Home Health Agency and Private Duty Nursing Services

Overview

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 (MSM) 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. Note: MSM 1403.1B, Initial assessments are considered administrative costs and not reimbursable unless skilled services begin at the time of the initial assessment.

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

The Provider Web Portal, at 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 the Gainwell Technologies Prior Authorization Department at **(800) 525-2395** or send an email to NevadaProviderTraining@gainwelltechnologies.com.

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 service authorizations are based on medical necessity and clinical documentation submitted with the prior authorization request (FA-16A).

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. **Initial Authorization**: If the recipient requires HHA services (as determined through an assessment), an initial prior authorization request may be authorized **up to 60 days**. The request must be submitted within **15 business days after the initial assessment and start of care.**
2. **Reauthorization**: 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.

3. **Long-term Authorization**: 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.

The following codes are billable for Home Health Services:

Procedure Code	Description
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes

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.

Private Duty Nursing services are authorized in four distinct periods as described below.

1. **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.

2. **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.

3. **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.

4. **Retrospective Authorization:** Medicaid may approve a retrospective authorization when:
   - A recipient's Medicaid eligibility is established retroactively. You must request retrospective authorization

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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 were 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.

The following codes are billable for Private Duty Nursing Services:

Procedure Code	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
S9123	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only; not to be used when CPT codes 99500-99602 can be used)
S9124	Nursing care, in the home; by licensed practical nurse, per hour

HHA Billing Instructions

Instructions specific to HHA claims for both Home Health Services and Private Duty Nursing Services are provided below. Please See Provider Web Portal (PWP) Chapter 3 Claims for billing instructions or the 837I Companion Guide online at 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. Recipients will automatically be assigned an indicator of Rural or Urban based on the Zip code of their residence.

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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*.

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.

Special Billing Instructions

Effective January 1, 2024, PT 29 is required to use an Electronic Visit Verification (EVV) system to document and bill for home health care services. Please see the Nevada Medicaid's EVV website for information.

Web Announcement 3364 notified HHA providers that the eight-minute rule applies when calculating units in the EVV system. Based on this guidance, a unit cannot be billed until a provider has rendered a minimum of eight minutes of service. Service durations of less than eight minutes are not considered billable.

PDN concurrent care for procedure codes S9123 and S9124:
Concurrent Care: 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.
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 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: medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

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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 and the PWP User Manual Chapter 3: Claims.