NEW JERSEY
DEPARTMENT
OF HUMAN SERVICES

Division of Medical Assistance and Health Services
EVV Home Health Care Services Provider Workgroup

Date: Thursday October 6, 2022
1:00 pm – 4:00 pm
Onsite: Life Station 2 Stahuber Avenue, Union, NJ 07083
Agenda

• Introduction and Overview

• DMAHS
  – Policy updates
  – Provider Requirements

• HHAx
  – Updates

• Health Plans
  – EVV updates

• HCAH Provider Q&A follow up
EVV Phase 2 - HHCS Updates
EVV Policy Updates

• **Multifactor Authentication (MFA)** has successfully completed its three phased implementation

• **DMAHS Fee for Service (FFS) Update**
  • DMAHS EVV Team working with the MACCs regarding the current process for prior authorizations for PCS and HHCS included in the EVV mandate.
  • DMAHS FFS training is in development
Update to HHAx Service Type

The Cognitive Therapy Service Type will be updated in the HHAx Provider Portal

- Currently the Cognitive Therapy Service Type is identified as “Other”
- The update will change to “Cognitive Therapy”
- Communication and a Job Aide from HHAx is forthcoming
# Phase 2: (Skilled Care/Therapies)
## EVV Implementation Milestones

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Activities</th>
<th>End of Period Goal</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onboarding</td>
<td>• Select Your EVV Vendor&lt;br&gt;• Complete the HHA Survey Questionnaire&lt;br&gt;• Complete Integration&lt;br&gt;• Secure HHA or CareBridge Portal Log on ID and password.&lt;br&gt;• Complete EVV Training&lt;br&gt;• Complete MCO Provider Training</td>
<td>Active communication of EVV visit Data to either the CareBridge or HHA Portal, obtain Provisionally Engaged Status</td>
<td>May 1, 2022 to July 18, 2022</td>
</tr>
<tr>
<td>Provisional</td>
<td>• Maximize visits reported with EVV Data.&lt;br&gt;• Gain experience in managing internal staff and Care Givers&lt;br&gt;• Learn to identify and resolve error code rejections.&lt;br&gt;• Billing activities are not impacted</td>
<td>Increased matching of the claim units billed with EVV supporting data to achieve Operational Status or on 9/30/22 are at risk for no longer receiving member referrals.</td>
<td>July 19, 2022 to September 30, 2022</td>
</tr>
<tr>
<td>Provisional</td>
<td>• No participation in onboarding activities&lt;br&gt;• No identified EVV solution and/or are not utilizing an EVV solution&lt;br&gt;• There are no integration activities</td>
<td>These providers must immediately address EVV requirements and move into Engaged status with all applicable payers.</td>
<td>July 19, 2022 to September 30, 2022</td>
</tr>
<tr>
<td>Operational</td>
<td>• Resolve any gaps in information exchange which result in less than a 100% Compliance Rate&lt;br&gt;• Begin billing activities&lt;br&gt;• Assure CHHA/License numbers are included on claims</td>
<td>Operational status must be achieved, MCOs may begin to limit referrals or transition existing members to providers who have achieved Operational Status.</td>
<td>October 1, 2022 to December 31, 2022</td>
</tr>
<tr>
<td>Full Compliance</td>
<td>Ongoing maintenance to ensure 100% compliance</td>
<td>All claims submitted must have supporting EVV data and license/certification numbers included on applicable claims</td>
<td>January 1, 2023 and thereafter</td>
</tr>
</tbody>
</table>
DMAHS EVV Updates:
MCO Enrolled Provider  September – October 2022

Phase 2
Home Health Care Services
Full Compliance
January 1 2023

- Attend individual MCO Provider Trainings
- Establish Operational Status for each MCO
  - All staff begin EVV process
  - Begin billing as outlined by the individual MCOs
- Each MCO will send notification regarding EVV Status
DMAHS Monitoring of MCO Reports

• MCOs will submit reports beginning Sept. 1st with the following information:

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Tax ID</th>
<th>Number of NJ FamilyCare Members Served</th>
<th>Number of FIDE Members Served</th>
<th>EVV Phase II Status</th>
<th>Risk Category</th>
</tr>
</thead>
</table>

• EVV Phase 2 Status:
  – Provisionally Engaged
  – Provisionally Disengaged
  – Operational
  – Fully Complaint

• Risk Category:
  – High
  – Medium
  – Low
EVV Requirements For Phase 2 Services Covered By Medicare

**Non-MLTSS member that are Dual Eligible** – EVV will be required when Medicare is exhausted and the NJ FamilyCare MCO authorizes the service.

**MLTSS members that are Dual Eligible** – EVV will be required for all Cohort 1 and Cohort 2 services covered by Medicare and Medicaid (refer to service list). The Provider must follow NJ FamilyCare MCO process to document EVV information when Medicaid paying all or only a part of the claim. The EVV data is required at minimum for quality data. Individual MCOs may also implement billing procedures.

**SNP** - For FIDE SNPs, the authorization originates with the FIDE plan. Therefore, FIDE SNPs Providers are required to complete EVV for all the identified Cohort 1 and 2 HHCS.
## EVV Cohort 1

### COHORT 1 Skilled Nursing / Private Duty Nursing / Home Health

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedure Name</th>
<th>Unit of Measure</th>
<th>Service Requirements</th>
<th>Requirements for EVV Information for MLTSS Dual Eligible Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>97597</td>
<td>Debridement, open wound, wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, total wound(s) surface area; first 20 sq cm or less</td>
<td>Per visit</td>
<td>PA - REQUIRED POS 12</td>
<td>EVV Data to be captured if there is a Medicare authorization</td>
</tr>
<tr>
<td>99601</td>
<td>Infusion- Skilled nursing</td>
<td>Up to 2 hours</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>99602</td>
<td>Infusion- Skilled nursing-additional hour(s)</td>
<td>Each additional hour</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>G0299*</td>
<td>Direct skilled nursing services of a registered nurse (run) in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td>When Medicaid Authorizes</td>
</tr>
<tr>
<td>S9122</td>
<td>Home Health Aide/Certified Nurse Assistant</td>
<td>Per hour</td>
<td>PA - REQUIRED POS 12</td>
<td>EVV Data to be captured if there is a Medicare authorization</td>
</tr>
<tr>
<td>S9123</td>
<td>Nursing care, in the home; by registered nurse</td>
<td>Per hour</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>S9124</td>
<td>Nursing care, in the home; by licensed practical nurse</td>
<td>Per hour</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>S9127</td>
<td>Social work visit, in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>T1000</td>
<td>Private duty / independent nursing service(s)</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>T1002</td>
<td>Private duty / independent nursing service(s) / RN</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>T1003</td>
<td>LPN/LVN SERVICES</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>T1030</td>
<td>Nursing care, in the home, by registered nurse</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>T1031</td>
<td>Nursing care, in the home, by licensed practical nurse</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
</tbody>
</table>

*G0299 EVV data is only required when Medicaid authorizes*
## EVV Cohort 2

### COHORT 2 Therapies

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedure Name</th>
<th>Unit of Measure</th>
<th>Service Requirements</th>
<th>Requirements for EVV Information for MLTSS Dual Eligible Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>Speech, Language and Hearing Therapy Individual</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
<td>EVV Data to be captured if there is a Medicare authorization</td>
</tr>
<tr>
<td>97110</td>
<td>Physical Therapy, Therapeutic procedure, 1 or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>97129</td>
<td>Cognitive Therapy, Individual</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>97130</td>
<td>Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact (List separately in addition to code for primary procedure)</td>
<td>Each additional 15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>97535</td>
<td>Occupational Therapy, Individual - Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>G0151</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>S9128</td>
<td>Speech therapy, in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>S9129</td>
<td>Occupational therapy, in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
<tr>
<td>S9131</td>
<td>Physical therapy; in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
<td></td>
</tr>
</tbody>
</table>
Provider Workgroup
Agenda

- Rounding Rules
- Provider Milestones and Onboarding
- HHAeXchange Support and Client Support Portal Review
- Contact Information
Phase 2 HHCS Rounding Rules

- Claims are generated off of the visit duration.
- Home Health Service Codes Round Down

Listed in N.J.A.C. 10:60. If a unit of service is defined as a 15-minute interval of face-to-face service, the provider must provide the required 15 minutes and rounding up is not allowed. For example:

15-Minute units per hour:
- 1-29 minutes = 1 unit
- 30-44 minutes = 2 units
- 45-59 minutes = 3 units
- 60-74 minutes = 4 units

Per Hour Services:
- 1 – 119 minutes = 1 unit
- 120 - 179 minutes = 2 units
Provider Onboarding Requirements

**June**
- Providers receive their welcome packet
- Providers attend Information Sessions to understand the next steps and timeline for their options
- Providers receive communication for HHAeXchange for their specified training
- Providers work on completing the training via LMS
- Providers work on EDI integration
- Providers receive their HHAX portal credentials/access to the system by logging in
- Providers build their internal workflows and prepare for go-live

**July**
- COHORT 1 & 2 Go-Live
- Providers ensure EVV compliance
- All EVV mandated services are being collected and reported to NJ DMAHS

**August**
- Providers should be scheduling and confirming visits using EVV.
- All EVV mandated services are being collected and reported to NJ DMAHS
- Complete EDI integration and send production visit data

**September**
- Providers continue to ensure EVV compliance
- All EVV mandated services are being collected and reported to NJ DMAHS
- EDI providers should be sending all visit data via API

**October**
- Providers ensure EVV compliance
- All EVV mandated services are being collected and reported to NJ DMAHS
- October 1: Provider should begin billing through the payers preferred billing method.
Provider Onboarding Steps

- **Survey Completion:** link to survey here **NJ Home Health Provider Enrollment Form**
- **Information Sessions:** All live sessions are completed. Recordings are available on the Provider Info Center [https://hhaexchange.com/nj-home-health/](https://hhaexchange.com/nj-home-health/) - under the Info Session Tab.
- **EDI Provider Training:** All live sessions are completed. Recordings are available on the Provider Info Center [https://hhaexchange.com/nj-home-health/](https://hhaexchange.com/nj-home-health/) - under the EDI Process Tab.

- **System User Training:** *(optional for existing providers)*
  - **LMS Training:** Should be completed by providers using the LMS Portal Access sent from HHAX at your own pace

- **Lunch ‘n Learns**
  - Rotating HHA topics every Thursday at noon EST ([https://hhaexchange.com/portal-webinars/](https://hhaexchange.com/portal-webinars/))
When to Contact HHAeXchange

- Issues/questions regarding system functionality or anything relating to your HHAeXchange portal – Reach out to HHAeXchange Support at njsupport@hhaexchange.com

- Issues/questions regarding your 3rd Party EDI Integration - Reach out to edisupport@hhaexchange.com

- Missing Authorizations and or members and information relating to Claims Payments – Reach out to your Payer directly.

Link to NJ DMAHS Provider Resource Page: https://hhaexchange.com/nj-dmahs/
  - In the FAQ section you can access a NJ Specific FAQ document for more details on commonly asked questions and scenarios.
Provider Outreach to HHAeXchange

How to access HHAeXchange Support:
• Within your HHAeXchange Portal select the Support Center Link:

Here you can select multiple options:
• **Support Center** – this is where you can find job aides, process guides, and videos on specific functionality within the HHAeXchange portal.
• **Live Chat Support** – this will connect you with a live support agent via a chat box while you continue to work in your portal.
• **Client Support Portal** – Allows a user to create and track system issues and questions in one portal.
• **Email Support** – you can also email directly to njsupport@hhaexchange.com
  • EDI Provider should reach out to edisupport@hhaexchange.com

You can also call our NJ specific Support Line at (866) 245-8337.

*Any time you reach out to Support via email, phone or chat a support ticket will be generated. Please make sure out support emails are not blocked by your SPAM filters.*
Support Center in HHAeXchange

Once in the Support Center search: “Provider Resource”
• Select “Provider Portal Resource Page”
Provider Portal Resources in HHAeXchange

Within the Provider Portal Resource Page, you can access:

- **Process Guides**: Provide full details and instructions of a particular system function
- **Job Aides**: Concentrated instructions of a specific function
- **Training Videos**: Video playlists providing step-by-step system function instructions

### Process Guides –
- System Introduction
- Patient Placement & Management*
- Communications (Linked Contracts)
- Caregiver Management
- Scheduling Visits*
- Visit Confirmation*
- Quick Visit Entry
- EVV Management*
- Mobile App (Agency)
- Mobile App (Caregiver)
- Reporting
- Prebilling*
- Billing*
- Admin Functions*

### Job Aids –
- [EVV Provider Resources](#) (Includes links to EVV documentation and videos for Caregivers)*
- [EVV Phone Instructions](#)
- [EVV Phone Instructions (Spanish)](#)
- Call Dashboard Resolutions*
- Mobile App Clock In/Out – Linked and Mutual Patients
- Mobile App Consecutive Shifts
- Mobile App Language Options
- Creating a New Patient and TEMP Authorization*

### Videos
- HHAX System Overview*
- HHAeXchange Management Playlist
- Scheduling and Visit Management Playlist* 
- Billing Processes Playlist*
- EDI Integration Playlist*
- HHAX Administration

* Most frequently used resources
Client Support Portal in HHAeXchange

The Client Support Portal is designed to allow clients to submit and track all questions and system issues submitted by the user to the Client Support Team.

The link below provide instructions on how to set up access to your own Client Support Portal: [Client Support Portal Job Aide](#)
How to sign up for the Client Support Portal

The below link can be used to access the portal to set up your account. This can also be found in the job aide provided.

https://hhaxsupport.atlassian.net/servicedesk/customer/portals

Check your email for link to complete your registration and set up your password.
Navigating the Client Support Portal

The client support portal has 5 sections:

1. Search Window
2. Customer Service Desk
3. EDI Support Desk
4. Requests
5. User Account

**Customer Service Desk:**
- General requests or to report an incident within the system

**EDI Support Desk:**
- Specific for EDI (Integration) issues relating to sending data to HHAeXchange
- I am a Provider
- Choose Inquiry Type
- Complete Form and Send Request
Managing Requests

Select **Requests** to see a list of tickets you created or have been added to by other team members. Here you can view:

- Request Type
- Reference (Ticket Number)
- Summary
- Status
- Service Desk
- Requestor Name
**Viewing Tickets**

1. **Description** - view description of the ticket
2. **Activity Log** – log of exchanged notes with all parties
3. **Notes** – enter new notes to support
4. **Status** – view the current status, i.e., waiting for support or waiting for customer
5. **Actions** – actions to take with the request
6. **Request Type** – label indicating type of request
7. **Shared With** – shows request originator and allows requestor to add additional users in the organization to the request.
HHAeXchange NJ EVVMS Support

**Support Emails**

NJsupport@hhaexchange.com  
Edisupport@hhaexchange.com

**NJ Support Phone Number**

(866) 245-8337
EVV Phase 2 – MCO Updates
EVV Provider Workgroup
10/6/22 Onsite

Wellcare On-Site Representatives:
Consuelo Taveras, Senior Manager, Provider Network Management
Elaine Aguirre, Director or Clinical Operations
Dave Van Meter, Director of Operations
Joan Cosme, Manager of Program Coordination
Integration Requirements:

• Providers should be Provisionally Engaged as of October 1, 2022. Those who are not Provisionally Engaged, We hope to see a progressive improvement on compliance up to Dec. 31.

• 100 % compliance by January 1, 2023.

Provider Communication:

• Fax blast of state newsletter was sent on 9/28/2022
• Provisionally Engaged communication 9/30/2022
• Not Engaged provider communication sent on 9/16/2022

If you did not received communication from Wellcare please feel free to reach out to us at njevv@centene.com
3rd Party EVV Vendor:

Providers who wish to use a 3rd party EVV Vendor (a vendor outside of HHAX) may choose to do so.

When completing the Phase 2 Survey The Provider needs to ensure that they select: “Provider is using a 3rd party vendor” and would like an integrated portal

Once your Portal is created; Provider can reach out to the HHA EDI Support Team at edisupport@hhaexchange.com to work with the HHAX Integration team on testing their API and making any necessary corrections to ensure proper data transmission.
Prior Authorization

Prior Authorization is required for elective, non-urgent or non-emergency services as designated by WellCare. Prior Authorization requirements by service type may be found on the Quick Reference Guide on WellCare’s website at www.wellcarenewjersey.com/providers/medicaid or on the searchable Authorization Look-up Tool.

Some Prior Authorization guidelines to note are:

- The Prior Authorization request should include the Member and Provider demographic information, the diagnosis to be treated and the CPT code describing the anticipated procedure, and any pertinent clinical information to support the request.

- A Prior Authorization may be given for a series of visits or services related to an episode of care. The Prior Authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.

The attending physician or designee is responsible for obtaining the Prior Authorization of the elective, non-urgent or non-emergency admission and late submission of a request for Prior Authorization will result in a denial.

Prior Authorization requirements by service type may be found on the Quick Reference Guide www.wellcarenewjersey.com/providers/medicaid or on the searchable authorization Look-up Tool at www.wellcare.com/NewJersey/Providers/Authorization-Lookup.
Prior Authorization

MLTSS Prior Authorization

To check the status of a Prior Authorization (medical, behavioral, pharmacy, dental) or changes to a Prior Authorization, please visit the secure provider portal at https://provider.wellcare.com/ or call Provider Services at 1-888-453-2534.

For information regarding the status of a Prior Authorization for LTC (PCA, Medical Day Care, PDN, or HCBS), please call 1-855-642-6185.

WellCare’s process for Prior Authorization acknowledgement includes a response to the request and/or a request for additional information. There is no formal acknowledgement policy in place. However, Providers may call Provider Services at 1-888-453-2534 to inquire on Prior Authorization requests not received within 15 days.
Prior Authorization

Authorization Request Forms:

WellCare requests that Providers use WellCare’s standardized Prior Authorization request forms to ensure receipt of all pertinent information and to enable a timely response to Provider requests, including:

- **Skilled Therapy Services** Request Form is used to request Prior Authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services:

- **Home Health Services** Request Form is used to request Prior Authorization for home health services including skilled nursing, physical therapy and other services rendered in a home setting. WellCare of New Jersey Medicaid/NJ FamilyCare Provider Manual Effective: May 12, 2022 Page 54 of 179 secure provider portal: https://provider.wellcare.com

- **Personal Care Assistant/Medical Day Care** Request Form is used to request Prior Authorization for PCA services, Adult Medical Day Care, Pediatric Medical Day Care services

To ensure timely and appropriate Prior Authorization processing and claims payment, all forms must:

- Have all required fields completed
- Be typed or printed in black ink for ease of review
- Contain a clinical summary or have supporting clinical information attached

Incomplete forms are not processed and will be returned to the requesting Provider. If Prior Authorization is not granted, all associated claims will not be paid.

