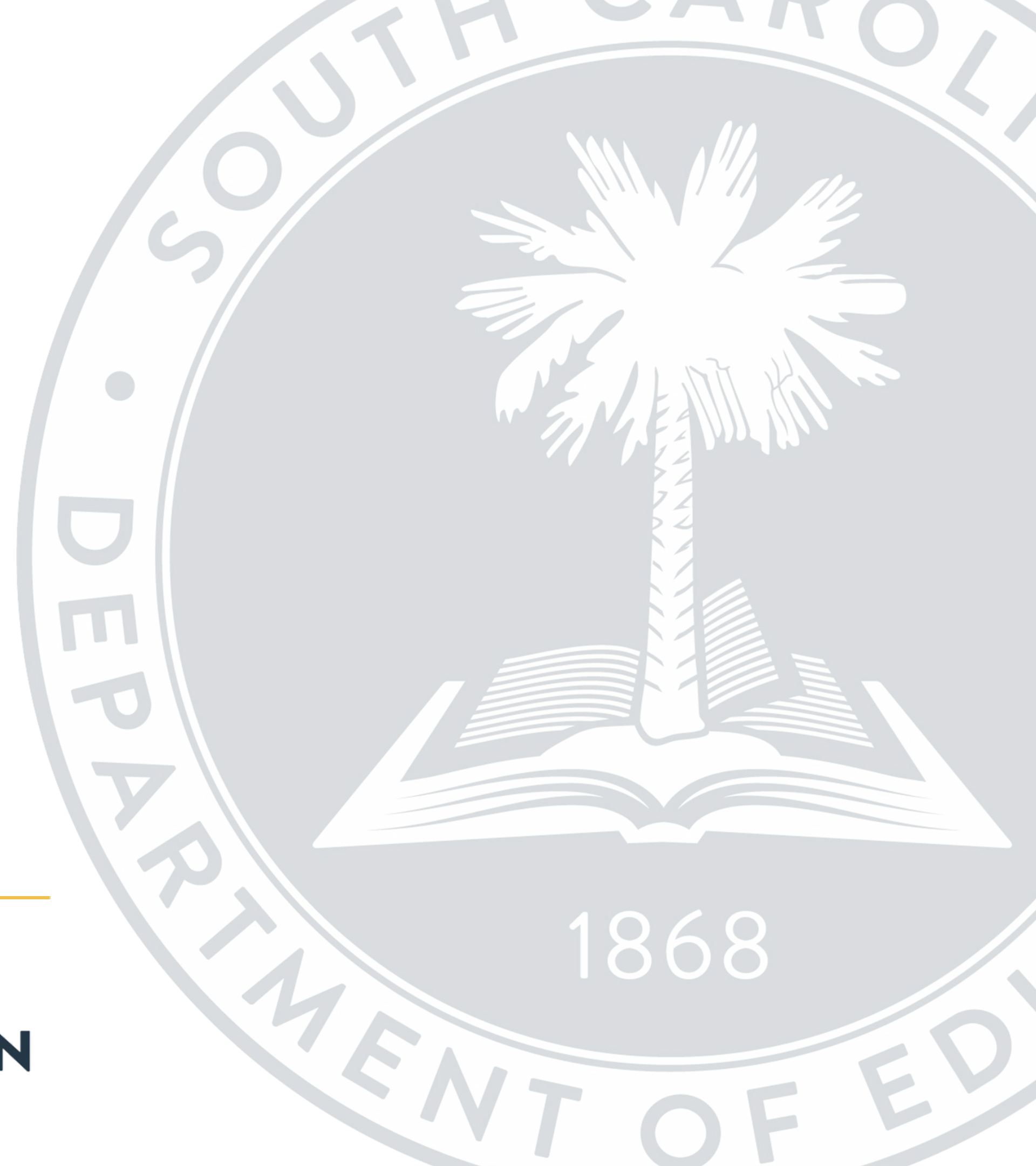


Individual Health Plan (IHP) Nursing Services Training

Office of Medicaid Services
2025-2026



**SOUTH CAROLINA
DEPARTMENT OF EDUCATION**



Overview of Individual Health Plan (IHP) Nursing Services

This training provides a brief overview of policy requirements specific to IHP Nursing Services. Districts are responsible for reviewing the LEA Provider Manual in its entirety for a comprehensive overview of policy requirements and expectations.



