DELAWARE HEALTH AND SOCIAL SERVICES

Delaware Electronic Visit Verification (EVV) Terms and Definitions

Term	Definition
837 Institutional (837I)	The 837I is the standard format used by institutional providers to transmit health care claims electronically. Used for hospital, nursing facility, and home health services. Services subject to EVV can be submitted on an 837I. Attending provider is a required field on the 837I; however, there is limited editing of this field in Delaware's Medicaid Enterprise System (DMES).
837 Professional (837P)	The 837P is the standard format used by health care professionals and suppliers to transmit health care claims electronically. Services subject to EVV can be submitted on an 837P. Since all fee-for-service (FFS) EVV Taxonomies are non-group, the rendering provider is not sent on an EVV FFS professional claim.
Aggregator	The view-only portal and underlying Sandata EVV repository for reporting and visit review of collected electronic visits transmitted by state providers.
Aggregator Visit File	A file sent from a third-party system to Sandata containing visit data collected within the third-party system. Visit data from a third-party system must be sent to Sandata within at least seven days from the date of service. Weekly uploads of visit data is strongly encouraged.
Alternate EVV Vendor	An EVV system, outside of the State's procured system (i.e., Sandata), utilized by and paid for by a provider to collect required EVV data. The system must meet federal and state specified requirements.
Attending Provider	The Affordable Care Act and federal regulations require the State Medicaid Agency to enroll ordering and referring providers. Centers for Medicare & Medicaid Services (CMS) interprets this enrollment requirement to include attending physicians supervising care in institutional settings, including hospitals, nursing facilities, and residential treatment centers or for home health services. For such services, the attending physician serves as the ordering, referring and, prescribing provider, and must be enrolled with the state Medicaid program for the service to be reimbursed by Medicaid. The attending physician certifies and recertifies the medical necessity of services.
Billing Provider	A provider who submits claims and/or receives payment for Medicaid services. This is included on both 837P and 837I.
Billing Provider Address	The address of the physical location of the billing provider.
CG Modifier	This informational modifier is assigned to claims with procedure codes that are typically subject to EVV to indicate that the service is not subject to EVV per Division of Medicaid and Medical Assistance (DMMA) policy. Reasons include: services provided by a paid caregiver who lives with the individual, services provided in a location outside of the home (e.g., school), services provided as part of the hospice benefit when the individual is enrolled in hospice, services provided to a newborn who does not yet have their own Medicaid ID number, services and service provided out of state.
Claim	A request for payment of health care services to a Medicaid recipient.

Term	Definition
Employee/Worker /Caregiver	The individual providing Medicaid reimbursable services to the member. Typically employed by an agency or in the case of self-direction co-employed by an Financial Management Services Agency (FMSA) and a member.
Encounter	A claim that was covered under a managed care arrangement under the authority of 42 CFR § 438; and therefore, not paid on a FFS basis directly by the state (or an administrative services only claims processing vendor). Encounter records often (though not always) begin as FFS claims paid by a managed care organization (MCO) or subcontractor, which are then repackaged and submitted to the state as encounter records.
Financial Management Services Agency (FMSA)	FMSA is a service/function that assists the family or participant to (a) facilitate the employment of staff by the family or participant by performing as the participant's agent such employer responsibilities as processing payroll, withholding and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; and (b) performing fiscal accounting and making expenditure reports to the participant and/or family and state authorities. In Delaware, the FMSA acts as the co-employer with the member. The Division of Developmental Disabilities Services (DDDS) contracts with a single FMSA for the individuals they serve, Easter Seals. The MCOs contract with three FMSAs that serve their members, JEVS, Easter Seals, and GT Independence.
Key Performance Indicator (KPI)	As a condition of the receipt of enhanced federal financial participation for the DMMA EVV system, the State is required to report on five KPIs related to EVV. These include: • Association of EVV record to claims/encounter • EVV records match against approved services, providers, and units • EVV records with manual edits • EVV system availability • Privacy and security
Manual Visit Entry	An EVV record input by a provider after the time of service delivery by administratively entering the required EVV data elements. Supporting documentation must be maintained to support visits that are entered manually in the EVV system. Manual entry of visits cannot exceed 10% of a provider's total EVV visits.
Medicaid Identifier (MCDID)	Generated by the DMES, the MCDID is a code used to identify Medicaid providers in Delaware. A combination of data elements including a provider's national provider identifier (NPI), taxonomy, and address generate the MCDID.
Member File	A file generated by DMES and sent to Sandata, containing demographic information for all individuals enrolled in Medicaid who are eligible to receive services subject to EVV. Changes in demographic information should be made in the DMMA system of record, e.g., Medicaid eligibility system, ASSIST. This information will be passed to Sandata via this file.

