AHCCCS E.V.V.

ELECTRONIC VISIT VERIFICATION

Frequently Asked Questions (FAQ)
Scheduling | November 2022

Why is AHCCCS requiring scheduling for EVV when it is not required under the 21st Century Cures Act or the Centers for Medicare and Medicaid Services (CMS)? (updated November 2022)

The scheduling requirement helps the provider agencies, health plans, and MCOs to document when and why service visits didn't happen according to the original plan. This information helps to support AHCCCS' EVV goals to track and monitor access to care, inform workforce development, and provider network adequacy. Specifically, this information helps to tell the story of service delivery. When a service does not occur as scheduled, the reason and resolution codes help to understand why the service does not take place as scheduled. Some examples of reasons are: Was the missed visit due to the member's preference? Was it simply a caregiver error where they may have forgotten to log in? Was there an issue with the device? It will help to understand the reason(s) why the visit didn't occur as originally planned and if there are reasons that are not concerning (i.e., the member didn't want service at that time or if there are concerning reasons (i.e., caregiver did not show up). Schedules are a plan for service and not meant to be inflexible. AHCCCS has provided many flexibilities, including the allowance of unscheduled visits (to account for everyday life events) as long as there is an explanation and resolution when a caregiver does not show up as planned. Scheduling does not require the caregiver to wait to log in in order to provide services. It is important to be aware that visits are not considered late until an hour after the scheduled start time.

Are provider agencies serving ALTCS members still required to submit the Non-Provision of Services (NPS) logs to the Health Plans?

EVV is replacing Gap reporting for the providers and Health Plans serving the ALTCS population. The AHCCCS Contractors Operations Manual, Policy 413 - Gap in Critical Services Policy has not been in effect since 01/01/21.

How can an agency enforce late or missed visits when members are in an area with no landline, cell coverage, or internet service or for those instances when the use of paper timesheets is allowed?

Members need to understand that if the direct care worker (DCW) is using the paper timesheet and FOB device option, the provider agency is unable to know in "real-time" if the DCW does not show up on time. As part of the contingency plan discussion, provider agencies are expected to provide assistance and guidance to l members on how to contact the agency in the event the DCW is late or does not show up at all to provide care. The member must notify the provider agency of these circumstances directly.

If a member has an unplanned support need or prefers services at a different time than originally planned, how can we make sure that scheduling requirements don't create access to care issues?

Even with a scheduling requirement, it is still acceptable for visits to:

- Start before the scheduled start time,
- Start after the scheduled time, and
- Occur without a schedule.

How can agencies comply with scheduling requirements for service in which the client has the right to adjust their own schedule?

Provider agencies are expected to develop a standard/recurring schedule in partnership with members (and as appropriate with their families and service planning/treatment teams) based upon the medical necessity requirements outlined in the service/treatment plan. Schedules may be modified based upon the member/family preferences following processes established by the provider agency. If scheduling arrangements are made between the member/family and the DCW, the provider agency will be able to explain the variance of the schedule using a reason code that documents the schedule change was initiated at the member's request. Provider agencies will be expected to counsel members and DCWs on these arrangements to make sure the DCW is providing care within the authorization limits and tasks performed are consistent with the medically necessary needs and preferences outlined in the service/treatment plan.

Are there any exemptions from the scheduling requirements for members with live-in caregivers or members managing their care under the Self-Directed Attendant Care service model?

Yes. AHCCCS does **not** require scheduling for members who employ their DCWs under the Self-Directed Attendant Care model. Additionally, AHCCCS does **not** require scheduling for members with live-in or onsite caregivers that often provide services on demand. These visits will trigger an "unscheduled visit" exception and the provider agency will be required to apply the appropriate reason code to document why the visit was unscheduled. Please reference the Live-In/Onsite Caregiver FAQ.

How far in advance must a schedule be made?

Schedules must be recorded in the system before the visit is scheduled to start.

Can schedules created in advance be changed/edited?

Schedules may be edited up until the visit is scheduled to start. The schedule cannot be edited retroactively. If a DCW does not arrive for the visit (no-shows) or is late (at least 60 minutes from the start time), the provider agency is expected to reschedule the visit based upon the member's contingency plan preferences. A visit is considered late if the DCW has not signed in within 60 minutes of the scheduled start time. The new visit is to be marked as a reschedule.

Can multiple visits be applied to one schedule?

No, only one visit can be applied to a schedule.

How do provider agencies document visits that don't occur as originally planned? (updated November 2022)

There are three instances that trigger exceptions in the EVV system regarding the schedule. These include instances whereby the:

- DCW does not show up to provide care,
- Visit is unscheduled, and
- Visit starts more than 60 minutes after originally planned.

