Electronic Visit Verification (EVV) Phase 2

Provider Training

Aetna Better Health of New Jersey (Medicaid) & Aetna Assure Premier Plus (FIDE SNP)

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Questions during the Meeting?

This Teams Meeting is being recorded.

Please use the chat box to ask questions during this meeting. We will read them out and answer them later in the agenda.

Audience for Today's Training

All participating Providers who are currently billing for Personal Care Services (PCS) and Home HealthCare Services (HHCS):

- Aetna Better Health of New Jersey
- Aetna Assure Premier Plus (HMO D-SNP)

Agenda

21st Century Cures Act

Section 12006 of the 21st Century Cures Act required states to implement an EVV system for Medicaid-funded Personal Care Services (PCS) by January 1, 2021 and for Home Health Care Services (HHCS) by January 1, 2023.

The six data elements required to be collected to meet the Cures Act EVV Requirement:

EVV Phase 2 Implementation Cohorts & Milestones

Cohort 1 Skilled Nursing
- Private Duty Nursing
- Home Health

Cohort 2 Therapies
- Cognitive
- Occupational
- Physical
- Speech

Cohort 3 Applied Behavioral Analysis
- Postponed – No requirements yet available

Milestones	Activities	Requirement Deadline
Onboarding HHAX 'Go live'	• Select Your EVV Vendor • Complete the HHA Survey Questionnaire • Complete integration with EVV vendor • Secure HHAX Portal Log on ID and password • Complete HHAX EVV Training • Complete Aetna Provider Training	July 18, 2022
Provisional Engaged	• Maximize visits reported with EVV data • Gain experience in managing internal staff and Care Givers • Learn to identify and resolve error code rejections	September 30, 2022
Provisional Disengaged	• No participation in onboarding activities • No identified EVV solution and/or are not utilizing an EVV solution • There are no integration activities • This categorization puts the Provider at high risk for of no longer receiving member referrals	September 30, 2022
Operational	• Secure EVV information for all visits • Work with Aetna to resolve gaps in EVV data exchange resulting in less than a 100% compliance rate. • Begin billing in HHAX system & ensure provider certification and license numbers are included on EVV applicable claims	January 1, 2023
Full Compliance	• Submit EVV data for all required services • Meet billing compliance; by utilizing the Aetna specific process for all services • Ensure rendering provider certification and license numbers are included on all EVV applicable claims • Ongoing maintenance to ensure 100% compliance	July 1, 2023

Verifying 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

- Aetna Better Health of New Jersey (Medicaid) at **1-855-232-3596**
- Aetna Assure Premier Plus (HMO D-SNP) at **1-844-362-0934**

Secure Website Portal

- ABHNJ Medicaid: **https://www.aetnabetterhealth.com/newjersey/login**
- Aetna Assure Premier Plus (HMO D-SNP): **https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html**

** Please note that although Aetna Assure Premier Plus is an Aetna Medicare plan, it is available under "Aetna Better Health" in Availity. Providers must select "Aetna Better Health to search FIDE SNP members.*

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. Once member eligibility is confirmed, providers are expected to proceed with the existing process as follows:

1 Be Proactive

For new prior authorization, 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.

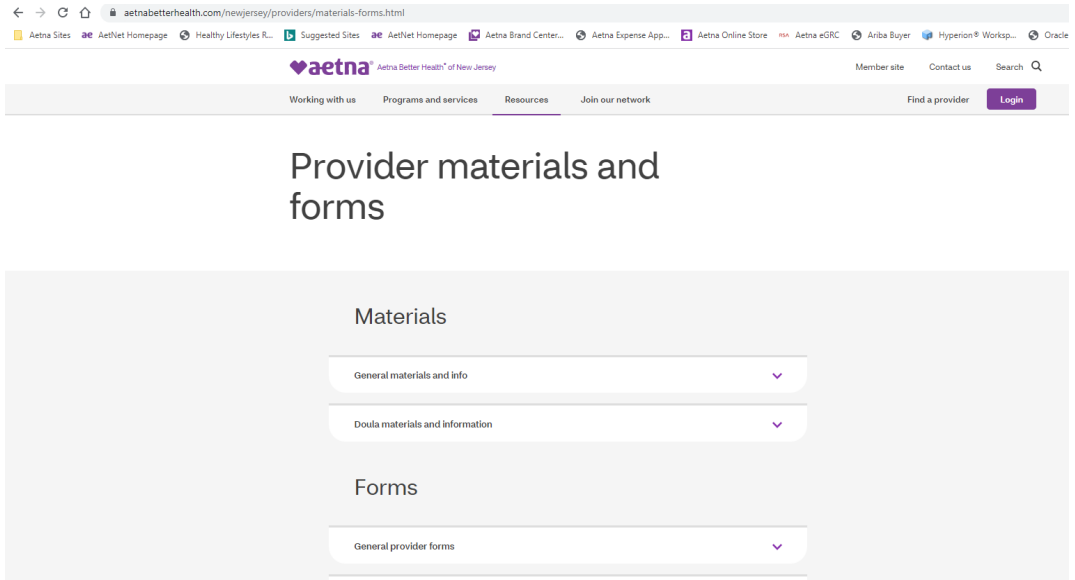
Authorizations following discharge from an inpatient hospital or skilled nursing facility stay are processed within 24 hours. HHAX portal displays the authorization within 2 days from approval.

Prior Authorization Process

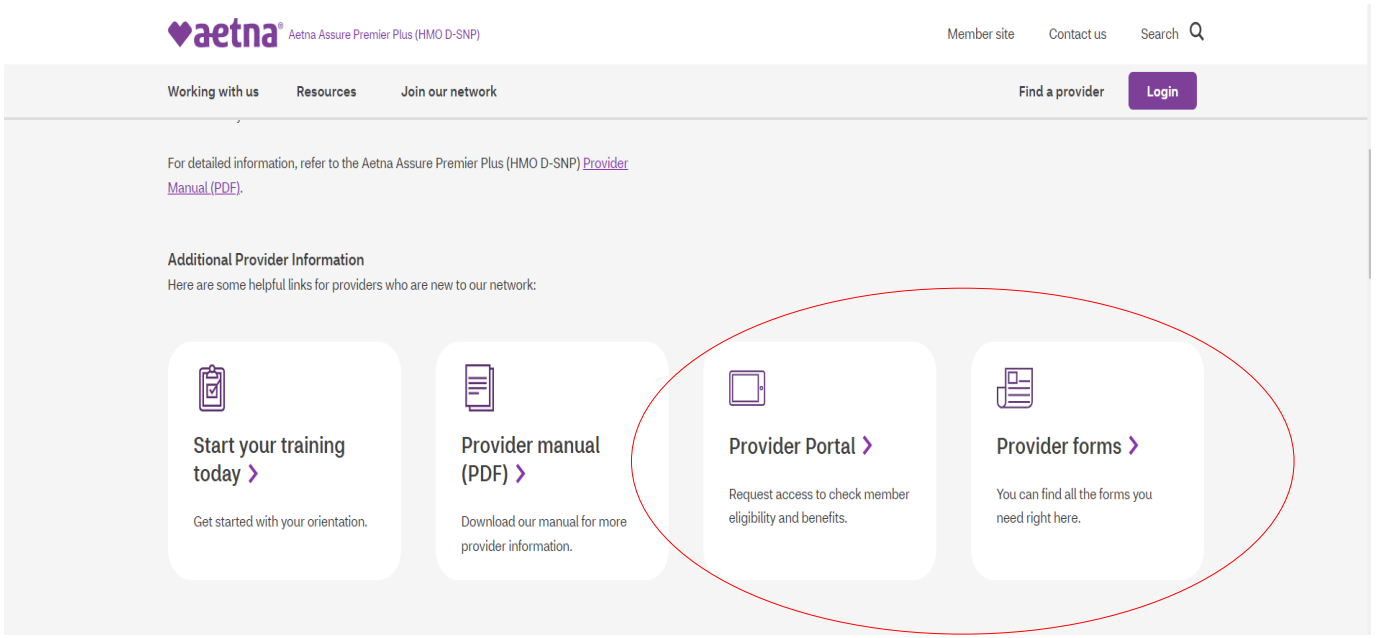
Aetna has kept the Prior Authorization Process the same for the existing EVV Phase 1 PCA services and expanded EVV Phase 2 Skilled Nursing and Therapies codes that are in scope. Once member eligibility is confirmed, providers are expected to proceed with the existing process as follows:

Leverage Aetna Provider Resources (Availity Portal or PA Form)

2 Go to ABHNJ Provider Website and download Prior Authorization Form https://www.aetnabetterhealth.com/newjersey/providers/materials-forms.html



2 Go to Aetna FIDE SNP Provider Website and download Prior Authorization Form https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/index.html



Prior Authorization Process
Availity Provider Portal – Electronic PA submissions

2a 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)
https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html

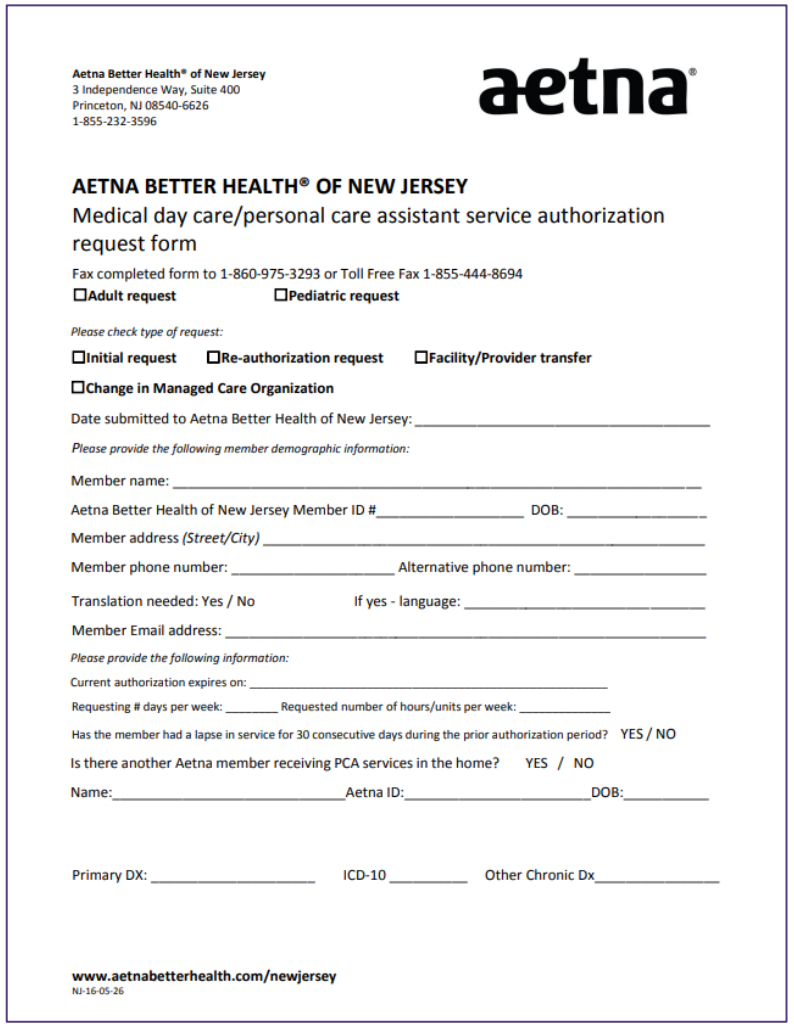
If you are not registered, we recommend that you do so immediately by going to the above portal location.

Prior Authorization Process

2b

Download and print the Prior Authorization Request Form (or utilize Availity Portal Form).

- Personal Care Services (PCS) – Continue using the existing form and process that went into effect during EVV Phase 1
- Providers access the form here: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/newjersey/pdf/ProviderForm-MedicalDaycare-PersonalCareAssistant-ServiceAuthorizationRequest-NJ.pdf



Aetna Better Health® of New Jersey
3 Independence Way, Suite 400
Princeton, NJ 08540-6626
1-855-232-3596

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AETNA BETTER HEALTH® OF NEW JERSEY

Medical day care/personal care assistant service authorization request form

Fax completed form to 1-860-975-3293 or Toll Free Fax 1-855-444-8694

☐**Adult request** ☐**Pediatric request**

Please check type of request:

☐**Initial request** ☐**Re-authorization request** ☐**Facility/Provider transfer**

☐**Change in Managed Care Organization**

Date submitted to Aetna Better Health of New Jersey: _____

Please provide the following member demographic information:

Member name: _____

Aetna Better Health of New Jersey Member ID #_____ DOB: _____

Member address *(Street/City)* _____

Member phone number: _____ Alternative phone number: _____

Translation needed: Yes / No If yes - language: _____

Member Email address: _____

Please provide the following information:

Current authorization expires on: _____

Requesting # days per week: _____ Requested number of hours/units per week: _____

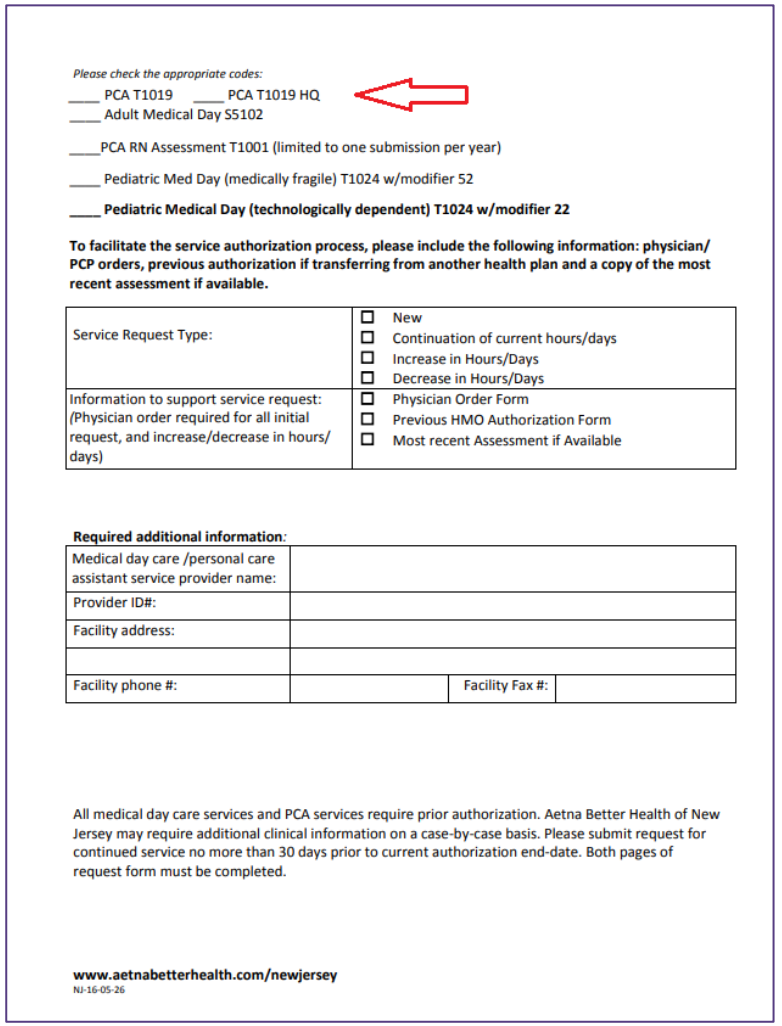
Has the member had a lapse in service for 30 consecutive days during the prior authorization period? YES / NO

Is there another Aetna member receiving PCA services in the home? YES / NO

Name:_____Aetna ID:_____DOB:_____

Primary DX: _____ ICD-10 _____ Other Chronic Dx_____

www.aetnabetterhealth.com/newjersey
NJ-16-05-26



Please check the appropriate codes:

____ PCA T1019 ____ PCA T1019 HQ
____ Adult Medical Day S5102

____PCA RN Assessment T1001 (limited to one submission per year)

____ Pediatric Med Day (medically fragile) T1024 w/modifier 52

____ **Pediatric Medical Day (technologically dependent) T1024 w/modifier 22**

To facilitate the service authorization process, please include the following information: physician/ PCP orders, previous authorization if transferring from another health plan and a copy of the most recent assessment if available.

Service Request Type:	☐ New ☐ Continuation of current hours/days ☐ Increase in Hours/Days ☐ Decrease in Hours/Days
Information to support service request: /Physician order required for all initial request, and increase/decrease in hours/ days)	☐ Physician Order Form ☐ Previous HMO Authorization Form ☐ Most recent Assessment if Available

Required additional information:

Medical day care /personal care assistant service provider name:			
Provider ID#:			
Facility address:			
Facility phone #:		Facility Fax #:	

All medical day care services and PCA services require prior authorization. Aetna Better Health of New Jersey may require additional clinical information on a case-by-case basis. Please submit request for continued service no more than 30 days prior to current authorization end-date. Both pages of request form must be completed.

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NJ-16-05-26

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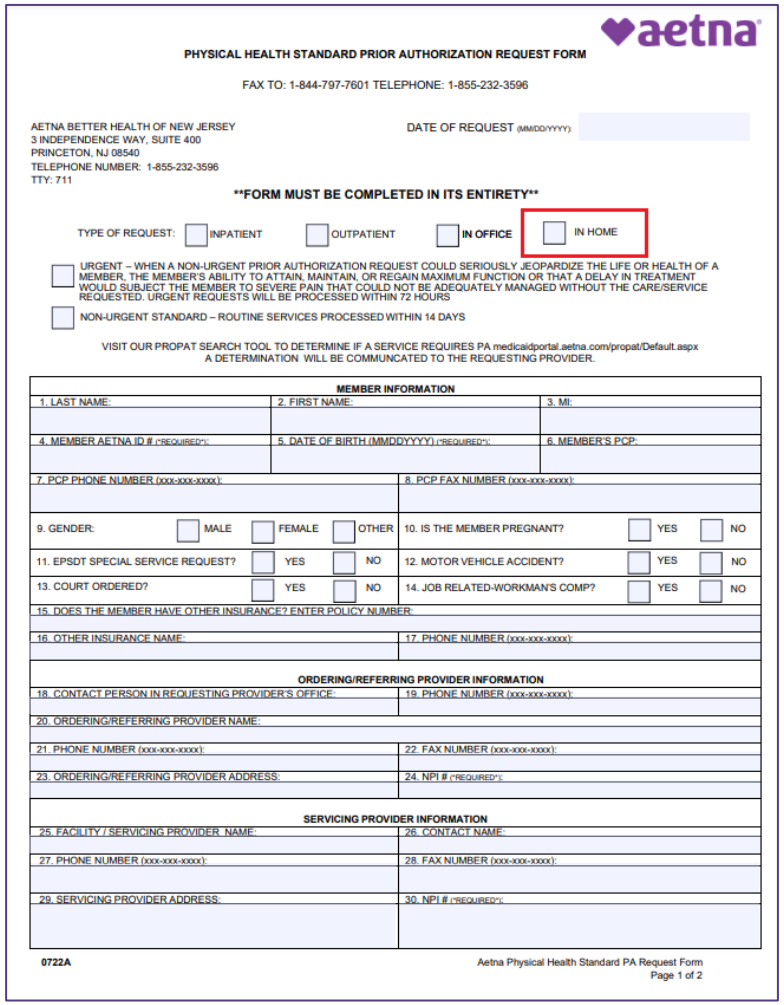
Prior Authorization Process

