State of New Jersey - Department of Human Services
Division of Medical Assistance and Services

Electronic Visit Verification

Home Care & Hospice Association of New Jersey Annual Conference

Wednesday October 20, 2021
12:00 – 1:15 pm
Zoom Meeting
Today’s Agenda

- Welcome and Introductions
- EVV Provider Status
- Program Monitoring and Provider Report
- MCO Overview of Prior Authorizations and Billing
  - Amerigroup
  - Horizon
  - HHAx demo
  - Aetna
  - United HealthCare
  - WellCare

Provider Newsletter Volume 31, no. 16:
https://www.state.nj.us/humanservices/dmahs/info/31-16 EVV NL.pdf
• No evidence of EVV engagement on July 1, 2021
• No new cases assigned as of July 15, 2021
• Existing cases moved to operational providers as of August 1, 2021

Disengaged Provider

Engaged Provider

• Engaged with an EVV solution as of July 1, 2021
• Provider addressing integration and/or billing changes
• No new cases assigned as of September 1, 2021
• All cases moved to Operational Providers as of October 1, 2021

Operational Provider

• All visits are verified with EVV
• Provider is submitting claims to payer using EVV specific billing process
• Effective October 1, 2021, all members will be served by an Operational Provider

Provisional Status

*Detailed in Provider Newsletter Volume 31, no. 16
Program Monitoring

MCOs
- Care management staff are working with members who are being moved if provider is non-compliant with EVV.
- MCOs are providing training to Providers regarding common billing errors.
- MCOs have outlined revised billing guidelines for Providers who are confirming all EVV visits but are not billing as outlined by the MCO.

HHAX
- HHAX Support Tickets – Tracking of operational issues in aggregate and at the provider level. At this time focus is claims payment issues.

State
- State is following up with Payers/Providers directly if issues require State intervention.
MCO Updates
Amerigroup – Claim Disputes and Resubmission

Fully compliant EVV claims will only deny due to regular claims processing rules. The process to submit claim disputes will not change on 10/1.

Claim payment disputes can now be submitted online. Log in to the secure provider website through the public provider website at https://providers.amerigroup.com/NJ or through Availity at https://www.availity.com

Once you are logged into Availity:
1. Choose **Claims & Payments** in the toolbar and select **Claim Status (New)**.
2. Search for the claim by completing the fields and select **Dispute Claim**.
3. Upload any documentation to support the dispute.

Please note that additional disputed claims for the same issue may be submitted by attaching a list. Claims with the same issue will have the same EOB denial.
**Amerigroup – Claim Resubmission**

**Claim Resubmission:** If a provider needs to submit a corrected claim, that would occur in the EVV system that the provider uses to submit visit and claim data.

For provider’s using a Third-Party EVV Vendor, the provider will execute most of the resubmission activities in their source system:

- Claims can only be updated or voided once they’ve reached a final/terminal status (Paid/Denied/Rejected etc.). Once the claim that the provider wants to correct has reach a terminal status:

- They would make the necessary adjustments/corrections within their EVV source system (update check-in / check-out times, update rates, void, etc.).

- After the updates are made, the provider would then re-bill/re-export the visit(s) from their source system – Providers should reach out directly to their EVV vendor for rebilling instructions within their EVV system.

- The provider’s EVV vendor would then send the visit(s) to CareBridge with the updated information and the ‘Claim Action’ field populated with a “C”, for corrected (it is critical that the same **Appt ID** remains the same from the initial visit submissions).

- Care Bridge will re-process the original claim, updating the unit total/billed amount based off the newly updated visits data. On the 837, either a ‘7’ or ‘8’ will be sent in the Claim Frequency Code field (CLM05-3) indicating that the claim is a replacement/correct to the prior claim or is Voiding/canceling the prior claim, respectively.

- Billing details and updates are returned to EVV Vendors via the “Appointment Status Report”. Referring to the following fields: Billed Units, Billed Amount, and Claim Status.
  - If setup to do so, providers can check the Availity/Amerigroup provider portal for billing details.
Amerigroup – Claim Resubmission

For CareBridge users:

- Providers will make necessary adjustments to their visit within the CareBridge Provider Portal.
- Once the claim has reached a final/terminal status, the provider can re-export the specific visits by selecting the checkbox next to one (or many) visits and then selecting the EXPORT TO BILLING button.
- The provider will be able to view claim status updates in the CareBridge portal.
  - If setup to do so, providers can check the Availity/Amerigroup provider portal for billing details.
Amerigroup – Authorizations in Care Bridge

AUTHORIZATIONS PAGE

The Authorizations page shows information such as start and end dates, authorization numbers, scheduled and billed utilization percentages, statuses, and assigned caregivers.
Amerigroup – Authorizations in Care Bridge

When looking for specific information in the Authorizations, Appointments, Visits, or Billing pages, just click **FILTERS** to set custom parameters. *Don’t forget to adjust your date ranges and updated date ranges to find the appropriate data.*
Amerigroup – Authorizations in Care Bridge

To save a FILTER that you use regularly, just click on SAVE FILTERS. This customized filter can be accessed easily in the future by selecting it from the Saved Filters dropdown menu. A saved filter will only be available on the page it was created, for the user who created it.

