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EVV Overview for Fidelis/Wellcare Providers

For Fully Integrated Dual Eligible (Wellcare Liberty) and NJ Family Care Plan Members

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EVV- Electronic Visits Verification

- Section 12006 of the Twenty First Century Cures Act (Cures Act) and the Centers for Medicare & Medicaid Services (CMS) requires the State of New Jersey and Fidelis Care/Wellcare to begin utilizing an Electronic Visit Verification System (EVV) for all Home Health Care Services (HHCS). The Cures Act mandate requires all visits to be timestamped via an electronic verification method utilizing EVV tools to record the member, caregiver, time the service begins and ends, location of the service, date of the service and the type of service performed.

- New Jersey DMAHS has partnered with HHAeXchange as their EVV Aggregation solution to ensure the provider community complies with the Cures Act Mandate requirements. The HHAeXchange solution will focus on collecting and reporting EVV compliant data for all Home Health Care Services (HHCS) for the New Jersey Family Care program.

- We understand that each MCO has offered their own solution to participating providers, and you may already have an enterprise EVV solution in place to help you be compliant. If you do not have an EVV solution at this time, Fidelis Care/Wellcare strongly suggests that you start the process with HHAeXchange.

EVV- Electronic Visits Verification System

- The EVV method is used to verify home health care visits to ensure patients are not neglected and to reduce fraudulently documented home visits. Health care providers can record visits using the beneficiary's home phone, an FOB device or a GPS mobile application.

- EVV is a software platform where Medicaid payers, Managed Care Organizations (MCOs) and their contracted network of health care providers communicate. EVV provides real-time visibility into visit confirmation and health care provider compliance, enhances care coordination, streamlines the billing process and provides an audit trail of all communication between the Medicaid payer, MCOs and health care providers.

- Providers can continue to perform EVV in their current system if they have one, however you will need to integrate with HHAX so the EVV and claims data can be received.

DMAHS NEWSLETTER Volume 33-14

August 2023

State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 33 No. 14 August 2023

TO: NJ FamilyCare Managed Care Organizations – **For Action**
NJ FamilyCare Fee-for-Service Providers (This includes Division of Developmental Disabilities Fee-for-Service Programs)–**For Action**
Providers Billing for Home Health Care Services (HHCS) Services – **For Action**

SUBJECT: **Summary of the NJ Electronic Visit Verification (EVV) Process and Frequently Asked Questions for Home Health Care Services subject to the EVV mandate of the 21st Century Cures Act**

EFFECTIVE: Immediately
Replace Volume 31 – Number 09
(Published April 2021)

PURPOSE: To provide clarification for Providers and Managed Care Organizations about the process for, and requirements of, Electronic Visit Verification (EVV) for Home Health Care Services

This Newsletter applies to all NJ FamilyCare/Medicare Managed Care Organization (MCO) Providers Billing for Home Health Care Services that are subject to the EVV mandate of the 21st Century Cures Act. Services covered by this federal mandate are detailed in the code list included in this Newsletter.

Please note that NJ Division of Developmental Disabilities (DDD) provider agencies billing FFS also must follow the guidelines of this Newsletter. Additionally, EVV requirements apply to self-directed services provided through the Personal Preference Program and the DDD Self-Directed Options.

BACKGROUND: The Division of Medical Assistance and Health Services (DMAHS) has implemented an EVV System in New Jersey. As of January 1, 2021, in collaboration with our EVV contractor, HHAeXchange, New Jersey is in compliance with Section 12006(a) of the 21st Century Cures Act for personal care services. Beginning January 1, 2023, home health care services will be required to meet EVV compliance guidelines.

The required EVV data elements are:

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.

Refer to the DMAHS website https://www.nj.gov/humanservices/dmahs/info/evv.html for DMAHS Newsletters, Fact Sheets and Provider Training documents.

INTRODUCTION

This Newsletter includes Frequently Asked Questions regarding: Electronic Visit Verification (EVV) claims payment for Division of Developmental Disabilities Fee for Service (FFS) and DMAHS Managed Care Organization (MCO) providers billing for Home Health and Personal Care Services subject to the EVV Mandate of the 21st Century Cures Act.

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A. EVV Service Applicability and Coordination

Below are the Home Health and personal care services in New Jersey that must use EVV as of January 1, 2023:

Type of Service:	Service Delivery Options:	Coordinated Through:
Home Health Personal Care Assistance (PCA) Services	✓ Agency ✓ Self-direction PCA through the **PERSONAL PREFERENCE PROGRAM***	Medicaid Managed Care Organization (MCO)
MLTSS Home-based Supportive Care	✓ Agency ✓ Self-direction	Medicaid Managed Care Organization (MCO)
MLTSS In-Home Respite	✓ Agency	
DDD Individual Supports DDD Community-based Supports DDD In-Home Respite	✓ Agency ✓ Self-direction through the **DDD SELF-DIRECTED EMPLOYEE OPTIONS****	NJ Division of Developmental Disabilities (DDD)

B. EVV Implementation Steps

1. Where can I find information from NJ Department of Human Services on EVV?

NJ DMAHS is maintaining an EVV specific webpage that providers should review for updated program information (https://www.nj.gov/humanservices/dmahs/info/evv.html). Additional information regarding HHAeXchange as the NJ EVV aggregator can be found on the HHAeXchange NJ EVV Information Center.

2. What steps do I need to take to be compliant with the EVV Mandate?

All information regarding EVV compliance is available on the NJ EVV Information Center. The steps you need to take as a provider in NJ are:

1. Complete the Provider Portal Survey found at Provider Portal Questionnaire
2. Follow the directions outlined in your EVV welcome packet
   HHAeXchange Provider EVV Welcome Packet
3. Attend a Provider Information session – all sessions are complete, but a recording can be found on NJ EVV Information Center
4. Complete System User Training
5. Start using or reporting your EVV visit data to HHAeXchange –see options below if your agency will use EVV solution other than HHAeXchange
6. Follow billing guidelines outlined by the individual MCOs as well as Fee for Service Medicaid.

3. If I have my own EVV solution what are my options for interfacing and reporting visit data to the MCOs and State?

Providers with their own EVV solution have two options for providing their EVV visit data.

- Option 1: Connect directly with HHAeXchange and report all visit data, regardless of payer. HHAeXchange will route the visit data to the appropriate payer. This only requires one data integration set up by your EVV vendor.
- Option 2: Connect directly with each Payer's EVV solution -- HHAeXchange for Aetna, United Health Care (UHC), Fidelis Care formerly WellCare and Fee-for-Service members; CareBridge for Amerigroup and Horizon members. This will require two separate integrations.

Next steps for EDI integration can be found in the HHAeXchange Provider EDI Welcome Packet.

If I have my own EVV solution, what steps do I need to complete to be ready for the EVV mandate?

Providers utilizing a third party EVV system will be required to comply with both the business requirements and technical specifications listed in this document, which are also found on the HHAeXchange website. The first step will be to review the content noted below and initiate contact with HHAeXchange to begin the integration process.

- **Business Requirements Link:** Business Requirements for Third Party EVV Data Aggregation NJ
- **Technical Specification document:** HHAeXchange EVV API Technical Specifications NJ
- **HHAeXchange Website**: https://HHAeXchange.com/nj-dmahs/

C. EVV Integration Procedures and Billing:

The procedure for integration of data and billing for PCA services that require EVV are summarized below based on the Provider Integration solution.

Scenario 1:

EVV Solution:	Provider has their own system – not HHAeXchange or CareBridge
Integration of Visit Data:	A - Third Party system connects directly with HHAeXchange as per HHAX EDI guidelines for New Jersey to share visit data with all payers **AND**

	B - Third Party system connects directly with CareBridge for Amerigroup and Horizon members
Billing Process:	Providers follow billing process as outlined by the individual MCOs and FFS. Refer to the MCO resources section for specific details regarding billing contacts.

Scenario 2:

EVV solution:	Provider uses HHAeXchange
Integration of Visit Data:	HHAeXchange will share visit data will all payers
Billing Process:	Providers follow billing process as outlined by the individual MCOs and FFS. Refer to the MCO resources section for specific details regarding billing contacts.

Scenario 3:

EVV Solution:	Provider uses CareBridge
Integration of Visit Data:	CareBridge connects directly with HHAeXchange to share visit date with all payers
Billing Process:	Providers follow billing process as outlined by the individual MCOs and FFS. Refer to the MCO resources section for specific details regarding billing contacts.

D. Best Practices for EVV Implementation:

What are the best practice guidelines for providers implementing EVV?

Milestone 1: Provider Portal entry

1. Add all agency provider detail in the HHAX provider portal
2. Enter Caregiver information in the HHAX Portal
3. Download of rates for each service code in the HHAX provider portal
    a. Please ensure rates are correctly added for all payers and complete for all service codes.

Milestone 2: Member specific entry

1. Confirm member specific information authorizations are included:
    - In the HHAX provider portal for Aetna, Fidelis Care formerly WellCare, UHC and FFS members.
    - For Amerigroup enter in CareBridge
    - For Horizon information must be manually entered in Carebridge or HHAX. The information in maintained in Navinet.
2. Enter schedules in the HHAX provider portal and/or on EDI Portal when authorization data is entered

Milestone 3: Visit Detail

1. Confirming visits

2. Reviewing visits for accuracy, i.e., clock in and clock out details are completed, missed visits corrected
3. Checking edit reason codes as needed
4. Batching visits and creating invoice(s)
5. Submitting invoice(s) for billing

Milestone 4: Review of visit information by payer

1. Ensure all visits contain the six data requirements:
    - Type of service performed; Individual receiving the service; Date of the service; Location of service delivery; Individual providing the service; Time the service begins and ends.
2. Ensure authorizations are current. If the authorization is due to expire, please be proactive and request an updated one from the correct payer.
3. Continue to utilize your current communication method with the MCOs to discuss unique member/service related concerns.

E. Compliance Calculation:

Below is detail of calculation that the individual MCOs and FFS Medicaid will use to determine Provider Compliance. Please note it is essential that Providers meet compliance criteria for each payer (MCO and FFS) in order to maintain good standing during Phase 1 of the EVV implementation.

