

540 – ELECTRONIC VISIT VERIFICATION

EFFECTIVE DATE: 01/01/21

APPROVAL DATE: 11/19/20

I. PURPOSE

This Policy applies to ACC, ALTCS E/PD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors; Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), Tribal ALTCS, TRBHA, and all FFS populations and providers, excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100).

This Policy establishes requirements for Contractors and providers regarding the mandated use of an Electronic Visit Verification (EVV) system for personal care and home health services pursuant to 42 U.S.C. §1396b(l).

II. DEFINITIONS

AGGREGATOR	A function of the AHCCCS EVV Vendor System that allows the state to compile all data and present it in a standardized format for review and analysis
AHCCCS ELECTRONIC VISIT VERIFICATION (EVV) VENDOR	The AHCCCS selected State-Wide EVV vendor to comply with the 21 st Century Cures Act (Cures Act).
ALTERNATE ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM	Any EVV system(s) chosen by a provider as an alternate to the AHCCCS selected State-Wide EVV vendor.
DESIGNEE	For the purposes of this Policy, an individual who is 12 years of age or older and who is delegated by the member or Health Care Decision Maker the responsibility of verifying service delivery on behalf of the member.
DIRECT CARE WORKER (DCW)	For the purposes of this Policy, a DCW is an individual providing one or more of the services subject to EVV.
ELECTRONIC VISIT VERIFICATION (EVV)	A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

**ELECTRONIC VISIT
VERIFICATION (EVV)
SYSTEM**

The AHCCCS procured system or an AHCCCS approved alternate EVV system.

**HEALTH CARE DECISION
MAKER**

An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§8-514.05, 36-3221, 36-3231 or 36-3281.

MANUAL EDIT

Any change to the original visit data. All edits shall include an appropriate audit trail.

PRIOR AUTHORIZATION

For purposes of this Policy, a process by which it is determined in advance whether a service that requires prior approval will be covered, based on the initial information received. Prior Authorization may be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. Prior Authorization is not a guarantee of payment.

SERVICE CONFIRMATION

A notification to AHCCCS through an online portal by a provider a service that does not require Prior Authorization will be provided to a member that is medically necessary.

SERVICE PLAN

A complete written description of all covered health services and other informal supports which includes individualized goals, peer-and-recovery support and family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

III. POLICY

AHCCCS is required to comply with the EVV requirements in the 21st Century Cures Act, 42 U.S.C. sec 1396b(l). Contractors and providers are required to utilize AHCCCS's single statewide EVV System for data collection or choose an AHCCCS approved alternate EVV System capable of sharing data with the Aggregator. AHCCCS is using EVV to help ensure, track, and monitor timely service delivery and access to care for members.

The list of provider types and services that will be mandated to use EVV can be found on the AHCCCS website.

A. SERVICE VERIFICATION

1. Contractors shall ensure that all providers who are subject to EVV utilize the AHCCCS procured system or an AHCCCS approved alternate EVV System to electronically track the defined data specifications available on the AHCCCS website.
2. The member/Health Care Decision Maker, or Designee, shall verify hours worked by the DCW at the point of care or within 14 days of the visit. The member/Health Care Decision Maker, or Designee shall also verify Manual Edits to visits.
3. If a member/Health Care Decision Maker, is unable or not in a position to verify service delivery on an ongoing basis, they shall arrange for a Designee to have the verification responsibility. In those instances, the member/Health Care Decision Maker is required to sign a standardized AHCCCS attestation specified in Attachment A, at a minimum on an annual basis, attesting that they have communicated the requirements of the verification responsibility to the Designee to whom they are delegating the verification responsibility. The provider shall assist the member/Health Care Decision Maker to make an informed decision about verification delegation. The member/Health Care Decision Maker can change decisions about verification delegation at any time by completing a new attestation.
4. Exceptions to the Designee age requirement shall be discussed with the treatment and/or planning team and documented on the Attachment A Designee Attestation form prior to the delegation of service delivery verification responsibility.
5. Neither the Health Care Decision Maker nor a Designee is allowed to verify service delivery for the services that they have personally rendered. If this situation presents barriers to verification, the member or Health Care Decision Maker shall document in Attachment A.