To view more information about an Authorization, click the (three dots) menu button on the far right and select Authorization Details.

The Authorization Details screen will open. Here you can see more information such as Diagnosis Code(s), Authorization Segments, and Appointments/Visits.
Current EOP – providers receive code E80 indicating “EVV claim will be paid as submitted. Risk of not receiving payment if not submitted through EVV vendor. Training and support are available.

10/1- EOP – providers will receive code ZEE (EVV submission error) says that the provider will need to use the EVV platform to submit claim.
EVV Claims Denial codes:

Effective 10/1/21, any claim units not supported with EVV data for EVV in scope services will deny. Below are the EVV Claims Denial Codes –

- **EV1** - Amount exceed the Electronic Visit Verification (EVV) data submitted through EVV vendor
- **EV2** - Units exceed the Electronic Visit Verification (EVV) data submitted through EVV vendor
- **EV3** - Line denied, Electronic Visit Verification (EVV) data must be submitted through EVV Vendor
- **EV4** - Line Denied; Multiple DOS Not allowed in a claim line qualified as EVV required

**Please note that there is no change to Horizon’s Claim submission process (Continue to submit claims either directly through Trizetto or through fiscal intermediary to Trizetto).**

Messages and Reason Code

The practice of balance billing Medicaid/NJFC beneficiaries, whether eligible for FFS benefits or enrolled in managed care, is prohibited under both Federal and State law. These prohibitions apply to both Medicaid/NJFC-only beneficiaries, as well as those eligible for Medicare coverage or other insurance. A provider enrolled in the Medicaid/NJFCFFS program or in managed care is required to accept as payment in full their reimbursement rate established by the FFS program or managed care plan.

**EV3**  Line denied, Electronic Visit Verification (EVV) data must be submitted through EVV Vendor.

**Access Navinet to identify “care gaps” concerning your patients. Let’s work together to improve our members’ health. Have questions? Contact your provider account executive.**
Claims Reprocessing Request Submission Process:

If a Claims Denial is received due to missing or Incorrect EVV data, a claims reprocessing request can be submitted by a provider. However prior to requesting reprocessing of claims, below actions should be taken –

- Check with your software portal to ensure that the visit was accepted by your EVV vendor and there are no unresolved rejections for the member/date of service.
- Confirm that the state issued Medicaid ID submitted in your EVV data matches the state billing Medicaid ID on the date of service.
- Validate claims data to ensure your claims has the same Tax ID, NPI and CPT coding as submitted on EVV data.
- Ensure that you are billing only one date of service per claim line.
- If no EVV data has been received by Horizon, follow up may be needed with the respective EVV vendor to resolve any data related issue.
Claims Reprocessing Request Submission Process:

- If all data appears to have been entered correctly and no unresolved rejection errors appear in your software, you may request reprocessing of claims by submitting a claims inquiry:
  - Either through NaviNet or
  - By calling our Provider Services Center at 1-800-682-9091

- EVV data has to be received by HNJH, for claims to process. If EVV data is not on file with all appropriate information, the claims will deny again

- Please note that you should not submit a corrected claim for denied services unless information previously supplied on the HCFA 1500 or 837 file is being modified
Viewing HNJH Authorizations:

- HNJH will continue to follow our existing authorization process. HNJH communicates responses to authorization requests either by Fax or through NaviNet. Providers may look up authorization information or status via NaviNet.

- HNJH does not provide authorization data for upload into the CareBridge platform. Authorization data is either manually entered by the CareBridge user on CareBridge software or provided by a third party software as entered by the agency.

- Once your authorization information is received from the initiating software by CareBridge then you are able to search for authorization information or detail as described in the slide tool bars in the following slides.

- Once you sign into your CareBridge Portal you should navigate to the authorization screen by selection “Authorization” on the left side tool bar.
**AUTHORIZATIONS PAGE**

The Authorizations page shows information such as start and end dates, authorization numbers, scheduled and billed utilization percentages, statuses, and assigned caregivers.

![Screen capture of Authorizations page](image-url)

<table>
<thead>
<tr>
<th>MEMBER</th>
<th>UPDATED DATE</th>
<th>START DATE</th>
<th>END DATE</th>
<th>UNITS</th>
<th>AUTH #</th>
<th>SERVICE</th>
<th>MODIFIERS</th>
<th>SCHEDULED UTILIZATION %</th>
<th>BILLED UTILIZATION %</th>
<th>PAYER</th>
<th>STATUS</th>
<th>EMPLOYEE</th>
</tr>
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<tbody>
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<td>09/10/2021</td>
<td>01/01/2021</td>
<td>12/31/2021</td>
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<td>T1019</td>
<td></td>
<td>0</td>
<td>0</td>
<td>CB Test Payer</td>
<td>Acknowledged</td>
<td></td>
</tr>
<tr>
<td>Stacy Jones</td>
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<td>12/31/2021</td>
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<td>219400B5232</td>
<td>T1019</td>
<td></td>
<td>0</td>
<td>0</td>
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<td>Acknowledged</td>
<td></td>
</tr>
<tr>
<td>Nick Jones</td>
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<td>12/31/2021</td>
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<td>5721P0P6533</td>
<td>T1019</td>
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<tr>
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To view more information about an Authorization, click the (three dots) **menu button** on the far right and select **Authorization Details**.

The Authorization Details screen will open. Here you can see more information such as **Diagnosis Code(s)**, **Authorization Segments**, and **Appointments/Visits**.
HHAeXchange Demo
Agenda

- Authorization Management
- Finding a Member and Authorization in HHAeXchange
- Billing in HHAeXchange
- Provider Resources
- Contact Information
Authorization Management

Providers will be receiving members and authorizations for the payers listed below:
- NJ DMAHS/DDD
- Aetna Better Health of NJ
- United Healthcare
- WellCare of NJ

Providers will be responsible for adding new members and entering authorizations into the system
- Amerigroup
- Horizon

Providers will manage the members phone 2 & 3 and additional addresses sections of the members profile page within HHAeXchange to reflect where services should be provided.
Finding Members and Authorizations In HHAeXchange

Find a Member/Patient in HHAeXchange:
- Log into HHAeXchange
- Follow Path: Patient > Search Patient
- Enter patient identifier in search field(s), i.e. last name, patient ID
- *Always check that you are searching under the correct status or use “ALL” if you are unsure of the member status

Check Pending Placement Queue for any pending placements waiting to be accepted.
- Follow Path: Action > Pending Placement Queue
- Once accepted you can access the patient profile using the patient search above.
Locating a patient’s authorization in HHAeXchange:
- In the member account select the Authorizations link on the left-hand side of the patient’s profile page

The Authorization page has all active and prior authorizations that have been imported into HHAeXchange for the member.
- Here you can view:
  - The contract for the authorization
  - Authorization Number (if you click on this you can see the units allocated and remaining)
  - From Date and To Date
  - Discipline and Service Code
Billing in HHAeXchange – HHAX Providers

Billing through HHAeXchange will only apply to services for NJ DMAHS FFS/DDD, Aetna, United Healthcare and WellCare

**Authorizations are required for billing through the HHAX platform**
- Each payer is responsible for sending the 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 Professional License Number (on Caregivers Profile)
- Patients Medicaid Number (on Patient Profile)
- Patients Diagnosis Code (on Patient Authorization)
Additional Provider Resources within HHAeXchange for Billing

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

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

Support Emails
NJsupport@hhaexchange.com
Edisupport@hhaexchange.com

NJ Support Phone Number
(866) 245-8337
Aetna Better Health of NJ
And
Aetna Assure Premier Plus (HMO D-SNP)

Summary of changes in provider interactions with Aetna

<table>
<thead>
<tr>
<th>Process</th>
<th>Is there a change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior authorization</td>
<td>No change. You still need to obtain your authorization from Aetna</td>
</tr>
<tr>
<td>Claims submission</td>
<td>Yes. You can only submit claims via the HHA portal</td>
</tr>
<tr>
<td>EOP/EOB</td>
<td>No change. You will still get the same documents from Aetna</td>
</tr>
<tr>
<td>Claims payment</td>
<td>No change. You will be paid the same way you are currently being paid by Aetna</td>
</tr>
<tr>
<td>Corrected claims</td>
<td>Yes. You can only submit corrected claims via the HHA portal</td>
</tr>
<tr>
<td>Appeals</td>
<td>No change. You still follow the same Aetna appeal processes</td>
</tr>
</tbody>
</table>
What is changing with our explanation of Payment (EOP/EOB) documents?

- There are no changes to the existing explanation of payment or explanation of benefit documents. Providers will still receive the same documents from Aetna they have always received and there are no messages related to EVV.

Why?

- Providers are only able to submit claims with EVV verified visits via the HHA portal. Visits that have not been verified won’t be transmitted to Aetna's clearinghouse for claims processing.

- If a provider were to try to bypass the HHA portal submission process and try submit a claim directly to Aetna, our Clearinghouse would not accept it for processing.
How to appeal a claim denial

How to submit a corrected claim?

