Let's simplify EVV for agency Virginia Medicaid providers.

Learn everything you need to know so your claims are always approved the first time.

What is EVV?

Electronic Visit Verification (EVV) was implemented in coordination with the Virginia Department of Medical Assistance Services (DMAS) and Virginia managed care organizations (MCOs) 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 implemented a **Provider Choice Model** for EVV. This model requires you to select and implement the EVV application that suits your business requirements.

Be aware that neither DMAS nor Aetna Better Health will endorse, approve, or recommend any specific EVV vendor to a provider.

Make sure your system meets requirements.

The EVV claims processing on behalf of the Virginia MCOs requires your EVV system to meet minimum requirements. Some of these requirements include:

- Adhering to *HIPAA* compliance.
- Operating in an offline mode when cellular or Wi-Fi connectivity is unavailable.
- Ensuring PHI is always encrypted.
- Maintaining historical data via backups for the minimums defined by DMAS.
- Capturing the required six data points.
- Submitting claims electronically on the 837P.

Don’t let your claims get denied.

There are six required data elements to be considered a valid EVV submission. If any of these EVV data elements are missing, the claim will be denied. If the EVV claim submission passes the intake rules, the standard claim processing rules will apply. The six required data elements include:

1. Member ID
2. Code of the service provided
3. Date the service
4. Time the service begins *and* ends
5. Location for the beginning *and* ending of the service
6. Attendant’s name and unique ID created by the agency

Important Coding Information for EVV Providers

There are unique codes and processes for submitting EVV claims. Make sure you are using correct codes and are adding each unit correctly. Otherwise, your claim might be denied.

Codes for EVV for Agency Providers

- T1019
- T1005

Unit Measurement

- 1 unit = 1 hour

Note: Be sure to confirm unit measurements with your EVV vendor; other states have different measurements for how much time equates to each unit.

Prior Authorization Requirements

All Personal Care requires prior authorization prior to service.

Where to fax prior authorization
Submit the DMAS 98R in addition to necessary documentation as described via fax to 844-459-6680.

Additional Requirements

A Nurse Supervisor must make an initial assessment home visit on or before the start of care. This assessment visit and required documentation is required for new members, for readmission after discharge from a hospital or level 1 or 2 nursing facility, or transfer from another provider.

Chapters four and five and the Appendices of the DMAS Commonwealth Coordinated Care Plus Waiver Manual include documentation DMAS 99 and 97 A-B requirements.

Details and DMAS forms for Personal and Respite Care Services can be found here:
dmas.virginia.gov/for-providers/managed-care/ccc-plus/provider-resources

DMAS Provider Manuals can be found here:
vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library

Get your claims right the first time.

Make sure you know when EVV is required. Also, be sure to know what modifiers to use if a member has a second visit in the same day. Lastly, make sure that you're using the right CPT codes in your submissions.

Exceptions to EVV

There are exceptions when EVV is not required. EVV is not required when service is provided:

- By a live-in caregiver.
- In a group home setting.
- In a school setting.

In these cases, claims must include the UB modifier. Additionally, the correct place of service is required on the claim.

Documenting Second Visits

If a member has a second visit during the day, then that visit should have the 76 modifiers indicating a second visit that same day. The first visit should not have the 76 modifiers; only the second visit of the day should have the 76 modifiers.

Consumer-Directed CPT Codes

S5126, Personal Care, and S5150, Respite Care, are both Consumer-Directed CPT codes. They cannot be billed by agency providers. S5135 are "Companion" Care Consumer-Directed, and they are carved out and will not be paid by Aetna Better Health.

Need more information?

Visit the DMAS website to learn more about EVV. Go to **dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/electronic-visit-verification**.

Visit us online.
Find this resource, plus many more,
by scanning the QR code here or by visiting our website at
AetnaBetterHealth.com/Virginia/providers/materials-forms.html.

Your patients have extra benefits that can improve their health.

By being a member of Aetna Better Health, your patients have access to a wide range of added benefits that can help them better meet their health needs, all at no cost. Call **1-800-279-1878 (TTY: 711)** to speak to a Care Manager to learn more about these benefits.

For all members

Extra help with rides: Members can enjoy free rides to local resources or services — up to 30 round trips or 60 one-way trips each year.

Free cell phone: Free Android™ smartphone with free data, texts, and minutes, plus 10 GB monthly hotspot

General Educational Development (GED) incentive: CampusEd is an online resource that can help members earn their GED and start a new career. We'll also pay for members' GED test (up to $120).

Hearing care: One hearing exam, $1,500 toward hearing aids, plus 60 batteries each year, plus unlimited visits for hearing aid fittings

Home meal delivery: Home-delivered meals after hospital discharge for seven days.

Mental health support through Pyx: A personalized program to support members' health. Pyx Health helps members get the most from their health plan, at no cost, whether it's help finding a doctor, food, transportation, or just needing someone to talk to.

MyActiveHealth Management: A personalized and interactive mobile program that sends texts regarding diabetes education and support; personal care management; appointment and medication reminders; and exercise/weight goal setting and tracking

Over-the-Counter Health Solutions® period stipend: $20 monthly for members with periods to spend on period products through CVS Pharmacy®

Vision care: One eye exam and $250 toward eyewear

Weight management: Personalized weight management with a registered dietitian, which includes a 12-week certified nutritionist program and six counseling visits

Wellness Rewards: Members can get gift cards for taking care of their health. Kids also get extra perks, like free swimming lessons and sports physicals, plus up to a $25 gift card when they join the Ted E. Bear, M.D.® Wellness Club!

For moms and children

Benefits for new moms: Eligible members who are pregnant through one year postpartum can get $25 monthly to spend on over-the-counter items for them and their baby through CVS Pharmacy. New moms can also attend baby showers and earn prizes. Plus, new moms can get 300 free size 1 baby diapers delivered to their home after their baby is born.

Breastfeeding support through Pacify: 24/7 access to a national network of International Board-Certified Lactation Consultants® and doulas via live video consultation

Youth sports physicals: Annual sports participation physical for members 12 to 18 years old

Youth swimming lessons: Water safety and swimming lessons for members 6 years and younger

Healthy food card: Eligible members can get $50 added to a special debit card every month to buy healthy groceries at nearby stores.

For members with certain health conditions

Asthma program: Members with asthma can get one set of hypoallergenic bedding and between $150 and $400, depending on area of service, to use towards one deep carpet cleaning annually.

Memory care: Two door alarms and six window locks available to members diagnosed with dementia or Alzheimer's disease (requires prior authorization)

Therapeutic shoes or shoe inserts: Eligible members with diabetes with a prescription from a podiatrist or orthopedic doctor can get pair of therapeutic shoes or shoe inserts per year (up to $200 annually).

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