Personal Care Services: Provider Agency and Intermediary Service Organization

A Nevada Medicaid-certified physical or occupational therapist must provide a functional assessment for initial services. See the Functional Assessments heading for details.

Program overview

Refer to Nevada Medicaid Services Manual (MSM) Chapter 2600 Intermediary Service Organization and Chapter 3500 Personal Care Services Program for complete personal care services (PCS) policy and guidelines.

Questions?

If you have questions about the PCS program, please contact Nevada Medicaid **(800) 525-2395**.

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 the Nevada Medicaid website weekly (https://www.medicaid.nv.gov/) and read any messages posted on your Remittance Advice.

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, grooming, toileting, incontinence, transferring, ambulation and eating

Bathing/Grooming/Dressing is one, all-inclusive service allowed up to 60 minutes per day:

- IADLs: More complex life activities limited to light housekeeping, laundry, meal preparation and essential 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 caregiver
- 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 (babysitting, supervision, social visitation and pet care for non-service animals)
- Exercise
- Respite services (temporary relief for a household member, a family member or a caregiver from the responsibility of caring for the recipient)

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- 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.

Request a functional assessment

A functional assessment must be submitted to Nevada Medicaid before service can be authorized.

To request that a functional assessment be performed, complete and submit form FA-24. This form and its instructions (FA-24-I) are on the Nevada Medicaid website.

A request for **initial** (first time) services must be submitted by one of the following individuals:

- The recipient
- The recipient's personal care representative
- The recipient's legal representative

A request for re-certification, an update visit or a one-time service may be requested by any provider who has an established relationship with the recipient as defined by the Health Insurance Portability and Accountability Act (HIPAA).

Functional assessment providers

The functional assessment for initial *and continued service* must be performed by a physical or occupational therapist who is certified with Nevada Medicaid to provide functional assessments.

Qualifications

Nevada Medicaid-certified physical and occupational therapists must 1) have received the specialized Nevada Medicaid functional assessment training and 2) have enrolled with Nevada Medicaid to perform functional assessments.

Billing for a functional assessment

On claims submitted by a physical or occupational therapist for a functional assessment, the following items apply:

- Third Party Liability does not apply; therefore, Medicaid may be billed first.
- Prior authorization is required to exceed one assessment in an 11-month period.
- A diagnosis code is not required in Field 21 of the claim form.
- Bill code T1015 for in-clinic assessments, code T1023 for in-home assessments and code A0160 for round-trip mileage.

Other billing instructions in this document do not apply to claims for functional assessments.

Prior authorization

All PCS services require prior authorization with the exception of one Functional Assessment per 11 rolling months.

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If, after reviewing the Functional Assessment, Nevada Medicaid determines the recipient is eligible for PCS, the recipient's PCS provider 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 provider 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 time allowed for all services combined – not the time for each individual service.

Online prior authorization

Providers may view prior authorization information online through the Electronic Verification System (EVS) at https://www.medicaid.nv.gov. For instructions on using EVS, see the EVS User Manual.

One-time services

Nevada Medicaid 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.

Billing instructions

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 the Nevada Medicaid website.

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.

Dates of service

Enter the date(s) of service for the claim line in Field 24A. 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.

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Place of service

Enter *12* for place of service code in Field 24B.

HCPCS codes

In 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 A0160 to bill for mileage
- All other PCS are billed with HCPCS code T1019 with no modifiers

Units

Enter the number of units you are billing for this claim line in Field 24G. Services are billed in 15-minute increments (15 minutes = 1 unit). Assessments are billed per occurrence (1 assessment = 1 unit). Mileage is billed in 1-mile increments (1 mile = 1 unit).

Billing scenarios

The scenarios on the following pages show how you would complete Fields 23 and 24A-J in these scenarios only. Placeholders are included for required Fields 24F (Charges), 24G (Units) and 24J (Rendering Provider ID #).

When completing your claim, enter the information appropriate for the actual services you provided.

Scenario 1: Multiple authorization periods

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	111111111111
Authorization Period 2	August 14, 2008 – August 14, 2009	222222222222

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: 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.

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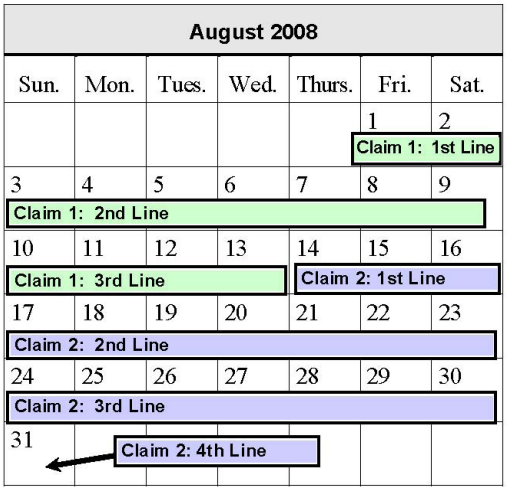
- Claim Form 1 will list services provided from August 1-13, 2008 (dates approved under the first authorization period). This claim form will have three claim lines.
- Claim Form 2 will list services provided from August 14-31, 2008 (dates approved under the second authorization period). This claim form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



Claim Form 1

23. PRIOR AUTHORIZATION NUMBER: 11111111111

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

Claim Form 2

23. PRIOR AUTHORIZATION NUMBER: 22222222222

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

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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	33333333333

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

28. PRIOR AUTHORIZATION NUMBER: 33333333333

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