Description of Column Entries:

A: Provider Name
B: Provider 9 Digit Tax ID
C: Number of Members being served by Provider other than live-in
D: Total number of Service Units for EVV mandated services (Claim Status=Paid)
E: Total number of Service Units for EVV mandated services with Matching EVV (Claim Status=Paid)
F: Total number of Service Units for EVV mandated services with Matching EVV without manual edits (Claim Status=Paid)
G: Percent of Service Units for EVV mandated services with Matching EVV (Column E/Column D)**
H: Percent of Service Units for EVV mandated services with Matching EVV without manual edits (Column F/ Column D)

Column A	Column B	Column C	Column D	Column E	Column F	**Column G****	Column H
Provider Name	Provider Tax Id	Number of members being served by provider other than live-in	Total # of Service Units for EVV Mandated Services (Where Claim Status = Paid)	Total # of Service Units for EVV Mandated Services with Matching EVV (Where Claim Status = Paid)	Total # of paid units for EVV mandated services w/ matching EVV without manual edits (Number of Units)	**% of Service Units for EVV Mandated services with Matching EVV (Column E/Column D)****	% of Service Units for EVV Mandated services with Matching EVV not edited manually (Column F/ Column D)
Provider A	123456799	24	500	250	100	**50%**	20%
Provider B	234567891	13	180	100	35	**56%**	19%
Provider C	323456789	4	80	24	20	**30%**	25%

**** Column G calculation indicates provider compliance**

F. Sample Compliance Calculation and Claims Payment

Member Last Name	Medicaid ID	Date of Service	Service Code	Units Billed	EVV Confirmed (Units)	Units Paid July 2021
Doe	123456789	**7/2/21**	**T1019**	**8**	**8**	**8**
Doe	123456789	**7/2/21**	**S5130**	**12**	**8**	**8**
Doe	123456789	**7/4/21**	**T1019**	**16**	**8**	**8**
Doe	123456789	**7/4/21**	**S5130**	**8**	**8**	**8**
Doe	123456789	**7/5/21**	**S5130**	**16**	**16**	**16**
Smith	912345678	**7/4/21**	**T1019**	**12**	**12**	**12**
Smith	912345678	**7/9/21**	**T1019**	**8**	**8**	**8**

Numerator	**68**
Denominator	**80**
Compliance	**85%**

In this scenario, only 85% of their units would be paid.
68 Units were confirmed /supported by EVV.

G. Authorization Process

1. Are authorizations required for services that require EVV?

DMAHS/MCOs provide authorizations based on Members care plan. The authorization will outline applicable service codes. Providers must work directly with the individual payer to secure authorizations, (i.e. FFS/MCOs.)

2. Whom does the Provider contact if an authorization has been received but member is not displayed in the HHAX portal?

Payer specific process to be followed. (DMAHS Fee for Service process will be outlined in a specific FFS Authorization and Billing Newsletter.)

Aetna: For both ABHNJ Medicaid and Aetna Assure Premier Plus (HMO D-SNP), please send questions to the Aetna Dedicated Email Mailbox AetnaEVVCompliance@AETNA.com

You may also call:

Aetna Better Health of NJ Medicaid Care Management team at 1-855-232-3596

Aetna Assure Premier Plus (HMO-DSNP) Care Management team at 1-844-362-0934

Amerigroup: Amerigroup does not provide HHAX with authorization information, Provider Tax ID, NPI, Payer ID, Service Code, Patient ID, Start and end date and units authorized. HHAX has indicated that the provider has to enter the authorization data. Currently we have been instructing providers to reach out to HHAX if there are questions on how to enter authorizations into the system. If the provider does not see their Provider information, they can reach out to Amerigroup to assist.

Horizon: To check status of Prior Authorization and/or changes to the Prior Authorization, go to https://www.horizonnjhealth.com/for-providers and sign into Navinet. Provider must enter Prior Authorization information manually into their EVV software solution.

United: Authorizations take up to 72 hours to load in HHAX. If not loaded in HHAx after this time the provider should outreach their assigned Advocate. If the provider does not know who the Advocate is please outreach to the general UHC contacts. Providers can also communicate using the HHAX communication tool regarding the display of an approved Prior Authorization.

Fidelis Care formerly WellCare: Providers should email ***njevv@centene.com*** and remember to include Prior Authorization number and member name.
For PCA, Respite and PDN please fax requests to 855-642-6185.
For ST/OT/PT please contact NIA (National Imaging Associates); NIA is the Fidelis Care in-network vendor that handles Physical, Occupational, and Speech Therapy. https://www1.radmd.com/solutions.aspx

3. **Are the Payers sending only confirmed authorizations to HHAX? What about Pending? If pending, do you then send confirmed authorizations at a later date?**

   Aetna: Confirmed authorizations are sent to HHAX, pending are not sent.

   Amerigroup: Sends confirmed authorizations only to CareBridge.

   Horizon: Providers must load authorization information manually into their own software solution. For Horizon, authorizations are not sent to HHAX.

   UHC: Confirmed authorizations are sent to HHAX, pending are not sent.

   Fidelis Care formerly WellCare: Confirmed authorizations are sent to HHAX, pending are not sent.

4. **Will Dual eligible member authorization details be displayed in HHAX?**

   Dual eligible members authorization detail will be displayed in HHAX if the provider is servicing the member for services that Medicaid requires EVV. If the member is solely receiving Medicare covered services from the provider at the current time, then the member will not be populated in the HHAX portal, as the payers are only sending members with authorized Medicaid services requiring EVV.

5. **Will Dual eligible members be displayed in CareBridge if Amerigroup is the payer?**

   Amerigroup members will be displayed in the provider portal when Amerigroup issues an authorization.
   Horizon members should be manually entered in CareBridge.

6. **Will service information for members who do not receive an authorization from NJ FamilyCare/Medicaid be aggregated to HHAX?**

   EVV data for services that are not authorized by NJ FamilyCare/Medicaid will not be aggregated by HHAX. However, MCO contracted providers are required to capture EVV data for MLTSS members and provide visit detail to MCO EQRO or DMAHS as needed.

H. Billing

1. **Why are there different billing processes for the MCOs?**
   Each MCO identified billing procedures for EVV individually based on the MCOs vendors and individual business process.

2. **Is there a way to test the billing for patients with Horizon NJ Health? They are not having us bill through HHAeXchange so we're not sure how to "test"?**
   Horizon does not use Carebridge or HHAX to bill EVV claims. The billing process to submit claims to Horizon does not change. Providers will continue to bill Horizon directly. There is no need to test claim submission with Carebridge or HHAX for Horizon members.

3. **What process does the Provider follow to report members Coordination of Benefits (COB) information?**
   EVV does not change policy requirements for COB. All providers should refer to the existing DMAHS Guidance regarding COB. https://www.state.nj.us/humanservices/dmahs/home/Coordination_of_Benefits_Guidance.pdf
   The individual payers may modify process for submission of TPL exhaustion of benefits information for services that billed through the EVV Vendor.
   Refer to the individual MCO training that outlines authorization and billing process for EVV services. The individual payers include the process to report COB in the training documents.

4. **Are the EVV and Billing data from HHAX being sent to Carebridge for Amerigroup?**
   - If a provider is using any vendor other than Carebridge or HHAX and servicing members for Amerigroup and Horizon, they should integrate directly with Carebridge for these two payers. The direct integration will eliminate rejections and/or complications for the provider.
   - If the provider is using HHAX as their EVV vendor directly then HHAX will send the visits and billing segment to Carebridge for the provider.
   - HHAX will send their visits and billing to Carebridge for Amerigroup.

5. **Are the EVV and Billing data from HHAX being sent to Carebridge for Horizon members?**

   EVV data is sent from HHAX to CareBridge and subsequently to Horizon.
   Billing data is not transferred because CareBridge or HHAX does not generate bills for Horizon members.

   For Horizon providers, CareBridge will accept visit info directly from the third-party EVV solution, or from HHAX (Third-Party Solution HHA CareBridge). Regardless of how data is received, CareBridge, will aggregate the visit once it meets the necessary criteria for aggregation (free of alerts).

6. **What is the process for Hospital Based Providers billing on 837I (UB04) to bill for services that require EVV as place of service is not included?**
All providers must follow individual MCOS Provider Training. Each MCO will outline process required if the Provider bills using the UB04.

Aetna Better Health NJ (NJ FamilyCare) - All billing should go through HHAX.
Aetna Assure Premier Plus (HMO D-SNP)-Members enrolled in integrated Medicaid/Medicare-allows continued billing on UB04 directly to the plan. All Medicare primary services should be billed directly to the plan. Providers should keep in mind that the requirement to submit EVV scheduling and visit data in HHAX is required for all codes.

Amerigroup*:* Providers should enter billing the transaction directly into the EVV vendor portal (Carebridge) and then the EVV vendor transmits the claim data directly to AGP. Providers will no longer submit claims directly to AGP for EVV required services. The CareBridge billing system mirrors the required billing process for 837P. For TPL scenarios where AGP is secondary (not authorizing service), these claims would continue to come directly to AGP and do not require EVV for payment; hence no change to provider process.

Horizon: Providers will not bill on UB04 for EVV required services. The Provider must bill on the CMS1500 or 837P format.

United: UHC allows billing on UB04 directly to the plan. Providers are still required to submit EVV scheduling and visit data in HHAX for all EVV required services**.** Providers will be notified when HHAX has configured the UB04 billing functionality to allow UHC contracted providers to bill in HHAX using the UB04.

Fidelis Care formerly WellCare: Providers do not bill place of service on UB04. Place of service determined based on bill type and revenue code

I. Coding

Refer to Newsletters for service codes that require EVV when delivered in the member's home.

Refer to Medicaid Newsletter	Volume 31 Number 1-	Phase I Codes
	Volume 33 Number 12	Phase II Codes

J. Licensing\Certification

1. **Will nurses be able to use an out-of-state license after January 1, 2023?**
Nurses must utilize the appropriate license required by NJ's Board of Nursing.
2. **What type of license and certification requirements have to be included?**
DMAHS requires the license and/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 and licensing requirement is to ensure NJ FamilyCare members are receiving care from qualified providers.

The Provider certification and/or licensing applies to the following: Certified Home Health Aides (CHHA), Registered Nurses (RN), Licensed Practical Nurses (LPN), Physical Therapists (PT), Cognitive Therapists, Occupational Therapists (OT), and Speech Therapists (ST).

3. **How do Providers remove assigned codes from a caregiver previously entered in HHAX? For example, an individual with a LPN obtains a RN license.**

Caregiver information can be updated directly in HHAX in the caregivers profile. If you are using a 3rd party EVV vendor please send these updates to HHAX. For any assistance or help making this update please reach out to njsupport@hhaexchange.com or enter a ticket via the Provider Support Portal**.**

K. Operations

1. **What is the required Shift Variance?**

All EVV tools must allow for **a minimum** of 10 minute scheduling variance that does not require manual override for EVV submission

2. Do the EVV vendor have to allow for **overlap of services**?

Home health services shall overlap to allow clinical staff to discuss member care during a shift change.
Note: If a members requires multiple staff at the same time this must be reflected in the member Plan of Care and authorized by MCOs

Below is a list of services that overlap shall be permitted:

Nursing Service codes below allow for overlap*:

S9123	Nursing care, in the home; by registered nurse,	Per hour	POS 12
S9124	Nursing care, in the home; by licensed practical nurse	Per hour	POS 12
T1000	Private duty / independent nursing service(s)	15 minutes	POS 12
T1002	Private duty / independent nursing service(s) / RN	15 minutes	POS 12
T1003	LPN/LVN SERVICES	15 minutes	POS 12
T1030	Nursing care, in the home, by registered nurse	Per diem	POS 12
T1031	Nursing care, in the home, by licensed practical nurse	Per diem	POS 12
G0299	Direct skilled nursing services (RN) in the home health or hospice setting	15 minutes	POS 12
G0300	Direct skilled nursing services LPN in the home health or hospice setting	15 minutes	POS 12

Home Health service codes below allow for overlap*:			
S9127	Social Work Visit in the home	Per diem	POS 12
S9128	Speech Therapy in the home	Per diem	POS 12
S9129	Occupational Therapy in the home	Per diem	POS 12
S9131	Physical Therapy; in the home	Per diem	POS 12
S9127	Social Work Visit in the home	Per diem	POS 12
S9128	Speech Therapy in the home	Per diem	POS 12
S9129	Occupational Therapy in the home	Per diem	POS 12
S9131	Physical Therapy; in the home	Per diem	POS 12

* A Prior Authorization is required for all services

3. **EPSDT services for school day: Are nurses serving EPSDT members required to clock in and out when they arrive at the school with the member and are not being paid by the Managed Care Organization?**

   Caregivers are not required to clock in an out multiple times during the school day. A reason code is included in the EVV specifications for EPSDT/PDN services during the school day. Caregivers will clock in at start of day and at the end of the day and the reason code "**223- EPSDT PDN During the School Day**" will be selected to indicate that billing does not tie directly to clock in and clock out due to the combination of Department of Education and MCO billing.