- There are no changes to the existing claim appeal process. The process is outlined on our website (https://www.aetnabetterhealth.com/newjersey/providers/appeals)

- Corrected claims for PCA services also need to be submitted via HHA portal since every visit needs to be verified with EVV data.
I’m not getting paid? What do I do?

It is critical that providers continually monitor their claim status reports from HHA so they confirm claims have been accepted by Aetna’s clearinghouse. Aetna does not know if the clearing house did not accept a claim for processing.

Not getting paid? Follow these steps:

1. Check HHA reports/portal to confirm the claim has been submitted, accepted, or rejected by our clearinghouse. Aetna cannot assist you with getting paid if the claim hasn’t been accepted for processing.

2. Not accepted by clearinghouse? Follow up with HHA for the reason and what needs to be done to fix the claim. If you are not using HHA as your EVV vendor, HHA may tell you to contact your chosen EVV vendor because the claim information was not sent to HHA to submit to Aetna.

3. After following the above steps, and if you are still not getting paid, send an email with claim and date(s) of service details to: AetnaEVVCompliance@AETNA.com.
• As of 10/1/2021 all services that require electronic visit verification must be submitted and billed through HHAeXchange

• If a provider directly submits a claim to United they will be denied with the following Remark code and the verbiage will display in the PRA.

• RMK Code: **M16** – “Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.”
Claims sent through HHAX the first time would be an original claim submissions. They would only follow the rebilling once an original claim submission out of HHAX is denied for any reason.

**Rebilling**

Providers can rebill a claim directly in the system; addressing any claims issues when initially submitting the claim. The two menu items to support this feature are **Batch Search** and **Resubmit Claims** located under the Billing tab (Billing > Electronic Billing).

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Navigate to Billing &gt; Electronic Billing &gt; New Batch &gt; Resubmit Claims.</td>
</tr>
<tr>
<td>2</td>
<td>On the Resubmit Claims E-submission Batch page, select the Contract. The system automatically generates a Batch Number for the claims resubmission. Click on the Add Claims button and then click on the Search button to generate a Claim Search.</td>
</tr>
<tr>
<td>3</td>
<td>On the Claim Search page, select the applicable batches and click the Add button.</td>
</tr>
<tr>
<td>4</td>
<td>On the Resubmit Claims E-submission Batch page, click on the E (edit) button to open the Claims Adjustment window. <strong>Note:</strong> To delete a record from the claim to be resubmitted click on the – icon.</td>
</tr>
</tbody>
</table>
1. Provider training will be provided on 10/4 and will cover Prebilling, Billing for EVV through HHAeXchange.

2. WellCare will provide Process guide for Rebilling with breakdown of the step-by-step process.

3. Appeals process remains the same.

4. Trends identified:
   a. Most commonly identified denial reasons issued by the WellCare claims system

<table>
<thead>
<tr>
<th>WellCare Claim Denial Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXDUC: DENIED: Exact duplicate of another claim or service</td>
</tr>
<tr>
<td>DN001: DENIED: Prior Authorization required but not obtained</td>
</tr>
<tr>
<td>CE054: Primary Diagnosis is Required</td>
</tr>
<tr>
<td>DNTOB: Denied: Resubmit with correct bill type</td>
</tr>
<tr>
<td>VSTEX: DENIED: The days/visits/units billed on claim exceed the Auth</td>
</tr>
<tr>
<td>CE007: DENIED: Duplicate Claim</td>
</tr>
</tbody>
</table>

For inquiries related to your Claims, please contact Provider Customer Service at **1-888-453-2534** or HHAeXchange: edisupport@hhaexchange.com, njsupport@hhaexchange.com
WellCare continues to do outreach via e-mails and phone calls to all providers, as well as assisting with provider inquiries sent directly to the Network team and Care Management via the HHAeXchange portal.

**Past Provider Trainings:**

- October 14th

**Up-coming Trainings:**

- October 26th & 29th

**WellCare EVV Contacts:**

* Network Management /Provider inquiries: Damaris.Camilo@wellcare.com, Consuelo.Taveras@wellcare.com; Anny.Chevalier@wellcare.com

*Authorizations/Care Management: Joan.Cosme@wellcare.com, Mariel.Plasencia@wellcare.com; Elaine.Aguirre@wellcare.com
Open Discussion & Next Steps

• Questions?
• Open Discussion

General EVV e-mailbox: Mahs.Evv@dhs.state.nj.us
Joe Bongiovanni: Joseph.Bongiovanni@dhs.state.nj.us
Becky Thomas: Rebecca.Thomas@dhs.state.nj.us
Geralyn Molinari: Geralyn.Molinari@dhs.state.nj.us