Purpose of Training

Provide training to promote a greater understanding of the Medicaid policies and procedures for the IHP nursing program.



Qualified Staff

Per the Local Education Agencies (LEA) Provider Manual, only a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Advanced Practice Registered Nurse (APRN) can render IHP Nursing Services.



Qualified Staff (Cont.)

- Per the LEA Provider Manual, “A nurse is defined as an individual who is currently licensed as a RN or an LPN by the state Board of Nursing for South Carolina.”
- Per the Nurse Practice Act, “RN means a person to whom the board has issued an authorization to practice as a RN”.
- Per the Nurse Practice Act, “An LPN means a person to whom the board has issued an authorization to practice as an LPN”.
- Per the Nurse Practice Act, “APRN means a registered nurse who is prepared for an advanced practice registered nursing role by virtue of additional knowledge and skills gained through an advanced formal education program of nursing in a specialty area that is approved by the board”.



Personnel Records

School districts are responsible for verifying the staff's credentials via the following authorities:

- South Carolina Department of Labor, Licensing and Regulation (SCLLR) — exclusions and terminations,
- South Carolina Department of Health and Human Services (SCDHHS) Office of Inspector General (OIG) website — exclusions and terminations,
- Federal OIG website — exclusions and terminations.

Copies of documents must be kept in the credential file or in the student's file. (Copies of the OIG lists must be date stamped.)

