AHCCCS E.V.V.

ELECTRONIC VISIT VERIFICATION

Frequently Asked Questions (FAQ)

Billing| December 2020

Will the authorization process change for EVV services? Will the health plans have different deadlines for sending authorizations to providers?

In order to demonstrate compliance with the Cures Act, AHCCCS must demonstrate the EVV system supports the State to avoid payment for unauthorized or unapproved services by reconciling linkages between the member, provider, services, units and visit data prior to claims payment.

The authorization process will not change for those services that require prior authorization by the health plan. Health plans will continue to approve and send authorizations as they do today. That said, EVV does provide an opportunity for AHCCCS and the health plans to have better data to monitor the timeliness of those approvals and/or submission of authorizations by the health plans. AHCCCS is open to receiving feedback from providers on the timeliness of authorizations once EVV has been implemented.

If a provider is using the Sandata EVV system, the authorizations will be automatically uploaded into the system for providers to view.

For services that do not require prior authorization, providers will need to use the AHCCCS Service Confirmation Portal. Please reference the Service Confirmation Portal FAQ for more information on that process.

What is a soft claims edit period?

AHCCCS is allowing for a soft-claim edit period for claims for dates of service beginning January 01, 2021 through March 31, 2021. This means that providers can still receive reimbursement for services if there is no EVV visit to match to a claim or the EVV visit data is incomplete. During this period, providers will be given information on issues with claims for EVV services in an effort to provide technical assistance and insight into EVV program implementation challenges. AHCCCS will be monitoring these issues to identify trends to help inform additional provider engagement and outreach. As it is today, for those services that require authorization, an authorization will be required for billing even during this grace period. For those services that don't require prior authorization, it is recommended to use the AHCCCS

Service Confirmation Portal during the grace period in an effort to avoid soft claim edit notices for missing authorizations. For more information, refer to the AHCCCS Service Confirmation Portal guidance on the AHCCCS EVV webpage (www.azahcccs.gov/EVV).

Beginning April 1, 2021, the hard claims edits will begin for EVV service claims for the dates of service beginning April 1, 2021 and thereafter. Providers will not get paid unless all the required EVV visit data is present.

Will EVV create a delay in the health plan's process to approve claims for payment?

The health plans are not using a new process for claims validation. They are, however, performing additional edit checks for EVV data required under the Cures Act. This process is being done at the point of claims adjudication to mitigate recoupments of payment after the fact. This process is automated and we do not anticipate any adverse impacts to the timeliness of claims payment.

After 04/01/21, when the hard claim edits are implemented, a provider may experience a delay in payment if the required EVV information is missing or incomplete. This means that the provider either didn't use EVV for the visit or there is missing documentation.

AHCCCS will be working in partnership with the health plans to monitor the timeliness of EVV service claims against a baseline of payment timelines for these services prior to the implementation of EVV. AHCCCS is open to receiving feedback from providers on the timeliness of claims payments once EVV has been implemented.

What new EVV data is required for claims payment?

In addition to the standard edits checks performed during the claims validation process today, the process will include new edits checks to ensure the following data is provided by the EVV system.

- Member
- Provider agency
- DCW
- Service
- Date and time the service began and ended
- Location of the service
- Authorization for the service

If the information required for claims payment is already captured within an EVV system why can't the EVV system just send the data directly to the health plans for payment and save providers from having to submit a claim to a health plan for payment?

AHCCCS Billing Guidelines require the use of defined Standard Claims forms and formats. The EVV system does not supplant normal claims billing requirements and providers are still expected to submit standard claims for payment just as they do today.

Does the billing process change with EVV?

The provider's billing process does not change because of EVV. Providers can use their existing billing processes and clearinghouses to submit claims for payment as they do today. What is different with EVV is that the health plans get the data from Sandata to perform edit checks during the claims validation process. New edits related to EVV data have been added to that process to make sure that AHCCCS is compliant with the Cures Act requirements.

Providers do have the option to change their current billing practices and contract with Sandata to use their billing module.

Some health plans generate authorizations under one ID number, but break up the authorization units for use of the service code with specific modifiers. The allowable units are specific to a combination of a service code with a modifier. Does the claims validation process check against service code modifiers? Will this scenario be impacted by the new edit checks for EVV in the claims validation process?

The claims validation process does not check against service code modifiers.

If my caregiver clocks in early for the shift and stays for the duration, they potentially could work more than the authorized limits. How is this addressed?

The EVV system must record the exact time the DCW works. The Sandata EVV System or an Alternate EVV System reports the visit minutes to the Sandata aggregator which converts the minutes into units for claims validation by the health plan. You continue to follow your regular billing procedures and will need to make sure (as you do today) that what you bill does not exceed the authorization limits.