Personal Care Services: Provider Agency and Intermediary Service Organization

Program overview

Personal Care Services (PCS) program is to assist, support and maintain recipients living independently in their homes. Nevada Medicaid offers two distinct PCS delivery models: The Provider Agency Model or the Self-Directed Model. 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.

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
- IADLs: More complex life activities limited to light housekeeping, laundry, meal preparation and essential shopping

Prior Authorization

All PCS services require a prior authorization. To request a prior authorization, submit a prior authorization request on the Nevada Medicaid Provider Web Portal (PWP), with a completed form FA-24. This form and its instructions (FA-24-I) are on the Nevada Medicaid provider website.

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

1. **Initial:** If the recipient requires PCS services (as determined through an assessment), an initial prior authorization request may be authorized. The QIO-like vendor will issue a prior authorization number to the recipient's chosen PCS Provider Agency.
2. **At Risk Recipient:** If a recipient is determined to be At Risk, a provider must be willing and able to initiate services within 24 hours. The approved service plan and authorization document are emailed to the provider upon acceptance.
3. **Annual Update:** To prevent a break in service, reassessment requests for ongoing services are to be submitted to the QIO-like vendor at least 60 days, but not greater than 90 days, prior to the expiration date of the current authorization.
4. **Significant Change in Condition:** Recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known and must be accompanied by documentation from the recipient's physician or health care provider. Requesting a reassessment does not guarantee an increase in previously approved PCS.
5. **Transfers:** Transfer requests must be submitted a minimum of 10 business days prior to the requested start date of the transferred services. If the requested start date is not listed or is not at least 10 business days or more from the date of submission, the prior authorization start date will be 10 business days from the date the transfer request is received by NV Medicaid.
6. **Temporary Service:** Unexpected change in condition or circumstance which requires short-term (less than eight weeks) modification of the current authorization, a new FASP is not required.
7. **One-time Services:** Nevada Medicaid assigns a separate Authorization Number to approved, one-time services.

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When completing your claim, be sure to enter this Authorization Number.
A one-time service must be billed on its own claim. Do not include it on a claim that also lists services on the recipient's service plan.

8. **Mileage:** Must be submitted in advance to the local NV Medicaid District Office for review and may be approved on a case-by-case basis. If approved, the NV Medicaid District Office will notify the QIO-like vendor to issue an authorization number for the approved mileage to the provider.

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.

Providers may view prior authorization information online through the PWP at medicaid.nv.gov. For instructions on using the PWP, see the PWP User Manual.

Electronic Visit Verification (EVV)

The 21st Century Cures Act of 2016 mandated that all state Medicaid programs implement an Electronic Visit Verification (EVV) system for Personal Care Services (PCS) and certain in-home, PCS-like services.

Electronic Visit Verification is a process that electronically captures details of home visits and services provided by caregivers while ensuring that Medicaid recipients are receiving the support they require, and that rendered services are billed accurately. The EVV system, must at a minimum, verify the following:

- The type of service(s) performed
- The individual receiving the service(s)
- The date of the service(s)
- The location of service delivery
- The individual providing the service(s)
- The time the service(s) begins and ends

Billing instructions

PCS providers are required to submit initial claims through an Electronic Visit Verification (EVV) system.

PWP Chapter 3 Claims and the Transaction 837P Professional claim companion guide, which are posted on the Nevada Medicaid provider website at medicaid.nv.gov.

Recipients eligible for Medicaid and Medicare

Currently, 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.

Dates of service

When entering the date(s) of service on the claim, dates on one claim line cannot span more than Sunday through Saturday of one calendar week. Only one calendar month of service may be billed per claim.

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 of whether the authorization period is the full week.

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Place of service

Enter *12* for place of service on the claim.

HCPCS codes

Enter one code (and modifier if applicable) per line as shown on your prior authorization approval letter.

- All PCS are billed using HCPCS code T1019 with no modifiers
- Self- directed, skilled services are billed using se HCPCS code T1019 with modifier TF (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

Units

Enter the number of units you are billing for this claim line.

- 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).

Authorization Periods

Claims must be submitted with the current authorization number for processing. Only one authorization number may be submitted per claim form. If a new authorization period begins, submit separate claims to report each authorization number. Only bill for authorized dates of service.

Questions?

If you have questions about the PCS program, please contact the QIO-like vendor at **(800) 525-2395**. If you have billing questions, please contact the Gainwell Technologies Contact Center at **(877) 638-3472.**

To stay current with policy and documentation updates, please visit the Nevada Medicaid provider website weekly medicaid.nv.gov) and read any messages posted on your Remittance Advice.