4. **Will DMAHS require all MCOs to contract using T codes for all nursing services?**

   The State has not mandated that the MCOs contract for nursing services only with the T codes. The individual MCOs will establish Provider contracts and authorizations for services independently.

5. **Will the rounding rules be updated for PDN?**

   Rounding rules for PCA, Home Health and PDN are outlined in the June 2023 Newsletter **Volume 33 Number 11: Updated Billing Policy for Home Health Care and Personal Care Services.**

   MCOS are required to implement rounding rules when paying claims. Clock in-clock out is required to correspond with 15 minute and hourly unit rules.

6. **Does EVV provide required documentation for clinical audits?**
   EVV will only provide caregiver visit information; providers must also maintain clinical service detail for individual members.

7. **What is the allowed tolerance range from member's address?**

   The standard allowable tolerance range is the distance, measured in feet, between the member's servicing address and the provider's clock in location. HHAX and all EDI vendors must enforce a 300-foot tolerance range.

If the caregiver is not within 300 feet of the members servicing location, the visit must be manually confirmed and an applicable exception code noted in the EVV record. The implementation date for 300-foot tolerance range is October 1, 2023.

L. HHAX Specific Functionality

1. **When HHAX completes an update to NJ Medicaid EVV Data Aggregator Specifications how are EDI providers notified?**
   System notifications are published when HHAX completes a system update. The notifications are published for all providers to review on the HHAX portal under the system notifications. These appear as an automatic pop-up upon log-in for all users at a provider location. Providers who are using a 3rd Party EDI vendor must communicate the updates with their specific EVV vendor.

2. **How are Providers notified if there are updates to the HHAX system that are not included in the Aggregator Specification?**
   System updates are done in monthly releases. Updates are published in a system notification in the HHAX portal for all providers to review. These appear as an automatic pop-up upon log in for all users. Providers can also find all past system updates in their HHAX portal within the support center, under Release Notes.

3. **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. The only option in the "absence/restriction" button, is for the nurse to call out for the entire day. If Provider goes into the calendar section and just "temp" the visit, then the call out is not recorded for the caregiver.**
   This is HHAX Paid Provider Portal Functionality. The provider will need to reach out to a Provider CSM Contact at HHAX to address this concern

4. **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.**
   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

5. **Providers may need an "other agency" option for scheduling purposes. There is not a way to schedule blocks with shared agencies, therefore agencies that are sharing services have no idea what shifts the other agency is covering on a co-vended case.**
   The HHAX system is set up by Provider and information for all MCOs is maintained. There is no way to link two provider portals together to share member and scheduling information.

M. Resources for Providers by MCO

Aetna Better Health of NJ (Medicaid) and Aetna Assure Premier Plus (HMO-DSNP)

Electronic Visit Verification

For EVV general inquiries providers should use the dedicated email box AetnaEVVCompliance@aetna.com

EVV Program Managers & Escalated Issues:

- Aetna Better Health of NJ (Medicaid) – Tahnee Garay, Director of Regulatory Affairs, garayt@aetna.com
- Aetna Assure Premier Plus (HMO-DSNP) – Eric Bowman, Senior Business Consultant, BowmanE@AETNA.com

Prior Authorizations To confirm the status of a prior authorization request:

- Aetna Better Health of NJ (Medicaid) - Please call 1-855-232-3596
- Aetna Assure Premier Plus (HMO-DSNP) - Please call 1-844-362-0934 **OR** Email box NJFIDE-EVV@AETNA.com

Claims: Providers may check the status of a claim by accessing the provider portal.

Aetna Better Health of NJ (Medicaid)

- Claims Inquiry Claims Research (CICR) please call 1-855-232-3596
- https://www.aetnabetterhealth.com/newjersey/providers/index.html

Aetna Assure Premier Plus (HMO-DSNP)

- Claims Inquiry Claims Research (CICR) please call 1-844-362-0934
- https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html

Contact information for EVV Aggregator Technical Support and Questions:

Providers should use HHAeXchange Contacts for technical issues:

- NJ Client Support Phone Number: (866) 245-8337
- NJ Client Support Email Mailbox: NJSupport@hhaexchange.com
- Providers Using a Third Party EVV Vendor: EDIsupport@hhaexchange.com

Amerigroup

EVV Lead :	Lynelle Steele	Fannie.steele@amerigroup.com
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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

Horizon NJ Health

Electronic Visit Verification

Authorization Telephone Numbers:

- Medicaid #1-800-682-9094
- FIDE SNP #1-855-955-5656
- MLTSS #1-855-777-0123

CareBridge Technical Support:

- CareBridge Users: 855-782-5976 njevv@carebridgehealth.com
- Third-Party EVV Solutions Integrated with CareBridge: 844-924-1755 evvintegrationsupport@carebridgehealth.com

Horizon New Jersey Health Billing Questions:
Horizon NJ Health Provider Services Team: 1-800-682-9094

Amerigroup

EVV Lead :	Lynelle Steele	Fannie.steele@amerigroup.com
Authorizations:	Keisha Woodson	keisha.woodson@amerigroup.com
Operations:	Eyreny Mekhaiel	eyreny.mekhaiel@amerigroup.com

MLTSS Authorizations:
Keisha.Woodson@Amerigroup.com
Phone: 1-855-661-1996, option 2

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
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suzanne.veit@amerigroup.com

Horizon NJ Health

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Horizon New Jersey Health Billing Questions:
Horizon NJ Health Provider Services Team: 1-800-682-9094

Please visit the DMAHS EVV Website for additional information: https://www.nj.gov/humanservices/dmahs/info/evv.html.

To submit questions or concerns about regarding EVV , please email the New Jersey Provider Resource account at Mahs.provider-inquiries@dhs.nj.gov

For HHAeXchange provider information, please visit the New Jersey Home Health Information Center website at: https://hhaexchange.com/nj-home-health/

RETAIN NEWSLETTER FOR FUTURE REFERENCE

PRIOR AUTHORIZATION PROCESS

Prior Authorization Process

- **Provider Responsibility**:
  - 100% EVV compliance
  - Submit **PRIOR AUTHORIZATION** request with required clinical notes, script, etc. as needed to establish Medical Necessity.
  - Inform/communicate to Fidelis Care/Wellcare of any gaps in service, critical Incidents, need for placing members on hold based on inpatient admission, vacation or members declining/refusing or no longer getting services for any other reason.
  - Check HHAeXchange portal for updates in authorizations, units, effective dates and member eligibility.

Prior Authorization – Nursing & PCA

Fax **Prior Authorization Request form** to the appropriate queue**:**

- 855-573-2346 for NJ Medicaid and FIDE MLTSS members.
- 866-886-4321 for NJ Medicaid - Non MLTSS members.
- 855-538-0454 or provider portal: Medicaid (fideliscarenj.com) for FIDE Non MLTSS members

Please make sure you are faxing the appropriate fax line to avoid any delays

What to do if you do not see an Authorization in HHA:

Please reach contact us at 855-642-6185 or email us at **njevv@centene.com.**

Authorizations are not created in HHA; They are created in our Medical Management system and sent to HHA.

URGENT REQUESTS:

For PCA, Respite and Private Duty Nursing please call 855-642-6185, Email us at **njevv@centene.com** or contact us via HHA Notification. Fidelis will prioritize all urgent requests within 24 hours of receipt. *Please indicate on subject line that request is urgent.*

For therapy codes: Please call 1-866-249-1583

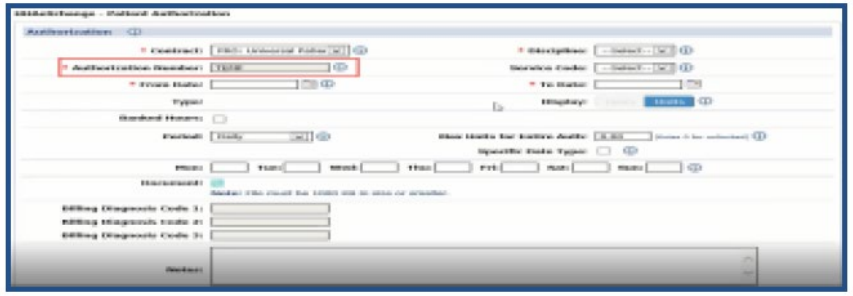
Prior Authorization – Nursing & PCA

- **a. <u>Favorable determination- Approval/Partial Approvals</u>**:
  - UM review to establish clinical/medical criteria is met
  - Confirmation Fax sent to provider upon determination
  - WC monitors expirations and reauthorizes prior to expirations as needed
  - WC monitors provider compliance at member level & utilization trends
- **b. <u>Unfavorable determinations: Denial/partial denial</u>**
  - - Provider will receive fax notification, phone call &/or letter with final determination
  - - Member have a right to Appeal, information will be provided
- **c. <u>Reauthorization requests</u>**:
  - ***Home Care & Therapies***: Providers can continue to fax reauthorization requests via fax prior to authorization expiring.
  - ***Private Duty Nursing (PDN):***
    - all members assigned a Care Manager
    - Face to face assessment is conducted prior to auth expiration
    - Provider can submit reauthorization request prior to authorization expiring & for change in condition as needed

Creating a TEMP Authorization

If a Payer does not send a timely authorization for a Patient, the Provider can create a TEMP Authorization. This enables the Provider to schedule visits and pay their Caregivers until the authorization is received from the Payer. An official Payer Authorization is required for billing; otherwise, the visits are stopped in Billing Review and cannot be billed.

To create a TEMP Authorization, navigate to ***Patient > Authorizations/Orders*** and click on the ***Add*** button to open the Patient Authorization window. Select the UPR Linked Contract from the **Contract** dropdown field. The **Authorization Number** field immediately auto-fills with *TEMP* (unavailable to edit), as seen on the image to the right.



