NEVADA HEALTH AUTHORITY
NevadaMedicaid.nv.gov

Nevada Medicaid and Nevada Check Up
Provider Type 29 (Home Health Agency and Private Duty Nursing Services) Prior Authorization (PA)
Frequently Asked Questions (FAQ)

Question	Answer
What is a Home Health Agency?	Home Health Agency (HHA) services are provided on an intermittent basis, certified by a physician, and provided under a physician approved Plan of Care (POC). The HHA service benefit provides Skilled Nursing (SN) services, and other therapeutic services such as Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), and Home Health Aides or Certified Nursing Aides (CNAs). Respiratory Therapists (RT) and Registered Dietitians (RD) are also a benefit with limitations. Services are generally provided on a short-term basis as opposed to long-term custodial services. See Medicaid Services Manual (MSM) Chapter 1400 Home Health Agency for more information.
What is Private Duty Nursing?	Private Duty Nursing (PDN) provides more individual and continuous care than is available from a visiting nurse for recipients who need four continuous hours of skilled nursing care per day. The intent of PDN is to assist recipients with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial, complex and continuous SN care to prevent institutionalization. See MSM Chapter 900 Private Duty Nursing for more information.
Does Nevada Medicaid accept electronic signatures for prior authorizations?	Nevada Medicaid prior authorization (PA) forms will accept electronic signatures using a tool that allows for electronic signatures (i.e., Adobe Sign® or DocuSign®) to be applied to the document and forms must include the necessary information.
What are the required PA forms for Home Health Services?	Forms that are required for Home Health Services: • Form FA-16A (Home Health Agency – Intermittent Services Prior Authorization Request) • CMS 485 form Home Health Certification and Plan of Care • Discharge/progress notes if discharged from a hospital Forms that are not required, but are helpful to reviewers: • Start of Care (SOC) • History & Physical All forms must be complete and signed.
What are the required PA forms for Private Duty Nursing services?	Forms that are required for PDN services: • Form FA-16B (Home Health Agency – Private Duty Nursing (PDN) Services Only Prior Authorization Request) • CMS 485 form Home Health Certification and Plan of Care

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	• Discharge/progress notes if discharged from a hospital Forms that are not required, but are helpful to reviewers: • Start of Care (SOC) if an adult • Pediatric admission assessment if a child • History & Physical All forms must be complete and signed.
What are some PA processing time frames?	1. Prior authorizations are processed in 5 business days; retroactive PAs are processed in 30 calendar days. a. 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 within 15 business days of the initial evaluation and start of care.** b. If the recipient requires an extension of the services initially authorized, the provider 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.** c. If the recipient requires services past the first 120 days, the provider 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. d. New requests for PDN services must be submitted within 15 business days of 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. e. For ongoing PDN authorizations, 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. 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. 2. All signatures are required. If the forms are incomplete, including the physician's signature, the prior authorization request will be denied. The PA review team does not pend for missing signatures.

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What are some requirements for First Visit Reimbursement?	Per HOME HEALTH AGENCY VISITS (MSM Chapter 1400 Section 1403.1B): Evaluation visit HHA's are required to have written policies concerning the acceptance of the recipient by the agency. This includes consideration of the physical facility available in the recipient's place of residence, homebound status, and the attitudes of family members for the purpose of evaluating the feasibility of meeting the recipient's medical needs in the home health setting. When personnel of the HHA make an initial visit to assess the recipient, the cost of the visit is considered an administrative cost and is not reimbursable as a visit at this point since the recipient has not been accepted for care. If during the initial visit, the recipient is determined appropriate for home health care by the agency and the recipient received the first skilled service as ordered under the POC, the visit becomes the first billable visit as an RN extended visit.
What are some time frames that a provider must be concerned with?	Per HOME HEALTH AGENCY (MSM Chapter 1400 Section 1403.1D): 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 within **15 business days of the initial evaluation and start of care.** If the recipient requires an extension of the services initially authorized, providers 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. After the initial 120-day authorization period, the provider may again request another extension of services and services may be approved for up to 1 year. Medicaid does not have a maximum number of authorization periods. Medicare also authorizes the initial certification period for 60 days and requires providers to recertify patients every 60 days. Medicare also does not limit the number of 60-day recertification periods for patients who continue to be eligible for the home health benefit. For both Medicare and Medicaid, the recertification must: a. Be signed and dated by the physician who reviews the home health POC. b. Indicate the continuing need for skilled services (the need for occupational therapy [OT] may be the basis for continuing services initiated because the individual needed SN, PT or SLP services).
How are authorization decisions made?	Per HOME HEALTH AGENCY (MSM Chapter 1400 Sections 1403.1D / 1403.2 / 1403.2A, 1403.3a / 1403.4A) and PRIVATE DUTY NURSING (MSM Chapter 900 Section 903.3A):

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	Authorizations are based on a medical necessity review with the fiscal agent and based on the recipient's care needs for wound management, PT/OT/ST, skilled nursing needs, medication administration, injections, teaching recipient or family to manage care at home, and skilled psychiatric nursing services. Each recipient has different care needs and no two recipients will be authorized the same exact number of units for home health or private duty nursing care. HHA and PDN services may be provided to eligible recipients based on medical necessity, program criteria, utilization control measures and the availability of the state's resources to meet recipient needs.
Is there a service list for Home Health Agencies?	Nevada Medicaid is in the process of creating a service list for Home Health Agencies and it will be posted on the NVHA Long Term Services & Support (LTSS) webpage. Please monitor the following for updates: https://www.nevadamedicaid.nv.gov/programs/long-term-services-support/ Providers may send policy-related questions to LTSS@nvha.nv.gov