Provider's qualifications and training requirements.

When an individual being considered to provide services to a consumer, resides in the same home as the consumer, the Provider should contact the Case Management Specialist to discuss service options. When this situation occurs, a referral to structured family caregiving services is required. Individuals that do not comply with the structured family caregiving referral requirement may be limited to services available.

C 3.11 PRIVATE PAY RATE: The Provider must attest to their established private pay rate (also known as the usual and customary charge) at the beginning of each state fiscal year. The private rate is the individual Provider's normal charge to the general public for a specific service. To verify and attest to your agency/agencies' private pay rate, please visit the DHS/LTSS Provider Resources webpage at: https://dhs.sd.gov/ltss/ltssproviders.aspx.

C 3.12 COUNTY COVERAGE AREA: The Provider is responsible for updating their county coverage areas for service(s). The State will review all updates monthly. To establish or update your agency/agencies' county coverage, please visit DHS/LTSS Provider Resources webpage at: https://dhs.sd.gov/ltss/ltssproviders.aspx.

C 3.13 EVV REQUIREMENT: The Provider must comply with federal Electronic Visit Verification (EVV) requirements for no less than 75% of all services that require EVV.

Manually entered EVV, or EVV that has an exception, is not considered compliant EVV due to the manual edits.

The State has purchased an EVV system for providers to utilize at no cost to the Provider. If the Provider determines utilization of the State purchased EVV system is not feasible, the Provider may complete the Provider Request for Approval for Alternative IT System for Electronic Visit Verification (EVV) form.

If an alternative IT system is approved, the Provider must ensure the minimum EVV requirements are met. EVV requirements include the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the times the service began and ended.

PROGRAM POLICY REQUIREMENTS

D 4.1 POLICY AND PROCEDURE MANUAL: The Provider must have a policy and procedure manual. The policy and procedure manual must be easily accessible upon request. The policies required within the Provider Provisions must be included in the policy and procedure manual.

D 4.2 INTAKE AND ADMISSIONS: The Provider must have an intake/admissions policy. The intake/admission policy must include the Provider's process for reviewing and accepting referrals as well as the process to ensure services will begin in a timely manner. The Provider will assign and begin provision of authorized services within seven (7) business days of receipt of the Therap Service Auth. If the Provider is unable to meet the seven-day deadline, the Provider must contact the consumer's LTSS Case Management Specialist to discuss the plan for ensuring services are provided.

D 4.3 DISCHARGE: The Provider must have a consumer discharge policy. When the Provider determines services to a consumer must be discontinued by their agency, the Provider must notify the State at least 30 days before the consumer is discharged, unless the consumer's home constitutes an unsafe environment for Provider's staff and/or the consumer. The notice must be in writing and must specify the reason for discharge in accordance with the Provider's discharge policy.

Any changes to a consumer's Individual Support Plan (ISP) will be communicated to the Provider as soon as the State is made aware of the change, including discontinuation of services. When the State determines that services to a consumer must be discontinued, the provider will be notified as soon as possible.

D 4.4 DOCUMENTATION: The Provider must have a documentation policy. The documentation policy must include how in-home aides and nurses document each interaction with a consumer and how the Provider will comply with records retention and EVV requirements. Documentation must be kept for each consumer. Records must be retained for six (6) years after a claim has been paid or denied. Documentation must

meet the minimum EVV requirements which include the type of service performed, the consumer receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. Additionally, the provider must retain documentation of all tasks completed during each visit with a consumer. A pattern of missed visits must be reported to the LTSS Case Management Specialist. Documentation must be easily accessible upon request.

D 4.5 STAFFING: The Provider must have a staffing policy. The staffing policy must include job qualifications, the process for conducting background checks, OIG exclusion, SAM exclusions, and the process for performance evaluations. The Provider must deactivate any staff member account in their Therap Provider account upon employee termination.

