

Billing Guidelines for Provider Types 30 and 83

Personal Care Services: Provider Agency and Intermediary Service Organization



Claims for Self-Directed Skilled services and EPSDT services ordered by a physician require the use of a modifier in Field 24D. See "Submitting a Claim" and billing scenarios 2 and 3 below.

Program Overview

Refer to the Nevada Medicaid Services Manual (MSM) [Chapter 3500](#) for complete PCS policy and guidelines.

Covered Services

Medicaid covers age appropriate, medically necessary assistance for persons with certain disabilities and chronic conditions. This can include direct, hands-on assistance and/or instructions that help the recipient to independently perform:

- ADLs: Self-care activities routinely performed on a daily basis including but not limited to bathing, dressing, toileting, transferring, continence and eating.
 - Bathing/Grooming/Dressing is one, all-inclusive service allowed up to 60 minutes per day (for dates of service on and after August 26, 2008).
- IADLs: More complex life activities and light housekeeping, laundry, meal preparation and grocery shopping.

Non-Covered Services

Medicaid does not cover:

- Any service that is not a part of the recipient's authorized service plan
- Duplicative services
- Services that could reasonably be performed by the recipient, a legally responsible adult or a willing care giver
- Services that support household members other than the recipient, e.g., shopping must be directly related to the recipient's needs only—shopping cannot be provided for the entire household

- Administrative functions (time spent on supervisory visits, scheduling, chart audits, surveys and review of service delivery records)
- Chore services (heavy household chores such as cleaning windows and walls, shampooing carpets, moving heavy furniture, minor home repairs and yard work)
- Companion care (baby-sitting, supervision, social visitation and pet care for non-service animals)
- Exercise (for dates of service on and after August 26, 2008)
- Respite services (temporary relief for a household member, a family member or a caregiver from the responsibility of caring for the recipient)
- Skilled services (care that state statute or regulation mandates must be performed by a licensed or certified health care professional) except under the provisions of Self-Directed, Skilled PCS
- Travel time to and from the place where services are rendered
- Routine supplies (including but not limited to non-sterile gloves)

Any other service not listed as a covered service in [MSM Chapter 3500](#)

Questions?

If you have questions about the PCS program, please contact First Health Services at **(800) 648-7593**.

If you have billing questions, please contact the Customer Service Center at **(877) 638-3472**.

To stay current with policy and documentation updates, please visit First Health Services' website weekly (<http://nevada.fhsc.com>) and read any messages posted on your Remittance Advice.

Functional Assessment Process (Obtaining an Approved Service Plan)

Before services are provided, First Health Services must perform a functional assessment to determine the recipient's needs.

To request that a functional assessment be performed, complete and submit [form FH-24](#), the Functional Assessment Request for Personal Care Services. This form and its instructions (FH-24-I) are on First Health Services' website (select "Forms" from the "Providers" menu.)

The recipient, their personal care representative or their legal representative must submit this form to request a functional assessment for initial services.

Any provider who has an established relationship with the recipient, as defined by the Health Insurance Portability and Accountability Act (HIPAA), may submit form FH-24 to request a functional assessment for recertification visits, update visits and one time services after First Health Services has determined the need for initial services.

If First Health Services determines the recipient eligible for PCS, the requestor is faxed an Authorization Notice along with the recipient's approved service plan (a service plan is not sent for one time services).

A second, "official" confirmation letter is mailed to the requestor 2-3 days later.

Both of these letters show approved services, dates and an authorization number for the request.



The number of approved units represent the total approved time for all services combined—not the time approved for each individual service.

Check the Status of Your Request

You may view the status of your functional assessment request online through the Electronic Verification System (EVS) by going to <http://nevada.fhsc.com> and selecting "Login" from the "EVS" menu.

For instructions on using EVS, see the "EVS User Manual" (select "User Manual" from the EVS menu).

Submitting a Claim

The instructions that follow are specific to PCS providers and must be used in conjunction with the complete [CMS-1500 Claim Form Instructions](#) provided on First Health Services' website (select "Billing Information" from the "Providers" menu).

