Home and Community Based Waiver for Structured Family Caregiving

Overview

The Home and Community Based Services (HCBS) Waiver for Structured Family Caregiving (SFCG) is offered to eligible Medicaid recipients who have a diagnosis of Dementia or other related conditions, who, without the waiver services, would require institutional care provided in a hospital or nursing facility. SFCG provides a waiver recipient with the option to receive personal care and related supports from a primary caregiver who lives in the same private residence as the recipient.

Nevada's Aging and Disability Services Division (ADSD) operates this waiver program in conjunction with Nevada Medicaid. Therefore, providers and recipients must agree to comply with all ADSD and Nevada Medicaid policies.

Policy

Nevada Medicaid's policies can be found on the Nevada Medicaid website, nevadamedicaid.nv.gov/resources/medicaid-services-manual/.

- MSM Chapter 2400
- MSM Chapter 100 (contains important information applicable to all provider types)

For additional references:

- Nevada Medicaid provider website at medicaid.nv.gov
- ADSD website at adsd.nv.gov

Covered Services

The following services are benefits of this waiver program only if the services are in accordance with the recipient's Person Centered Service Plan (PCSP):

- Case Management: T1016 (per 15 minutes)
- Respite: S5150 (per 15 minutes)
- SFCG Services: T2031 (daily rate)

Service Limitations

The following limitations apply to covered services:

T1016: Limit 12 hours or 48 units per day per recipient.

S5150: Limit to 336 hours per rolling year.

NOTE: If S5150 exceeds 6 hours, then T2031 will not be paid for the same date of service per recipient.

Prior Authorization (PA)

The following services require prior authorization:

- Respite
- SFCG Services

NOTE: Case Management does not require prior authorization. Case Managers must provide recipients with an appropriate amount of case management service to ensure the recipient's health and welfare.

All direct waiver services must be prior authorized. It is important to verify that an approved prior authorization is in place before providing services. This can be verified online through the Provider Web Portal (PWP), 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 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.

Billing Requirements or Instructions

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

In addition:

- You may only bill for the dates included on your approved authorization.
- You may only enter one authorization number per claim.
- You may only bill one calendar month of service per claim, e.g., August 1, 2025, through August 31, 2025.
- You may bill up to one week of service per claim line. A week is designated as Sunday through Saturday.

  Example: You are billing from August 19, 2025, through September 30, 2025. You will use two claims as detailed below.

  - Claim #1, Line #1 will list services from August 19 through August 23.
  - Claim #1, Line #2 will list services from August 24 through August 30.
  - Claim #1, Line #3 will list services on August 31.
  - Claim #2, Line #1 will list services on September 1 through September 6.
  - Claim #2, Line #2 will list services from September 7 through September 13.
  - Claim #2, Line #3 will list services from September 14 through September 20.
  - Claim #2, Line #4 will list services from September 21 through September 27.
  - Claim #2, Line #5 will list services from September 28 through September 30.

Effective with claims processed on or after December 21, 2015, provider type 95 is no longer required to submit an EOB or denial letter from the other health care (OHC) coverage provider.