Home Health Agency and Private Duty Nursing Services

A Home Health Agency (HHA) provides skilled health care services in the recipient's home on an intermittent and periodic basis as medically necessary.

An HHA may also provide Private Duty Nursing (PDN) services to eligible recipients. PDN services offer more individual and continuous care than is available from a visiting nurse providing intermittent and periodic care.

See the Nevada Medicaid Services Manual, Chapters 100, 900 and 1400 for complete policy on HHA services.

Billing disposable medical supplies

HHAs may bill for an **initial 10-day supply** of medically necessary disposable medical supplies. If needed for **longer than 10 days**, items must be billed by a Durable Medical Equipment, Prosthetics, Orthotics, and Disposable Medical Supplies provider (provider type 33).

To bill for disposable medical supplies, **enter revenue code 0270** and the appropriate **HCPCS code** on the claim.

Prior authorization

All HHA and PDN services require prior authorization, except the following:

- Mileage (do not include mileage information on your prior authorization request)
- Initial assessments

If the recipient has Medicare and Medicaid coverage, any non-covered Medicare service must be prior authorized.

The Provider Web Portal, at www.medicaid.nv.gov must be used to request authorization for all services. Authorization requests will not be accepted via mail or fax.

If you have any prior authorization questions, please call **(800) 525-2395.**

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Authorization periods and extensions

Home Health Services

Home health services are authorized in three distinct periods as described below. This section does not apply to Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS).

1. If the recipient requires HHA services (as determined through an assessment), an initial prior authorization request may be approved for **up to 60 days**. The request must be submitted within **15 business days after the initial evaluation and start of care.**
2. If the recipient requires an extension of the services initially authorized, you may request authorization to continue services. This period combined with the initial authorization period may be up to 120 days total. The request to extend services must be submitted within 15 business days after the expiration date of the existing authorization.
3. If the recipient requires services past the first 120 days, you may request another extension of services. After the 120-day period, additional **extensions may be approved for up to one year**. The request to extend services must be submitted within 15 business days after the expiration date of the existing authorization.

Home Health Agency and Private Duty Nursing Services

Private Duty Nursing Services

Private Duty Nursing service authorizations are based on medical necessity and clinical documentation submitted with the prior authorization request (FA-16B). PDN services may be authorized for a maximum of six months.

For initial PDN authorizations

New requests for PDN services must be submitted **within 15 business days after the initial evaluation and start of care**. Providers are required to provide any recent hospital discharge summaries, and any other documentation to support the number of hours requested.

For ongoing PDN authorizations

Requests for continuing PDN services must be submitted within 15 business days after the expiration date of the existing authorization. Providers are required to include 7-10 consecutive days of PDN nursing notes, including all nursing shifts, and any other documentation to support the number of hours requested. Supporting documentation examples include, but are not limited to: PDN nursing notes, discharge summaries from any recent hospital admissions, and recent physician office notes.

One-time requests for Home Health Services

A one-time request (or *PRN*) may be submitted to authorize additional **home health services** during an existing authorization period. One-time requests must include justification for necessary services (e.g., an emergency visit). Requests for one-time services must be submitted **within 30 days** of the service being provided.

Retrospective authorization

Medicaid may approve a retrospective authorization when:

- A recipient's Medicaid eligibility is established retroactively. You must request retrospective authorization **within 30 days** from the date on which the recipient was determined eligible for Medicaid benefits.
- Services were provided in an **emergent situation**. An emergent situation exists when skilled nursing services are required immediately such as in the case of wound care, IV medication, etc. You must request retrospective authorization within two working days after care is initiated.

HHA billing instructions

Instructions specific to HHA claims are provided below. Please See Electronic Verification System (EVS) Chapter 3 Claims for billing instructions or the 837I Companion Guide online at www.medicaid.nv.gov for additional instructions.

Type of bill

Effective with claims submitted on or after April 21, 2014, provider type 29 (Home Health Agency) must use type of bill (TOB) 32X. TOB 33X has been discontinued.

Type of bill code

Enter the 4-digit Type of Bill code according to the following instructions:

1. The first digit must be a *0*.
2. The second digit must be a *3*. This specifies the service was a *Home Health* service.
3. The third digit must be one of the following:
   - *2* for HHA visits under a Medicare Part B plan of treatment;
   - *3* for HHA visits and Durable Medical Equipment (DME) under a Medicare Part A plan of treatment;

- *4* for HHA medical and other health services not under a plan of treatment, and/or Skilled Nursing Facility (SNF) diagnostic clinical laboratory services to *non-patients* and/or referred diagnostic services.

4. The fourth digit must be one of the following:
   - *2* for the first claim in a home health episode.
   - *3* for a continuing care claim in a home health episode.
   - *9* for the final claim in a home health episode.

Urban and rural regions

For HHA billing purposes, Nevada is divided into *urban* and *rural* regions as described below. Payment for HHA services is based partly on the location of the recipient's residence at the time the service is rendered.

In Southern Nevada, the *urban regions* include Boulder City and the portion of Clark County within Las Vegas Valley including the cities of Las Vegas, North Las Vegas, Henderson and the urbanized townships.

In Northern Nevada, the *urban regions* include the cities of Reno, Sparks and Carson City and unincorporated areas of Washoe County within 30 miles of Reno. All areas outside of Nevada and any area within Nevada not listed above are classified as a *rural region*.

To complete the claim:

1. In the Code area, enter *61*.
2. In the Amount area:
   - Enter *500* if the location of the recipient's residence is considered urban. Enter this exactly as shown below, ensuring that the *00* is past the dotted line.
   - Enter *400* if the location of the recipient's residence is considered rural or if the claim is being submitted by an out-of-state provider. Enter this exactly as shown below, ensuring that the *00* is past the dotted line.

Fee-for-service and managed care

HHA services are covered by Managed Care Organizations (MCOs). If a recipient is enrolled in an MCO, you must bill the MCO directly. If the recipient is enrolled in the Fee-for-Service benefit plan, submit your claim to Nevada Medicaid's fiscal agent, Gainwell Technologies, which is referred to as Nevada Medicaid.

Special billing instructions

PDN concurrent care procedure codes S9123 and S9124

The definition of concurrent care is: The provision of PDN services by a single nurse to care for more than one recipient simultaneously. A single nurse may provide care for up to three (3) recipients if care can be safely provided.

For concurrent care, modifier TT is required for each individual claim when billing PDN concurrent care services. PDN concurrent care must be prior authorized by including the TT modifier. If there is no matching TT modifier on the approved authorization, the claim will deny.

When the provision of PDN concurrent care is altered by an unexpected event such as the hospitalization of one of the recipients, an unscheduled revision must be submitted by the provider within three business days of the end date of the event. Nevada Medicaid will retroactively authorize PDN (non-concurrent) for the time period in which services were provided to the single recipient.

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and

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Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature:
https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx and the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx