Aetna Better Health® of Virginia
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AETNA BETTER HEALTH® OF VIRGINIA

Provider Notification: Electronic Visit Verification

April 2, 2020

All personal, respite care, and companion services provided to members **using Agency Providers or Consumer Directed will require Electronic Visit Verification (EVV)**.

Virginia is in the middle of a soft launch that began October 1, 2019 for Agency Providers. However, please note that Consumer Directed went live in early January 2020.

All agency provided claims for services dated **October 1, 2019**, to **August 31, 2020**, will only be accepted in the old format until **August 31, 2020**. Because of COVID-19, beginning **September 1, 2020**, any claim for services delivered on **October 1, 2019**, or after, must be EVV compliant. **Claims submitted incomplete or on paper will be denied.**

This change is in coordination with the Virginia Department of Medical Assistance Services (DMAS) and the managed care organizations (MCOs) in Virginia to comply with the 21st Century Cures Act and the Virginia Appropriations Act. Together, we are embracing technology to verify, simplify, and improve service delivery to our members.

The Commonwealth of Virginia is implementing a Provider Choice Model for EVV. This model requires that **ALL** providers **select and implement the EVV application that suits their organizations business requirements**. Neither DMAS nor Aetna Better Health of Virginia will endorse, approve, or recommend any specific EVV vendor.

The EVV claims processing on behalf of the Virginia MCOs requires that the EVV system used meets minimum requirements. Some of these requirements include:

- Being HIPAA compliant.
- Operating in an offline mode when cellular or Wi-Fi connectivity is unavailable.
- Ensuring all PHI is always encrypted.
- Maintaining historical data via backups for the minimums defined by DMAS.
- Capturing the required six data points.
- Making sure that claims are submitted electronically on an 837P.

Currently claims are collecting the following three of the six required data elements, member ID, code of the service provided, and the date the service. The **three additional data elements that must be included are the 1) time the service begins and ends, 2) the location for the beginning and ending of the service, 3) and the attendants name and unique ID that you created for your staff member**. The EVV vendors must supply the data in the correct format and fields of the 837P.

Aetna Better Health began testing in July with providers who are ready with their EVV systems. Those that would like to participate should contact their Network Relationship Consultant.

Resources to help prepare for this transition to EVV.

- DMAS has EVV FAQs, examples, training, and more on its website at **www.dmas.virginia.gov/#/longtermprograms**.
- Contact your Aetna Network Relations Representative about EVV or any concerns. Their contact details are on our website at **www.aetnabetterhealth.com/virginia/providers**.
    - On the left side of the screen, select *Resources*, then the subcategory *Provider Relations*. At the bottom of the right side, select *Network Relations Consultant contact list* to display a list of Network Relations Consultants that are providers liaison to Aetna Better Health of Virginia.

EVV Supplemental Information

DMAS initiated a soft launch on **October 1, 2019** for EVV. Claims that are EVV noncompliant are being paid, including personal and respite claims submitted on paper. Initially, Aetna supplied generic warning messages if a claim did not have all the EVV elements. Beginning in mid-February, Aetna enhanced the message codes included on the remit statements.

Note this claim was **paid** but the provider received messages.

	Billed Amount	Disallowed	Allowable Amount	Co-Pay	Ded.	Co-Ins	COB Paid	Processed Amount	Discount/ Penalty	Net Amount
Remit Totals	2,150.90	0.00	2,150.90	0.00	0.00	0.00	0.00	2,150.90	0.00	2,150.90

Below are sample EVV remit adjustment reason codes that appear as warnings:

N252 means that the attendants' **name** (could be either last or first name) details were incomplete.

MA130 - YOUR CLAIM CONTAINS INCOMPLETE AND/OR INVALID INFORMATION, AND NO APPEAL RIGHTS ARE AFFORDED BECAUSE THE CLAIM IS UNPROCESSABLE. PLEASE SUBMIT A NEW CLAIM WITH THE COMPLETE/CORRECT INFORMATION
N252 - MISSING/INCOMPLETE/INVALID ATTENDING PROVIDER NAME

MA114 means that the **location**, either beginning or end, was not entered or was incomplete.

MA114 - MISSING/INCOMPLETE/INVALID INFORMATION ON WHERE THE SERVICES WERE FURNISHED.
MA130 - YOUR CLAIM CONTAINS INCOMPLETE AND/OR INVALID INFORMATION, AND NO APPEAL RIGHTS ARE AFFORDED BECAUSE THE CLAIM IS UNPROCESSABLE. PLEASE SUBMIT A NEW CLAIM WITH THE COMPLETE/CORRECT INFORMATION

This example shows three codes for incorrect data, including N252 the attendants **name is invalid or missing**, N253 the attendants unique **ID is missing**, and N443 the **time** service began or ended is missing or invalid.

MA130 - YOUR CLAIM CONTAINS INCOMPLETE AND/OR INVALID INFORMATION, AND NO APPEAL RIGHTS ARE AFFORDED BECAUSE THE CLAIM IS UNPROCESSABLE. PLEASE SUBMIT A NEW CLAIM WITH THE COMPLETE/CORRECT INFORMATION
N252 - MISSING/INCOMPLETE/INVALID ATTENDING PROVIDER NAME
N253 - MISSING/INCOMPLETE/INVALID ATTENDING PROVIDER PRIMARY IDENTIFIER
N443 - MISSING/INCOMPLETE/INVALID TOTAL TIME OR BEGIN/END TIME.

There will always be a general message MA130, the other codes/message are specific to what may have been the concern.