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Modified/Edited Visits	Visits that are modified/edited in an EVV record by a provider after the time of service delivery. DMMA recognizes the practical need for visits to be modified; however, doing so should only be done as an exception to normal practice, and the majority of all EVV records should remain unmodified. Supporting documentation must be maintained to support any changes to visit information after a visit has been confirmed. Modified or edited visits are considered to be manually modified and are included in the count of manually entered visits. Manual entry of visits cannot exceed 10% of a provider's total EVV visits.
National Provider Identifier (NPI)	The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).
Ordering Provider	An ordering provider (usually a physician) is one who orders services for the individual such as home health services, diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment services. Sometimes used interchangeably with referring provider.
Payer	An entity that generates authorizations for care, and accepts claims (837s) or encounter information to adjudicate and pay for services performed. For purposes of Delaware EVV the payers are AmeriHealth Caritas Delaware, Highmark Health Options, and the State (DMMA or DDDS).
Pre-Adjudication Process	A process by which claims for services subject to EVV will be matched to EVV visit data prior to claims payment. If there is no visit data for the date of service on the claim or if other key data elements (e.g., number of units) do not match, the claim will be denied.
Place of Service (POS)	POS codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. For valid EVV claims only the following POS codes are used: 12 (Home) and 99 (Other).
Prior Authorization (PA) File	A file generated by DMES and by each of the MCOs and sent to Sandata containing PA information for members.
Procedure Code	A Current Procedural Terminology or Healthcare Common Procedure Coding System code that uniquely identifies a service or procedure for a professional service.
Program	A waiver or other state-level initiative that defines a set of services whose costs will be covered by the state or federal programs. Programs often define specific requirements for individual eligibility, services covered, reporting or auditing requirements, and rules for delivery of service, limiting or administering it, and how those activities are submitted for payment.
Provider File	A file generated by DMES and sent to Sandata containing demographic information for EVV providers including MCDID, taxonomy, NPI, etc.

Term	Definition
Referring Provider	A referring provider (usually a physician) is one who requests an item or service for the member for which payment may be made. Sometimes used interchangeably with ordering provider.
Rendering Provider (Servicing Provider)	The rendering provider is the provider agency who provided the service to the member. Also referred to as the servicing provider.
Rendering Provider Address	The address of the physical location of the rendering provider.
Revenue Code	Maintained by the National Uniform Billing Committee (NUBC), revenue codes are defined by NUBC as "codes that identify specific accommodations, ancillary services, or unique billing calculations, or arrangements relevant to the claim". For purposes of Delaware EVV, home health FFS PAs can be set up using the revenue code.
Sandata	The vendor, contracted by DMMA, to provide EVV services within the State of Delaware.
Sandata Claims Gateway	An enhanced Sandata Aggregator portal with a Claims Submission tab that ALL providers (i.e., those using Sandata or an alternate EVV system) will use to upload 837 claims. Upon receipt of an 837 claim, Sandata will check for the existence of matching EVV visits and will perform 5010 validation and formatting requirements specific to Payer 837 requirements. Clean claims where there is a visit that matches the claim will be passed to the payer for adjudication. Providers will receive immediate notification on upload if there are 837 format or EVV data issues and will be trained on how to immediately resolve the identified issues.
Self-Directed Services	A program by which individual recipients of care are empowered to select and co-employ their own caregivers. Payments to caregivers are made through the FMSAs. Self-directed services are subject to EVV.
Taxonomy	These codes define the health care service provider type, classification, and area of specialization.
Visit	The provision of services subject to EVV to a Medicaid member. A visit can start and end in a home or a community setting. Visits whose entire duration occur in settings entirely outside of the home are not subject to EVV.
Worker ID	A unique number, generated by Sandata, to identify individual direct service workers employed by a specific provider.