If staffing shortages occur, the Provider must make every reasonable effort to actively recruit and hire in-home aide and nursing staff to serve the geographical area specified in the In-Home Services Schedule.

D 4.6 STAFF TRAINING: The Provider must have a staff training policy. The staff training policy must include identification of the processes and timelines for new staff orientation and annual staff training. The Provider must provide a new employee orientation to each new employee before the employee enters a consumer's home unsupervised.

The Provider must ensure that each in-home aide receives a minimum of six (6) hours of training annually and must maintain a training record for each in-home aide, documenting the date, length, and topic of each training completed.

The Provider is responsible for the oversight of staff (including relatives/legal guardians) in the completion of their assigned tasks. The review process must include unannounced visits to the assigned work site of each employee. Documentation of staff monitoring visits must be available for review.

D 4.7 OIG/LEIE AND SAM VERIFICATION: The Provider must have a policy that specifies both process(es) (OIG & SAM) for conducting staff exclusion search and the policy must have a mechanism for ensuring that the staff who perform the verifications are not listed on either exclusion list(s).

For review purposes, all employee files should contain evidence that the OIG list and SAM list was checked. A page can be printed from the OIG web page and SAM web page, or the file should contain documentation of the date the list was checked and the outcome of the check and who did the check. Background checks or screening information should also be contained in the personnel file and available to state program staff.

D 4.8 ABUSE NEGLECT AND EXPLOITATION: The Provider must have a policy for abuse neglect and exploitation. In accordance with South Dakota law, the Provider is

mandated to immediately report any suspected abuse neglect or exploitation of a consumer. The policy for abuse neglect and exploitation reporting must conform to the mandatory reporting laws and address the requirement to provide training on mandatory reporting laws to staff on an annual basis. See South Dakota Codified Law (SDCL) 22-46 for South Dakota's mandatory reporting laws for elders and adults with disabilities. To make a referral to Adult Protective Services (APS), visit https://dhs.sd.gov/ltss/adultprotective.aspx

D 4.9 INCIDENT REPORTING: The Provider must have an incident reporting policy. The Provider must submit a Critical Incident Report to the LTSS Case Management Specialist documenting the circumstances of any incident that involves serious injury, a missing person, restraint, seclusion, abuse, neglect, exploitation or death incidents, or any consumer-related concerns, incidents or occurrences not consistent with routine care.

Examples of serious injuries include fracture, concussion, laceration requiring sutures, severe burn, dislocation of major limb, internal injury, etc. Examples of a consumer-related concern, incident or occurrence include falls without serious injury, stroke, heart attack, malnutrition, dehydration or any reports of hospitalizations or emergency room visits due to illness, etc. An incident report does not relieve a Provider of any mandatory reporting requirements under South Dakota law.

Upon being informed that an LTSS consumer has been hospitalized or discharged from the hospital, the Provider will communicate this information to the LTSS Case Management Specialist to assure the consumer's need for service provision continue to be met appropriately. The LTSS Critical Incident Report can be found on the DHS LTSS Provider Resources page, link: https://dhs.sd.gov/ltss/ltssproviders.aspx.

D 4.10 EMERGENCY RESPONSE: The Provider must have an emergency response policy. An "emergency" is defined as a situation that is sudden, generally unexpected, and demands immediate attention to prevent or reduce physical harm to an individual. When a staff member is in a consumer's home and an emergency occurs, the staff member must call 911 immediately. The Provider must notify the LTSS Case Management Specialist of the emergency upon resolution of the emergency or transfer of the consumer to emergency responders.

D 4.11 HEALTH AND SAFETY: The Provider must have a health and safety policy. The health and safety policy must detail the use of universal precautions. The Provider must provide all supplies and equipment needed for staff members performing home visits to practice infection control.

D 4.12 CONFIDENTIALITY: The Provider must have a consumer confidentiality policy. The confidentiality policy must include specifics on maintenance of consumer records, transmission of personal consumer information and confidentiality practices by staff.

