



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 Plan of Care (POC).

Verify prior authorization before providing service

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 at www.medicaid.nv.gov.

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 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



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Las Vegas

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

Reno

9670 Gateway Drive, Suite 200
Reno, NV 89521
Phone: (775) 687-0800
Fax: (775) 688-2969

Billing instructions

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

Providers must submit claims to Nevada Medicaid. Claims must comply with the claim billing instructions in the EVS Chapter 3 Claims and the Transaction 837P Professional claim companion guide, which are posted on the Nevada Medicaid provider website at www.medicaid.nv.gov.

Please note:

- Diagnosis or nature of illness or injury is required.
- You may only enter one authorization number per claim.
 - 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 28, 2019, through February 2, 2019, 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 when billing for services provided each day from January 28, 2019, through February 28, 2019. Two claim forms are required.

Claim #	Line #	Dates to Bill
1	1	January 28-31
2	1	February 1-2
2	2	February 3-9
2	3	February 10-16
2	4	February 17-23
2	5	February 24-28



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- 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
- 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.