



## Home and Community Based Waiver for Persons with Physical Disabilities

### Definition

Nevada Medicaid's Home and Community Based Waiver for Persons with Physical Disabilities (PD) program offers home and community-based services to recipients with physical disabilities. Recipients enrolled in this program would require institutional care without these waiver services.

### 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 approves 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](http://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:

#### Las Vegas

1860 East Sahara Avenue  
Las Vegas, NV 89104  
Phone: (702) 486-3545  
Fax: (702) 486-3572  
Email: [adsd@adsd.nv.gov](mailto:adsd@adsd.nv.gov)

#### Reno

9670 Gateway Drive, Suite 200  
Reno, NV 89521  
Phone: (775) 687-0800  
Fax: (775) 688-2969  
Email: [adsd@adsd.nv.gov](mailto:adsd@adsd.nv.gov)

#### Carson City

3416 Goni Road, Suite D-132  
Carson City, Nevada 89706  
Phone: (775) 687-4210  
Fax: (775) 687-0574  
Email: [adsd@adsd.nv.gov](mailto:adsd@adsd.nv.gov)



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### Elko

1010 Ruby Vista Drive, Suite 104  
Elko, NV 89801  
Phone: (775) 738-1966  
Fax: (775) 753-8543  
Email: [adsd@adsd.nv.gov](mailto:adsd@adsd.nv.gov)

### Billing instructions

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](http://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. One *calendar* week is defined as Sunday through Saturday—e.g., a Wednesday through Wednesday billing contains days from two different calendar weeks and cannot be billed on one claim line.
  - 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

Enter one of the codes below to bill for services rendered according to the recipient’s POC.

- S5120 (chore services); 15 minutes = 1 unit
- S5125 (attendant care service); 15 minutes = 1 unit
- S5130 (homemaker service NOS); 15 minutes = 1 unit
- S5150 (unskilled respite care); 15 minutes = 1 unit



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- S5160 (emergency response system installation and testing)
- S5161 (emergency response system monthly service fee)
- S5165 (home modifications per service)
- S5170 (home-delivered, prepared meal)
- S5199 (personal care item NOS, each)
- T1016 (case management)
- T2031 (Assisted Living waiver); paid per diem
  - Diagnosis pointer is required.

Effective with claims processed on or after December 21, 2015, provider type 58 is no longer required to submit an EOB or denial letter from the other health care (OHC) coverage provider.