2c

Download and print the Prior Authorization Request Form (or utilize Availity Portal 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
- Providers access the form here: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/new-jersey-medicaid/provider/pdf/nj-PH-prior-auth-form.pdf

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



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PHYSICAL HEALTH STANDARD PRIOR AUTHORIZATION REQUEST FORM

FAX TO: 1-844-797-7601 TELEPHONE: 1-855-232-3596

AETNA BETTER HEALTH OF NEW JERSEY
3 INDEPENDENCE WAY, SUITE 400
PRINCETON, NJ 08540
TELEPHONE NUMBER: 1-855-232-3596
TTY: 711

DATE OF REQUEST (MM/DD/YYYY):

FORM MUST BE COMPLETED IN ITS ENTIRETY

TYPE OF REQUEST: ☐ INPATIENT ☐ OUTPATIENT ☐ IN OFFICE ☐ IN HOME

☐ URGENT – WHEN A NON-URGENT PRIOR AUTHORIZATION REQUEST COULD SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF A MEMBER, THE MEMBER'S ABILITY TO ATTAIN, MAINTAIN, OR REGAIN MAXIMUM FUNCTION OR THAT A DELAY IN TREATMENT WOULD SUBJECT THE MEMBER TO SEVERE PAIN THAT COULD NOT BE ADEQUATELY MANAGED WITHOUT THE CARE/SERVICE REQUESTED. URGENT REQUESTS WILL BE PROCESSED WITHIN 72 HOURS

☐ NON-URGENT STANDARD – ROUTINE SERVICES PROCESSED WITHIN 14 DAYS

VISIT OUR PROPAT SEARCH TOOL TO DETERMINE IF A SERVICE REQUIRES PA medicaidportal.aetna.com/propat/Default.aspx
A DETERMINATION WILL BE COMMUNCATED TO THE REQUESTING PROVIDER.

MEMBER INFORMATION

1. LAST NAME:	2. FIRST NAME:	3. MI:
4. MEMBER AETNA ID # (*REQUIRED*):	5. DATE OF BIRTH (MMDDYYYY) (*REQUIRED*):	6. MEMBER'S PCP:
7. PCP PHONE NUMBER (xxx-xxx-xxxx):	8. PCP FAX NUMBER (xxx-xxx-xxxx):	
9. GENDER: ☐ MALE ☐ FEMALE ☐ OTHER	10. IS THE MEMBER PREGNANT? ☐ YES ☐ NO	
11. EPSDT SPECIAL SERVICE REQUEST? ☐ YES ☐ NO	12. MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO	
13. COURT ORDERED? ☐ YES ☐ NO	14. JOB RELATED-WORKMAN'S COMP? ☐ YES ☐ NO	
15. DOES THE MEMBER HAVE OTHER INSURANCE? ENTER POLICY NUMBER:		
16. OTHER INSURANCE NAME:	17. PHONE NUMBER (xxx-xxx-xxxx):	

ORDERING/REFERRING PROVIDER INFORMATION

18. CONTACT PERSON IN REQUESTING PROVIDER'S OFFICE:	19. PHONE NUMBER (xxx-xxx-xxxx):
20. ORDERING/REFERRING PROVIDER NAME:	
21. PHONE NUMBER (xxx-xxx-xxxx):	22. FAX NUMBER (xxx-xxx-xxxx):
23. ORDERING/REFERRING PROVIDER ADDRESS:	24. NPI # (*REQUIRED*):

SERVICING PROVIDER INFORMATION

25. FACILITY / SERVICING PROVIDER NAME:	26. CONTACT NAME:
27. PHONE NUMBER (xxx-xxx-xxxx):	28. FAX NUMBER (xxx-xxx-xxxx):
29. SERVICING PROVIDER ADDRESS:	30. NPI # (*REQUIRED*):

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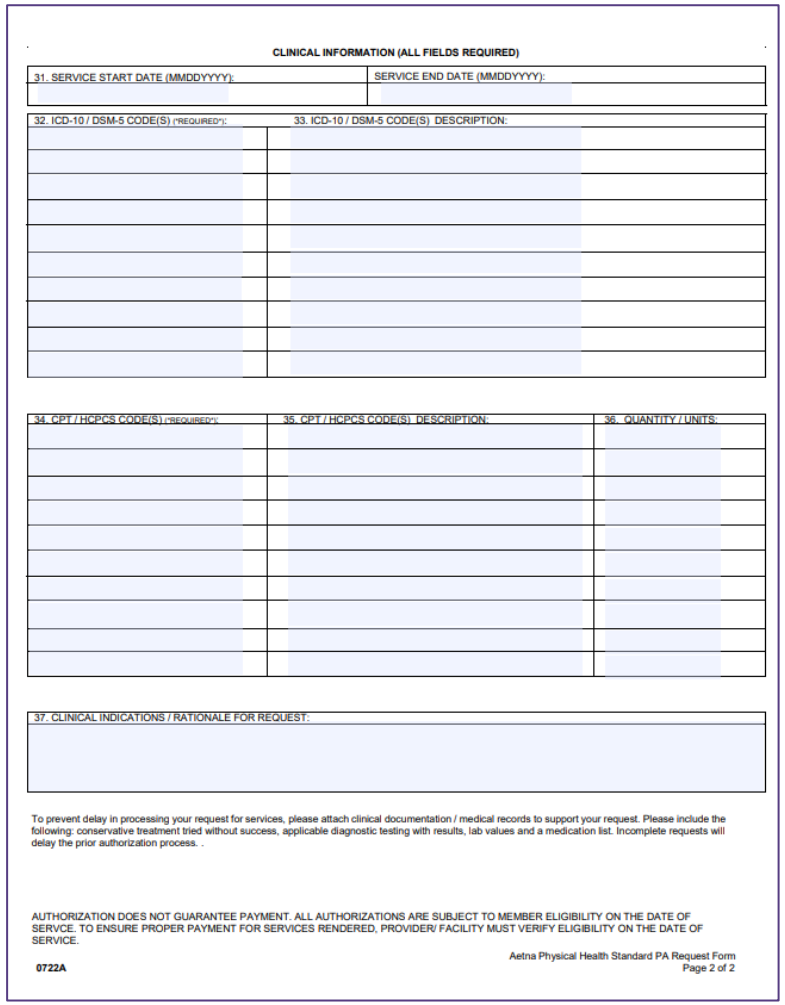
Aetna Physical Health Standard PA Request Form
Page 1 of 2



CLINICAL INFORMATION (ALL FIELDS REQUIRED)

31. SERVICE START DATE (MMDDYYYY):	SERVICE END DATE (MMDDYYYY):

32. ICD-10 / DSM-5 CODE(S) (*REQUIRED*):	33. ICD-10 / DSM-5 CODE(S) DESCRIPTION:

34. CPT / HCPCS CODE(S) (*REQUIRED*):	35. CPT / HCPCS CODE(S) DESCRIPTION:	36. QUANTITY / UNITS:

37. CLINICAL INDICATIONS / RATIONALE FOR REQUEST:

To prevent delay in processing your request for services, please attach clinical documentation / medical records to support your request. Please include the following: conservative treatment tried without success, applicable diagnostic testing with results, lab values and a medication list. Incomplete requests will delay the prior authorization process. .

AUTHORIZATION DOES NOT GUARANTEE PAYMENT. ALL AUTHORIZATIONS ARE SUBJECT TO MEMBER ELIGIBILITY ON THE DATE OF SERVCE. TO ENSURE PROPER PAYMENT FOR SERVICES RENDERED, PROVIDER/ FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE.