B. PAPER TIMESHEETS

The use of paper timesheets is allowable when the actual date, start and end time of the service provision is independently verified, for example, a code that represents a time and date stamp through the EVV System and under the following circumstances:

1. The DCW and the member live in geographic areas with limited/intermittent or no access to landline, cell, or internet service.
2. Individuals for whom the use of electronic devices would cause adverse physical or behavioral health side effects/symptoms.
3. Individuals electing not to use other visit verification modalities on the basis of moral or religious grounds.
4. Individuals with a live-in caregiver or caregiver accessible on-site 24 hours and for whom the use of other visit verification modalities would be burdensome.

5. Individuals who need to have their address and location information protected for a documented safety concern (i.e. witness protection or domestic violence victim).

The member/Health Care Decision Maker and provider are required to sign a standardized AHCCCS attestation as specified in Attachment B and utilize the standardized paper timesheet specified in Attachment C. Attachment B is utilized to justify the allowance of the use of paper timesheets. The attestation is specific to the member and the services they receive from a single provider. Contractors shall review annually and monitor the use of these attestations to ensure they are utilized for allowable instances only. It is permissible for provider agencies to utilize their own paper timesheet as long as the minimum data elements are captured.

The provider shall enter the paper timesheet into their EVV System no more than 21 days past the date of service rendered as long as timeliness filing standards, as found in ACOM Policy 203 or the provider's contract with the Health Plan, are also met. The signature does not have to be recorded in the EVV System, but Agencies shall have the original, wet copy of the signature on file for audit purposes. A faxed copy of the signature is permissible for billing purposes.

C. EVV MODALITIES

1. The member/Health Care Decision Maker is able to choose, at a minimum on an annual basis, the device that best fits their lifestyle and the way in which they manage their care. At least two different types of visit verification modalities shall be available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service. The provider shall assist the member/Health Care Decision Maker to make an informed decision about the choice of data collection modality. The member/Health Care Decision Maker shall be permitted to change the modality at any time.
2. It is allowable for provider agencies to allow DCWs to utilize personal devices such as a smartphone. If the provider elects this option, the provider is responsible to have a back-up plan for EVV if the device becomes inoperable.
3. If the provider chooses to allow for GPS tracking while the DCW is on the clock, the provider shall disclose to members how and why the DCW is being tracked. The disclosure should be documented and on file.
4. Members shall be afforded the opportunity to change their preference for the visit verification device the DCW will use.

For members who receive service(s) on an intermittent basis, such as respite care or home health services, the choice of a modality may be limited.

D. EVV PRIOR AUTHORIZATIONS AND SERVICE CONFIRMATION PORTAL

Some EVV services require Prior Authorization and some do not. To ensure all EVV services have an authorization record in the EVV System, AHCCCS has instituted and will require the use of Service Confirmations for EVV services that currently do not require Prior Authorization. Service Confirmations are simply a notification to AHCCCS for any EVV services not Prior Authorized by a provider that a service will be provided to a member that is medically necessary. AHCCCS has created an online web-based Service Confirmation portal for providers to enter the required data for the service (service code, units, and dates of service). The Service Confirmation Portal is available on the AHCCCS website.

The medical necessity determination date is an additional element required for EVV Services on the Prior Authorization or Service Confirmation. The medical necessity determination date is the date the need for a new service was determined as specified in guidance documents available on the AHCCCS website.

E. CONTINGENCY/BACK-UP PLAN

Provider agencies shall use the standardized AHCCCS Contingency/Back-Up Plan form as specified in Attachment D to plan for missed or late service visits and discuss the member's preference on what to do should a visit be late or missed. The preferences shall be noted for each service the provider is providing. It is allowable for members to choose different preference options based upon the service. The Contingency/Back-Up Plan shall be reviewed by the Provider with the member at least annually. In the event a visit is late or missed, the provider is required to follow up with the member to discuss what action needs to or can be taken to meet the service need. The member/Health Care Decision Maker can change decisions about these preference levels and the Contingency/Back-Up Plan at any time. Should the member not choose a preference, a default preference may be applied based upon the service.