All forms are located on WellCare’s website at www.wellcarenewjersey.com/providers/medicaid/forms. All forms should be submitted via fax to the number listed on the form. In no instance may the limitations or exclusions imposed by WellCare be more stringent than those specified in the Medicaid/NJ FamilyCare Handbooks.
Phase II of the EVV implementation includes services which may be covered by Medicare as primary

- **HHAX EVV System Standard Billing Process for:**
  - NJ FamilyCare Medicaid Members (Non-dual eligible, MLTSS or Non-MLTSS)
  - Liberty HMO Dual FIDE SNP Members

- **Additional Billing Procedure for:**
  - Dual Eligible MLTSS Members
  - Dual Eligible Non-MLTSS members when Medicare is exhausted
DUAL ELIGIBLE PROCESS FOR EVV (NON MLTSS)

DUAL Eligible Process For EVV Through 3rd Party (WellCare)

Provider:
- Member Needs Service
- Medicare Benefit Exhausted
  - Yes: Provider Bills and Receives Payment From Medicare Payer
  - No: Medicare Payor Auth?
    - Yes: Medicare Payment Process
    - No: END

Medicare:
- Medicare Payor Auth?
  - Yes: Medicaid Liability?
    - Yes: Submit Claim With COB Info
    - No: Medicare Payment Process
  - No: END

3rd Party (EVV):
- Auth Received By 3rd Party
- Provider Completes EVV Process

HHAX:
- WellCare Auth Received By HHAX
- EVV And Claim Data Received By HHAX

WellCare (Medicaid):
- WellCare Auth?
  - Yes: Claim Received From Provider
  - No: END
MLTSS DUAL ELIGIBLE PROCESS FOR EVV

MLTSS DUAL Eligible Process For EVV (WellCare)

Provider
- Member Needs Service
- Medicare Benefit Exhausted
  - Yes
  - No

Medicare
- Medicare Payor Auth?
  - Yes
  - No

END

HHAX
- WellCare Auth Received By HHAX
- Provider Completes EVW Process In HHAX
- Provider Completes EVW Process In HHAX

WellCare (Medicaid)
- WellCare Auth?
  - Yes
  - No

END

Provider Bills and Receives Pmt From Medicare Payor
Submit Claim With CUB Info

Medicare Payment Process

Claim Received From Provider

Claim Received From HHAX
Key Contacts:

Wellcare General email box:  njevv@centene.com

Network team:
• Jennifer Huang  Account Manager (813) 220-5844  Jennifer.huang1@wellcare.com
• Anny Chevalier Provider Network Specialist I, 973-985-5283  Anny.Chevalier@wellcare.com
• Send an email inquiry to  NJPR@wellcare.com

Case Management/Utilization Management:  Contact #  855-942-6185
• Joan Cosme, Manager, Program Coordination Joan.Cosme@wellcare.com
• Mariel Plasencia, Supervisor, Program Coordination, Mariel.Plasencia@wellcare.com

HHAeXchange: Our EVV Aggregator
• For questions or help with HHAX, please email HHAeXchange at  NJSupport@HHAeXchange.com or visit us at  hhaexchange.com/nj-home-health.
NJ United Healthcare EVV Implementation
EVV Overview Process

• A Prior Authorization and visit verification is required for all services requiring Electronic Visit Verification (EVV).

• United will exchange the authorization information with HHAeXchange (HHAx) for the providers to verify the visits and bill through HHAx for the services.

• Providers must complete the survey and register with HHAx and obtain access to the HHAx portal to verify visits and submit claims for reimbursement.

• During Soft Go live, we accept claims from HHAX and providers directly. If providers submit claims directly to us the claim will edit with a warning message.

  Claim not submitted per EVV guidelines. N363 - Alert: in the near future we are implementing new policies/procedures that would affect this determination.

• When Hard Go live goes into effect (1/1/2023), then all services requiring EVV must be submitted and billed through HHAX for reimbursement. If a provider bills us directly, the claim will be denied.

  Claim not submitted per EVV guidelines. M16 - Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision

• United will be tracking and monitoring the provider EVV compliance rates throughout the implementation. Providers will be outreached when they are not compliant and will be provided with a list of non-compliant services to review.
Effective 7/1/2022 validation of authorization elements went from a two-point match of Tax ID and NPI to a one-point match of Tax ID only, allowing the authorizations to load in HHAx.

All providers will be required to accept new placements and select the office location as shown below:

Since implementation on 7/1/22 we have not seen any authorizations rejected related to NPI mismatch or providers who are not accepting placements.
Both In-Network and Out-of-Network Providers require a prior authorization.

- Request a prior authorization by calling our provider services (800-262-0305) or fax (855-583-4041 or 855-489-1553)

- The fax form is available at our provider portal UHCprovider.com (Provider Forms and References | UHCprovider.com)

Fax Form

- The provider can view the status of the prior authorization request on our online prior authorization portal – PAAN (Prior Authorization And Notification)
Non-MLTSS Members- PDN/Therapy

Both In-Network Providers and Out-of-Network Providers require prior authorization.

- Request prior auth on the online portal (PAAN).

- Select the member requiring service, service type for PT/OT/ST, Place of Service as ‘Home’.

- The provider can view the status of the prior authorization request on the online prior authorization portal – PAAN

- An approved authorization will be sent to HHAx within (48-72 hrs.)
Both In-Network Providers and Out-of-Network Providers require prior authorization.

- Request prior auth on the online portal (PAAN).

- Select the member requiring service, service type for PDN, Place of Service as ‘Home’.

- The provider can view the status of the prior authorization request on the online prior authorization portal – PAAN

- An approved authorization will be sent to HHAx within (48-72 hrs.)
EVV Updates

Key Contacts

<table>
<thead>
<tr>
<th>Service type</th>
<th>Contact</th>
<th>Provider Services Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Home- and Community-Based</td>
<td>Email <a href="mailto:nj_hcbs_pr@uhc.com">nj_hcbs_pr@uhc.com</a></td>
<td>(888) 362-3368</td>
</tr>
<tr>
<td>Services (HCBS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Private duty nursing/home health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Skilled nursing / Home Care</td>
<td>Email <a href="mailto:northeastprteam@uhc.com">northeastprteam@uhc.com</a></td>
<td></td>
</tr>
<tr>
<td>• Therapy services (OT, PT, speech)</td>
<td>Optum Physical Health Contracted: Contact Provider Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UnitedHealthcare Contracted: email <a href="mailto:northeastprteam@uhc.com">northeastprteam@uhc.com</a></td>
<td></td>
</tr>
</tbody>
</table>

HHAx Communication Tool

- Currently, communications through the HHAx tool are only being monitored for issues or questions related to authorizations.

- United is reviewing the use of the HHAx tool for all EVV communications in the future.
Horizon EVV Training
October 6, 2022

Horizon BCBSNJ – Government Programs

All information presented applies solely with respect to services rendered to Horizon New Jersey Health members and may not reflect policies or practices of any other MCO.
EVV Data Transmission and Integration

HHAx ("HHAx") is the state of New Jersey’s vendor for aggregation. HHAx will aggregate incoming EVV Data from Providers

Horizon NJ Health has chosen CareBridge as our EVV Data Aggregator. If you are using a non HHA or CareBridge platform you will need to ensure your software is integrated with HHA or CareBridge for your EVV data to be received by Horizon NJ Health.

Horizon BCBSNJ – Government Programs
Software Integration

• If you are using an EVV software solution other than CareBridge or HHAx, your EVV software vendor will be required to ensure that they can transmit all required data elements to either HHAx or CareBridge in specified formats

• The communication process between your vendor and HHAx or CareBridge will need to be tested and validated to ensure that data is able to be communicated correctly. Working through the process of exchanging data in the mandated format is commonly known as “integration”

• Agencies choosing to utilize an alternative software solution are responsible for the performance of their software vendor in compliance with timely communication of data in the correct format.

• If you are a provider using a integrated software option and were not able to fully integrate with CareBridge or HHA by July 18, 2022, you should still be recording EVV for visits on and after July 18, 2022. Once integrated, any visits for July 18, 2022 dates of service and after should still be sent to the aggregator that you have chosen.
• HNJH does not upload member information into either the CareBridge or HHAx system. How member information is populated depends on your integration set up.

• HHAx, CareBridge and CareBridge integrated providers must manually input HNJH member information into their software solution.

• Integrated providers sending to HHAx submit a member’s first visit and the member’s profile information will populate from the State of New Jersey eligibility file. Please see more detailed information at the following link: https://mailchi.mp/cfb6a09a217e/njintegration_data_requirements.
• All EVV Phase II Services to be billed directly to HNJH by the provider. There is no change in how you submit your claims to HNJH. EVV data comes in separately from claims and is stored in our claims system. When your claim is submitted, HNJH will match the EVV data to the member active billing recipient Medicaid ID, date of service, CPT and modifier combination, Tax ID and NPI billed.

• For “EVV Service Codes” claim submissions should only have one date of service for each claim line. Claims can still be submitted with multiple dates of service but only one date of service for each claim line. Billing a date range with more than one DOS per claim line will result in the claim line being denied.