- Field 24A: Enter the date(s) of service for the claim line. Dates on one claim line cannot span more than Sunday through Saturday of one calendar week.
 - Bill only for the dates when services were actually provided. If a service was provided on one day only, enter the same date in the "From" and "To" Date(s) of Service fields. If services were provided on Monday and also on Wednesday of the same week, but not on Tuesday, bill Monday and Wednesday individually on separate claim lines. Do not bill as one claim Monday through Wednesday or Sunday through Saturday, regardless if the authorization period is the full week.
- Field 24B: Enter "12" for Place of Service code.
- Field 24D: Enter one code (and modifier if applicable) per line as shown on your prior authorization approval letter.
 - Use HCPCS code **T1019 with modifier TF to bill for self-directed, skilled services** (billable by provider type 83 only; use only when denoted on the recipient's approved service plan)
 - Use HCPCS code **T1019 with modifier EP to bill for PCS to EPSDT recipients** (use only when denoted on the recipient's approved service plan)
 - Use HCPCS code A0160 to bill for mileage
 - **All other PCS are billed with HCPCS code T1019 with no modifiers**
- Field 24G: Enter the number of units you are billing for this claim line. Services are billed in 15-minute increments (15 minutes = 1 unit). Mileage is billed in 1-mile increments (1 mile = 1 unit).

When completing your claim, enter the information appropriate for the services you provided. The illustrations below show how you would complete Fields 23 and 24A-J for these scenarios only. Placeholders are included for required Fields 24F (Charges), 24G (Units) and 24J (Rendering Provider ID #).

You are billing for PCS provided in August 2008. During this month, the recipient's current authorization period ends and a new one begins as shown below.

Authorization Period	Authorized Dates	Authorization Number
Authorization Period 1	August 13, 2007 – August 13, 2008	11111111111
Authorization Period 2	August 14, 2008 – August 14, 2009	22222222222

Rule #2: You may bill only one calendar month of service per claim form.

Rule #3: You may enter only one Authorization Number per claim form.

Rule #4: You may bill only for authorized dates of service.

Proper Billing

To bill for the month of August 2008, complete two claim forms.

- “Claim Form 1” will list services provided from August 1-13, 2008 (dates approved under the first authorization period). This claim form will have three claim lines.
- “Claim Form 2” will list services provided from August 14-31, 2008 (dates approved under the second authorization period). This claim form will have four claim lines.

August 2008						
Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
					1	2
					Claim 1: 1st Line	
3	4	5	6	7	8	9
Claim 1: 2nd Line						
10	11	12	13	14	15	16
Claim 1: 3rd Line				Claim 2: 1st Line		
17	18	19	20	21	22	23
Claim 2: 2nd Line						
24	25	26	27	28	29	30
Claim 2: 3rd Line						
31	Claim 2: 4th Line					

Claim Form 1

23. PRIOR AUTHORIZATION NUMBER																			
11111111111																			
24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	H.	I.	J.	
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)				DIAGNOSIS	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY		SERVICE		CPT/HCPCS	MODIFIER									
1	08	01	08	08	02	08	12		T1019						U&C \$		##	N5	10-digit API
2	08	03	08	08	09	08	12		T1019						U&C \$		##	N5	10-digit API
3	08	10	08	08	13	08	12		T1019						U&C \$		##	N5	10-digit API

Claim Form 2

23. PRIOR AUTHORIZATION NUMBER 2222222222															
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY							B. PLACE OF SERVICE EMG	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTNER	F. \$ CHARGES	G. DAYS OF UNITS	H. EPST Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	08	14	08	08	16	08	12		T1019		U&C \$\$	##	N5 NPI	10-digit API	
2	08	17	08	08	23	08	12		T1019		U&C \$\$	##	N5 NPI	10-digit API	
3	08	24	08	08	30	08	12		T1019		U&C \$\$	##	N5 NPI	10-digit API	
4	08	31	08	08	31	08	12		T1019		U&C \$\$	##	N5 NPI	10-digit API	

Billing Scenario 2: Self-Directed Skilled PCS

You are billing for Self-Directed Skilled PCS as authorized on the recipient's service plan.

Authorized Dates	Approved Code / Modifier	Authorization Number
January 1, 2009 – January 10, 2009	T1019 / TF	3333333333

Rule #1: You may bill up to one calendar week of service per claim line (Sunday through Saturday).

