Home and Community Based Waiver for the Frail Elderly

Definition
The Home and Community Based Waiver (HCBW) for the Frail Elderly is offered to eligible Medicaid recipients who, without the waiver services, would require institutional care provided in a hospital or nursing facility.

Nevada’s Aging and Disability Services Division (ADSD) operates this waiver program in conjunction with the Division of Health Care Financing and Policy (DHCFP). Therefore, providers and recipients must agree to comply with all ADSD and DHCFP policies.

Prior authorization
All services, except Case Management, must be prior authorized in order to receive payment.

It is important to verify that an approved prior authorization is in place before providing services. This can be verified online through the Electronic Verification System (EVS), by calling the Automated Response System (ARS) at (800) 942-6511 or by utilizing a swipe card system. Each method is described in Chapter 3 of the Billing Manual on the Nevada Medicaid provider website (www.medicaid.nv.gov/).

Billing instructions
Providers must submit claims to Nevada Medicaid. Claims must comply with the CMS-1500 Claim Form Instructions on the Nevada Medicaid provider website (at www.medicaid.nv.gov select “Billing Information” from the “Providers” menu).

In addition:
• You may only bill for the dates included on your approved authorization.
• You may only enter one authorization number per claim form.
• You may only bill one calendar month of service per claim form, e.g., August 1, 2016, through August 31, 2016. (Note: A claim form has six claim lines.)
• You may bill up to one week of service per claim line. A week is designated as Sunday through Saturday.

Example: You are billing from August 21, 2016, through September 30, 2016. You will use two claim forms as detailed below.
1. Form #1, Line #1 will list services from August 21 through August 26.
2. Form #1, Line #2 will list services from August 27 through August 31.
3. Form #2, Line #1 will list services from September 1 through September 3.
4. Form #2, Line #2 will list services from September 4 through September 10.
5. Form #2, Line #3 will list services from September 11 through September 17.
6. Form #2, Line #4 will list services from September 18 through September 24.
7. Form #2, Line #5 will list services from September 25 through September 30.

Effective with claims processed on or after December 21, 2015, provider type 48 is no longer required to submit an EOB or denial letter from the other health care (OHC) coverage provider.

Covered Services and Procedure Codes
The following services are benefits of this waiver program only if the services are prior authorized by ADSD.
• Homemaker Services: S5130 (per 15 minutes)
• Respite: S5150 (per 15 minutes) and S5151 (per diem)
• Chore: S5120 (per 15 minutes)
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- Personal Emergency Response System: S5160 (installment) and S5161 (per month)
- Adult Companion Services: S5135 (per 15 minutes)
- Social Adult Day Care: S5100 (per 15 minutes) and S5102 (per day)*
- Case Management: T1016 (per 15 minutes)

*When six or more hours of service are prior authorized and performed in a single day, bill the established per diem rate.

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