F. REPORTING

At a minimum, Contractors shall utilize EVV data to monitor and analyze the following to support provider compliance with EVV as well as inform network adequacy and workforce development planning:

1. Member access to care, including:
 - a. Late and missed visits and adherence to contingency planning preferences, and
 - b. Timeliness of new services from the date it was determined medically necessary to the date the service was provided for newly enrolled and existing members. Additional information on this requirement is specified in AMPM Policy 1620-A, AMPM Policy 1620-D, AMPM Policy 580, and AMPM Policy 310-B.
2. Provider Performance, including:
 - a. Unscheduled visits,
 - b. Manual Edits,

- c. Device utilization,
 - d. EVV modality types in use,
 - e. Visits that follow the member's Contingency/Back-Up Plan, and
 - f. Monitoring of service hours authorized compared to service hours actually provided.
3. The Provider shall self-monitor and analyze the following:
 - a. Performance, including:
 - i. Location discrepancies, and
 - ii. Visit exceptions.
 - b. Devices
 - i. Monitor and maintain the list of AHCCCS EVV Vendor devices assigned to the provider.
 - c. Service Delivery
 - i. Monitor service hours authorized compared to service hours actually provided.

G. PROVIDER REQUIREMENTS AND CONTRACTOR OVERSIGHT

Contractors shall monitor all provider responsibilities specified in this Policy as part of annual monitoring to ensure compliance for the following roles and responsibilities of providers required to utilize EVV, including but not limited to:

1. Notifying the AHCCCS EVV Vendor of all new users and user terminations and all data security incidents.
2. Collecting and maintaining records for the audit period of at least six years from the date of payment, applicable attestations regarding verification delegation, paper timesheet allowances, and contingency/back-up plans as specified in this Policy.
3. Counseling the member/Health Care Decision Maker on the scheduling flexibility based on the member's Service Plan or provider plan of care and what tasks can be scheduled and modified depending on the DCWs scheduling availability at least every 90 days.
4. Developing a general weekly schedule for each service. The EVV System shall record the schedule for each service. The system is prohibited from canceling a scheduled visit; however, visits may be rescheduled. The EVV System shall denote what scheduled visits are rescheduled visits. Scheduling is not required for members that have live-in or onsite caregivers.
5. Ensuring that all associated EVV System users have access to training on the EVV System.
6. For providers using an Alternate EVV System, submitting data timely to AHCCCS as a condition of reimbursement as specified in technical requirement documents available on the AHCCCS website.

7. Providers shall comply with member responsiveness including requirements that provider agencies shall answer the phone 24/7 or return a phone call within 15 minutes for members who are reporting a missed or late visit.
8. For providers using the AHCCCS procured EVV System, developing and implementing policies to account for and ensure the return of devices issued by providers to DCWs.
9. Ensuring the provider has at least two different types of visit verification devices available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service.
10. Ensuring any device used to independently verify start and end times without the use of GPS is physically fixed to the member's home to ensure location verification.
11. Ensuring any providers that permit DCWs to utilize personal devices such as a smartphone have an alternate verification method or option if the device becomes inoperable.
12. Ensuring that member devices are not used for data collection unless the member has chosen a verification modality that requires use of their device (e.g. landline telephone).
13. Contacting the member to validate any visit exceptions including instances when the member indicates the service or duration does not accurately reflect the activity performed during the visit. The documentation of exceptions should be consistent with CMS's Medicare signature and documentation requirements for addendums to records. Changes as a result of the exceptions process are considered an addendum to the record and do not change the original records.
14. Documenting Manual Edits to visits within the system and/or maintaining hard copy documentation.