Rule #2: Billing for these services requires you to enter modifier "TF" after the T1019 procedure code in Field 24D.

Rule #3: You may bill only for authorized dates of service.

Proper Billing

To bill for Self-Directed Skilled PCS as authorized, complete one claim form with two claim lines.

- “Claim Line 1” will list services provided from January 1-3, 2009 (the first calendar week of authorized service).
- “Claim Line 2” will list services provided from January 4-10 (the second calendar week of authorized service).

January 2009						
Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
				1	2	3
1st Claim Line						
4	5	6	7	8	9	10
2nd Claim Line						
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

24. A. DATE(S) OF SERVICE													23. PRIOR AUTHORIZATION NUMBER												
From To													3333333333												
B. PLACE OF SERVICE													F. \$ CHARGES												
C. EMG													G. DAYS OR UNITS												
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)													H. EPSDT Family Plan												
E. DIAGNOSIS POINTER													I. ID. QUAL.												
J. RENDERING PROVIDER ID. #																									
1	01	01	09	01	03	09	12		T1019	TF												N5	10-digit API		
2	01	04	09	01	10	09	12		T1019	TF												N5	10-digit API		
3																						NPI			
4																						NPI			
5																						NPI			
6																						NPI			

Billing Scenario 3: Early Periodic Screening, Diagnosis and Treatment (EPSDT) PCS

You are billing for EPSDT PCS provided during March 2009 and April 2009.

Authorized Dates	Approved Code / Modifier	Authorization Number
January 1, 2009 – December 31, 2009	T1019 / EP	44444444444

Rule #1: You may bill up to one calendar week of service per claim line (Sunday through Saturday).

Rule #2: You may bill only one calendar month of service per claim form.

Rule #3: Billing for these services requires you to enter modifier "EP" after the T1019 procedure code in Field 24D.

Rule #4: You may bill only for authorized dates of service.

Proper Billing

To bill for the months of March 2009 and April 2009, complete two claim forms. You will enter the same Authorization Number in Field 23 on both of the claim forms.

- “Claim Form 1” will list services provided during March.
- “Claim Form 2” will list services provided during April.

Claim Form 1

														23. PRIOR AUTHORIZATION NUMBER 44444444444						
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E.	F.	G.	H.	I.	J.
From To										EMG	CPT/HCPCS		MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY															
1	03	01	09	03	07	09	12				T1019	EP				U&C \$	##	N5	10-digit API	
2	03	08	09	03	14	09	12				T1019	EP				U&C \$	##	N5	10-digit API	
3	03	15	09	03	21	09	12				T1019	EP				U&C \$	##	N5	10-digit API	
4	03	22	09	03	28	09	12				T1019	EP				U&C \$	##	N5	10-digit API	
5	03	29	09	03	31	09	12				T1019	EP				U&C \$	##	N5	10-digit API	

Claim Form 2

														23. PRIOR AUTHORIZATION NUMBER 44444444444						
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E.	F.	G.	H.	I.	J.
From To										EMG	CPT/HCPCS		MODIFIER	DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY															
1	04	01	09	04	04	09	12				T1019	EP				U&C \$	##	N5	10-digit API	
2	04	05	09	04	11	09	12				T1019	EP				U&C \$	##	N5	10-digit API	
3	04	12	09	04	18	09	12				T1019	EP				U&C \$	##	N5	10-digit API	
4	04	19	09	04	25	09	12				T1019	EP				U&C \$	##	N5	10-digit API	
5	04	26	09	04	30	09	12				T1019	EP				U&C \$	##	N5	10-digit API	

One Time Services

First Health Services assigns a separate Authorization Number to approved, one time services. When completing your claim form, be sure to enter this Authorization Number in Field 23.



A one time service must be billed on its own claim form. Do not include it on a claim that also lists services on the recipient's service plan.

Recipients Eligible for Medicaid and Medicare

At this time, Medicare does not provide coverage for HCPCS codes T1019 and A0160. If a recipient is eligible for both Medicare and Medicaid, you may bill Medicaid first. Do not write "Bypass Medicare" on your claim form.