0722A

Aetna Physical Health Standard PA Request Form
Page 2 of 2

Tip – Page 2
Providers must enter the service code and description utilizing the in-scope codes provided on slides 14 & 15

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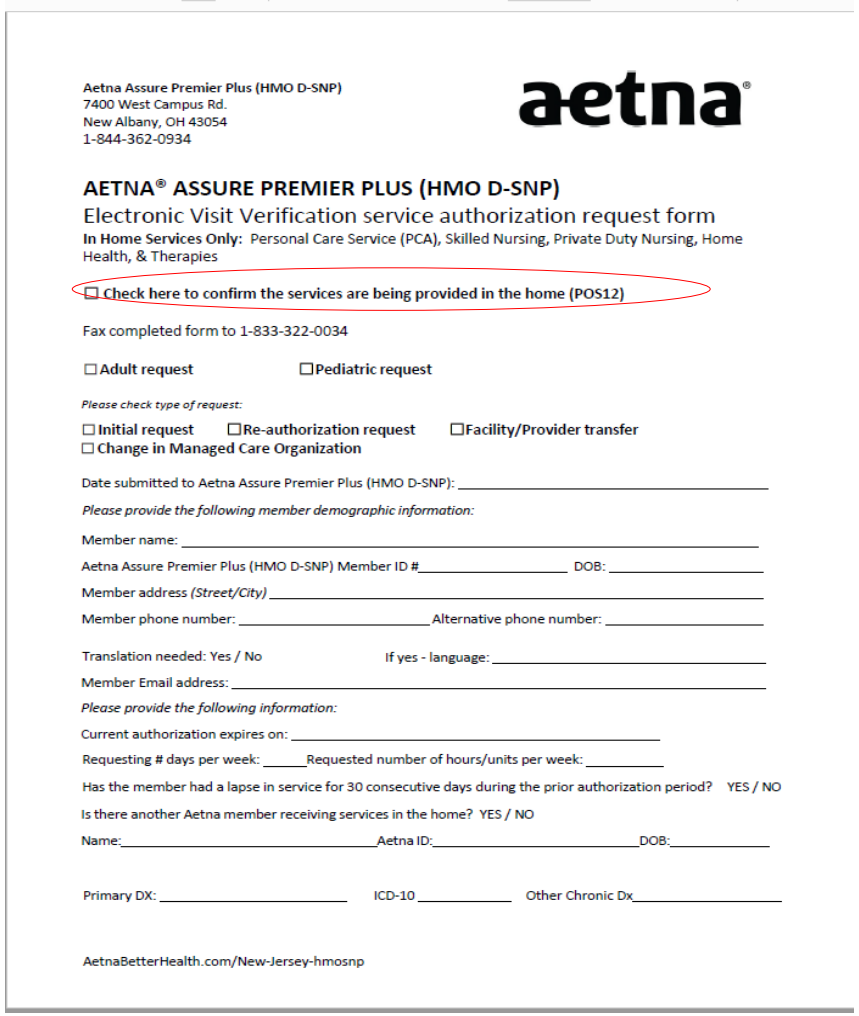
Prior Authorization Process

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.



Aetna Assure Premier Plus (HMO D-SNP)
7400 West Campus Rd.
New Albany, OH 43054
1-844-362-0934

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AETNA® ASSURE PREMIER PLUS (HMO D-SNP)
Electronic Visit Verification service authorization request form
In Home Services Only: Personal Care Service (PCA), Skilled Nursing, Private Duty Nursing, Home Health, & Therapies

☐ **Check here to confirm the services are being provided in the home (POS12)**

Fax completed form to 1-833-322-0034

☐ **Adult request** ☐ **Pediatric request**

Please check type of request:

☐ **Initial request** ☐ **Re-authorization request** ☐ **Facility/Provider transfer**
☐ **Change in Managed Care Organization**

Date submitted to Aetna Assure Premier Plus (HMO D-SNP): _____

Please provide the following member demographic information:

Member name: _____

Aetna Assure Premier Plus (HMO D-SNP) Member ID #_____ DOB: _____

Member address *(Street/City)* _____

Member phone number: _____ Alternative phone number: _____

Translation needed: Yes / No If yes - language: _____

Member Email address: _____

Please provide the following information:

Current authorization expires on: _____

Requesting # days per week: _____ Requested number of hours/units per week: _____

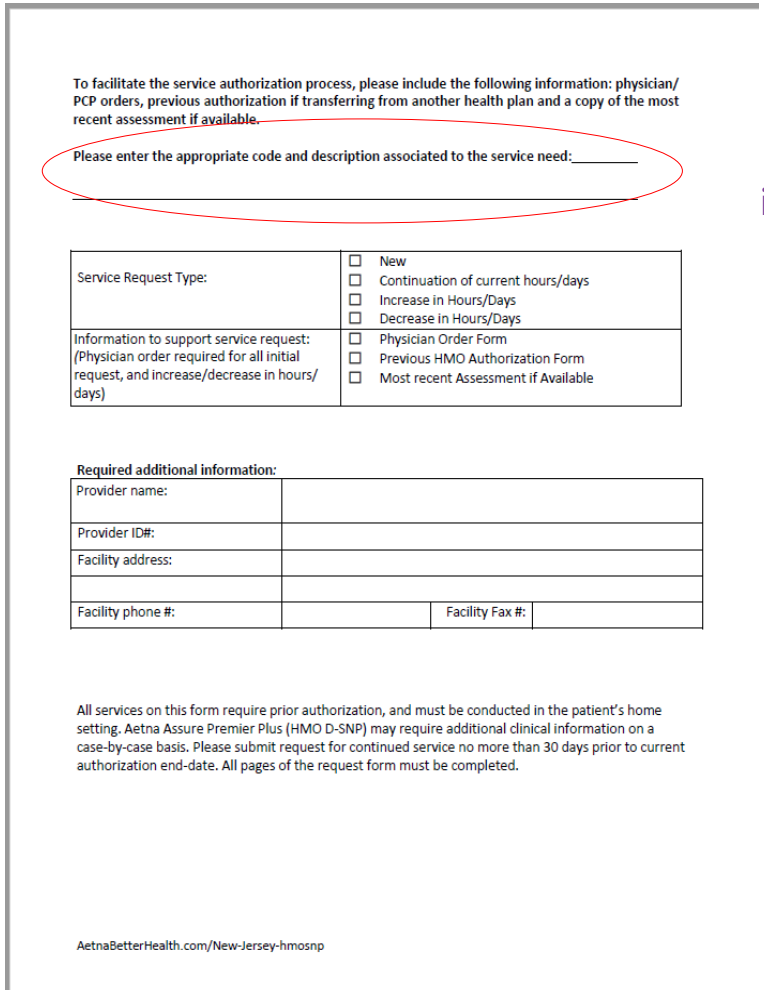
Has the member had a lapse in service for 30 consecutive days during the prior authorization period? YES / NO

Is there another Aetna member receiving services in the home? YES / NO

Name:_____ Aetna ID:_____ DOB:_____

Primary DX: _____ ICD-10 _____ Other Chronic Dx_____

AetnaBetterHealth.com/New-Jersey-hmosnp



To facilitate the service authorization process, please include the following information: physician/ PCP orders, previous authorization if transferring from another health plan and a copy of the most recent assessment if available.

Please enter the appropriate code and description associated to the service need:_____

_____

Service Request Type:	☐ New ☐ Continuation of current hours/days ☐ Increase in Hours/Days ☐ Decrease in Hours/Days
Information to support service request: (Physician order required for all initial request, and increase/decrease in hours/ days)	☐ Physician Order Form ☐ Previous HMO Authorization Form ☐ Most recent Assessment if Available

Required additional information:

Provider name:			
Provider ID#:			
Facility address:			
Facility phone #:		Facility Fax #:	

All services on this form require prior authorization, and must be conducted in the patient's home setting. Aetna Assure Premier Plus (HMO D-SNP) may require additional clinical information on a case-by-case basis. Please submit request for continued service no more than 30 days prior to current authorization end-date. All pages of the request form must be completed.

AetnaBetterHealth.com/New-Jersey-hmosnp

Tip – Page 2
Providers must enter the service code and description utilizing the in-scope codes provided on slides 14 & 15

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Prior Authorization Process

Aetna uses the state mandated codes for HHCS Services, with a service requirement of Place of Service (POS12)

FIDE SNP providers are required to complete EVV scheduling and visits in HHAX for data quality purposes. All the identified Phase 2 Cohort 1 and 2 HHCS are required except for code G0299. G0299 EVV data is only required when it is an authorized Medicaid service.

Cohort 1 - Skilled Nursing / Private Duty Nursing / Home Health

Procedure Code	Procedure Name	Unit of Measure
97597	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	Per visit
99601	Infusion- Skilled nursing	Up to 2 hours
99602	Infusion- Skilled nursing-additional hour(s)	Each additional hour
G0299	Direct skilled nursing services of a registered nurse (run) in the home health or hospice setting	15 mins
S9122	Home Health Aide/Certified Nurse Assistant	Per hour
S9123	Nursing care, in the home; by registered nurse,	Per hour
S9124	Nursing care, in the home; by licensed practical nurse	Per hour
S9127	Social work visit, in the home	Per diem
T1000	Private duty / independent nursing service(s)	15 mins
T1002	Private duty / independent nursing service(s) / RN	15 mins
T1003	LPN/LVN SERVICES	15 mins
T1030	Nursing care, in the home, by registered nurse	Per diem
T1031	Nursing care, in the home, by licensed practical nurse	Per diem
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home or hospice setting	15 mins

Prior Authorization Process

Aetna uses the state mandated codes for HHCS Services, with a service requirement of Place of Service (POS12)

FIDE SNP providers are required to complete EVV scheduling and visits in HHAX for data quality purposes

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Cohort 2 - Therapies

Procedure Code	Procedure Name	Unit of Measure
92507	Speech, Language and Hearing Therapy Individual	Per diem
97110	Physical Therapy, Therapeutic procedure, 1 or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 mins
97129	Cognitive Therapy, Individual	15 mins
97130	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)	Each additional 15 mins
97535	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	15 mins
G0151	Services performed by a qualified physical therapist in the home health or hospice setting	15 mins
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting	15 mins
G0153	Services performed by a qualified speech language pathologist in the home health or hospice setting	15 mins
G0155	Services performed by clinical social worker in the home health or hospice setting	15 mins
S9128	Speech therapy, in the home	Per diem
S9129	Occupational therapy, in the home	Per diem
S9131	Physical therapy; in the home	Per diem

Prior Authorization Process

3 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.

