# AHCCCS E.V.V.

## ELECTRONIC VISIT VERIFICATION

# Frequently Asked Questions (FAQ)
# Designee| December 2022

### *What is a Designee?*

When a member/Health Care Decision Maker is unable or not in a position to verify service delivery on an ongoing basis, they can assign a Designee to have the verification responsibility. A Designee can be any person at least 12 years of age or older who is willing and able to accept the responsibility of verifying and approving the Direct Care Worker's (DCWs) service delivery and time in the Electronic Visit Verification (EVV) system. The Designee must either verify service delivery at the end of the visit or within 14 days of the visit.

### *When should a Designee be used?*

First and foremost, if a member is able and willing to verify their DCW's service delivery, they should have that opportunity. The member's service/treatment planning team can help inform a decision as to whether or not the member is in a position to verify service delivery. If a member has a Health Care Decision Maker in place, the Health Care Decision Maker already has more authority than what the Designee attestation would allow and can verify services without completing the attestation form. The Designee cannot be a paid caregiver. For example, if the Health Care Decision Maker is also the paid caregiver, they cannot verify service delivery for the services they are providing. In these instances, a Designee should be considered.

When a member/Health Care Decision Maker is unable to verify service delivery on an ongoing basis, then they have the option to use a Designee to verify service delivery in their place.

### *What is the difference between a Designee and a Health Care Decision Maker?*

A Health Care Decision Maker or guardian has a legal authority to make health care decisions for the member.

A Designee has no authority to make health care decisions for the member. They can only sign off to verify services were received.

### *How old does a Designee need to be?*

The Designee can be any individual who is 12 years of age or older that is designated by the member or Health Care Decision Maker. Exceptions to the age requirement must be discussed with and agreed to by the treatment or planning team prior to verification of service responsibility. The Designee cannot be a paid caregiver.

### *At what age can a member verify service delivery?*

A member of 12 years of age or older should be able to verify their DCW's service delivery; however, the member's Health Care Decision Maker and service/treatment planning team can help inform a decision as to whether or not the member is in a position to verify service delivery.

### *Can a caregiver act as a Designee for another caregiver?*

Yes, if the caregiver is acting as a Designee for a service they are **not** providing, this would be acceptable.

### *Where do we file the Designee attestation?*

The provider agency should keep the attestation on file for audit purposes. The form shall be reviewed at least annually with the member/Health Care Decision Maker.

### *What if there is no one who can verify services?*

For situations where the member cannot verify service delivery, the Health Care Decision Maker is the paid caregiver and no one else is able to act as a Designee, this needs to be documented under the "No Available Designee" section on the attestation with the treatment or planning team.

When the exception is filled out on the attestation form, this is stating that there will be **NO** Designee available and all visits will be unverified. The agency should keep the attestation on file for audit purposes and use the appropriate reason codes for the exception to explain this in the EVV system in order to get the visit to a verified state for billing purposes.

### *Is member/Health Care Decision Maker/Designee approval required for claims payment?*

The approval is not required for payment. A visit can still get to a verified (billable) state without approval. In the event the approval is not provided at the end of a visit or before the provider wants to bill for the visit, the provider will need to clear exceptions in order to get the visit to a verified (billable) state. AHCCCS and the Health Plans will monitor the approvals within the 14 days from the date of service. More information on how to clear the exceptions is found in the Visit Maintenance and Documentation FAQ on the AHCCCS website.

***More information on Designees may be found on the AHCCCS website under the AHCCCS Medical Policy Manual, Electronic Visit Verification 540 policy.***