• Prior to billing you should confirm receipt of the your EVV visit by HNJH. If a claims is denied for a lack of EVV supporting data, you must first correct EVV data to allow it to flow to HNJH and then file a corrected claim to receive payment. Claims do not automatically reprocess solely because EVV data has been modified.
Prior Authorization Process for Phase II- Cohort 1 and 2

- Provider or Member request authorization for services for initial and renewal auths
  - Email
  - electronically via Navinet (Care Affiliate)
  - phone call.
- Request is received and assigned for medical necessity determination
  - Supporting documentation should be included with request from provider
  - Request for needed documentation from provider to complete determination if request is from member
- Authorization determination is based on medical necessity needs
- Provider receives approval/limited/denial both verbally and via Navinet/Fax
- Member denials are provided in writing
- When entering auth into EVV solution please review to make sure it matches auth provided.
- For request that require a Retrospective Review, medical necessity reviews will be conducted for in-home services rendered within 6 calendar days of services being rendered and receipt of all needed documentation
Prior Auth Escalation

For Medicaid Home Care (PT, OT, ST, SN, HHAx, Cog Thrpy)
Michele Favoroso, Supervisor Utilization Management
Michele_Favoroso@horizonblue.com
609-537-3233

For Medicaid Non-MLTSS PDN
Prisscilla Radion, Supervisor Utilization Management
Prisscilla_Radion@horizonblue.com.
732-256-6384

If no resolution to either Medicaid Home Care or Medicaid Non-MLTSS PDN
Margaret Lacey, Manager RN Clinical Operations
Margaret_Lacey@horizonblue.com
(609) 537-3236

Vivian Keller, Director Utilization Management
Vivian_Keller@horizonblue.com
732-256-5684

For MLTSS PDN and MLTSS TBI Therapies
Kristen Taggines, Supervisor MLTSS
Kristen_Taggines@horizonblue.com
609-537-3120

Kelly Jelus, Supervisor MLTSS
Kelly_Jelus@horizonblue.com
609-

If no resolution to MLTSS PDN or MLTSS TBI Therapies
Carol Cianfrone, Director Medicaid Care Mngmt Programs
Carol_Cianfrone@horizonblue.com
609-310-0949
Customer Service Contacts
• CareBridge Users: NJEVV@carebridgehealth.com
• CareBridge Integrated Software Users: evvintegrationsupport@carebridgehealth.com
• HHAx Software Users: Support@HHAx.com
• Other Software sending data to HHAx-EDI: EDISupport@HHAx.com
• Horizon New Jersey Health: Stephen_Fitch@horizonblue.com

Bi-Weekly Update Webinars
• Bi-weekly training and update webinars began on May 25, 2022. Update webinars are held on alternate Mondays from 9:30 am to 11:00 am (EST). Our next update Webinar is October 17, 2022. You can join bi-weekly updates at: http://carebridgehealth.com/trainingnjevv. To join click on the Zoom Link. There is no need to register in advance.
EVV Aggregator: CareBridge

- If you support Amerigroup members, providers must integrate directly with CareBridge
  - If you are using CareBridge as your EVV vendor – you are all set
  - If you are using HHAX as your EVV vendor – you are all set
  - If you are using a 3rd party EVV vendor (other than CareBridge or HHAX) – please contact your EVV vendor to make sure your vendor is integrated with CareBridge
    - If your vendor is **not** integrated with CareBridge – please ask your vendor to email evvintegration@carebridgehealth.com to begin the integration process ASAP.
    - If your vendor is integrated with CareBridge – please ask your vendor to enable EVV visit data transfer over to CareBridge ASAP.
  - Providers and Vendors can also go to http://evvintegration.carebridgehealth.com/ for information on CareBridge technical requirements and other integration related questions.
  - Providers can also call: 844-924-1755

- **Please note, if your EVV vendor has not changed from Phase 1 and is already integrated with CareBridge, additional action is not required.**
# MLTSS Authorization Process

**NEW REQUEST**

- To request a new, an increase or an update to an authorization, please contact Amerigroup Authorizations Department.
  
  Please note authorizations cannot be managed through the Care Bridge portal

- If a new, transfer or increase is being requested, please complete and submit the
  
  a. Personal Care Assistant (CHHA) Request form and fax it to 1-888-240-4716.
  
  b. Home Health Services (MLTSS) call 1-855-661-1996, option 1

**Within 14 days you will receive approval or denial from Amerigroup.**

**MCO TRANSFER – Continuity of Care Auth**

If a member is new to Amerigroup and has an existing authorization from their previous Managed Care Organization (MCO) that requires continuity of care. Please follow the instructions below:

- Fax a copy of the existing authorization to the Amerigroup Authorizations team at 1-888-826-9762.

  Please note authorizations cannot be managed through the Care Bridge portal

  Upon receipt of the authorization from the previous Managed Care Organization (MCO) Amerigroup will issue an authorization from the date of eligibility for the continuity period at the same level of care authorized by the previous MCO.

- Confirmation of the authorization will be faxed to the agency

**BENEFITS INQUIRY**

If a provider has an inquiry regarding member benefits

- Provider can reach out to Amerigroup MLTSS Customer Service at 1-855-661-1996 Option 1

- If the provider has the contact information for the member's Care Manager, they can reach out to the Care Manager directly

- Please note standard benefits would be quoted for the service requested.

Authorization is dependent upon member assessment to determine approval status and frequency

**HOW TO CLAIM MISSING or RETROACTIVE Authorization**

- Provider will need to contact Amerigroup Care Manager to secure missing, retroactive or an update to an existing authorization

- If the provider is requesting an update to an existing authorization or care plan, the provider will contact the member's Care Manager to request the change

  o Care Manager will review the request and approve as appropriate

  o Amerigroup has 14 days to provide a response to a provider request for a missing/retroactive authorization

  o Provider will be sent a confirmation via fax of the updated authorization.

- If services were initiated prior to receipt of authorization and you were not able to schedule the visit, Provider will need to follow process to manually enter visit and submit claims.

*Services provided for MLTSS Dual product requires EVV data to be captured, but provider can continue to bill primary carrier for payment & Amerigroup as secondary*

**All processes apply to FIDE-DSNP**
NON-MLTSS MEDICAID PRODUCTS- Authorization Process

**ACUTE SERVICES** - Procedure codes in scope where member is treated short term for severe episode of illness, for conditions that are the result of disease, trauma, or hospitalization. Example: Nursing Services, PDN, OT, PT, ST

- Once provider is aware member has Amerigroup, provider should submit authorization request to Amerigroup using process outlined on “Authorization Slide”.
  - Phone: 1-800-452-7101
  - Fax: 1-877-244-1720
- If Amerigroup is not notified as mentioned above:
- Provider needs to request authorization within 72hrs of the start of service
- Approved authorization will be back-dated to up to 72hrs

**NON ACUTE SERVICES** - Procedure codes in scope for EVV where the member is receiving treatment long term. Example: Nursing Services, PDN

- The agency or the physician may fax a letter of medical necessity to 1-877-244-1724.
- The Amerigroup team will review the clinical information submitted and provide an authorization within 14 days for standard requests and then update the temporary authorization.

**For MCO Transfer** – Continuity of Care Authorization is provided, please then:

- Send request for PDN services via fax to 1-877-244-1724

Please Provide:
- The Authorization from the previous HMO
- The Plan of Care
- The RN progress report
- Two weeks of nursing notes
- A letter of medical necessity from the treating provider
- The Amerigroup team will review the request within 10 days and a final authorization will be updated.

**For Missing Authorizations**, please contact the Care Management line at 800-452-7101 x106-134-2111 for assistance.

***Please note that authorization must be obtained for the date that services begin***

Both processes apply to FIDE-DSNP as well
Provider will need to contact Amerigroup Care Manager to secure missing, retroactive or an update to an existing authorization.

If the provider is requesting an update to an existing authorization or care plan, the provider will contact the member’s Care Manager to request the change.

- Care Manager will review the request and approve as appropriate.
- Amerigroup has 14 days to provide a response to a provider request for a missing/retroactive authorization.
- Provider will be sent a confirmation via fax of the updated authorization.

If services were initiated prior to receipt of authorization and you were not able to schedule the visit, Provider will need to follow process to manually enter visit and submit claims.
AUTHORIZATION NOTIFICATION PROCESS

Codes below currently do not require an authorization. However in an effort to administer EVV the following codes will now require notification in order to capture visit data. Please note, this notification process does not include medical necessity review. Notification process is only used to obtain an authorization number which will connect to the CareBridge system. The notification process can be completed in two ways:

1. Submit through Availity using ICR (Interactive Care Reviewer) Details and Instructions on following slides. Provider will receive a confirmation of completion via Availity. There are no letters currently being generated as these notifications are auto approved.

2. Send a Request via Fax: 1-800-964-3627

<table>
<thead>
<tr>
<th>CPT/HCPC</th>
<th>Service Description</th>
<th>Medicaid Prior Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>97597</td>
<td>Debridement, open wound, wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, total wound(s) surface area; first 20 sq cm or less</td>
<td>Notification</td>
</tr>
<tr>
<td>99601</td>
<td>Infusion - Skilled nursing</td>
<td>Notification</td>
</tr>
<tr>
<td>99602</td>
<td>Infusion - Skilled nursing - additional hour(s)</td>
<td>Notification</td>
</tr>
<tr>
<td>S9127</td>
<td>Social work visit, in the home</td>
<td>Notification</td>
</tr>
</tbody>
</table>
AUTHORIZATION NOTIFICATION PROCESS – ICR

Interactive Care Reviewer Resources-Accessed through Availity located on the Custom Learning Center

To get started using ICR, you may need some tips on how to navigate the application to submit and check the status of authorizations, or request an appeal following Health Plan guidelines. The Custom Learning Center on Availity Payer Spaces has both courses and resources that will help you get up and running quickly. Access to the Custom Learning Center requires Availity registration. You need to have your own unique user ID and password.

