



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

### Policy

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

Eligibility for the physically disabled waiver program is determined by the Division of Health Care Financing and Policy (DHCFP).

### References

The **Medicaid Services Manual (MSM)** is on the DHCFP website at <http://dhcfp.nv.gov> (click *Medicaid Manuals* on the DHCFP Index at left, then select *NV Medicaid Services Manual*).

- [MSM Chapter 100](#) contains important information applicable to all provider types.
- [MSM Chapter 2300](#) covers policy for WIN waiver providers.
- [MSM Chapter 3200](#) covers policy for the hospice program.
- [MSM Chapter 3500](#) discusses coverage for the Personal Care Services (PCS) program.

**Reimbursement rates** are on the DHCFP website at <http://dhcfp.nv.gov> (from the *DHCFP Index* at left, select *Rates and Cost Containment/Util-Fin. Reports*, then *Rates Unit*, then scroll down and click [Provider Type 58 Physically Disabled Waiver \(WIN\)](#)).

**Claim Form Instructions**, the **Billing Manual** and **Billing Guides** for each provider type are on the HP Enterprise Services website at <https://www.medicaid.nv.gov> (select *Billing Information* from the *Providers* menu).

### Covered services

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

Services listed below are benefits of this waiver program only if the service is documented on the recipient's Plan of Care (POC) and, with the exception of case management, prior authorized by DHCFP.

- Case management services
- Homemaker services
- Chore services
- Respite care
- Attendant care services
- Specialized medical equipment and supplies
- Environmental accessibility adaptations
- Personal Emergency Response System (PERS)
- Assisted living services





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

## Covered services (continued)

- Home delivered meals

Providers may only render services that are identified in the recipient’s POC.

## Verify eligibility before providing service

Recipients must meet and maintain all criteria to be eligible during the period of time the recipients receive services under the auspices of the WIN waiver. Eligibility is determined on a monthly basis.

Please verify recipient eligibility at the beginning of each month.

When a recipient is enrolled in the WIN waiver program, you must verify recipient eligibility at the beginning of each month.

**Nevada Department of Health and Human Services**  
Division of Health Care Financing and Policy Provider Portal

My Home | Eligibility | Claims | Care Management | Resources

Eligibility Tuesday 09/06/2011 11:16 AM PST

**Eligibility Verification Request**

\* Indicates a required field.  
Enter the Patient information. Verification for a Member requires either Member ID or SSN.

Recipient ID       \*Last Name       \*First Name   
 SSN       \*Birth Date       Effective To   
 \*Effective From

  

**Eligibility Verification Information for JAE S PARK from 08/01/2011 to 08/30/2011**

Recipient ID	Coverage	Birth Date	Effective Date	End Date	Primary Care Provider
	MEDICAID FFS	11/21/1926	08/01/2011	08/31/2011	0000000000
	MED CO & DED		08/01/2011	08/31/2011	0000000000

[Other Insurance Detail Information](#)

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For more information about verifying recipient eligibility through EVS, refer to the [EVS User Manual](#) online at <https://www.medicaid.nv.gov> (select *EVS Manual* from the *EVS menu*).

Eligibility may also be verified by calling the Automated Response System (ARS) at (800) 942-6511 or by utilizing a **swipe card** system.



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

### 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 DHCFP District 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 POC.

#### **Verify prior authorization before providing service**

Providers should verify that an approved prior authorization is in place before providing service. It is the DHCFP case manager's responsibility to obtain prior authorization.

Approved authorization can be verified online through **EVS**, by calling **ARS at (800) 942- 6511** or by utilizing a **swipe card system**. Each of these methods is described in Chapter 3 of the [Billing Manual](#) on the HP Enterprise Services website (select *Billing Information* from the *Providers* menu).

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 DHCFP District Offices:

1000 East William St. Suite 111  
**Carson City**, Nevada 89701  
Phone: (775) 684- 3651

1010 Ruby Vista Drive, Suite 103  
**Elko**, NV 89801  
Phone: (775) 753-1191

1210 S. Valley View, Suite 104  
**Las Vegas**, NV 89102  
Phone: (702) 668-4200

1030 Bible Way  
**Reno**, NV 89502  
Phone: (775) 687-1900

### Billing instructions

Submit claims to HP Enterprise Services. Claims must comply with the [CMS-1500 Claim Form Instructions](#) on the HP Enterprise Services website (select *Billing Information* from the *Providers* menu at <https://www.medicaid.nv.gov>).



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

Please note:

- **Field 21** is not required.
- In **Field 23**, you may only enter one authorization number per claim form.
- In **Field 24A**:
  - 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 30, 2011 through February 5, 2011 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.

January						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

  

February						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

2011



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

As an example, the following table illustrates the dates to enter on each claim line in Field 24A when billing for services provided each day from January 24, 2011 through February 28, 2011. Two claim forms are required.

Form #	Line #	Dates to Bill
1	1	January 24-29
1	2	January 30-31
2	1	February 1-5
2	2	February 6-12
2	3	February 13-19
2	4	February 20-26
2	5	February 27-28

In the un-shaded area of **Field 24D**, 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
- 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

## Records and reporting

Each provider must have a **file for each recipient**.

For the recipient’s file, providers are required to **complete and sign a daily record** for each service provided, indicating the scope and frequency of services (see MSM Section 3903.3B.4 for additional information).

This record must be **signed by the recipient** unless the recipient is unable to provide a signature due to cognitive and/or physical limitations as clearly documented in the recipient’s file.

All service records must be available for review by ADSD.



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

### Serious occurrences

Per MSM Section 3903.3B.6, providers must **report any serious recipient incidents** or issues regarding the provider/employee's ability to deliver services to the ADSD case manager by telephone/fax within 24 hours of discovery.

In addition, a completed **Serious Occurrence Report (SOR) form** must be submitted to ADSD within five working days (on <http://dhcfp.nv.gov> from the *DHCFP Index* at left, select *Providers*, then click [3430 Serious Occurrence Report](#)).

This form must also be maintained in the agency's recipient record.

### Hospice and waiver services

Recipients enrolled in a hospice program may be eligible for waiver services if the service:

- Allows the recipient to remain in the community and;
- Is palliative or basic self care and;
- Is not covered under the hospice program.

Refer to [MSM Chapter 3200](#) for complete information on Nevada Medicaid's hospice program.