Patient Authorization Created by Provider

Complete required fields (denoted with a red asterisk) and click ***Save*** to finalize. In this case, once the Payer sends the official authorization, then applicable visits can be updated, and billing can take place. The TEMP Authorization can be deleted.
When the placement is sent, accept the placement from the Payer (UPR Linked Contract). Then, merge the placement with the "Temporary" Patient record and manually change the Contract on the *Schedule* tab to the UPR Linked Contract.

Solutions for TEMP Patient and/or Authorizations

The following are examples and recommended resolutions to handle missing Patient and/or Authorization scenarios.

Continuation of Creating a TEMP Authorization...

Scenario	Recommended Steps
Brand New Placement with Authorization	Review and accept Pending Placement. A Patient Record with access to Internal and UPR Linked Contracts is created with an authorization.
Brand New Placement without Timely Authorization	1. Review the Pending Placement and accept. Once accepted, a new Patient record is created with access to both Internal and UPR Linked Contracts. 2. Create a TEMP Authorization. Refer to Creating a TEMP Authorization section. 3. Create and process visits as usual (from scheduling through payroll). ***Note:*** *Claims are held in Billing Review for TEMP Authorization.* **When the official Payer Authorization is received, two authorizations now exist for the Patient.** 1. Delete the TEMP Authorization. 2. Click on the Update link to recalculate. The recalculation process applies the Payer Authorization to the visits. Invoices are updated with the Payer Authorization number and claims can be processed.
No Timely Placement or Authorization	1. Create a new Patient record. 2. Assign an existing UPR Linked Contract to the Patient record. 3. Create a TEMP Authorization. Refer to Creating a TEMP Authorization section. 4. Create and process visits as usual (from scheduling through payroll). ***Note:*** *Claims are held in Billing Review for TEMP Authorization.* **When the official Payer Placement and Authorization are received.** ▪ **Issue: The contract for the Payer Placement has overlapping Start of Care dates with the contract for the newly created Patient Record.** ▪ **Resolution:** Adjust the overlapping dates, as follows: 1. Compare the dates on the contracts for the 2 Patient records. 2. Change the **Start of Care** date and **Discharge** date on both Contracts so that no overlap occurs. Contracts must have different period of care (date ranges). 3. Merge the records. 4. Click the Update link on the Authorization page. The Payer Authorization is applied to all services once the nightly process completes.

NIA aka National Imaging Associates

NIA (National Imaging Associates) is our in-network vendor that handles **Physical, Occupational, and Speech Therapy.** https://www1.radmd.com/solutions.aspx

Providers can Contact NIA for all authorization-related submissions for the services listed above rendered in outpatient places of service (including the home setting*). Web submissions are faster and if the procedure requested meets clinical criteria, the web provides an immediate approval that can be printed for easy reference. Member eligibility and authorization requests may be submitted via the **NIA Provider Web Portal**. A searchable **Authorization Lookup** tool is also available online and criteria can be accessed through links provided on this slide. https://www1.radmd.com/radmd-home.aspx

- Urgent Authorization and Provider Services: 1-866-249-1583

NIA's current process **does not** change. NIA's program is not a CPT based program. Within the 278 (Authorization File) feed to Fidelis Care/Wellcare, NIA is sending generic approvals for PT under 97116, OT under 97533, and ST under 92507. Once the authorization is accepted in Fidelis Care/Wellcare; we allow the provider to bill CPTS codes allowed under the PT, OT, ST structure (Provided below) and visits are then deducted from our system based on what was on the approved authorization.

*****Authorizations are provided in number of visits, not units and HHA authorization reflects the number of total authorized visits regardless of which CPT codes that are billed*****

Physical Therapy

S9131 is a stand-alone code, it is not part of the bundle.

Effective October 19, 2023 - NIA will be able to mirror the codes as requested:

- **If a Home Health Provider request S9131; NIA will send the code requested in the authorization.**

Standard CPT code NIA sends through our 278 (Authorization File) feed for approved Physical Therapy:

Procedure Code: 97116
Only for Place of Service: 12 (HOME)

Contract Code	Category
97110	Physical /Occupational
97129	Passive/Physical/Occupational
97130	Passive/Physical/Occupational
G0151	Physical Therapy

Providers will receive the authorization via HHA with CPT Code: 97116 however they will be able to bill with the state mandated CPT code under the bundle codes identified on this slide for Physical Therapy.

Occupational Therapy

S9129 is a stand-alone code, it is not part of the bundle.
Effective October 19, 2023 - NIA will be able to mirror the codes as requested:

- **If a Home Health Provider request S9129; NIA will send the code requested in the authorization.**

Standard CPT code NIA sends through our 278 feed (Authorization File) for approved Physical Therapy:

Procedure Code: 97533
Only for Place of Service: 12 (HOME)

Contract Code	Category
97110	Physical /Occupational
97129	Passive/Physical/Occupational
97130	Passive/Physical/Occupational
97535	Physical/Occupational/Speech
G0152	Occupational Therapy

Providers will receive the authorization via HHA with CPT Code: 97533 however they will be able to bill with anyone of the bundle codes identified on this slide for Occupational Therapy based on the service provided.

Speech Therapy

**S9128 is a stand-alone code, it is not part of the bundle.

Effective October 19, 2023 - NIA will be able to mirror the codes as requested:

- **If a Home Health Provider request S9128; NIA will send the code requested in the authorization.**

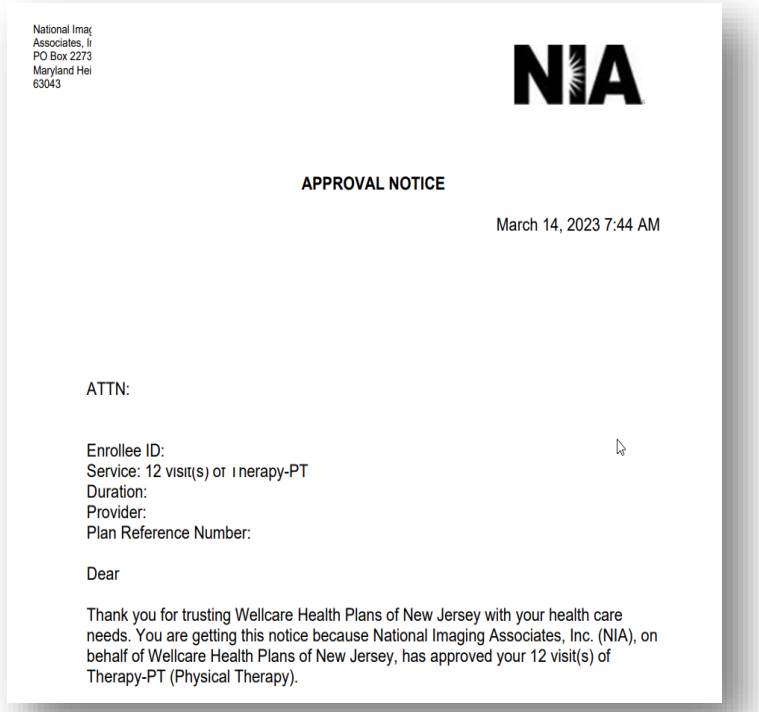
Standard CPT code NIA sends through our 278 feed (Authorization File) for approved Physical Therapy:

Procedure Code: 92507
Only for Place of Service: 12 (HOME)

Contract Code	Category
92507	Speech Therapy
97535	Physical/Occupational/Speech
G0153	Speech Therapy

Providers will receive the authorization via HHA with CPT Code: 92507 however they will be able to bill with anyone of the bundle codes identified on this slide for Speech Therapy based on the service provided.

Sample Approval Notice Sent by NIA to Providers



National Imag
Associates, I
PO Box 2273
Maryland Hei
63043

NIA

APPROVAL NOTICE

March 14, 2023 7:44 AM

ATTN:

Enrollee ID:
Service: 12 visit(s) of Therapy-PT
Duration:
Provider:
Plan Reference Number:

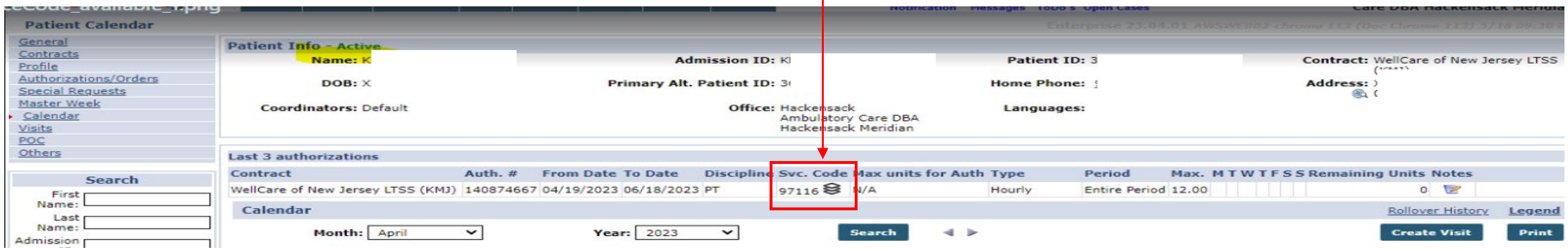
Dear

Thank you for trusting Wellcare Health Plans of New Jersey with your health care needs. You are getting this notice because National Imaging Associates, Inc. (NIA), on behalf of Wellcare Health Plans of New Jersey, has approved your 12 visit(s) of Therapy-PT (Physical Therapy).

Authorizations received in HHA are tied to a Fidelis/Wellcare Auth #

Sample authorization in HHA.

Click the paper stack near the Serv. Code to view codes available for selection under the bundle codes



Evaluation Codes:

- The Evaluation Procedure codes are not part of the Newsletter/State Mandate.

- If there is no PT/OT/ST authorization on file in HHA, Providers can bill Fidelis/Wellcare directly for their evaluation.

Retroactive Authorization Policy

- Fidelis Care/Wellcare will only provide retroactive authorization for services if Medical Necessity is met, when relevant information is submitted and after Medical Director Review:
  - ***Home Care - maximum of 5 days from initial visit***
  - ***Therapies in the home - maximum of 2 days from initial visit***

- Providers will be able to schedule caregivers through the HHAeXchange portal either by creating schedules based on the authorization provided by the payer, or through automatic creation of schedules based on EVV data imported into the HHAeXchange portal from your 3rd party EVV system.

- Temporary schedule pending authorization is available via HHAeXchange portal, however it is not a guarantee of approval or payment of services until Utilization Management processes the request for services.

