Home and Community Based Waiver for Persons with Physical Disabilities

Definition

The Home and Community Based Waiver (HCBW) for Persons with Physical Disabilities (PD) is offered to recipients, who, without waiver services would otherwise require institutional care provided in a hospital or nursing facility (NF).

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.

Prior Authorization

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 Instructions

Providers must submit claims to Nevada Medicaid. Claims must comply with the claim billing 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:

- Diagnosis or nature of illness or injury is required.
- You may only bill for dates within the approved authorization period.
- You may only enter one authorization number per claim.
- You may only bill one calendar month of service per claim, e.g., August 1, 2018, through August 31, 2018.
- 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 21, 2018, through September 30, 2018. You will use two claims as detailed below.
    1. Claim #1, Line #1 will list services from August 21 through August 25.
    2. Claim #1, Line #2 will list services from August 26 through August 31.
    3. Claim #2, Line #1 will list services on September 1.
    4. Claim #2, Line #2 will list services from September 2 through September 8.
    5. Claim #2, Line #3 will list services from September 9 through September 15.
    6. Claim #2, Line #4 will list services from September 16 through September 22.
    7. Claim #2, Line #5 will list services from September 23 through September 29.
    8. Claim #2, Line #6 will list services on September 30.

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.

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Covered Services and Procedure Codes

The following direct services are benefits of this waiver program only if the services are prior authorized by ADSD and in accordance with the recipient's POC:

- Chore Services: S5120 (per 15 minutes)
- Attendant Care Services: S5125 (per 15 minutes)
- Homemaker Services: S5130 (per15 minutes)
- Respite Care: S5150 (per 15 minutes)
- PERS: S5160 (installation and testing)
- PERS: S5161 (monthly service fee)
- Environmental Accessibility Adaptations: S5165 (home modifications per service) and S5165 with modifier U1 (assessment fee and flat rate mileage for a single transport)
- Home Delivered Meals (HDM): S5170
  Note: Provider type 58 with specialty 204 may also render HDM to Frail Elderly Waiver recipients
- Specialized Medical Equipment and Supplies: S5199 (personal care item NOS, each)
- Assisted Living Waiver: T2031 (paid per diem)
  - Diagnosis pointer is required.

The following non direct waiver service does not require a prior authorization:

- Case Management: T1016 (per 15 minutes)

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

Providers rendering direct waiver services cannot bill for Case Management.

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

Service Limits

The following limits apply to covered services:

S5150: 120 hours per calendar year per recipient.
S5165: Annual limit amount per calendar year. See the Fee-for-Service Schedule for the actual rate.
S5165 U1: Assessment fee (maximum of one hour) plus flat rate travel cost. See the Fee-for-Service Schedule for the actual rate.
S5170: Limit two (2) meals per day.
S5199: Annual limit amount per calendar year. See Fee-for-Service Schedule for the actual rate.

References

For additional information, refer to:

- Medicaid Services Manual (MSM) Chapter 100 (contains important information applicable to all provider types)
- MSM Chapter 2300
- Nevada Medicaid provider website at medicaid.nv.gov
- ADSD website at adsd.nv.gov

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