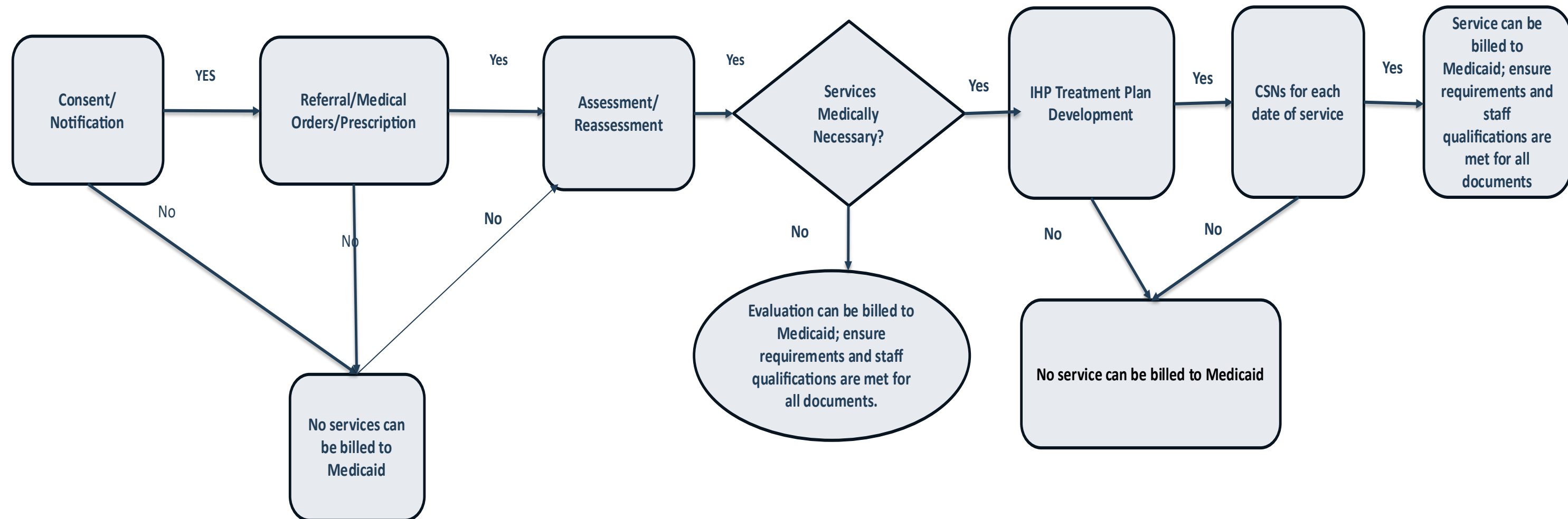


Overview of Nursing Services

- Medicaid recognizes nursing services as those that fall within the scope of practice of an RN or LPN as authorized by the South Carolina State Board of Nursing.
- Reimbursable nursing services under this program will include any service that an RN or LPN is allowed to provide under state licensure and regulation.
- Nursing services can include, but are not limited to, the following: nursing care assessments, nursing procedures, emergency care or individual health counseling, and medication administration.



IHP Nursing Sequence of Documentation



Consent

Consent is the act of providing express permission, in writing, for some particular action to take place. To comply with legal requirements and the guidelines established by Health Insurance Portability and Accountability Act (HIPAA), Individuals with Disabilities Education Act (IDEA), and the Family Educational Rights and Privacy Act (FERPA), the person providing written consent must be fully informed of all information, in his or her native language, relevant to the activity for which consent is sought and understand the activity for which consent is sought. For purposes of Medicaid, consent refers to express permission to medically assess/evaluate, provide treatment, share information to a third-party, and bill Medicaid and/or third-party insurance providers for covered services within the guidelines established by the State Medicaid program, the HIPAA, IDEA and FERPA.

The General Consent form can be found at the [Office of Medicaid Services \(OMS\) webpage](#).



Release of Information

- A Release of Information Form must be signed by the child's parent or guardian and be present in the clinical record.
- A Release of Information Form authorizes the release of any medical information necessary to process Medicaid claims.
- OMS has incorporated the Release of Information Form into the RBHS Consent Form, General Consent for Treatment Form, and the Non-IEP Nursing Consent form.



Electronic Signatures

The South Carolina Department of Health and Human Services (SCDHHS) Electronic Signature policy guidance:

- SCDHHS will accept electronic signatures on Medicaid documentation when an electronic health record/system is being utilized.
- Please review the SCDHHS Provider Administrative and Billing Manual to review/identify the requirements and standards specific to electronic signatures.

Note: The electronic signatures must be clearly seen on all documents and must include the nurse's name, title, and date.



Referral/ Medical Order/ Prescription

A medical order is a written order by an authorized licensed prescriber for a medication, treatment or procedure; may also be referred to as a treatment order, medication permission form, or prescription.

Medical orders must be:

- given for prescriptions,
- written for treatments, and
- written for procedures.



Prescribing of a Referral/ Medical Order/ Prescription

A medical order for prescriptions or treatment must be prescribed by one of the following:

- Medical Doctor (M.D.),
- Doctor of Osteopathy (D.O.),
- Dentist (D.M.D., D.D.S),
- Advanced Practice Registered Nurse (APRN), Nurse Practitioner (NP), Certified Nurse Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Nurse Specialists (CNS), or
- Physician Assistant (PA).



Prescribing of a Referral/ Medical Orders/ Prescription (Cont.)

The documentation must include:

- student name,
- date,
- reason for the Medical Order,
- description of services to be rendered, and
- name, date, and title of the provider.



Assessment

Nursing assessments must be completed for the following events:

- Applicants registering for early child development programs,
- Children referred for special education eligibility evaluation,
- New or previously identified medical/health problems based on child initiated or teacher/staff referral including substance abuse, child abuse, pregnancy confirmation, etc.,
- Related to the IEP/IFSP, ITP, and IHP,
- Home visits for comprehensive health developmental, and/or environmental assessments, and
- Emergency care.



Assessment (Cont.)