Follow these steps to access ICR courses and resources: From the Availity home page > Payer Spaces > Amerigroup Community Care tile > Applications > Access Your Custom Learning Center.
1. Select **Catalog** from the menu located on the upper-left corner of the *Custom Learning Center* screen.
2. Use the catalog filter and select **Interactive Care Reviewer-Online Authorizations** or **Authorizations** from the *Category* menu.
3. Select **Apply**.
   
There are two pages of online courses consisting of on-demand videos and reference documents. Find the course(s) you want to take then:
4. Select **Enroll** and choose **Start** to take the course immediately or to save for later, select **Return to dashboard**
Additionally, illustrated reference guides that you can print are located on Custom Learning Center Resources.

1. Select Resources from the menu located on the upper-left corner of the screen.
2. Use the catalog filter and select Authorizations or Interactive Care Reviewer-Online Authorizations from the Category menu.
3. Select Download to view and/or print a reference guide.
TPL Authorization Process when Amerigroup is secondary carrier

• Once provider is aware member has Amerigroup as secondary, provider should submit authorization request to AGP using process outlined in slide 8 (authorizations).

• Provider needs to request authorization within 72hrs of the start of service
• Once reviewed and approved, the authorization date provided will reflect the date of request.

The current authorization process for TPL does not change, we will continue to require providers to submit an authorization request. However, it is important to note the difference of when EVV visit data is captured:
  o when Dual is MLTSS = EVV verification is required (from the start of service)
  o when Dual is NOT MLTSS = EVV verification required when Medicare is exhausted
EVV PHASE 2-Billing Review

For ALL dual members, providers must bill primary first and then bill Amerigroup directly as secondary. For MLTSS members, CareBridge will capture visit data for quality purposes. Care Bridge will not submit claim data on these visits. Please see chart for reference.

<table>
<thead>
<tr>
<th></th>
<th>Dual MLTSS</th>
<th>Dual Non-MLTSS</th>
<th>FIDE SNP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auths</strong></td>
<td>Standard authorization process, no change to current process</td>
<td>Standard authorization process, no change to current process</td>
<td>Standard authorization process, no change to current process</td>
</tr>
<tr>
<td><strong>EVV verification</strong></td>
<td>EVV verification required</td>
<td>EVV verification required when benefits are exhausted with Primary payer</td>
<td>EVV verification required</td>
</tr>
<tr>
<td><strong>Billing</strong></td>
<td>Bill Primary and bill Amerigroup as secondary using current process, no change to current process</td>
<td>Bill Primary and bill Amerigroup as secondary using current process, no change to current process</td>
<td>Bill Primary and bill Amerigroup as secondary using current process, no change to current process</td>
</tr>
</tbody>
</table>
PROVIDER TRAINING DATES

EVV Home Health Information Sessions

**September, 2022**
Friday, September 16th – 1:00 pm EST  
Tuesday, September 20th – 4:00pm EST

**October, 2022**
Friday, October 14th – 12:00 Noon EST  
Tuesday, October 25th -4:00 pm EST

**November, 2022**
Thursday, November 10th –3:00 pm   EST  
Monday, November 14th-1:00pm EST

All Live Sessions can be accessed at:

https://www.carebridgehealth.com/nj-evv-hh-provider

A replay of the training will be available on the Amerigroup Provider Website under “News”

On November 1, 2022

https://provider.amerigroup.com/new-jersey-provider/communications

*Please hit “ctrl and click” at the same time to open link.*
KEY CONTACTS

• Lynelle Steele- EVV Lead
  Fannie.steele@amerigroup.com

• Keisha Woodson-Authorizations
  keisha.woodson@amerigroup.com

• Eyreny Mekhaiel – Operations
  eyreny.mekhaiel@amerigroup.com

MLTSS Authorizations
Authorization: Keisha.Woodson@Amerigroup.com
Phone: 1-855-661-1996, option 1

Non-MLTSS Authorizations:
1-800-452-7101, x106-134-2111

Contracting:
Carol.diprisco@amerigroup.com
Alejandro.valentin@amerigroup.com

Provider Experience:
avis.skipper@amerigroup.com
maria.peralta@amerigroup.com

Clinical MLTSS:
jennifer.iskandar@amerigroup.com

Clinical Non-MLTSS:
suzanne.veit@amerigroup.com

EVV
Training: http://carebridgehealth.com/trainingnjevv
Agenda

1. Integration Requirements and Options for Contracted Providers
2. Prior Authorization Process for Acute and Non-Acute services
3. Billing
4. Key Contacts
Aetna has partnered with HHAeXchange (HHAX) to provide an EVV aggregation solution for participating providers. For Providers to be compliant with the EVV Phase 2 mandate, there are three integration scenarios to choose from that best fits your agencies operating model:

**Option 1**
Provider Agencies without an EVV Vendor Platform
- Select the Free HHAX solution
- Complete the HHAX Survey Questionnaire
- Secure HHAX Portal Log on

**Option 2**
Provider Agencies with a Third Party EVV Vendor Platform
- Retain your current EVV vendor
- Complete the HHAX Survey Questionnaire
- Configure with HHAX via the Electronic Data Interchange (EDI) process

**Option 3**
Provider Agencies already using HHAX as their EVV Platform
- No integration actions is needed.
- Data has been linked from Aetna to HHAX, with the new EVV Phase 2 service codes in scope

Contact [edisupport@hhaexchange.com](mailto:edisupport@hhaexchange.com) with any questions regarding integration
Prior Authorization Process

Aetna has kept the Prior Authorization Process the same for the existing EVV Phase 1 PCA services and expanded EVV Phase 2 Skilled Nursing and Therapies codes that are in scope. Providers are expected to proceed with the existing process as follows:

1. **Verify Eligibility**
   
   All providers must verify a member’s enrollment status prior to the delivery of non-emergent, covered services. Member eligibility can be verified through one of the following ways:

   **Telephone Verification**
   Call our Member Services Department to verify eligibility at:
   - Aetna Assure Premier Plus (HMO D-SNP) 1-844-362-0934

   **Secure Website Portal**
   - Aetna Better Health of NJ Medicaid: https://www.aetnabetterhealth.com/newjersey/login
   - Aetna Assure Premier Plus (HMO D-SNP):

2. **Be Proactive**

   For new prior authorizations, and continuation of service, providers should send their requests at least two weeks in advance of the service date needed, or of the previous authorization end date.

   Authorizations following discharge from an inpatient hospital or skilled nursing facility stay are processed within 24 hours. HHAX portal displays the authorization within 2 days from approval.
Aetna utilizes the Availity Provider Portal. **This alternative mechanism follows the same prior authorization process, but the request is submitted electronically instead of via fax.**

**Provider Portal Benefits include:**

- Payer Spaces
- Claim Submission Link
- Contact Us & Messaging
- Claim Status Inquiry
- Grievance Submission
- Appeals Submission
- Grievance and Appeals Status
- Provider Data Management
- Ambient (Business Intelligence Reporting)
- Clear Claim
- ProPAT
- Provider Intake
- Dynamo (Case Management)

If you are already registered in Availity, you will simply select **Aetna Better Health** from your list of payers to begin accessing the portal and all of the features.

**ABHNJ Medicaid**
https://www.aetnabetterhealth.com/newjersey/login

**Aetna Assure Premier Plus (HMO D-SNP):**

If you are not registered, we recommend that you do so immediately by going to the above portal location.
Prior Authorization Process

Form/Fax Submission

Download and print the Prior Authorization Request Form

- Skilled Nursing and Therapies – Continue using the existing Physical Health Form that was leveraged for services in scope, prior to the expansion of EVV codes

Tip – Page 1:
It is important for providers to check the box confirming the service is being provided in the home.

Tip – Page 2
Providers must enter the service code and description utilizing the in-scope codes.
Download and print Prior Authorization for EVV Request Form, or utilize Availity Portal Form

Tip – Page 1:
It is important for providers to check the box confirming the service is being provided in the home.

Tip – Page 2
Providers must enter the service code and description utilizing the in-scope codes.
Prior Authorization Process

When submitting the Prior Authorization request, it is critical that providers validate and verify that authorization information accurately reflects the correct hours, units, service codes, and dates that are expected.

After Prior Authorization Form is completed in its entirety it is submitted via the Availity Provider Portal or faxed as follows:

- **ABHNJ Medicaid**
  - PCA Requests - Fax to 1-860-975-3293 or Toll Free Fax 1-855-444-8694
  - Skilled Nursing and Therapy Requests – Fax to 1-844-797-7601
- **FIDE SNP Prior Auth Department – Fax to 1-833-322-0034**

Aetna conducts clinical review and approves or denies authorization request.

Aetna transmits prior authorization decisions to providers, and we also send this information to HHAX. There is a normal 1-2 day lag from authorization approval to appearance in the HHAX portal.

Approved authorization appears in HHAX portal.

Please note:

- **MLTSS Members – Authorization and EVV is required for all in scope codes, except G0299**
- **Non MLTSS & Non FIDE Members – Authorization and EVV is required when Aetna authorizes the service for all in-scope codes.**
Clinical Contacts for Prior Authorization

**MEDICAID**

To confirm the status of prior authorization for Aetna Better Health of NJ Medicaid Members, call **1-855-232-3596**.

