Home and Community Based Waiver for the Frail Elderly in an Assisted Living Facility

Definition

The Home and Community Based Waiver (HCBW) for Frail Elderly (FE) Augmented Personal Care (APC) is a service provided in a licensed Residential Facility for Groups or an Assisted Living Facility. It is a 24-hour in-home service that provides assistance for functionally impaired elderly recipients with basic self-care and activities of daily living (ADLs), 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 care is over and above the mandatory service provision required by regulation for Assisted Living Facility, 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.

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.

Prior Authorization

APC is a direct waiver service that must be prior authorized by ADSD and in accordance with the recipient's Plan of Care (POC).

Case Management is a non-direct waiver service which does not require prior authorization.

Case Managers must provide recipients with the appropriate amount of case management services to ensure the recipient's health and welfare.

Providers rendering direct waiver services cannot bill for Case Management.

Each recipient is assigned an ADSD case manager. The case manager may authorize direct waiver services based on medical necessity as documented in the recipient's POC.

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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.

Billing Instructions

APC service is not a covered service by Medicare. Medicaid may be billed first.

Providers must submit claims to Nevada Medicaid. Claims must comply with the claim form instructions in the EVS User Manual 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.

In addition:

- 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

- 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.
  - **T2031 with modifier U1** (attendant care service, Level of Care 1); paid per diem
  - **T2031 with modifier U2** (attendant care service, Level of Care 2); paid per diem
  - **T2031 with modifier U3** (attendant care service, Level of Care 3); paid per diem
  - **T2031 with modifier U4** (attendant care service, Level of Care 3); paid per diem
  - Case management: T1016 (per 15 minutes)

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.

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

References

For additional information, refer to:

- Medicaid Services Manual (MSM) Chapter 100 (contains important information applicable to all provider types)
- MSM Chapter 2200
- Nevada Medicaid provider website at https://www.medicaid.nv.gov
- ADSD website at http://adsd.nv.gov

Contact information for the ADSD regional offices is provided on the Aging and Disability Services website.