Aetna Better Health® of Virginia

FAQ for PRSS/Cures Act Compliance

1. **Why is this a requirement?**
   The *21st Century Cures Act* has a provision that requires DMAS to validate specific requirements for providers. This requirement includes billing, servicing, ordering, referring, or prescribing (ORP) providers who serve members through managed care organizations (MCOs), fee-for-service (FFS), or both.

2. **Where does a provider start their application?**
   Providers can access the DMAS site at **vamedicaid.dmas.virginia.gov/provider/mco#gsc.tab=0** to start an application or check enrollment status by downloading a file from the state site.

3. **Who can providers contact for information on their application or the enrollment list?**
   Providers can contact DMAS' PRSS vendor, Gainwell, by phone at **1-888-829-5373** or by email at vamedicaidproviderenrollment@gainwelltechnologies.com.

4. **Is there any documentation or guide you can provide to assist in providers enrolling?**
   DMAS has published a tutorial for all providers. Access the following for PDF guides, videos, and FAQs on the enrollment process and requirements at **vamedicaid.dmas.virginia.gov/training/providers#gsc.tab=0**.

5. **How can a provider appeal their status?**
   Providers can contact DMAS' PRSS vendor, Gainwell, by phone at **1-888-829-5373** or by email at vamedicaidproviderenrollment@gainwelltechnologies.com.

6. **Was I notified that I am not compliant with this *Cures Act* provision requirement?**
   MCOs and DMAS have completed many multitouch outreach campaigns to any non-compliant providers via email, letters, and faxes. The first communication was in July 2022 and subsequent communications were sent in early 2023. Communications indicated that non-compliance would have impacts on claims payment.

7. What if a provider is not compliant on July 1, 2023?

Suspensions for non-compliance started on July 1, 2023. Suspension means:

- Provider claims will deny with RARC codes that are applicable to the non-*Cures Act* compliant provider—see reference section below for the RARC code that will be visible on provider claims remittance advice.
- Providers will be removed from Aetna Better Health's provider directory.
- Providers will have PCP flags removed if applicable.
- Provider's member panel will be moved to another compliant provider.

8. How does a provider suspension lift for a newly compliant provider?

MCOs use a combination of state data to determine if providers are compliant or have submitted their enrollment with DMAS's provider Enrollment Wizard and waiting final approval. A provider who submits an application will have their suspension lifted when that is communicated to Aetna Better Health by DMAS (there may be a two-week delay):

- Provider suppression from the directory will be reverted
- PCP providers can accept any members
- New claims will adjudicate

9. If the provider still does not certify, how long will they have before we move to term?

We expect providers who are not fully compliant to move from suspension to full termination by end of year, or sooner. Operation teams are still awaiting DMAS guidance.

10. Are we sending a letter to advise the providers that they are suspended? If yes, when and can we have a copy of that letter?

Yes. The last letter communication went out June 26, 2023, to non-compliant providers that were contracted and participating in our network.

11. What if providers become compliant, and had claims were denied because they were non-compliant?

When a provider takes action to become compliant with the state, the state will update weekly those providers. providers should resubmit claims approximately two weeks after they complete their application using the DMAS provider Enrollment Wizard. It is *recommended* that a provider check their status directly on the state's site (**vamedicaid.dmas.virginia.gov/provider/mco#gsc.tab=0**) to see if their status is reflecting as enrolled or pending. Claims with a DOS after the date of provider enrollment will be paid.

Providers may also call our provider helpline at **1-800-279-1878**, and we can confirm whether or not the given NPIs in question that will be on a claim are reflecting as enrolled or pending enrollment (either will allow claim to pass *Cures Act* claims validation). Keep in mind that there will be a delay before MCOs will not be notified that an application has been received by the state.

12. What will providers see on their remittance notices if they are denied for non-*Cures Act* compliance?

The provider on the claim who is not noted as being *Cures Act* compliant will result in a CARC and RARC code combination on the remit (see reference section below). Before resubmitting claims, all providers on the claim should be Cures-compliant before resubmitting the corrected claim. Providers do not need to submit Corrected Claim Frequency Type 7. Providers simply resubmit it as sent originally because it never made it to adjudication.

An internal Aetna Better Health claim memo for all the below CARC and RARC codes (*in reference* that will be possible for the denials based on the provider that is non-*Cures Act* compliant will be visible to our call center representatives: "In Virginia, DMAS requires contracted MCOs to verify that all providers, provider Groups, and their affiliates who wish to provide services to Medicaid participants have their Medicaid Enterprise System (MES) enrollment completed and verified prior to rendering dates of service. Medicaid providers will use the PRSS portal, located on the MES website at **virginia.hppcloud.com** to complete enrollment. Please verify the submitted provider NPI referenced in your remittance advice is registered for the date of service and resubmit your claim upon receiving active enrollment"

Reference Section

CARC/RARC codes reference:

Billing Loop: 2010AA: (Both Professional and Institutional)

CARC Code	CARC DESCRIPTION	RARC Code	RARC Code
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service	N257 & N767	Missing/incomplete/invalid billing provider/supplier primary identifier. The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.

Rendering Loop 2310B (Professional)

CARC Code	CARC DESCRIPTION	RARC Code	RARC Code
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service	N290 & N767	Missing/incomplete/invalid rendering provider primary identifier. The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.

Referring Loop 2310A (Professional)

CARC Code	CARC DESCRIPTION	RARC Code	RARC Code
183	The referring provider is not eligible to refer the service billed.	N286 & N767	Missing/incomplete/invalid referring provider primary identifier. The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.

Attending Loop 2310A (Institutional)

CARC Code	CARC DESCRIPTION	RARC Code	RARC Code
283	Attending provider is not eligible to provide direction of care.	N253 & N767	Missing/incomplete/invalid attending provider primary identifier. The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.

Ordering/Prescribing Loop 2420E (Professional)

CARC Code	CARC DESCRIPTION	RARC Code	RARC Code
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	N31	Missing/incomplete/invalid prescribing provider identifier.

Supervising Loop 2310DD (Professional)

CARC Code	CARC DESCRIPTION	RARC Code	RARC Code
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service	N297 & N767	Missing/incomplete/invalid supervising provider primary identifier. The Medicaid state requires provider to be enrolled in the member's Medicaid state program prior to any claim benefits being processed.