4 After Prior Authorization Form is completed in its entirety;

- ABHNJ PCA Requests - Fax to 1-860-975-3293 or Toll Free Fax 1-855-444-8694
- ABHNJ Skilled Nursing and Therapy Requests – Fax to 1-844-797-7601
- FIDE SNP all Prior Auth Requests – Fax to 1-833-322-0034
- Or submit via the Availity Provider Portal.

5 Aetna conducts clinical review and approves or denies authorization request.

6 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.

7 Approved authorization appears in HHAX portal.

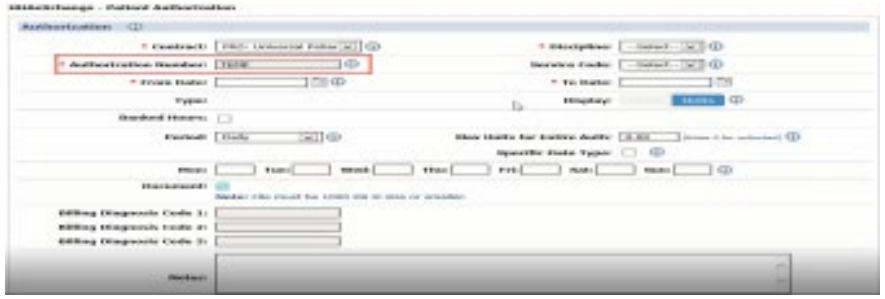
Dual Eligible MLTSS – EVV Requirement

- Providers must complete the EVV scheduling and visit verification process for all required codes.
- It is the responsibility of the Provider to capture and maintain accurate quality data for Dual Eligible MLTSS members.
- ABHNJ and the State of NJ will audit this information, and can request reporting at any time, which must be furnished by the providers via a detailed visit report from your EVV vendor.
- If you are a provider using HHAX as your EVV vendor, this action will be facilitated via a temporary authorization in the HHAX portal.
- If you are a Provider using a third party EVV vendor, you must work with your vendor to determine how to capture the EVV quality data information in their system for MLTSS Duals members.

Instructions for Temporary Authorizations in HHAX Provider Portal

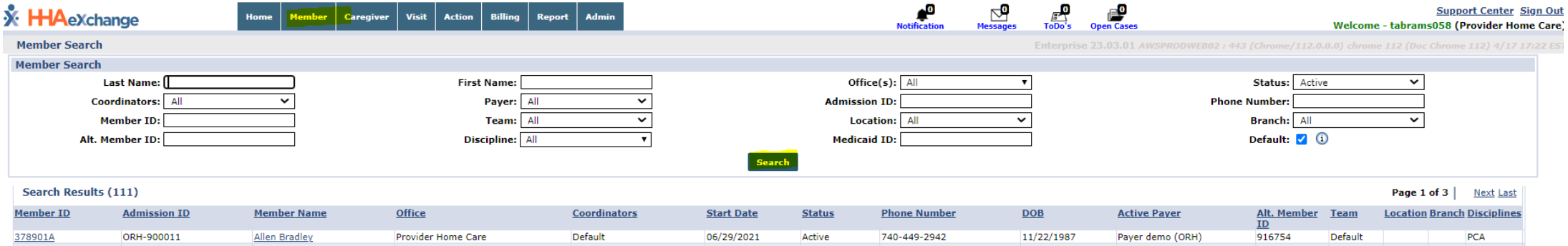
Creating a TEMP Authorization

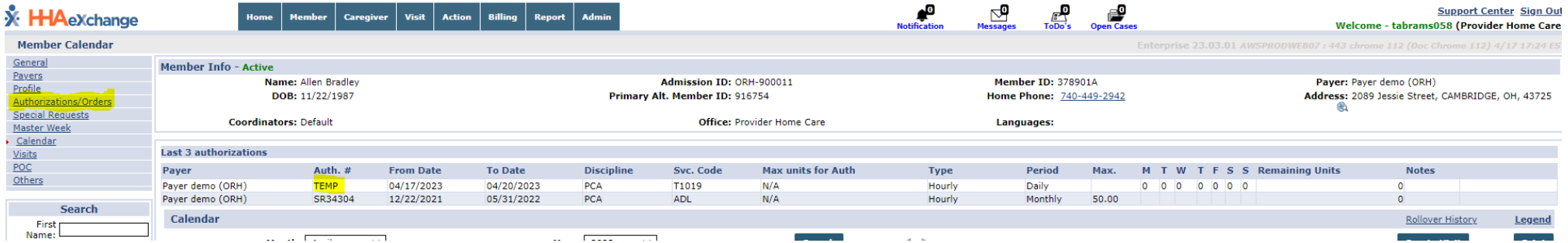
1. To create a TEMP Authorization, navigate to ***Patient > Authorizations/Orders*** and click on the ***Add*** button to open the Patient Authorization window.
2. Select the UPR Linked Contract from the **Contract** dropdown field.
3. The **Authorization Number** field immediately auto-fills with *TEMP* (unavailable to edit).
4. Complete required fields (denoted with a red asterisk) and click ***Save*** to finalize.



Searching for a TEMP Authorization

1. Navigate to **Member** tab **> Type Member's Demographic Information >** Select **Search** for member profile
2. On the **Member Profile page**, on left bar click **Authorizations/Orders.** This link will populate and show the user the types of authorizations that are connected to this patient. Select the applicable **TEMP** authorization.





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Clinical Contacts for Prior Authorization

To confirm the status of prior authorization:

MEDICAID

- **ABHNJ Medicaid Members, please call 1-855-232-3596.**

FIDE SNP

- **Aetna FIDE SNP members, please call 1-844-362-0934.**
- **Clinical Staff 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

- 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.
- **Providers cannot request prior authorizations via the HHAX portal.**
- 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.**

Continuity of Care Requests

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 council 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.

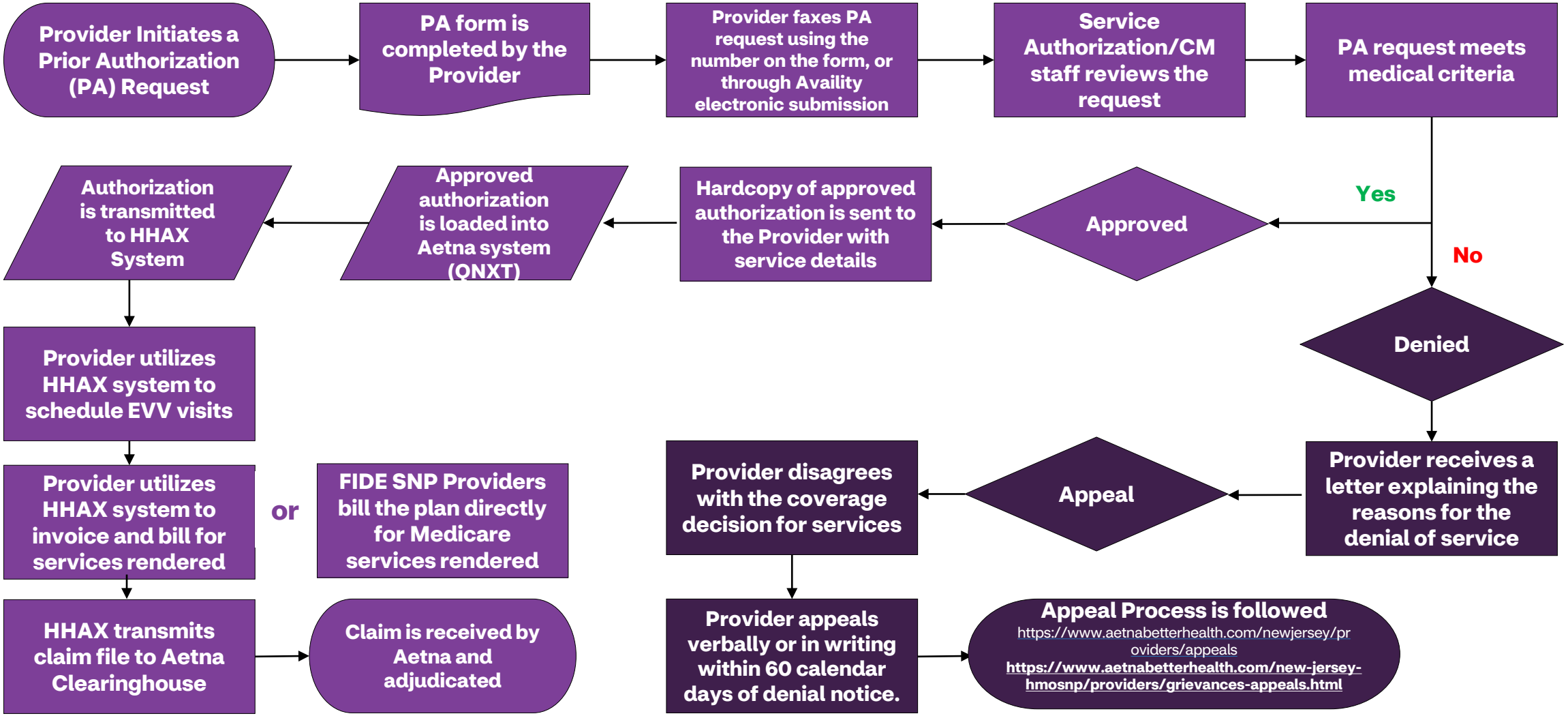
Approved requests:

- 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.