Continuity and Transition of Care

- ***When a member transfers from one MCO to another, authorization for services at the same level member was receiving prior to transfer will be granted.***

  - Provider needs to submit prior authorization request via fax with copy of authorization from previous MCO

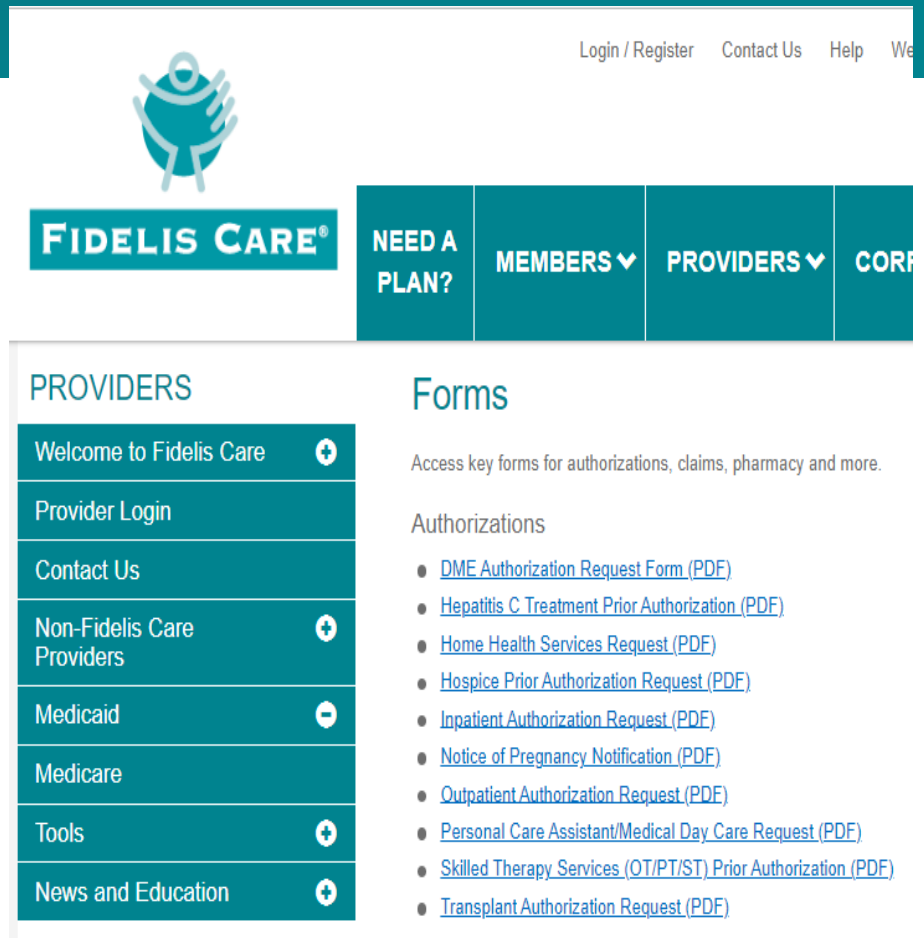
  - If needed a new assessment will be performed to determine current eligibility for the service

PROVIDER RESOURCES:

Forms (fideliscarenj.com)(Click on the link)

For questions or help with HHAX, please email HHAeXchange at **NJSupport@HHAeXchange.com** or visit us at **hhaexchange.com/nj-home-health.**

Care Management Referrals (non-MLTSS members)	MLTSS Care Management
1-844-901-3781 TTY: 711	1-855-642-6185 Hours: M-F 8-6 p.m. Eastern F:1-855-573-2346
1-866-287-3286 Hours: M-F 8-7 p.m. Eastern	



FOB Request Process

For providers/members with need of a different way /method of reporting, tracking visits, there is an opportunity/solution with the use of a FOB device.

Process for FOB request:

1. Providers should request via the HHAX Portal or telephonically to Fidelis Care/Wellcare. Provider Relations Rep discusses request with provider to confirm that this is the last resort, and other methods should be used if possible.
2. Network Management will confirm with Care Management/Utilization Management teams that criteria is met and coordinate delivery with HHAeXchange to the provider.
3. CM/UM- will confirm with member/caregiver that installation and use of FOB is appropriate and meeting member's needs.
4. Provider is responsible for installation at member's home and utilization for visit verification.
5. CM/UM team will confirm FOB installation upon outreach to member and document as needed as well as confirmed use through HHAeXchange verified visits.

Appropriate Reasons for an FOB include, but not limited to:

- Member lives in a rural area with poor cell communications
- Member has no landline

Tolerance Range

What is the allowed tolerance range from member's address?

The standard allowable tolerance range is the distance, measured in feet, between the member's servicing address and the provider's clock in location. HHAX and all EDI vendors must enforce a 300-foot tolerance range.

If the caregiver is not within 300 feet of the members servicing location, the visit must be manually confirmed, and an applicable exception code noted in the EVV record.

The implementation date for 300-foot tolerance range is October 1, 2023.

Reference: DMAHS Newsletter 33-14 & 33-12

Manual Edits:

Occasionally, manual edits are needed to update or correct a record. A manually entered visit is defined as one where there is no electronic check-in and check-out, and the visit information is typed in manually. While sometimes necessary, manually entered visits do not meet CMS requirements for an EVV visit and should be a rare occurrence.

- Caregivers should always be using EVV to capture home care service visit. In those few instances where the caregiver is unable to use EVV, a manual entry is allowed. Manual Edits will not cause a claim denial. Manual edits should be kept to a **minimum**.
- EVV visits should only be edited if the information is incorrect. For example, a manual edit would be necessary if a worker was actively providing services but was unable to clock in or out, due to technical difficulties, an emergency etc.
- The expectation is that all Providers are 85% compliant with EVV. The plan will run monthly exception report to monitor trends with manual edits. Communication will be sent via email to Providers. Failure to comply with EVV compliance will result in “non-payment of the visit”

Licensing\Certification

1. Will nurses be able to use an out-of-state license after January 1, 2023?

Nurses must utilize the appropriate license required by NJ's Board of Nursing.

2. What type of license and certification requirements have to be included?

DMAHS requires the license and/or certification number information in the EVV aggregation system for rendering service providers of Personal Care Services (PCS) 12 and Home Health Care Services (HHCS). The certification and licensing requirement is to ensure NJ FamilyCare members are receiving care from qualified providers.

The Provider certification and/or licensing applies to the following: Certified Home Health Aides (CHHA), Registered Nurses (RN), Licensed Practical Nurses (LPN), Physical Therapists (PT), Cognitive Therapists, Occupational Therapists (OT), and Speech Therapists (ST).

The plan will run monthly Caregiver report and send Communication via email to Providers with missing Caregiver license.

Reference: DMAHS Newsletter 33-14 & 33-12

CLAIMS/BILLING

Phase II of the EVV implementation includes services which may be covered by Medicare as primary

HHAX EVV System Standard Billing Process for:
UB04- Providers billing UB04 can continue to do so until further notice.

NJ Family Care Medicaid Members (non-dual eligible, non-MLTSS)- Providers will use the HHAX system and follow the standard direct billing process.

- Liberty HMO Dual FIDE SNP Members
- FIDE claims are paid within the WellCare Medicare System. Medicare is paid as primary, and the secondary claim is spawned for payment automatically. Providers should use the HHAX system and follow the standard direct billing process. There is no need to send separate claims for Medicare and Medicaid.

Dual Eligible Members-

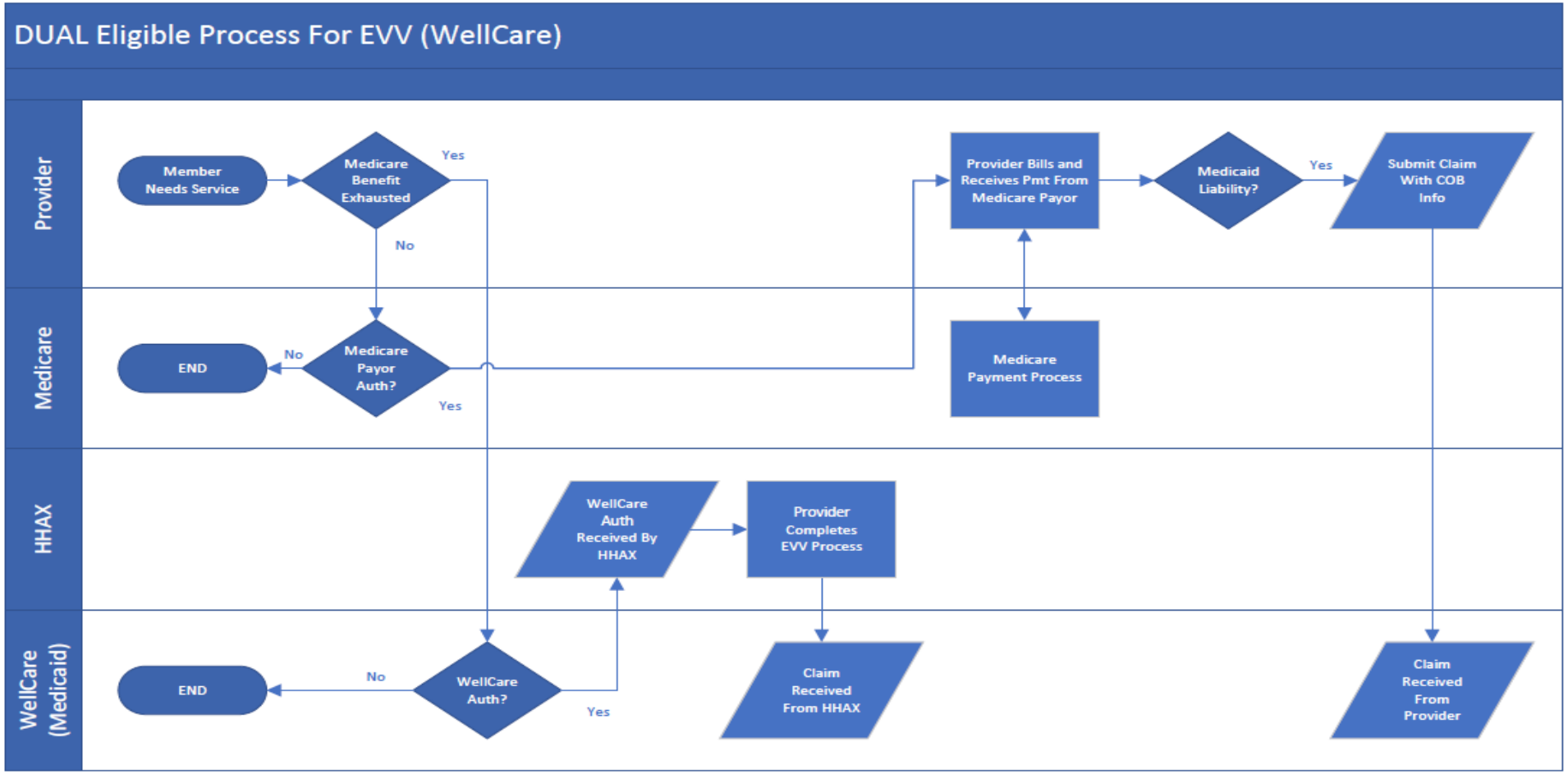
- For non-MLTSS NJFC dual eligible members the provider should first determine if the Medicare benefit is still available or has been exhausted. If the Medicare benefit is still available, the provider should obtain authorization from and bill the primary payor. Once primary payment info is received the provider can then bill Fidelis Care/WellCare with the COB info for any Medicaid liability. If the Medicare benefit is exhausted Medicaid becomes the primary payor. The provider must contact Fidelis Care/WellCare for authorization then utilize the HHAX system for scheduling, verifying and billing.