D 4.13 CONSUMER RIGHTS: The Provider must have a consumer rights and responsibilities policy. The consumer rights and responsibilities policy must include the rights and responsibilities of the consumer; and how rights and responsibilities are conveyed to the consumer as well as the consumer's right to remain free from restraints and seclusion. The Provider must provide annual staff training on the prohibition of restraints and seclusion on an annual basis.

D 4.14 QUALITY ASSURANCE: The Provider must have a quality assurance policy. The Provider must have a written quality assurance plan detailing all activities conducted by the Provider to ensure quality service provision. The Provider must also have a quality assurance policy specifying how the Provider will discover, fix, and report problems. The Provider will cooperate with quality performance audit activities conducted by the State.

The Provider agrees to participate in any evaluation and/or consumer satisfaction program developed and conducted by the State to determine the effectiveness of service provisions statewide.

D 4.15 CONSUMER GRIEVANCE: The Provider must have a consumer grievance policy. The consumer grievance policy must include how the consumer is notified of the grievance policy, where grievances are reported and the process for addressing and resolving consumer grievances and feedback.

D 4.16 GIFTING: The Provider must have a gifting policy. The gifting policy must detail the Provider's expectations and prohibitions regarding staff acceptance of gifts from consumers.

D 4.17 MEDICATION ADMINISTRATION: The Provider must have a medication administration policy. The medication administration policy must include recording and tracking of medication errors and ensuring appropriate physician notification and follow up was conducted. The recording and tracking of all medication errors, as well as documentation of physician notification and follow up must be readily available upon request.

NURSING SERVICES

E 5.1 NURSING SERVICE: Nursing services may be authorized when a consumer has a medical condition that requires medical observation, needs services that fall within the scope of practice of a licensed nurse, or has other needs that require the supervision of a nurse. The Nursing services to be performed will be specified in the Therap Service Auth and accompanying documents.
Nursing services must be performed by or under the direct supervision of an RN. Services delegated by professional medical staff to non-medical staff within their scope of practice will be monitored by the Provider and the professional medical staff. Certain nursing services may not be delegated according to ARSD **20:48:04.01:07.** The Provider is required to ensure that only qualified individuals complete authorized tasks. Questions

regarding scope of practice and delegated services should be directed to the SD Board of Nursing. Services that are delegated to an unlicensed person will be authorized and reimbursed as personal care.

E 5.2 LICENSURE VERIFICATION: The Provider must verify, through the South Dakota Board of Nursing, licensure for each newly employed nursing staff who will be providing services to consumers. The Provider must have a Staffing Policy that specifies the processes for conducting this verification.

E 5.3 SUPPLIES AND EQUIPMENT: The State is not responsible for providing or obtaining the supplies and equipment needed to perform nursing tasks.

E 5.4 INITIAL NURSING VISIT: During an initial visit for nursing, the Provider may only bill for time spent completing nursing tasks indicated on the Therap Service Auth. Time spent completing the Provider's Initial Admit Assessment may not be billed; however, the State may utilize the nurse's professional assessment findings to authorize additional services in accordance with LTSS Program guidelines. If additional services require a physician's order, the nurse will obtain a copy of the physician's order and provide a copy to the State. The LTSS Case Management Specialist will adjust the Individual Support Plan (ISP) if it is deemed necessary.

E 5.5 PHYSICIAN'S ORDER: The nurse must also retain a copy of all physician's orders in the consumer's record. It is the nurse's responsibility to maintain routine communication with the consumer's physician and ensure nursing tasks are completed according to the current physician's order

E 5.6 NURSING NOTIFICATION: If the consumer exhibits any abnormal signs and symptoms that do not rise to level of an emergency during a visit, the Provider will notify the physician, the State, and any other appropriate individuals as necessary within five (5) business days. It is the responsibility of the nurse to obtain physician's orders for additional services requested by the physician.