Nursing Assessments must include:

- new medical health problems,
- existing medical health problems,
- medications,
- treatments,
- procedures, and
- child development.



Individual Health Plan (IHP)

- An IHP is a nursing treatment plan, which outlines the plan of care of the student.
- If the assessment indicates that nursing services are medically necessary, an IHP must be developed, and the service must be appropriately documented/included on the IHP.
- The nursing treatment plan should be reviewed and updated according to the level of progress. If a determination is made during treatment that additional services are required, these services should be added to the treatment plan.



Criteria for Developing an IHP

- Nursing services must be for children under 21 years of age.
- The medical service or medication must be authorized and prescribed by a physician or dentist and/or other licensed/authorized healthcare personnel.
- Children who require direct care and require monitoring or medical charting require an IHP for the following:
 - Special health conditions,
 - Medical treatment,
 - Medical procedures, and
 - Medications, and/or medication administration.
- The medical services must not impact the child's ability to receive a free appropriate public education in the least restrictive environment.



IHP Components

To bill Medicaid, the treatment plan must include the following components:

- individualization,
- specify problems to be addressed,
- goals of treatment,
- short term objectives, if the student participates in SC-ALT program,
- types of interventions to be utilized,
- planned frequency of service delivery,
- estimated duration,
- criteria for achievement,
- exact service the beneficiary should be receiving,
- beneficiary's strengths and weaknesses (strongly recommended),
- name date, signature, and title of the nurse.



Purpose of the Clinical Service Note (CSN)

The purpose of these notes are to record the nature of the child's treatment by capturing the services provided and summarizing the child's participation in treatment.

Note: Electronic signatures must be present and clearly indicate the nurse's name, title, and date signed.



Clinical Service Notes (CSN)

CSNs must include a narrative summary of each treatment encounter and must justify the number of units billed. The following are CSN required components:

- provide a pertinent clinical description of the activities that took place during the session,
- student's level of participation/response to treatment,
- reflect the delivery of a specific billable service as identified in the physician's order,
- date of service,
- type of service and number of units billed,
- individualized and student specific,
- name, date signature, and professional title of the provider delivering the service.



Supervision

An LPN must be supervised at all times by a RN.

- RN must be physically present or accessible by phone/pager.
- RN must be readily available (i.e., physically accessible to the individual being supervised within a certain response time based upon the medical history and condition of the beneficiary and competency of personnel).



Supervision (Cont.)

- The RN supervisor will provide the initial assessment of the child's condition as appropriate and establish a plan of care based on the child's medical condition in accordance with state licensure and regulation.
- If the LPN receives additional information regarding the child's health condition after the initial assessment, the LPN will consult with the RN.
- Supervision by the RN of the LPN must be performed at a minimum of every 60 days via direct observation or review of the CSNs.



Clinical Records and Maintenance

Medicaid policy requirement guidelines for clinical records and maintenance are as follows:

- Each clinical entry must be typed or legibly handwritten in ink,
- Clinical records must be arranged logically,
- All clinical entries must be filed in the student's clinical records,
- A signature sheet must be available that identifies the staff's name, signature and initials,
- An abbreviation and symbols key must be available, and
- Each entry must stand on its own and not include arrows, ditto marks, etc.



Clinical Records and Maintenance (Cont.)

- LEAs are required to maintain a clinical record on each Medicaid eligible child that includes documentation of all Medicaid-reimbursable services to justify Medicaid payment.
- Clinical records must be current, meet documentation requirements, and provide a clear descriptive narrative of the services provided.
- Records are key documents for post-payment review. In the absence of appropriately completed clinical records, previous payments may be recovered by SCDHHS.
- It is essential that an internal records review be conducted by each LEA to ensure that the services are medically necessary and appropriate both in quality and quantity, and that service delivery, documentation and billing comply with Medicaid policy and procedures.

Note: If an error occurs on any documentation the nurse must place a line through the error, make the correction, initial and date.





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