



## Home and Community Based Waiver for the Frail Elderly (Augmented Personal Care Services)

### Definition

Augmented personal care 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. Augmented personal care 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 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](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:

#### **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**

**Assisted Living waiver services are not covered by Medicare. Medicaid may be billed first.**

Provider 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 form.
  - 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.
  - **T1016 with no modifier** (case management); 15 minutes = 1 unit
  - **T2031 with modifier U1** (Assisted Living waiver, Level of Care 1); paid per diem
  - **T2031 with modifier U2** (Assisted Living waiver, Level of Care 2); paid per diem
  - **T2031 with modifier U3** (Assisted Living waiver, Level of Care 3); paid per diem
- Diagnosis pointer is required.

Effective with claims processed on or after December 21, 2015, provider type 59 is no longer required to submit an EOB or denial letter from the other health care (OHC) coverage provider.