

## Home and Community Based Waiver for the Frail Elderly (Elderly in Adult Residential Care)

### Definition

This service is provided in a licensed residential facility for groups or an assisted living facility. It is a 24-hour in-home service that provides assistance with basic self-care and activities of daily living, including homemaker services; personal care services; chore services; companion services; therapeutic social and recreational programming; medication oversight; and services to ensure safety, security and adequate supervision. This service is over and above the mandatory service provision required by regulation, which includes the provision of transportation to and from the facility to the hospital, a nursing facility, to routine medical appointments and for social outings organized by the facility. This service includes 24-hour in-home supervision to meet scheduled or unpredictable needs.

### Prior authorization

**All services except case management must be prior authorized in order to receive payment.**

Each recipient is assigned a case manager from the nearest Aging and Disability Services Division (ADSD) office. The case manager requests prior authorization for all services (with the exception of case management) based on medical necessity as documented in the recipient's POC.

#### *Verify prior authorization before providing service*

Providers should verify that an approved prior authorization is in place before providing service. It is the ADSD case manager's responsibility to obtain prior authorization.

Approved authorization can be verified online through **EVS**, by calling **ARS at (800) 942-6511** or by utilizing a **swipe card** system. Each of these methods is described in Chapter 3 of the [Billing Manual](#) on the Hewlett Packard Enterprise website (at [www.medicaid.nv.gov](http://www.medicaid.nv.gov) select "Billing Information" from the "Providers" menu).

Providers may also **contact the recipient's case manager** to verify that a service(s) has been prior authorized. Case managers may be reached at the following ADSD offices:

#### **Carson City**

3416 Goni Road, Suite D-132  
Carson City, NV 89706  
Phone: (775) 687-4210  
Fax: (775) 687-0574

#### **Elko**

1010 Ruby Vista Drive, Suite 104  
Elko, NV 89801  
Phone: (775) 738-1966  
Fax: (775) 753-8543

#### **Las Vegas**

1860 East Sahara Avenue  
Las Vegas, NV 89104  
Phone: (702) 486-3545  
Fax: (702) 486-3572

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**Reno**

445 Apple Street, Suite 104  
Reno, NV 89502  
Phone: (775) 688-2964  
Fax: (775) 688-2969

**Billing instructions**

**Elderly in Adult Residential Care Waiver services are not covered by Medicare. Medicaid may be billed first.**

Submit claims to Hewlett Packard Enterprise. Claims must comply with the [CMS-1500 Claim Form Instructions](#) on the Hewlett Packard Enterprise website (at [www.medicaid.nv.gov](http://www.medicaid.nv.gov) select "Billing Information" from the "Providers" menu).

Please note:

- **Field 21** (Diagnosis or nature of illness or injury) is required.
- In **Field 23**, you may only enter one authorization number per claim form.
- In **Field 24A**:
  - You may only bill for dates within the approved authorization period.
  - You may only bill for dates on which service was provided — per diem services may not be billed for days the recipient is not present in the facility.
  - You may bill up to one calendar week of service per claim line provided that service was rendered on each day and the week does not span calendar months, e.g., billing January 30, 2011, through February 5, 2011, on one claim line is unacceptable.
  - You may only bill one calendar month of service on a claim form, e.g., you may bill January 1 through January 30 on one claim form or February 1 through 28 on one claim form — but not January 15 through February 15.

As an example, the following table illustrates the dates to enter on each claim line in Field 24A when billing for services provided each day from January 25, 2016, through February 29, 2016. Two claim forms are required.

Form #	Line #	Dates to Bill
1	1	January 25-30
1	2	January 31
2	1	February 1-6
2	2	February 7-13
2	3	February 14-20
2	4	February 21-27
2	5	February 28-29

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- In the un-shaded area of **Field 24D**, enter one of the codes below and a modifier, if appropriate, to indicate the level of care provided (1, 2 or 3) as specified in the recipient's POC.
  - **S5126 with modifier U1** (attendant care service, Level of Care 1); paid per diem
  - **S5126 with modifier U2** (attendant care service, Level of Care 2); paid per diem
  - **S5126 with modifier U3** (attendant care service, Level of Care 3); paid per diem
  - **T1016 with no modifier** (case management); 15 minutes = 1 unit
- **Field 24E** (Diagnosis pointer) is required.

Effective with claims processed on or after December 21, 2015, provider type 57 is no longer required to submit an EOB or denial letter from the other health care (OHC) coverage provider.