Medicaid Members -

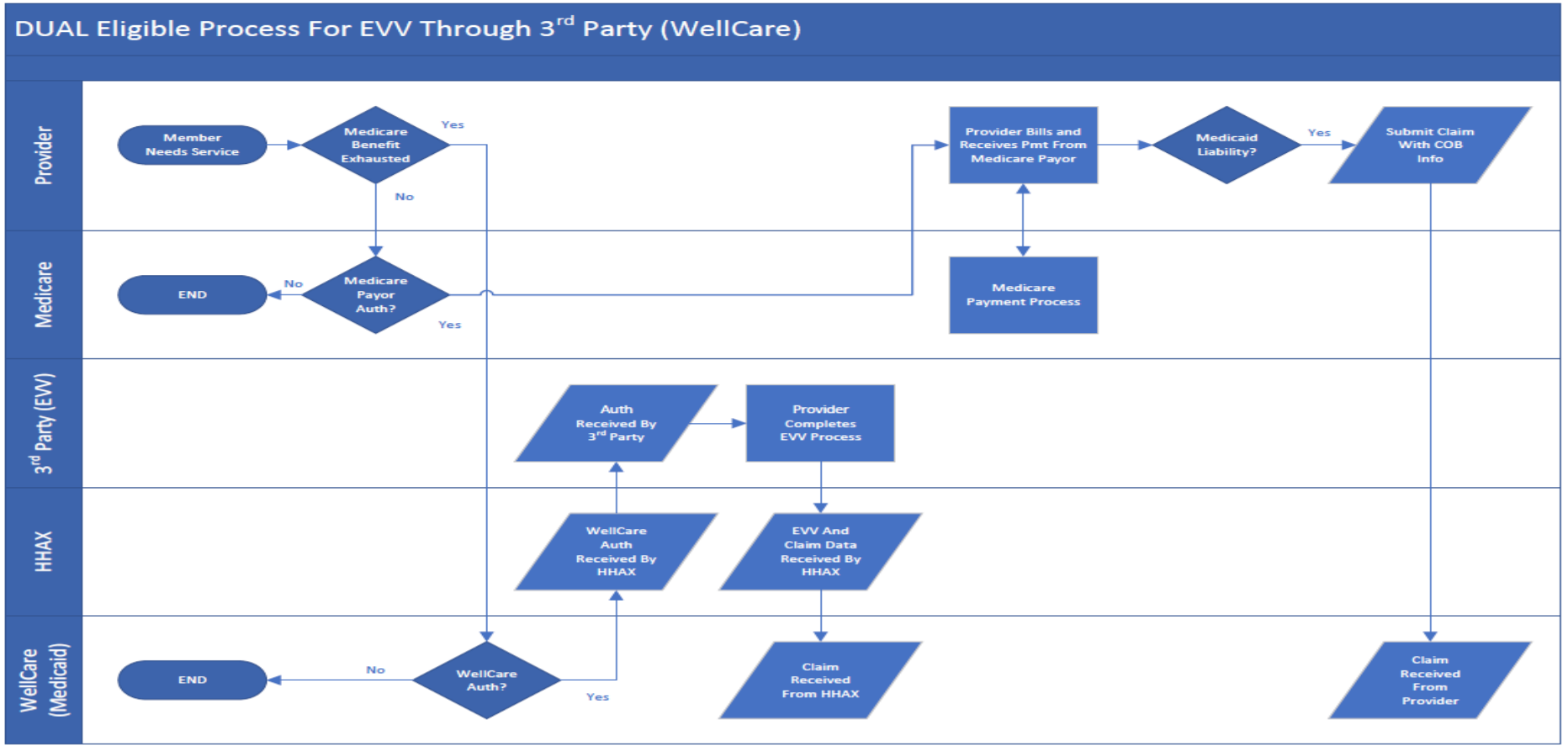
- MLTSS Members- For those members in NJFC Medicaid (both MLTSS and non- MLTSS) who are not dual eligible the provider will use the HHAX system and follow the standard direct billing process.

DMAHS has mandated that all MLTSS members visit information be tracked by EVV. If the Medicare benefit is still available, Provider will obtain authorization from the primary payor. The provider will then need to go into the HHAX system and create a connection between the care-giver and the member so the visit can be scheduled and verified. Provider will follow the standard process of billing the primary payor. If the Medicare benefit is exhausted Medicaid becomes the primary payor. The provider must contact Fidelis Care/WellCare for authorization then utilize the HHAX system for scheduling, verifying and billing.

DUAL ELIGIBLE PROCESS FOR EVV (NON MLTSS)



DUAL ELIGIBLE PROCESS FOR EVV through 3rd Party

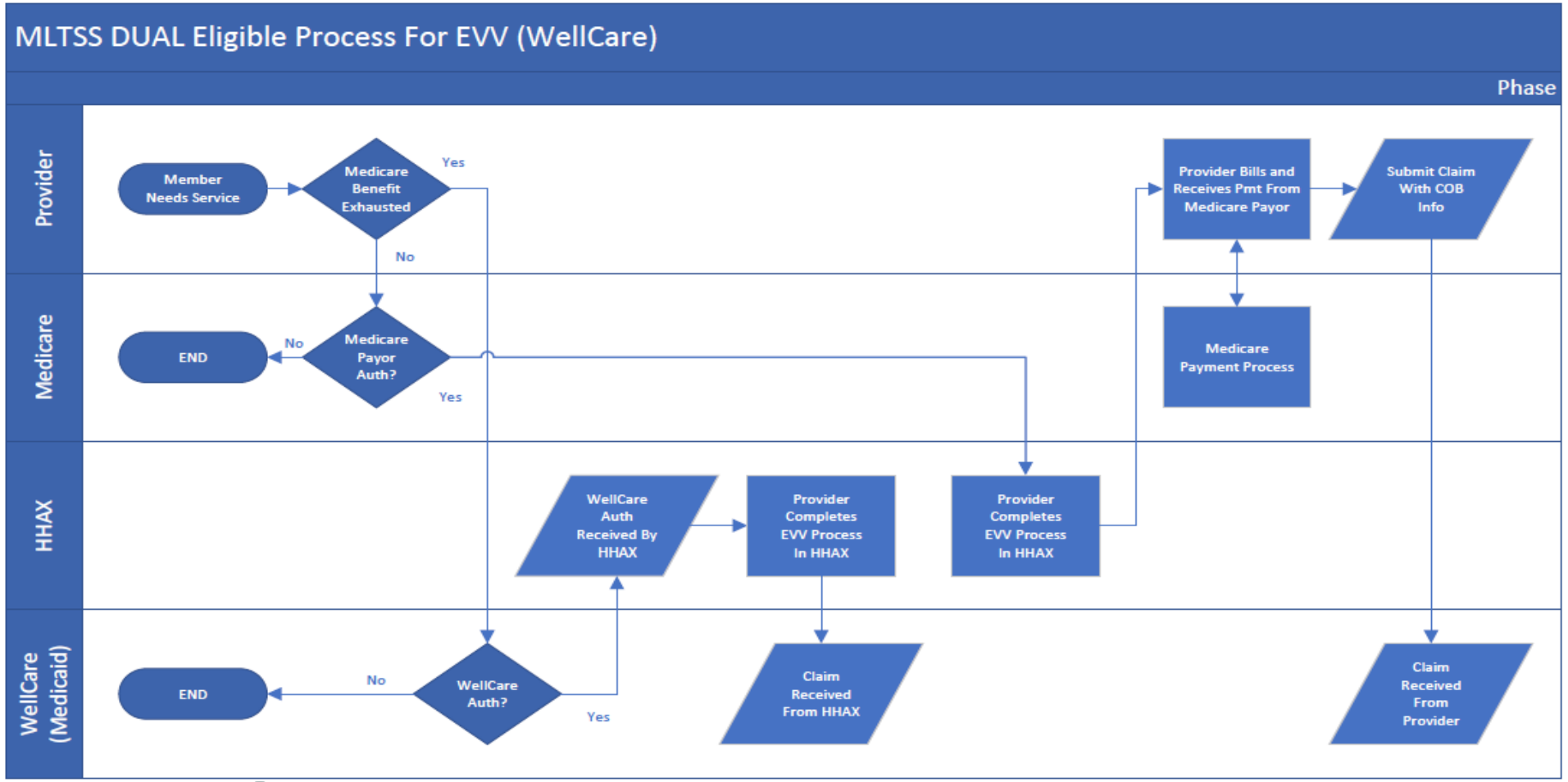


DUAL Eligible process for EVV (NON MLTSS)

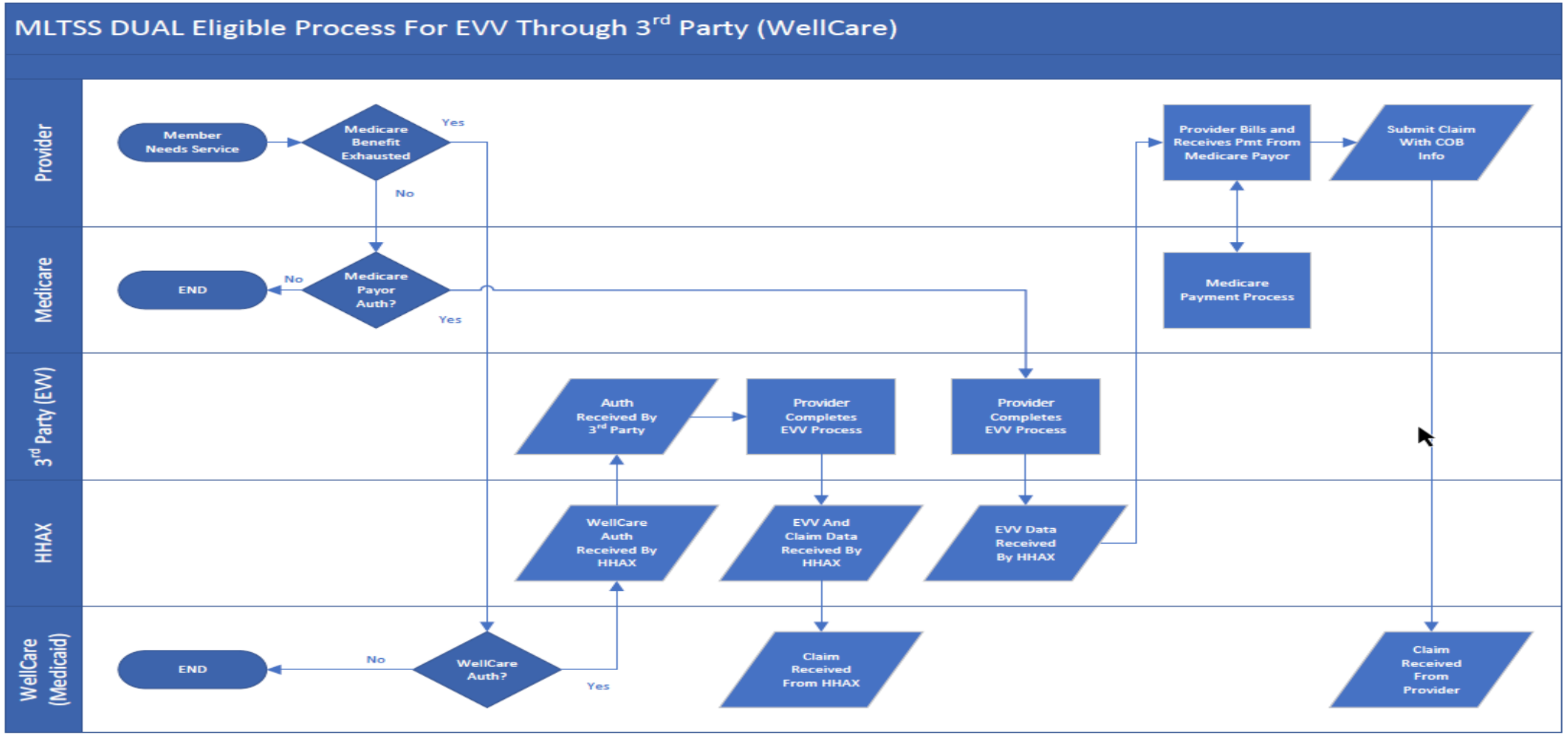
- For non-MLTSS NJFC dual eligible members the provider should first determine if the Medicare benefit is still available or has been exhausted. If the Medicare benefit is still available, the provider should obtain authorization from and bill the primary payor. Once primary payment info is received the provider can then bill Fidelis Care/WellCare with the COB info for any Medicaid liability.