Provider agencies will use reason codes to explain why these instances happened and use resolution codes to document what the agency did to ensure the member's needs were met when a DCW no-showed or was late.

How are missed and late defined? (updated November 2022)

- Missed Visit - The DCW does not show up at all for the visit.
- Late Visit - The DCW shows up more than 60 minutes after the scheduled start time.

What are some examples of reasons for missed or late that may or may not be concerning?

Generally, it may raise concerns if the reasons why these circumstances occur are not directed by the member or member preferences. For example, it generally won't raise concerns if the member chooses not to have services that day unless this is occurring regularly and the medically necessary services are not being provided. Examples of reason codes that could be applied to a missed or late visit that indicate member direction generally include:

- Member No Show
- Member Refused Service
- Member Preference

How are AHCCCS and the Health Plans going to use the data reported about scheduling?

AHCCCS will look at the data to help inform workforce development and network adequacy planning. The scheduling data helps to identify why visits are not occurring as originally planned while the data on the contingency planning helps to highlight what the agency was able to do to accommodate the member when a visit was late or missed.

Will provider agencies be penalized for instances when visits are late or missed?

Provider agencies will be able to bill for missed or late when:

- Reason codes are applied to document why the visit did not occur as originally planned, and
- Resolution codes document what the agency did to ensure the member's needs were met when a DCW no-showed or was late.

For more information on how to address exceptions to get paid for visits, reference the Visit Maintenance and Audit Documentation FAQ on the EVV web page.

AHCCCS and the Health Plans will monitor the data during a baseline period in an effort to develop performance metrics that may be used to incentivize performance through vehicles such as value-based purchasing arrangements, Differential Adjusted Payment initiatives, or quality monitoring reviews. AHCCCS anticipates the baseline period to start after the onset of the claims enforcement period (January 1, 2023) .

Can caregivers create and edit their own schedules? (updated November 2022)

AHCCCS will allow caregivers to create and edit their own schedules with the following conditions to ensure the schedule is directed/informed by the member/family and the schedule is in accordance with the member's service plan.

- Incorporate into the supervisory visits a discussion with the member/family whether or participated in the development of the schedule.
- The agency administrators must either pre-approve the schedules prior to the visit or conduct post reviews on a sampling of schedules for all caregivers no less than weekly. The purpose of the review is to ensure the schedule aligns with the service/treatment including any needs assessment (i.e., ALTCS HCBS Needs Tool) and that the schedule was entered in advance of service delivery.
- The EVV system being used by the provider agency secures member protected health information by only allowing the caregiver to view members in the system who are assigned to them and that the access to member data is limited to only what is necessary to schedule and provide services.
- Under no circumstances is the caregiver allowed to perform any visit maintenance including making adjustments to visit data or clearing exceptions with reason and resolution codes

If AHCCCS identifies concerns associated with allowing this flexibility, the flexibility may be modified or rescinded.

What are some common scenarios related to scheduling and how should they be addressed? (updated November 2022)

The following are a few examples of common scheduling scenarios and considerations for how to address them within the EVV system. For more detailed information on how to address visit exceptions, visit the Visit Maintenance and Audit Documentation FAQ on the EVV web page.

1. The Member is scheduled for one service and when the caregiver arrives, the member is not in a position to receive that service so the family decides to have respite care provided instead.

   The original scheduled visit would trigger a "no show" exception and the agency would need to clear the exception by using a reason code (clinical need) and resolution code (i.e., next scheduled visit).

   The new service (respite) would be provided as an unscheduled visit. The visit would trigger an "unscheduled" visit exception and the agency would need to clear the exception by using a reason code (member preference).

2. The caregiver is scheduled for 4 hours and the caregiver is going to be more than 60 minutes late.

   The visit does not have to be rescheduled in the EVV system for the new anticipated arrival time unless the new arrival time is going to be later than the member's contingency plan (i.e., two hours) and another caregiver has to be scheduled and dispatched to meet the member's immediate needs. Otherwise, the visit would trigger a "late" exception and the agency would need to clear the exception by using a reason code (Caregiver Error) along with a memo as to why the caregiver was late.

3. The member has a neighbor who is a caregiver. The guardian has an unexpected need for respite and contacts the neighbor to see if they can come over for an hour to support the member. The neighbor/caregiver is available and comes over to provide respite care.

   It is preferred and recommended for the caregiver or agency to enter a schedule if sufficient time is available to do so.. If there is not sufficient time to enter the schedule, the visit would trigger an "Unscheduled" visit exception. The agency would have to clear the exception by using a reason code (member preference).