**Primary Clinical Contacts**

**ABHNJ MLTSS**
Danielle Almero Rodriguez, Care Management Assoc.
AlmeroRodriguezD@aetna.com

**ABHNJ Medicaid Non-MLTSS**
Jacqueline Alvarez, Supervisor of Health Services
AlvarezJ5@aetna.com

**ABHNJ Acute Care**
Natasha Sealey, Manager Clinical Health Services
SealeyN@cvshealth.com

**FIDE SNP**

To confirm the status of prior authorization for Aetna Assure Premier Plus (HMO D-SNP) Members, call **1-844-362-0934**.

If you are having any issues with authorizations, please send a message to Clinical Staff Dedicated EVV Email Mailbox:

NJFIDE-EVV@AETNA.com

Mailbox is monitored by a Care Management Associate who will route questions to the appropriate clinical staff for resolution.
Prior Authorization Management Tips

• Providers cannot request prior authorizations via the HHAX portal.
• If you aren’t using our Availity provider portal to request prior authorizations, make sure you use the prior authorization request form for PCA and HHCS Services.
• If your authorization doesn’t load into the HHAX portal, contact AetnaEVVCompliance@AETNA.com. Your request will be triaged and routed to the appropriate colleague to assist.

Common Prior Authorization Discrepancy-Resolution
• It is very important that you include your NPI on the prior authorization request so we can authorize services at your correct office location.

EXAMPLE:
• If you have 3 offices and you are providing services for a member via your Cherry Hill office, you must ensure that the prior authorization request has the NPI Number of that location, and not another one of your locations such as Camden or Woodbury.
• If the NPI number of the current authorization doesn’t match the NPI of the previous authorization, the authorization transmission will fail.
In the event an Aetna member is a new enrollee and was receiving services that were approved by another MCO previously, Aetna will honor the existing approved authorization.

- Provider should follow the same Prior Authorization process outlined on preceding slides, but also include existing member’s approved authorization in their submission request.
- Provider will receive a new authorization for service with a start date as of the effective date of enrollment, with a 3-month date span, to allow time for the member to be assessed.
- Care Management staff will conduct an assessment within 90 days
- Care Manager will counsel member on utilizing participating providers
- Members will select a participating provider to continue to provide the service(s)
- Non-par provider authorizations will be terminated, and the provider will be notified
- The new provider authorization that is created transmits to HHAX system, as per the typical authorization process.
Retro Authorizations

A retroactive authorization is sometimes needed, when member requires services prior to an approved authorization. In this circumstance, the Provider should:

- Follow the same Prior Authorization process outlined on preceding slides, but also will furnish a justification, and/or supporting documentation with the retroactive dates of the service requested.
- Care Management staff will review and confirm the reasoning and date is valid, and either approve or deny the request.

Approved requests:
- If the member has an existing authorization, the current authorization is modified to reflect the retroactive date.
- If the member doesn’t have an existing authorization, a new authorization is issued with the retroactive date.
- The authorization that is modified, or newly created transmits to HHAX system, as per the typical authorization process.

Denied requests:
- Provider should follow the standard appeal process if they disagree with the decision.
Prior Authorization Workflow

1. **Provider Initiates a Prior Authorization (PA) Request**
   - PA form is completed by the Provider
   - Provider faxes PA request using the number on the form, or through Availity electronic submission
   - Service Authorization staff reviews the request
   - PA request meets medical criteria

2. **Approved**
   - Hardcopy of approved authorization is sent to the Provider with service details
   - Approved authorization is loaded into Aetna system (QNXT)
   - Authorization is transmitted to HHAX System
   - Provider utilizes HHAX system to schedule EVV visits
   - Provider utilizes HHAX system to invoice and bill for services rendered
   - HHAX transmits claim file to Aetna Clearinghouse
   - Claim is received by Aetna and adjudicated

3. **Denied**
   - Provider disagrees with the coverage decision for services
   - Provider appeals verbally or in writing within 60 calendar days of denial notice.
   - Provider appeals verbally or in writing within 60 calendar days of denial notice.
   - Provider receives a letter explaining the reasons for the denial of service

4. **Appeal**
   - Appeal Process is followed

5. **No**
   - Provider disagrees with the coverage decision for services
   - Provider appeals verbally or in writing within 60 calendar days of denial notice.
   - Provider receives a letter explaining the reasons for the denial of service

6. **Yes**
   - Provider disagrees with the coverage decision for services
   - Provider appeals verbally or in writing within 60 calendar days of denial notice.
   - Provider receives a letter explaining the reasons for the denial of service

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Billing Overview

*HHAX Portal*

**Authorizations are required for billing through the HHAX platform**
- Aetna will send authorizations into HHAeXchange
- Provider is to use the appropriate service codes for scheduling services

**Providers are required to resolve all prebilling issues before billing**
- HHAeXchange runs each invoice through a series of common billing error rules prior to the claim being processed

**Key Field for Billing:**
- Caregivers NPI Number (on Caregivers Profile)
- Caregivers Professional License Number (on Caregivers Profile)
- Patients Medicaid Number (on Patient Profile)
- Patients Diagnosis Code (on Patient Authorization)

**3rd Party Providers Billing:**
- 3rd party Invoice number is required on your visit/billing data and HHAX will automatically bill out your claims to Aetna

**Link to Billing Process Guide:**
Is EVV required when Aetna Better Health of NJ Medicaid is the secondary payor?

Yes, in certain circumstances you are required to utilize EVV when you are submitting a secondary claim to ABHNJ to coordinate benefits. Provider should submit secondary claims to ABHNJ as they do now via Availity. This table clarifies the codes and procedures subject to this requirement:

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Name</th>
<th>Unit of Measure</th>
<th>Service Requirements</th>
<th>MLTSS Members</th>
<th>Non MLTSS and Non-FIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>97597</td>
<td>Debridement, open wound, wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, total wound(s) surface area; first 20 sq cm or less</td>
<td>Per visit</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>99601</td>
<td>Infusion - Skilled nursing</td>
<td>Up to 2 hours</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>99602</td>
<td>Infusion - Skilled nursing-additional hour(s)</td>
<td>Each additional hour</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>G0299</td>
<td>Direct skilled nursing services of a registered nurse (run) in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Not required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>S9122</td>
<td>Home Health Aide/Certified Nurse Assistant</td>
<td>Per hour</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>S9123</td>
<td>Nursing care, in the home; by registered nurse,</td>
<td>Per hour</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>S9124</td>
<td>Nursing care, in the home; by licensed practical nurse</td>
<td>Per hour</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>S9127</td>
<td>Social work visit, in the home</td>
<td>Per diem</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>T1000</td>
<td>Private Duty Nursing/Independent Nurse Service(s)</td>
<td>15 mins</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>T1002</td>
<td>Private duty / independent nursing service(s) / RN</td>
<td>15 mins</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>T1003</td>
<td>LPN/LVN SERVICES</td>
<td>15 mins</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>T1030</td>
<td>Nursing care, in the home, by registered nurse</td>
<td>Per diem</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>T1031</td>
<td>Nursing care, in the home, by licensed practical nurse</td>
<td>Per diem</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
</tbody>
</table>
## Is EVV required when ABHNJ is the secondary payor?

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Name</th>
<th>Unit of Measure</th>
<th>Service Requirements</th>
<th>MLTSS Members</th>
<th>Non MLTSS and Non -FIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>Speech, Language and Hearing Therapy Individual</td>
<td>Per diem</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>97110</td>
<td>Physical Therapy, Therapeutic procedure, 1 or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
<td>15 mins</td>
<td>PA – REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>97129</td>
<td>Cognitive Therapy, Individual</td>
<td>15 mins</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>97130</td>
<td>Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact (List separately in addition to code for primary procedure)</td>
<td>Each additional 15 mins</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>97535</td>
<td>Occupational Therapy, Individual - Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact</td>
<td>15 mins</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>G0151</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>S9128</td>
<td>Speech therapy, in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>S9129</td>
<td>Occupational therapy, in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
<tr>
<td>S9131</td>
<td>Physical therapy; in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS12/Home</td>
<td>EVV Required</td>
<td>EVV Required when Aetna Authorizes the service</td>
</tr>
</tbody>
</table>
Key Contacts

HHAX NJ Client Support Phone Number
(866) 245-8337

HHAX NJ Client Support Email Mailbox
NJSupport@hhaexchange.com

Providers Using a Third Party EVV Vendor
EDIsupport@hhaexchange.com

Aetna Dedicated Email Mailbox
AetnaEVVCompliance@AETNA.com
Questions?
HCAH Provider Q & A Follow Up
Q & A

Q: Insurance companies need to allow overlapping shifts so we can pay nurses to train on-site. In this case we do have two nurses on the case. One should be billable/payable while the other is non-billable/payable.

A: Specific detail on process that allowed for Providers to pay nurses to train on-site prior to EVV requirements is needed. Individual member service delivery does not typically incorporate trainees.

Q: Our nurses need to be able to clock in at the home, take the patient to school and clock out at the home without having to clock in/out multiple times. The ‘visits’ should be linked so only one clock in/clock out is required.

A: This is being worked on currently and updates will be provided as soon as they are available.

Q: Our nurses need to be able to clock in at 11p and out at 7a without having to clock out at 1159 and back in at midnight on every night shift. Those ‘visits’ should be linked so only one clock in/clock out is required.