- If the Medicare benefit is exhausted Medicaid becomes the primary payor. The provider must contact Fidelis Care/WellCare for authorization then utilize the HHAX system for scheduling, verifying and billing.

MLTSS DUAL ELIGIBLE PROCESS FOR EVV



MLTSS DUAL ELIGIBLE PROCESS FOR EVV through 3rd Party



MLTSS DUAL Eligible Process for EVV (FidelisCare/WellCare)

- DMAHS has mandated that all MLTSS members visit information be tracked by EVV. If the Medicare benefit is still available, Provider will obtain authorization from the primary payor. The provider will then need to go into the HHAX system and create a connection between the care-giver and the member so the visit can be scheduled and verified. Provider will follow the standard process of billing the primary payor.

- If the Medicare benefit is exhausted Medicaid becomes the primary payor. The provider must contact Fidelis Care/WellCare for authorization then utilize the HHAX system for scheduling, verifying and billing.

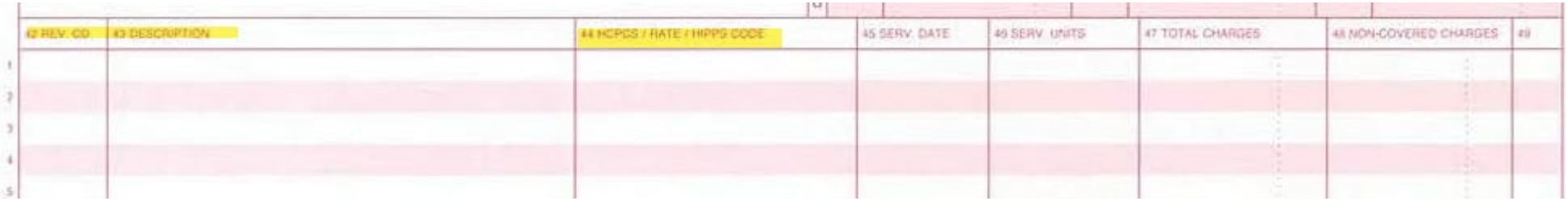
Billing for Coordination of Benefit for Services may be covered by Medicare or Commercial Insurance

Please be advised that pursuant to Federal and NJ State status and consistent with our contractual obligations, health care providers and their representatives are prohibited from attempting to collect payment from Fidelis Care/WellCare Subscribers for covered services, unless it is the member's co-payment, deductible, or Co-Insurance.

- All COB claims must bill with primary insurance EOP or Certification of Coverage from Primary Insurance.
- Provider can bill Fidelis Care/Wellcare of New Jersey directly for members who have TPL with EOP or Certificate of Coverage from Primary Insurance.

Claims Billing Form

- Fidelis Care/WellCare accept UB04 claim from CMS Certified Home Health Care providers.
  - Recommend HCPCs code included on the UB04 (authorized code)



- Fidelis Care/WellCare strongly recommend CMS 1500 claim form for authorized CPT/HCPCs (services).

CMS Mandate EVV - Provider Training Calendar

Fidelis/Wellcare will be hosting a series of provider training/seminars via zoom.

The next slide will contain information on the upcoming trainings.

Note: Should there be any calendar changes, we will notify providers via email. Any questions, please e-mail us at njevv@centene.com or NJPR@fideliscarenj.com.

Date	Topic	Time	Call information
Tuesday June 25th, 2024	EVV Phase 2 Implementation	1:00 pm to 2:00 pm	Join by Telephone Dial: US: +1 646 931 3860 or +1 669 444 9171 Meeting ID: 959 7377 2719 Passcode: 042459 Meeting URL: https://centene.zoom.us/j/95973772719?pwd=K3VFcHM3V1BYSjZOaXlKcE9FN3BZZz09
Tuesday July 23rd, 2024	EVV Phase 2 Implementation	1:00 pm to 2:00 pm	Join by Telephone Dial: US: +1 646 931 3860 or +1 669 444 9171 Meeting ID: 959 7377 2719 Passcode: 042459 Meeting URL: https://centene.zoom.us/j/95973772719?pwd=K3VFcHM3V1BYSjZOaXlKcE9FN3BZZz09
Tuesdays August 27th,2024	EVV Phase 2 Implementation	1:00 pm to 2:00 pm	Join by Telephone Dial: US: +1 646 931 3860 or +1 669 444 9171 Meeting ID: 959 7377 2719 Passcode: 042459 Meeting URL: https://centene.zoom.us/j/95973772719?pwd=K3VFcHM3V1BYSjZOaXlKcE9FN3BZZz09
Tuesday, Sept 24th,2024	EVV Phase 2 Implementation	1:00 pm to 2:00 pm	Join by Telephone Dial: US: +1 646 931 3860 or +1 669 444 9171 Meeting ID: 959 7377 2719 Passcode: 042459 Meeting URL: https://centene.zoom.us/j/95973772719?pwd=K3VFcHM3V1BYSjZOaXlKcE9FN3BZZz09
Tuesday Oct 22nd, 2024	EVV Phase 2 Implementation	1:00 pm to 2:00 pm	Join by Telephone Dial: US: +1 646 931 3860 or +1 669 444 9171 Meeting ID: 959 7377 2719 Passcode: 042459 Meeting URL: https://centene.zoom.us/j/95973772719?pwd=K3VFcHM3V1BYSjZOaXlKcE9FN3BZZz09
Tuesday, Nov 26th,2024	EVV Phase 2 Implementation	1:00 pm to 2:00 pm	Join by Telephone Dial: US: +1 646 931 3860 or +1 669 444 9171 Meeting ID: 959 7377 2719 Passcode: 042459 Meeting URL: https://centene.zoom.us/j/95973772719?pwd=K3VFcHM3V1BYSjZOaXlKcE9FN3BZZz09

RESOURCES

Fidelis Care/Wellcare General email box for EVV: njevv@centene.com

Network team:

- Send an email inquiry to NJPR@fideliscarenj.com

Case Management/Utilization Management: Contact # 855-942-6185

Providers can contact the plan via HHA Notifications

Our EVV Aggregator: HHAeXchange

For questions or help with HHAX, please email HHAeXchange at **NJSupport@HHAeXchange.com** or visit us at **hhaexchange.com/nj-home-health.**

Thank you.
At this time, HHA will conduct their portion of the Training.

HHAeXchange

Fidelis Care/WellcareNJ Provider Training Session

Agenda

- About HHAeXchange
- Authorizations and Members in HHAeXchange
- Billing Requirements
- Provider Resources
- Contact Information

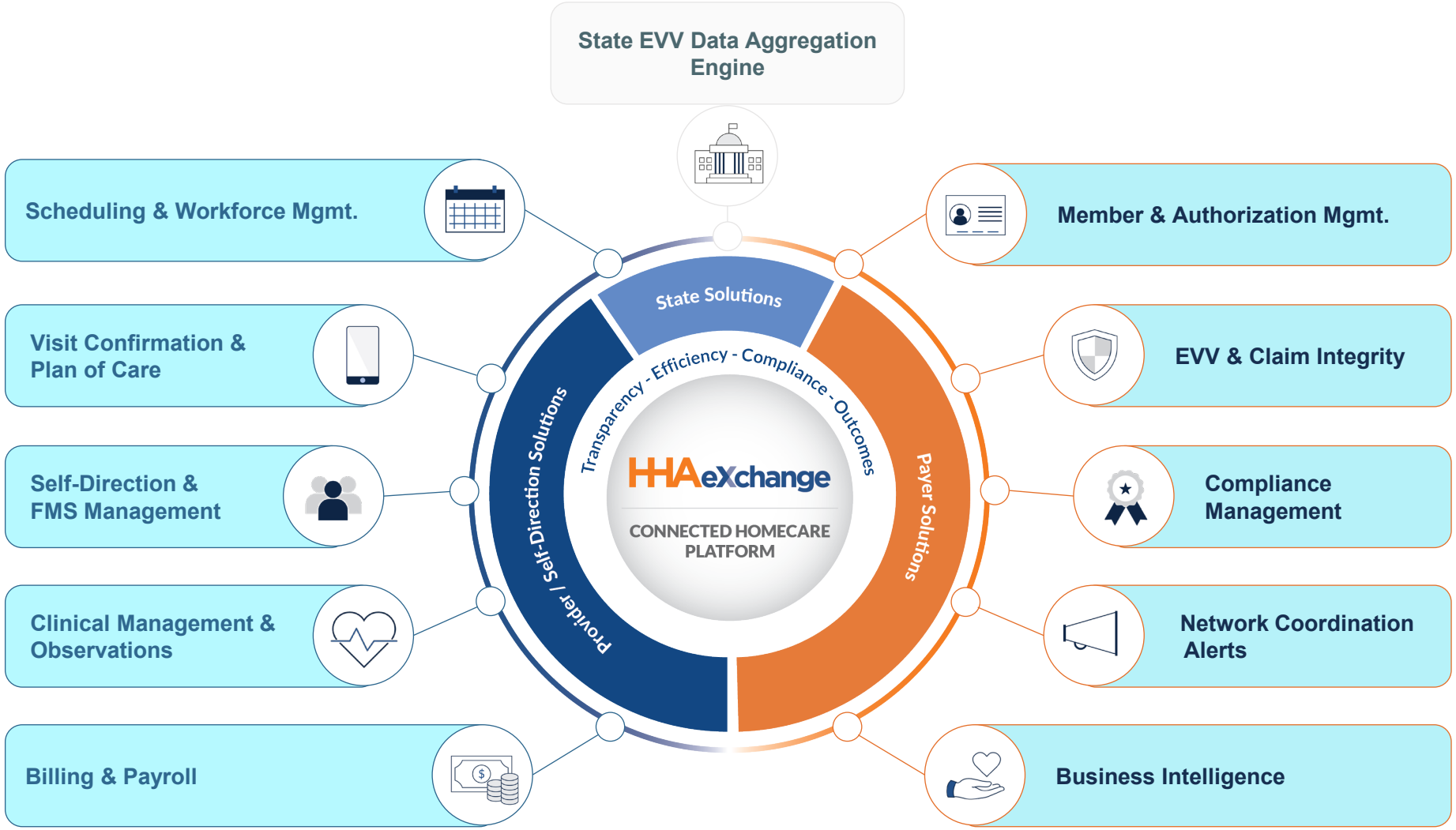
MISSION & PURPOSE

Enable the most effective homecare ecosystem everyday

Empowering **simpler** and **better outcomes** for patients who represent some of the most vulnerable and fragile members of our society. **HHAeXchange** connects the dots among states, managed care payers, providers, members and caregivers.