End to End Visual Process Workflow

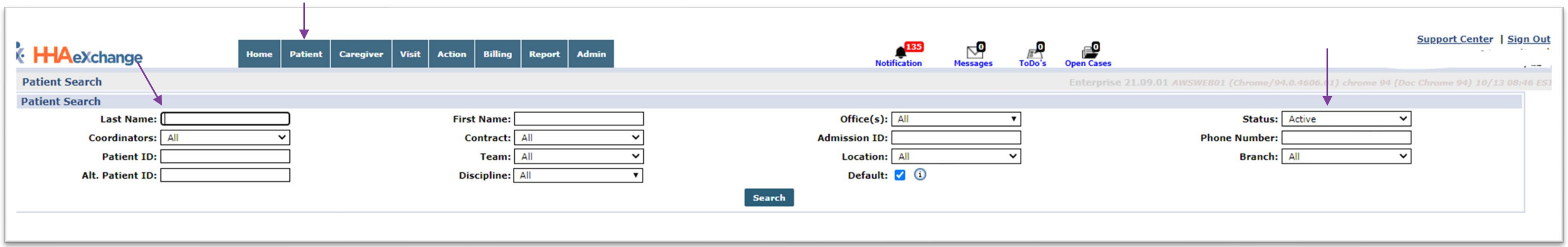


HHA eXchange Portal Overview

Finding Members and Authorizations In HHAeXchange

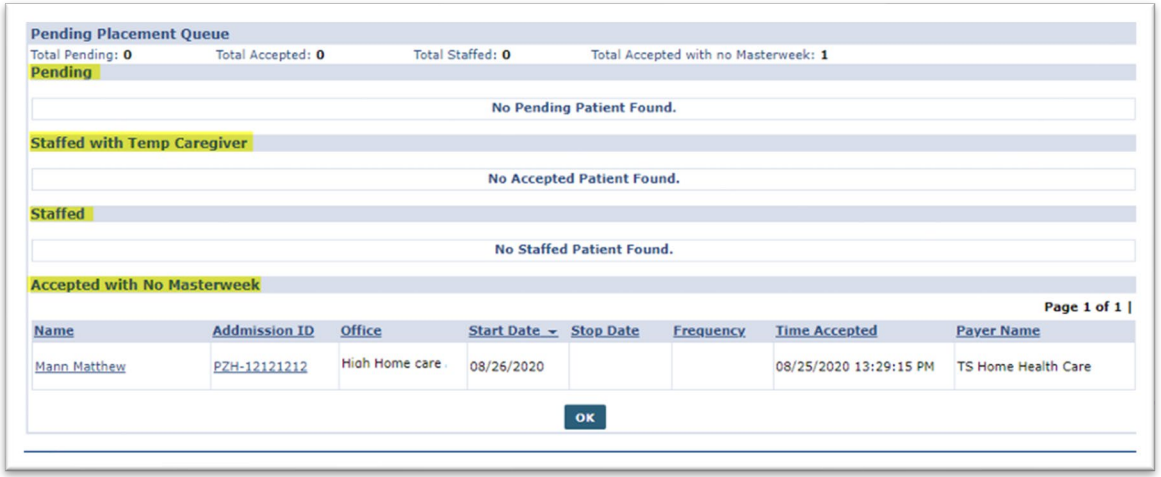
Find a Member/Patient in HHAeXchange:

- 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.

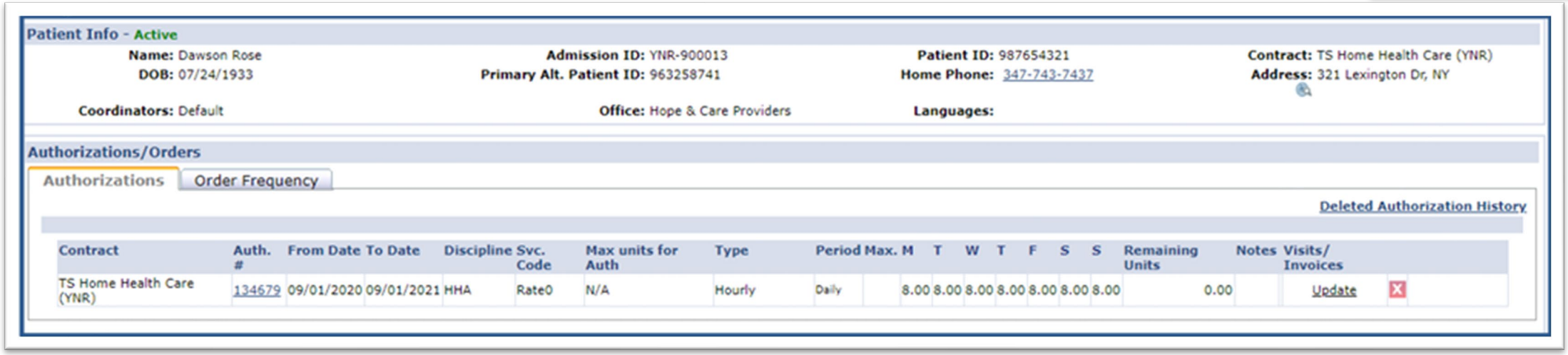
Locating a patient's authorization in HHAeXchange:

- 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



Scheduling Visits in HHAeXchange

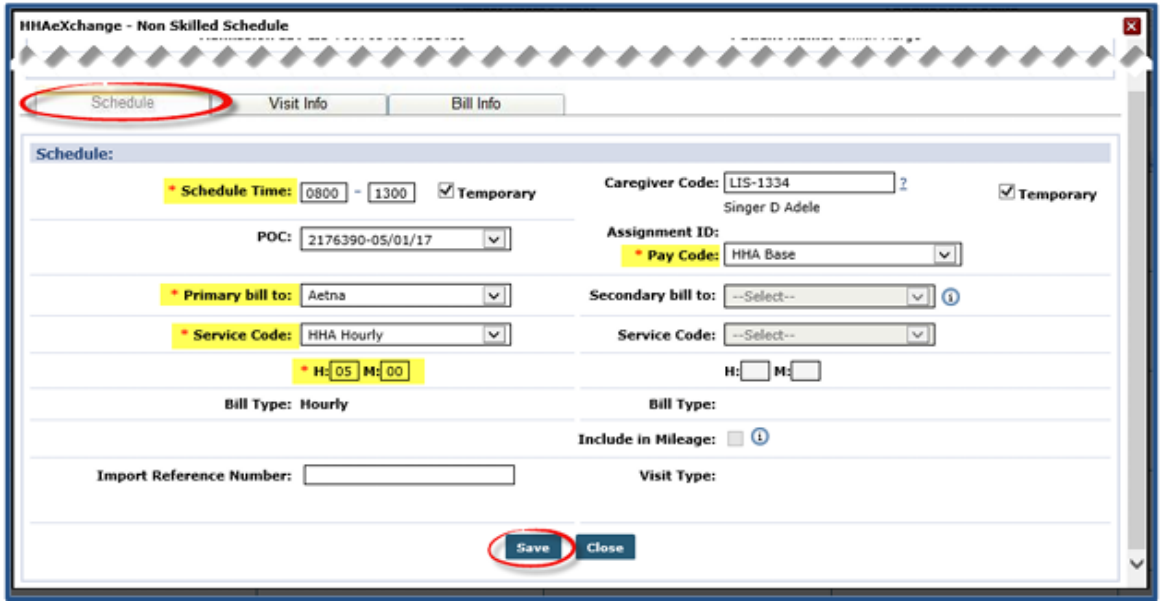
3 Ways to Schedule Visits in HHAeXchange

- Manually entering the new visit on the Patient's or Caregiver's Calendar page
- Using the Copy and Create function on the Patient's or Caregiver's Calendar page.
- Creating a Master Week

Key Fields for Scheduling Visits:

- Schedule Time
- Service Code
- Caregiver Code
- Primary Bill To

Scheduling Job Aides can be found in the Support Center in the Providers HHAX portal



Billing in 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)

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

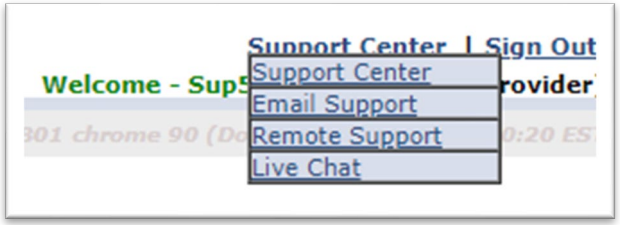
Link to Billing Process Guide:

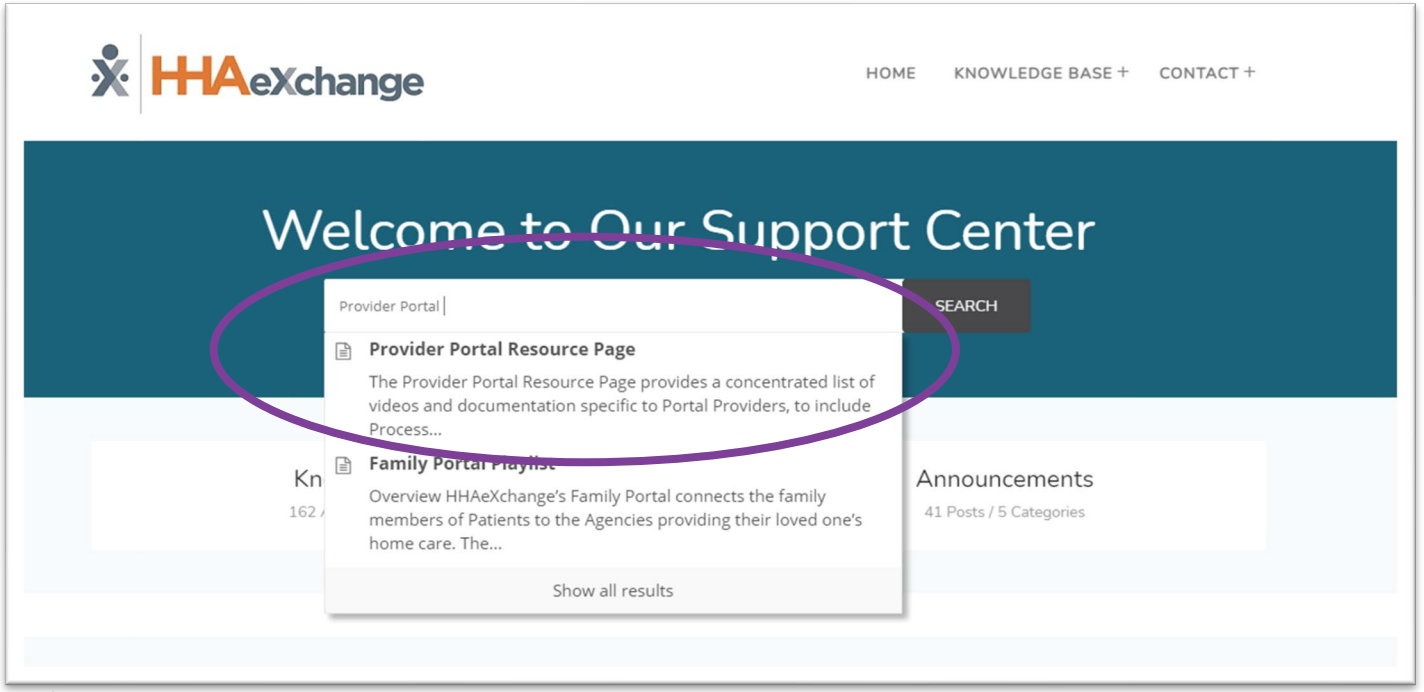
https://hhaxsupport.s3.amazonaws.com/SupportDocs/ENTF/Process+Guides/ENTF+Process+Guide+-+Billing.pdf

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*
- EDI Provider Rebilling*

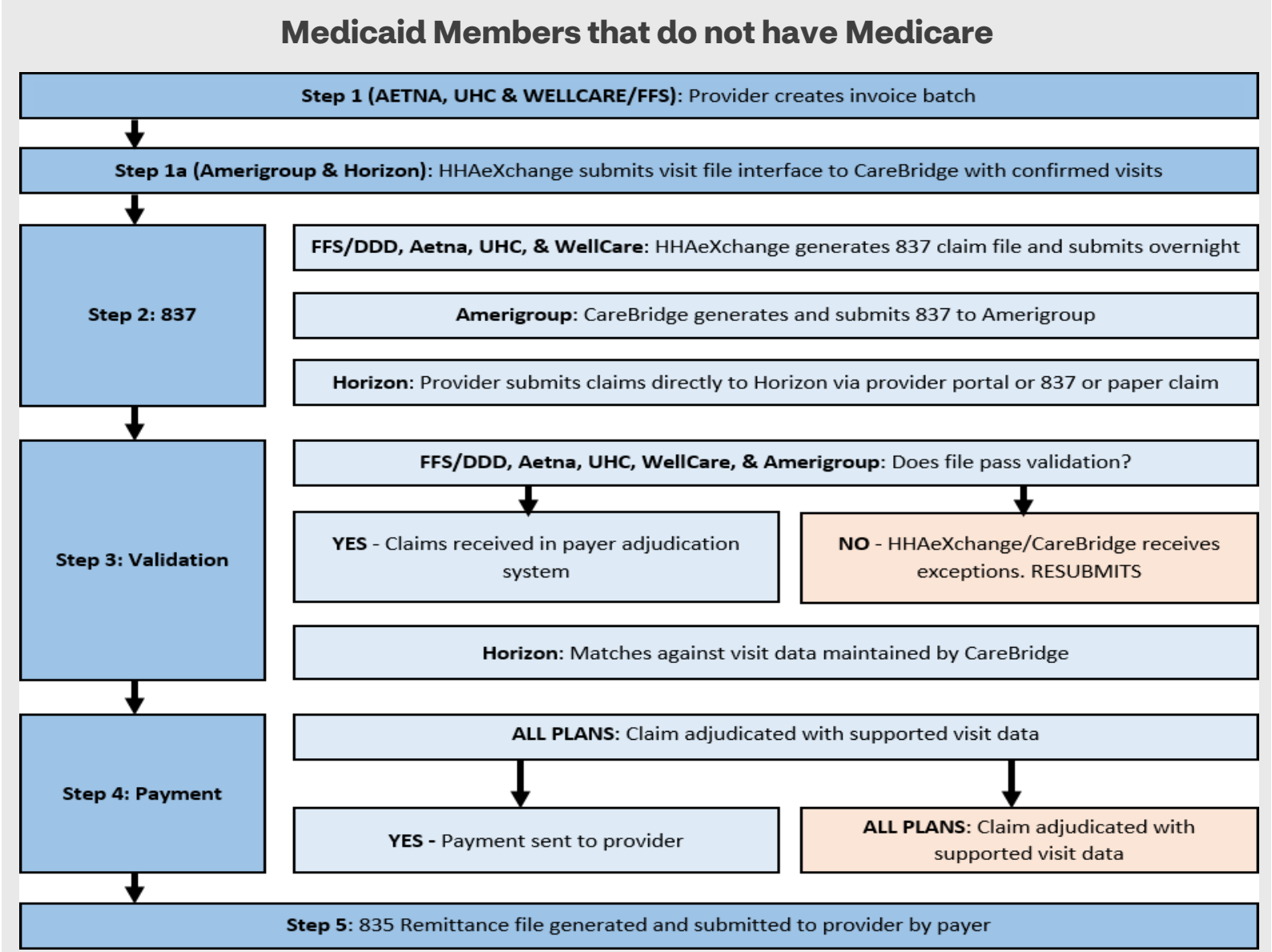
Videos

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

*Most frequently used resources

Claim Submission Process:

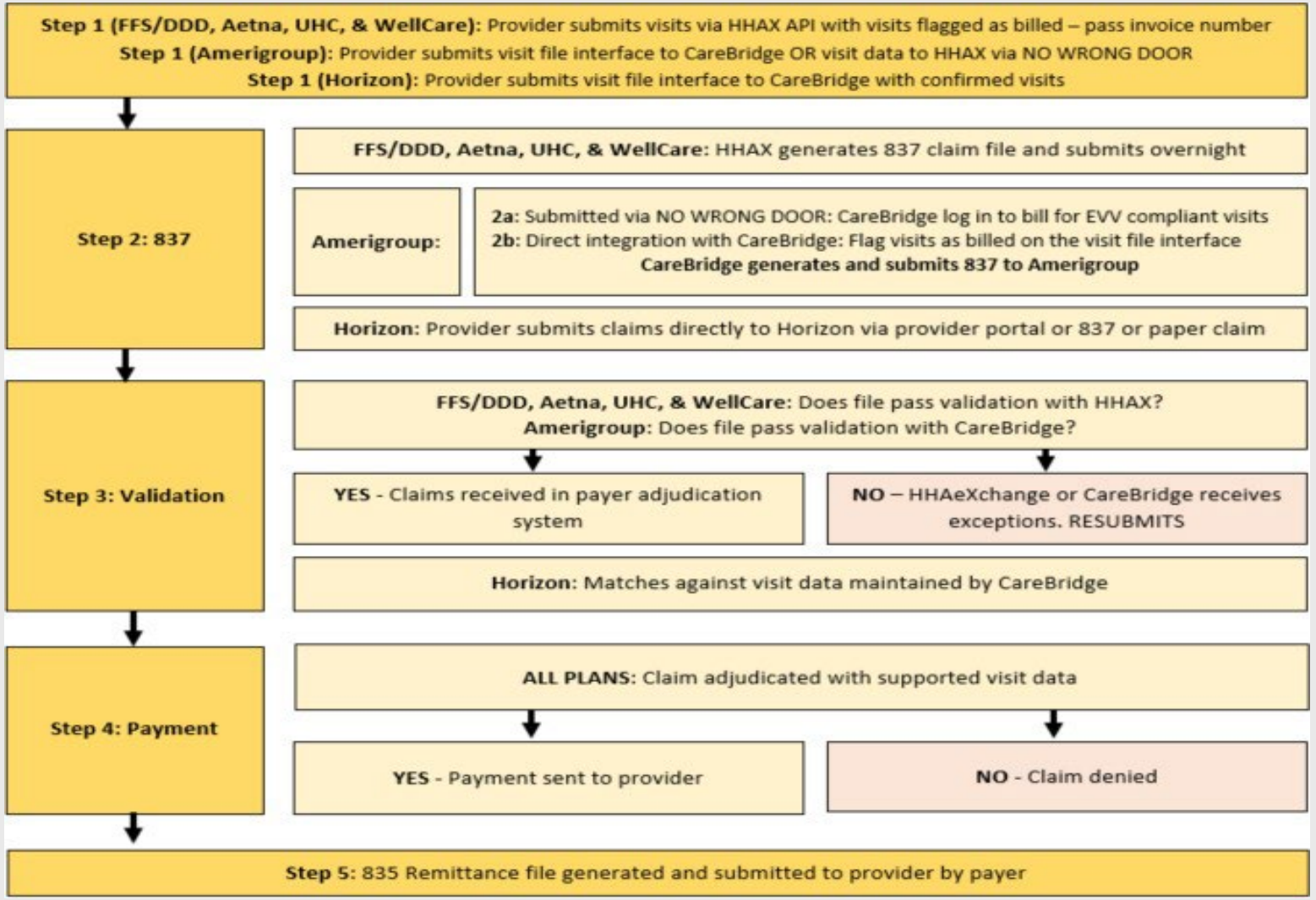
Providers using HHAeXchange



Claim Submission Process:

Providers using a Third Party

Medicaid Members that do not have Medicare



Billing Medicare Covered EVV Phase 2 Codes

- Providers must complete the EVV scheduling and visit verification process for all required codes in HHAX portal
- Medicare services requiring UB04 such as required for CMS (PDGM) and CMS HHPPS should be billed to Aetna following your normal process.
- EVV required codes billed on 1500 should be billed through HHAX
- Use FIDE SNP Member ID and submitter ID #46320 when submitting claims
- Providers will receive a separate remit for Medicare and any applicable Medicaid payment

Payments FAQs – Medicaid

Is anything changing with the explanation of payment documents?

- There are no changes to the existing explanation of payment documents.
- Only verified visits submitted through HHAX to our clearinghouse will be accepted for claims processing. As such, you will not see denial reasons for missing EVV data on claims remittance advice.

I'm not getting paid. What do I do?

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

Providers can check their claims submission status in their HHAeXchange portal under Billing>Invoice Search>By visit in order to see if the claim file was submitted, accepted or rejected by the Clearinghouse.

Not getting paid? Follow these steps:
Check HHAX 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.

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

Payments FAQs - Medicaid

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 services also need to be submitted via HHAX since every visit needs to be verified with EVV data.

Communications and Claims status

Please communicate with HHAX on EVV issues via the Communication Notes module. Providers may check the status of a claim by accessing ABHNJ's provider portal.

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

For claims issues, you can also contact ABHNJ's Claims Inquiry Claims Research (CICR) Department at **1-855-232-3596**.

Payments FAQs - Medicaid

What is Aetna's Coordination of Benefit Process?

Aetna's Process

- EVV does not change the Aetna COB process.
- If other insurance is the primary payer before Aetna, prior authorization of a service is not required, unless it is known that the service provided is not covered by the primary payer. If the service is not covered by the primary payer, the provider must follow our prior authorization rules.
- Providers are required to submit an EOB from the primary insurer for Aetna to process the claim. If the EOB indicates the benefits have been exhausted or the service isn't covered, Aetna will enter a TPL bypass in the system for the remainder of the policy year. If the primary policy does pay for any portion of the benefit, Providers are required to submit the EOB with every claim until the benefits are exhausted.
- If the member has other coverage as recorded on the State TPL file, and the claim is submitted without the primary payer details, the claim will deny. The provider will receive a message on the remit that indicates that prior insurance payment information is required.
- Providers should capture EVV quality data in the HHAX aggregator but will be allowed to submit claims directly to Aetna, when a member has primary coverage.
- When the primary coverage is completely exhausted, and Medicaid is authorizing the service; then both EVV scheduling and billing should be conducted for the member in the HHAX portal following the standard procedure.

Payments FAQs - Medicaid

How will ABHNJ ensure 21st Century Cures Act Compliance on secondary claims?

Provider should submit secondary claims to ABHNJ as they do now via Availity.

ABHNJ will be implementing a post payment claims auditing program and will be asking provider for medical records to confirm time spent delivering hands on care. If a review determines inadequate record keeping or billing errors, funds will be recouped.

Provider must continue to keep detailed records of actual hands-on patient care for each unit authorized.

Payments FAQs – Dual Eligible MLTSS

Is EVV required when ABHNJ 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. This table clarifies the codes and procedures subject to this requirement:

Code G	Procedure Name	Unit of Measure	Service Requirements	MLTSS Members	Non MLTSS and Non -FIDE
97597	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	Per visit	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
99601	Infusion- Skilled nursing	Up to 2 hours	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
99602	Infusion- Skilled nursing-additional hour(s)	Each additional hour	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
G0299	Direct skilled nursing services of a registered nurse (run) in the home health or hospice setting	15 mins	PA – REQUIRED POS12/Home	EVV Not required	EVV Required when Aetna Authorizes the service
S9122	Home Health Aide/Certified Nurse Assistant	Per hour	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
S9123	Nursing care, in the home; by registered nurse,	Per hour	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
S9124	Nursing care, in the home; by licensed practical nurse	Per hour	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
S9127	Social work visit, in the home	Per diem	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
T1000	Private Duty Nursing/Independent Nurse Service(s)	15 mins	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
T1002	Private duty / independent nursing service(s) / RN	15 mins	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
T1003	LPN/LVN SERVICES	15 mins	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
T1030	Nursing care, in the home, by registered nurse	Per diem	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
T1031	Nursing care, in the home, by licensed practical nurse	Per diem	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home or hospice setting	15 mins	PA-REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service

Payments FAQs – Dual Eligible MLTSS cont.

Is EVV required when ABHNJ is the secondary payor?					
Code	**Procedure Name**	**Unit of Measure**	**Service Requirements**	**MLTSS Members**	**Non MLTSS and Non -FIDE**
92507	Speech, Language and Hearing Therapy Individual	Per diem	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
97110	Physical Therapy, Therapeutic procedure, 1 or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility	15 mins	PA – REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
97129	Cognitive Therapy, Individual	15 mins	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
97130	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)	Each additional 15 mins	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
97535	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	15 mins	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
G0151	Services performed by a qualified physical therapist in the home health or hospice setting	15 mins	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting	15 mins	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
G0153	Services performed by a qualified speech language pathologist in the home health or hospice setting	15 mins	PA-REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
G0155	Services performed by clinical social worker in home health or hospice setting	15 mins	PA-REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
S9128	Speech therapy, in the home	Per diem	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
S9129	Occupational therapy, in the home	Per diem	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service
S9131	Physical therapy; in the home	Per diem	PA - REQUIRED POS12/Home	EVV Required	EVV Required when Aetna Authorizes the service

Payments FAQs – FIDE SNP

Is anything changing with explanation of payment documents?

- ✓ There are no changes to the existing explanation of payment documents.
- ✓ When submitting Medicare covered services directly to the plan.
- ✓ Only verified visits submitted through HHAX to our clearinghouse will be accepted for claims processing. As such, you will not see denial reasons for missing EVV data on claims remittance advice.

I'm not getting paid? What do I do?

Providers submitting Medicare primary services to Aetna should check Availity or call Aetna Assure Premier Plus (HMO D-SNP) Inquiry Claims Research (CICR) Department at **1-844-362-0934** for payment concerns.

Providers can check their claims submission status in their HHAeXchange portal under Billing>Invoice Search>By visit in order to see if the claim file was submitted, accepted or rejected by the Clearinghouse. For services billed through HHA, it is critical that providers continually monitor their claim status reports from HHAX 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:
Check HHAX 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.

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

Payments FAQs – FIDE SNP

How to dispute a claim payment? How to submit a corrected claim?

- ✓ There are no changes to the existing participating provider claim dispute process. The process is outlined on our website: https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/grievances-appeals.html
- ✓ Corrected claims for services will need to be submitted via HHA or directly to the plan depending on the initial submission. Medicare primary services should be paid directly to the plan.

Communications and Claims status

Please communicate with HHAX on EVV issues via the Communication Notes module. Providers may check the status of a claim by accessing the provider portal

Disputes will be settled according to the terms of our contractual agreement. There will be no disruption to — or interference with — the provision of services to enrollees as a result of disputes.

Aetna Assure Premier Plus HMO D-SNP
https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html

For claims issues, you can also contact Aetna Assure Premier Plus (HMO D-SNP) Inquiry Claims Research (CICR) Department at **1-844-362-0934**.

Authorization FAQs – FIDE SNP

What is the process for authorizing services when members are discharged from the hospital?

- ✓ The Aetna Transition of Care lead will coordinate with the hospital discharge planner to obtain discharge orders.
- ✓ PA form is completed by the provider.
- ✓ Authorizations will be entered for new services or to resume services based on discharge orders.
- ✓ Providers will receive verbal and written notification.
- ✓ HHAX portal displays the authorization within 2 days of approval.

I need assistance with this process. How do I contact Aetna for assistance with authorizations at time of discharge?

Contact the Care Management team by calling 1-844-362-0934

Clinical Staff Dedicated EVV Email Mailbox: NJFIDE-EVV@AETNA.com

Additional Support

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

Open Discussion/Q&A