A: If the provider is using HHAX, scheduling back to back will allow the caregiver to clock in and out once.
Q & A continued

Q: We need an “other agency” option for scheduling purposes. We have no way of scheduling blocks that are with shared agencies, so we have no idea what shifts the other agency is covering on a co-vended case. Our schedule should match the authorized hours to ensure the client is getting full coverage and so the co-vending agencies can cover each other’s call outs when possible. It’s extremely difficult to keep track of otherwise.

A: HHAx cannot accommodate this request. There is no way to link two provider portals together to share member and scheduling information.

Q: When a nurse is scheduled for multiple shifts on the same day, there is no way for them to call out for just one of the shifts. When we go into the “absence/restriction” button, the only option is for the nurse to call out for the entire day. If we go into the calendar section and just “temp” the visit, then the call out isn’t recorded for the caregiver.

A: This is HHAX Paid Provider Portal Functionality. The provider will need to reach out to their Provider CSM Contact at HHAX to address this concern.
Q & A continued

Q: We need a code for DDD to differentiate it from PCA/HHA. Otherwise, our schedulers can schedule an HHA on a DDD case even if they aren’t DDD qualified.

A: All DDD Service codes are currently set up as PCA in HHAX. Please provide an example/more detail on this issue.

Q: We need to be able to remove a code from a caregiver. We have a caregiver who used to have an HHA license and did HHA work for us. She let her license lapse but still works for us on DDD. We can’t remove the PCA/HHA code because she was paid/billed under that code in the past. The system won’t let you remove a code from a caregiver once it’s been billed. This could cause us to schedule her incorrectly in the future. The same would be true for an LPN that gets an RN license. We wouldn’t be able to remove the LPN code.

A: This tested on the HHAX side we were able to successfully remove this from a provider. Please reach out to njsupport@hhaexchange.com with examples for further assistance.
Q & A continued

Q: We need an electronic MAR so the nurses can sign off on their meds electronically or at least so it can be printed from the profile database and sent to the home. Currently our nurses are hand-writing a MAR each month which is archaic.

A: This is an HHAX Paid Provider Functionality and not part of the Free EVV option offered to comply with the Cure’s Act Mandate. For additional assistance please reach out to njsupport@hhaexchange.com or your Provider CSM at HHAX.

Q: There needs to be a way to create a form in the caregiver’s section for annual evaluations/competencies. Currently, we have it attached to the edocs within the visit, but that gets filed into the patient’s chart versus the nurse’s chart. It needs to go into the nurse’s chart.

A: This is an HHAX Paid Provider Functionality and not part of the Free EVV option offered to comply with the Cure’s Act Mandate. For additional assistance please reach out to njsupport@hhaexchange.com or your Provider CSM at HHAX.
Next Steps

- Next Meeting: Thursday, October 20, 2022

Resources

- DMAHS: https://www.state.nj.us/humanservices/dmahs/info/evv.html

Contact Information

- General EVV mailbox: Mahs.Evv@dhs.nj.gov
- General Provider Inquiries mailbox: mahs.provider-inquiries@dhs.nj.gov
- CSOC EVV mailbox: dcf.evvcsoc@dcf.nj.gov
- DDD EVV mailbox: DDDEVV@dhs.nj.gov
- Geralyn Molinari: Geralyn.Molinari@dhs.nj.gov
- Becky Thomas: Rebecca.Thomas@dhs.nj.gov
EVV RESOURCES

Contents:

• The Federal Mandate
• EVV Vision & North Star Principles
• NJ EVVMS – Provider Onboarding
• Provider Outreach to DMAHS EVV
• EVV Inquiry Form
• EVV Payer Contacts
• Options for EVV Compliance
• NJ EVVMS – Free HHAX tools
• NJ EVVMS – Alternate EVV or 3rd party Providers
• 2023 HHCS Codes
• Certification/Licensing Number Policy Details
The Federal EVV Mandate

Section 12006 of the Twenty First Century Cures Act (Cures Act) and The Centers for Medicare & Medicaid Services (CMS) has mandated that Electronic Visit Verification (EVV) will be required for all Personal Care Services by January 1, 2020 and all Home Health Care Services by January 1, 2023.

NJ DMAHS received approval from CMS for a good faith effort exemption to the January 2020 implementation mandate. The new implementation deadline was January 1, 2021.

Mandate Requirements:
1. Type of service performed;
2. Individual receiving the service;
3. Date of the service;
4. Location of service delivery;
5. Individual providing the service;
6. Time the service begins and ends.

Future focus to include program integrity, CM/missed visits, data completeness.
# EVV Vision & North Star Principles

**Vision:** To implement an EVV system that meets state and federal requirements with broad public support and a strong/enthusiastic stakeholder process.

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will serve people the best way possible.</td>
<td>We will create an electronic visit verification system that ensures New Jersey FamilyCare members receive the home care services authorized in their care plans.</td>
</tr>
<tr>
<td>We will keep communication clear and simple.</td>
<td>We will communicate to build understanding as we respond to the federal mandate and roll out this new technology.</td>
</tr>
<tr>
<td>We will support accurate and efficient data exchange.</td>
<td>The new system will support data exchange between providers and MCOs to promote strong collaboration, timely claims processing, and accurate payment.</td>
</tr>
<tr>
<td>We will use data to solve real-life problems</td>
<td>We will work with health plans and providers to use EVV data to reduce missed visits, address trends, and improve our program in measurable ways.</td>
</tr>
<tr>
<td>We will support our community through this change.</td>
<td>Empathy, positive energy, and collaborative focus will be our hallmark, internally and externally.</td>
</tr>
</tbody>
</table>
NJ EVVMS – Provider Onboarding

• Visit the New Jersey Home Health Information Center: to go live next week on 4/11/2022
  • www.hhaexchange.com > Resources > Provider Information Center > NJ Home Health

New Providers

• Welcome Letter for Phase 2: Week of 4/11/2022
• Complete the Provider Portal Survey – under the “Overview” tab
• Sign up for the Provider Information Sessions and attend the webinar to learn next steps/details
• Be on the lookout for additional communication regarding training and implementation timelines
• For 3rd Party / EDI Providers ONLY:
  • Review the BRD and API specifications
  • Complete the attestation
  • Contact HHAX Provider Integration team to begin onboarding process edisupport@hhaexchange.com
  • Register for EDI Training Session – link will be sent via email

Existing Providers

• Complete the Provider Portal Survey – under the “Overview” tab & sign up for Info Sessions
  • Welcome Letter for Phase 2: Week of 4/11/2022
• Ensure you are training any staff that handle home health services for Phase 2 on the EVV tools you selected
• 3rd Party / EDI Providers ONLY:
  • Consult with your EVV vendor to ensure the solution you have implemented can support EVV for the additional service
  • Keep your vendor informed of any implementation timelines communicated
Provider Outreach to DMAHS EVV

Addressing Provider Issues /Concerns

1. Provider contact Payer (MCOs and/or FFS)
2. If issue is not resolved and/or payment is interrupted contact DMAHS using the EVV Mailbox and /or Provider Resource account
   – mahs.evv@dhs.nj.gov
   – mahs.provider-inquiries@dhs.nj.gov
3. DMAHS Providers must submit detail that EVV guidelines were followed and MCO and/or EVV Vendor was contacted prior to outreach to DMAHS - (Refer to the EVV Inquiry Form)
## EVV Inquiry Form

<table>
<thead>
<tr>
<th>Service Information</th>
<th>MCO/Health Plan if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Type of Inquiry</td>
</tr>
<tr>
<td></td>
<td>EVV Implementation/Operations</td>
</tr>
<tr>
<td></td>
<td>Service Provider</td>
</tr>
<tr>
<td></td>
<td>Service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MCO Contact:</th>
<th>Date of Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of follow up with MCO:</td>
<td></td>
</tr>
<tr>
<td>Specify if existing inquiry or email sent to HHAx and/or DMMAHS</td>
<td></td>
</tr>
<tr>
<td>Summary of follow-up with HHAx:</td>
<td></td>
</tr>
<tr>
<td>Specify Ticket Number:</td>
<td></td>
</tr>
</tbody>
</table>

| Member's Impacted if Prior Authorization | |
|------------------------------------------| |

**NOTES, as needed**

General Provider Inquiries mailbox: mahs.provider-inquiries@dhs.nj.gov
## Provider Issues Reporting – EVV Payer Contacts

