

## Policy

The Elderly in Adult Residential Care waiver program is available to eligible Medicaid recipients age 65 or older 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.

## References

The **Medicaid Services Manual (MSM)** is on the DHCFP website at <http://dhcftp.nv.gov> (click "Medicaid Manuals" on the DHCFP Index at left, then select "NV Medicaid Services Manual").

- [MSM Chapter 100](#) contains important information applicable to all provider types.
- [MSM Chapter 2700](#) covers policy for Home and Community-Based Waiver (HCBW) for the Elderly in Adult Residential Care program.
- [MSM Chapter 3200](#) covers policy for the hospice program.
- [MSM Chapter 3500](#) discusses coverage for the Personal Care Services (PCS) program.

**Reimbursement rates** are on the DHCFP website at <http://dhcftp.nv.gov> (from the "DHCFP Index" at left, select "Rates and Cost Containment/Util-Fin. Reports," then "Rates Unit," then scroll down and click "Provider Type 57 Adult Group Care Waiver").

**Claim Form Instructions**, the **Billing Manual** and **Billing Guides** for each provider type are on the Magellan Medicaid Administration website at <http://nevada.fhsc.com> (select "Billing Information" from the "Providers" menu).

## Covered Services

In addition to waiver services, recipients eligible under this waiver program are also eligible for full Medicaid benefits.

Services listed below are benefits of this waiver program only if the service is documented on the recipient's Plan of Care (POC) as being necessary to avoid institutionalization and, with the exception of case management, prior authorized by DHCFP.

- Case management
- Attendant care

**Attendant care** provided in a licensed residential facility for groups is a 24-hour in home service. It provides assistance with basic self care and activities of daily living (ADLs) such as:

- Homemaker services
- Personal care services
- Chore services
- Companion services
- Therapeutic social and recreational programming
- Medication oversight (to the extent permitted under State law)
- Services which will ensure that residents of the facility are safe, secure and adequately supervised

**Providers may only render services that are identified in the recipient's POC.**

## Non-Covered Services

Room and board is not a covered benefit for this waiver program.

## Verify Eligibility before Providing Service

Recipients must meet and maintain all criteria to be eligible during the period of time the recipients receive services under the auspices of the Elderly in Adult Residential Care waiver. Eligibility is determined on a monthly basis.

**Please verify recipient eligibility at the beginning of each month.**

When a recipient is enrolled in the Elderly in Adult Residential Care waiver program, the **Electronic Verification System (EVS)** will display two benefit plans on the recipient eligibility response screen: “Medicaid FFS” and “AGED GRP WVS.”

Benefit Plan (Plan Coverage Desc)	Begin-End (Date Time Period)	Eligibility or Benefit Info	Patient Pay (Benefit Amt)	Provider ID (Benefit Related Entity ID)	Phone Number Communication Number
MEDICAID FFS	01/01/2004-01/31/2004	1	0.00	000000000	000-000-0000
AGED GRP WVS	01/01/2004-01/31/2004	1	0.00	000000000	000-000-0000

For more information about verifying recipient eligibility through EVS, refer to the [EVS User Manual](#) online at <http://nevada.fhsc.com> (select “EVS Manual” from the “EVS” menu).

Eligibility may also be verified by calling the **Automated Response System (ARS) at (800) 942-6511** or by utilizing a **swipe card** system.

## 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 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 Magellan Medicaid Administration website (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:

3416 Goni Rd., Bldg D, Suite 132  
**Carson City**, Nevada 89706  
 Phone: (775) 687-4210  
 Fax: (775) 687-4264

1010 Ruby Vista Dr, Ste 104  
**Elko**, Nevada 89801  
 Phone: (775) 738-1966  
 Fax: (775) 753-8543

1860 E. Sahara Ave  
**Las Vegas**, Nevada 89104  
 Phone: (702) 486-3545  
 Fax: (702) 486-3572

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

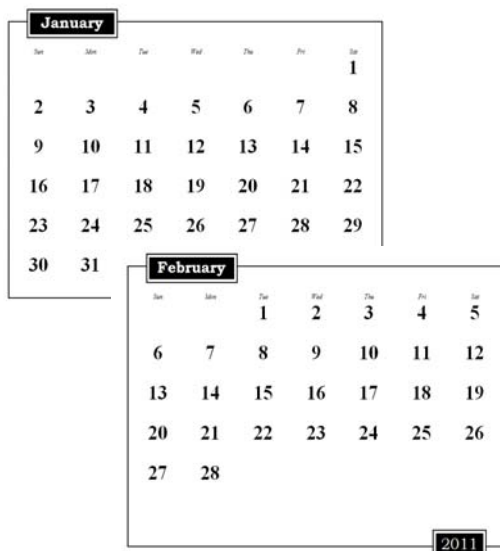
## Billing Instructions

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

Submit claims to Magellan Medicaid Administration. Claims must comply with the “[CMS-1500 Claim Form Instructions](#)” on the Magellan Medicaid Administration website (select “Billing Information” from the “Providers” menu at <http://nevada.fhsc.com>).

Please note:

- **Field 21** is not 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 24, 2011 through February 28, 2011. Two claim forms are required.

Form #	Line #	Dates to Bill
1	1	January 24-29
1	2	January 30-31
2	1	February 1-5
2	2	February 6-12
2	3	February 13-19
2	4	February 20-26
2	5	February 27-28

- In the unshaded 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** is not required.

## Records and Reporting

Each provider must have a **file for each recipient**.

For the recipient's file, providers are required to **complete and sign a daily record** for each service provided, indicating the scope and frequency of services (see MSM Section 3903.3B.4 for additional information).

This record must be **signed by the recipient** unless the recipient is unable to provide a signature due to cognitive and/or physical limitations as clearly documented in the recipient's file.

All service records must be available for review by ADSD.

### **Serious Occurrences**

Per MSM Section 3903.3B.6, providers must **report any serious recipient incidents** or issues regarding the provider/employee's ability to deliver services to the ADSD case manager by telephone/fax within 24 hours of discovery.

In addition, a completed **Serious Occurrence Report (SOR) form** must be submitted to ADSD within five working days (on <http://dhcftp.nv.gov>, from the "DHCFP Index" at left, select "Providers," then click "[3430 Serious Occurrence Report](#)").

This form must also be maintained in the agency's recipient record.

## Hospice and Waiver Services

Recipients enrolled in a hospice program may be eligible for waiver services if the service:

- Allows the recipient to remain in the community and;
- Is palliative or basic self care and;
- Is not covered under the hospice program.

Refer to [MSM Chapter 3200](#) for complete information on Nevada Medicaid's hospice program.