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 in Field 42** and the appropriate **HCPCS code in Field 44** of the UB claim form.

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
- Family planning education

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, can be used to request authorization for all services, which will eliminate the need to mail or fax in prior authorizations.

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

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).

Private Duty Nursing Services

Private Duty Nursing service authorizations are based on medical necessity and clinical documentation submitted with the prior authorization request. Requests for continuing PDN services must be submitted **at least 10 business days but not more than 30 business days prior to the expiration date of the existing authorization**. The completed request must be submitted along with a current nurse assessment and PDN prior authorization form (FA-16B). **PDN services may be authorized for a maximum of six months.**

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 at least **two days prior to the 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 **at least 10 but not more than 30 business days** prior to the expiration of the current 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 **at least 10 but not more than 30 business days** prior to the expiration of the current authorization.

One-time requests

A one-time request (or *PRN*) may be submitted to authorize additional **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 the UB Claim Form Instructions or 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 (Field 4)

In Field 4, 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 (Field 39)

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.

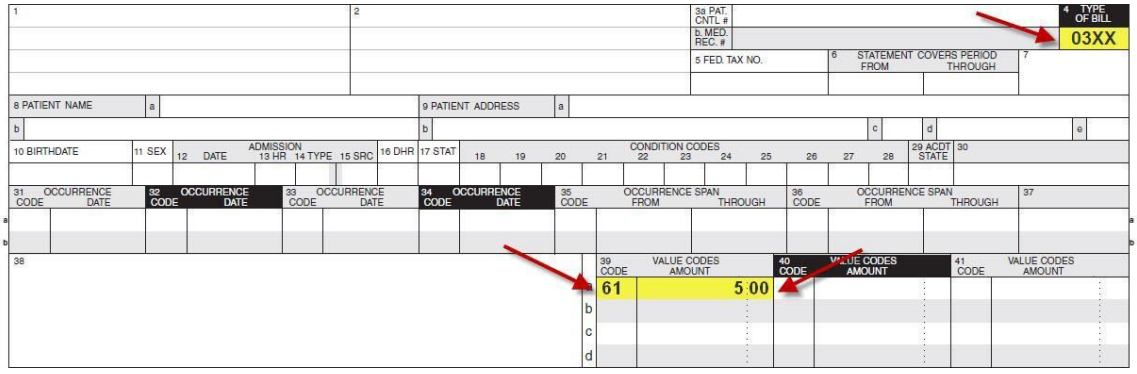
In Northern Nevada, the *urban regions* include the cities of Reno, Sparks and Carson City and unincorporated areas of Washoe County within 30 miles of Reno. All areas outside of Nevada and any area within Nevada not listed above are classified as a *rural region*.

To complete Field 39:

1. In the Code area of Field 39, enter *61*.
2. In the Amount area of Field 39:
   - 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.

Fields 4 and 39 illustrated

The following illustration shows proper completion of Fields 4 and 39 when services are provided to a recipient whose residence is in an ***urban*** region. The 4-digit Type of Bill code in Field 4 will vary as previously described (do not enter an *X* in Field 4).



The following illustration shows proper completion of Fields 4 and 39 when services are provided to a recipient whose residence is in a ***rural*** region. The 4-digit Type of Bill code in Field 4 will vary as previously described (do not enter an *X* in Field 4).

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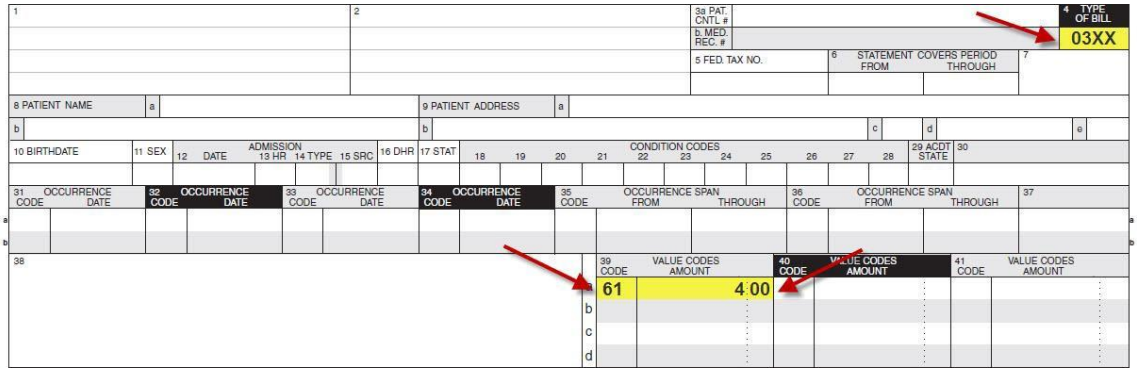

Fee for service and managed care

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, DXC Technology, 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 in Field 44 of the UB claim form 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.