<table>
<thead>
<tr>
<th>Payer</th>
<th>Payer Contact information for EVV Questions</th>
<th>EVV Solution for Data Submission and Technical Support</th>
<th>Claims submission Portal for services after <em>July 1, 2021</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS Medicaid</td>
<td><a href="mailto:EVV@dhs.nj.gov">EVV@dhs.nj.gov</a></td>
<td>HHAeXchange; <a href="mailto:Njsupport@hhaexchange.com">Njsupport@hhaexchange.com</a> 866-245-8337</td>
<td>All EVV mandated services will be submitted and billed through HHAeXchange as of 7/1/2021</td>
</tr>
<tr>
<td>FFS Medicaid DDD</td>
<td><a href="mailto:DDDEVV@dhs.nj.gov">DDDEVV@dhs.nj.gov</a></td>
<td>HHAeXchange; <a href="mailto:Njsupport@hhaexchange.com">Njsupport@hhaexchange.com</a> 866-245-8337</td>
<td>All EVV mandated services will be submitted and billed through HHAeXchange as of 7/1/2021</td>
</tr>
<tr>
<td>FFS Medicaid CSOC</td>
<td><a href="mailto:dcf.evvcsoc@dcf.nj.gov">dcf.evvcsoc@dcf.nj.gov</a></td>
<td>HHAeXchange; <a href="mailto:Njsupport@hhaexchange.com">Njsupport@hhaexchange.com</a> 866-245-8337</td>
<td>All EVV mandated services will be submitted and billed through HHAeXchange as of <em>10/8/2021</em></td>
</tr>
<tr>
<td>Aetna</td>
<td>Joseph Manger <a href="mailto:MangerJ@aetna.com">MangerJ@aetna.com</a> Namrata Sood: <a href="mailto:SoodN@aetna.com">SoodN@aetna.com</a> Constance Offer: <a href="mailto:OfferC@aetna.com">OfferC@aetna.com</a></td>
<td>HHAeXchange; <a href="mailto:Njsupport@hhaexchange.com">Njsupport@hhaexchange.com</a> 866-245-8337</td>
<td>All EVV mandated services will be submitted and billed through HHAeXchange as of 7/1/2021</td>
</tr>
<tr>
<td>Amerigroup</td>
<td>Eyreny Mekhaiel: <a href="mailto:eyreny.mekhaiel@amerigroup.com">eyreny.mekhaiel@amerigroup.com</a> Lynelle Steele: <a href="mailto:fannie.steele@amerigroup.com">fannie.steele@amerigroup.com</a> Keisha J Woodson: <a href="mailto:keisha.woodson@amerigroup.com">keisha.woodson@amerigroup.com</a></td>
<td>CareBridge: <a href="mailto:njevv@carebridgehealth.com">njevv@carebridgehealth.com</a></td>
<td>All EVV mandated services will be submitted and billed through CareBridge as of 7/1/2021</td>
</tr>
<tr>
<td>Horizon</td>
<td>Denaire Johnson: <a href="mailto:Denaire_Johnson@horizonblue.com">Denaire_Johnson@horizonblue.com</a> Stephen Fitch: <a href="mailto:Stephen_Fitch@horizonblue.com">Stephen_Fitch@horizonblue.com</a></td>
<td>CareBridge: <a href="mailto:njevv@carebridgehealth.com">njevv@carebridgehealth.com</a></td>
<td>All EVV mandated services to be billed directly to Horizon. No Change to claims submission - Refer to Section 9.3 – Electronic Billing Guide in the Provider Manual</td>
</tr>
<tr>
<td>United HealthCare</td>
<td><a href="mailto:nj_hcbs_pr@uhc.com">nj_hcbs_pr@uhc.com</a></td>
<td>HHAeXchange; <a href="mailto:Njsupport@hhaexchange.com">Njsupport@hhaexchange.com</a> 866-245-8337</td>
<td>All EVV mandated services will be submitted and billed through HHAeXchange as of 7/1/2021</td>
</tr>
<tr>
<td>WellCare</td>
<td>Marjorie Forgang: <a href="mailto:Marjorie.Forgang@wellcare.com">Marjorie.Forgang@wellcare.com</a> Elaine M Aguirre: <a href="mailto:Elaine.Aguirre@wellcare.com">Elaine.Aguirre@wellcare.com</a> Joan Cosme: <a href="mailto:Joan.Cosme@wellcare.com">Joan.Cosme@wellcare.com</a></td>
<td>HHAeXchange; <a href="mailto:Njsupport@hhaexchange.com">Njsupport@hhaexchange.com</a> 866-245-8337</td>
<td>All EVV mandated services will be submitted and billed through HHAeXchange as of 7/1/2021</td>
</tr>
</tbody>
</table>
Options for EVV Compliance

Option 1 – Use your existing 3rd Party EVV system to collect and report to each plan and/or to DMAHS; requires EDI integration with HHAX (Aetna, UHC, WellCare, and NJ Medicaid members) and CareBridge (Horizon & Amerigroup)

Option 2 – Use Free EVV tools provided by each Health Plan (HHAeXchange for Aetna, UHC, WellCare, and NJ Medicaid members; CareBridge for Horizon and Amerigroup members)

Option 3 – Use the Free EVV tools provided by DMAHS (HHAeXchange) to collect, and report visit data for all members
<table>
<thead>
<tr>
<th>EVV</th>
<th>Member Management for NJ Medicaid and MCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clock-In / Clock-Out Exception Dashboard</td>
</tr>
<tr>
<td></td>
<td>Submission / Aggregation of EVV Data to NJ Medicaid &amp; MCOs</td>
</tr>
<tr>
<td></td>
<td>Quick Visit Timesheet Entry</td>
</tr>
<tr>
<td></td>
<td>Caregiver Mobile Application in Multiple Languages</td>
</tr>
<tr>
<td></td>
<td>Telephony Lines in English and Spanish</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Clock-In / Clock-Out Exception Dashboard</td>
</tr>
<tr>
<td></td>
<td>Submission / Aggregation of EVV Data to NJ Medicaid &amp; MCOs</td>
</tr>
<tr>
<td>Communication</td>
<td>Real-Time Two-Way Messaging with NJ Medicaid, Aetna, United, and WellCare</td>
</tr>
<tr>
<td>Billing</td>
<td>Pre-billing Claims Scrubbing</td>
</tr>
<tr>
<td></td>
<td>eBilling (837) / eRemittance (835) for NJ Medicaid, Aetna, United, and WellCare</td>
</tr>
<tr>
<td></td>
<td>Visit submission to Horizon &amp; Amerigroup aggregator for billing</td>
</tr>
<tr>
<td>Compliance</td>
<td>Automatic Authorization Receipt from NJ Medicaid, Aetna, United, and WellCare</td>
</tr>
<tr>
<td></td>
<td>Manual Authorization Input for Amerigroup and Horizon</td>
</tr>
<tr>
<td></td>
<td>Plan of Care Adherence</td>
</tr>
<tr>
<td></td>
<td>Visit Confirmation Compliance</td>
</tr>
</tbody>
</table>

**Everything you need to be EVV compliant!**
Prepare for EVV EDI Integration with HHAX by:

- Reviewing the Business Requirements document & data specifications found here:
- Please note, these documents are also located on the NJ DMAHS Info Center, found here: [https://hhaexchange.com/nj-dmahs/](https://hhaexchange.com/nj-dmahs/)
- Complete provider attestation found in the BRD:
  - [https://www.cognitoforms.com/HHAeXchange1/thirdpartyevvattestation](https://www.cognitoforms.com/HHAeXchange1/thirdpartyevvattestation)

Providers contracted with Horizon and Amerigroup will need to integrate their 3rd Party EVV solution with CareBridge
• Contact HHAX Provider Integration team to begin onboarding process:
  • edisupport@hhaexchange.com
  • Provide following information:
    • Provider legal name
    • Provider Medicaid ID
    • Provider Tax ID
    • Provider NPI
    • Provider primary point of contact (name, email, phone number) for integration efforts with HHAX
    • Provider mailing address
    • Vendor legal name
    • Vendor primary point of contact (name, email, phone number) for integration efforts with HHAX
## EVV Cohort 1

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedure Name</th>
<th>Unit of Measure</th>
<th>Service Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>97597</td>
<td>Debridement, open wound, wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, total wound(s) surface area; first 20 sq cm or less</td>
<td>Per visit</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>99601</td>
<td>Infusion, Skilled nursing</td>
<td>Up to 2 hours</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>99602</td>
<td>Infusion, Skilled nursing-additional hour(s)</td>
<td>Each additional hour</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>G0299</td>
<td>Direct skilled nursing services of a registered nurse (run) in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>S9122</td>
<td>Home Health Aide/Certified Nurse Assistant</td>
<td>Per hour</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>S9123</td>
<td>Nursing care, in the home; by registered nurse</td>
<td>Per hour</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>S9124</td>
<td>Nursing care, in the home; by licensed practical nurse</td>
<td>Per hour</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>S9127</td>
<td>Social work visit, in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>T1000</td>
<td>Private duty / independent nursing service(s)</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>T1002</td>
<td>Private duty / independent nursing service(s) / RN</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>T1003</td>
<td>LPN/LVN SERVICES</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>T1030</td>
<td>Nursing care, in the home, by registered nurse</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>T1031</td>
<td>Nursing care, in the home, by licensed practical nurse</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
</tr>
</tbody>
</table>
## EVV Cohort 2

### COHORT 2 Therapies

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedure Name</th>
<th>Unit of Measure</th>
<th>Service Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>92507</td>
<td>Speech, Language and Hearing Therapy Individual</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>97110</td>
<td>Physical Therapy, Therapeutic procedure, 1 or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>97129</td>
<td>Cognitive Therapy, Individual</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>97130</td>
<td>Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity, direct (one-on-one) patient contact (List separately in addition to code for primary procedure)</td>
<td>Each additional 15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>97535</td>
<td>Occupational Therapy, Individual - Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>G0151</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>G0152</td>
<td>Services performed by a qualified physical therapist in the home health or hospice setting</td>
<td>15 mins</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>S9128</td>
<td>Speech therapy, in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>S9129</td>
<td>Occupational therapy, in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
</tr>
<tr>
<td>S9131</td>
<td>Physical therapy; in the home</td>
<td>Per diem</td>
<td>PA - REQUIRED POS 12</td>
</tr>
</tbody>
</table>
Certification/Licensing Number Policy

- The DMAHS requires the license or certification number information in the EVV aggregation system for rendering service providers of personal care services (PCS) and home health care services (HHCS).
- The certification/licensing requirement is intended to ensure NJ FamilyCare members are receiving care from qualified providers.
- **Compliance timeline:** Providers have until 12/31/22 to add this information to rendering providers’ profiles.
- Provider training will be offered to walk through this process.