Better Homecare, Better Health

Our Strategic Framework for Homecare Stakeholders: Providers, Payers, States



Authorization Management

Providers will be receiving members and authorizations in the HHAX portal:

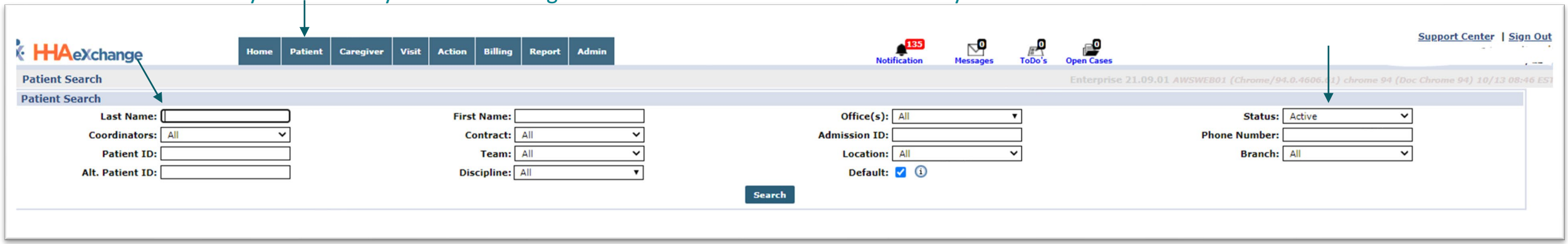
- **Authorizations are sent from the MCO and imported into the provider's portal.**
- **If members and/or authorizations are missing from your portal reach out to the MCO for assistance.**

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

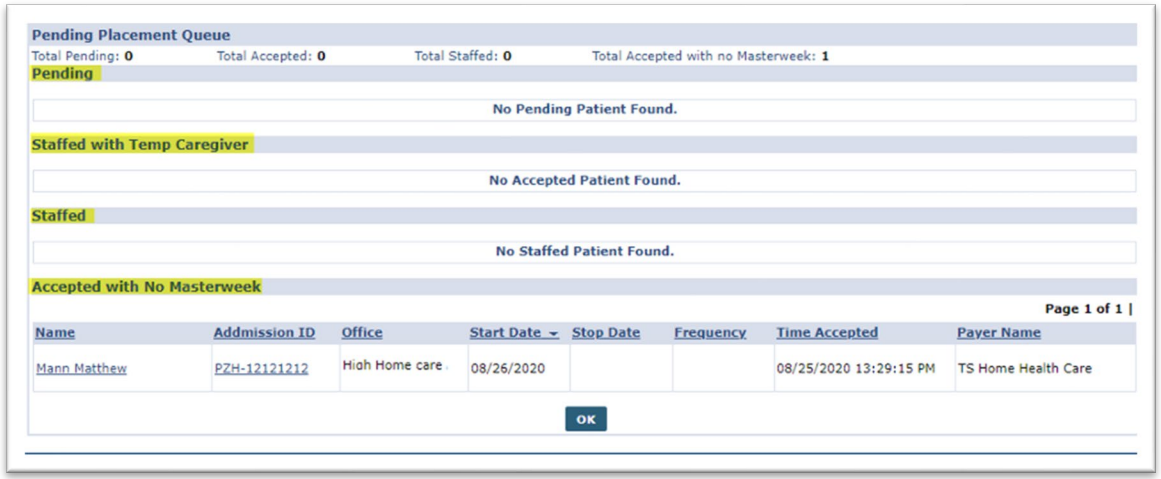
Find a Member/Patient in HHAeXchange:

- 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.



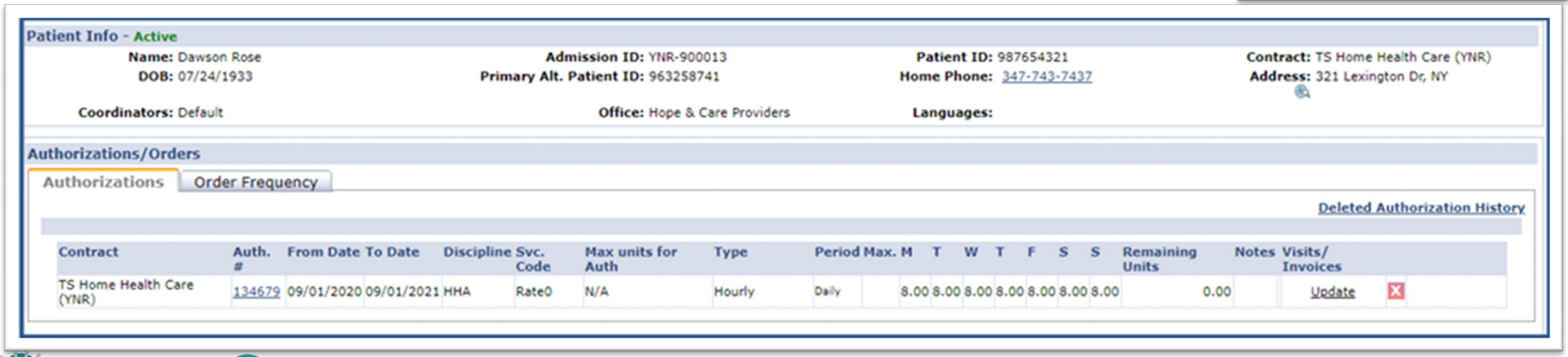
Finding Members and Authorizations In HHAeXchange cont.

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 through HHAeXchange

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 NPI Number (on Caregivers Profile)
- Caregivers Professional License Number (on Caregivers Profile)
- Patients Medicaid Number (on Patient Profile)
- Patients Diagnosis Code (on Patient Authorization)

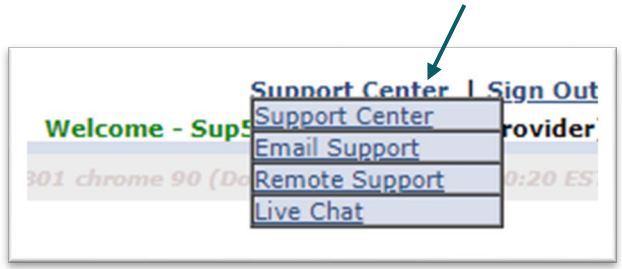
Link to Billing Process Guide:

https://hhaxsupport.s3.amazonaws.com/SupportDocs/ENTF/Process+Guides/ENTF+Process+Guide+-+Billing.pdf

Provider Resources

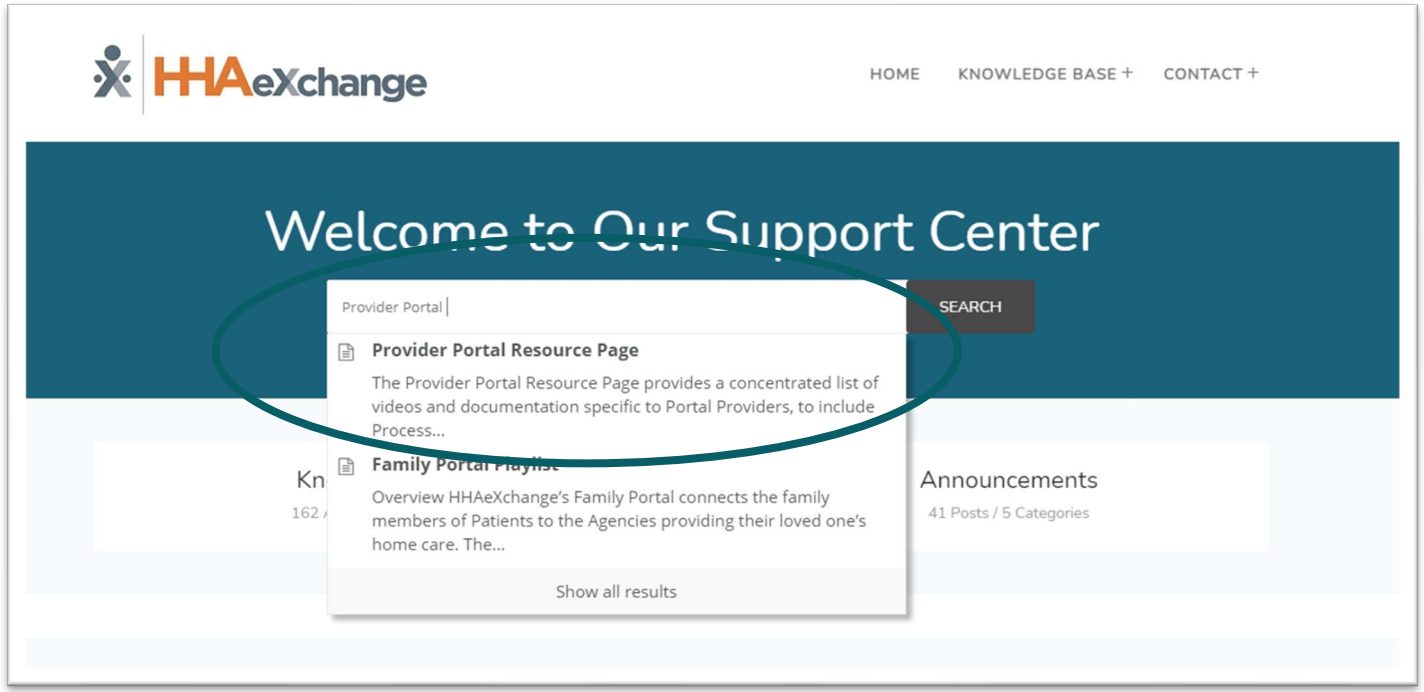
How to access the Support Center:

- **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*
- EDI Provider Rebilling*

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

*Most frequently used resources

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Contacts

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