

AHCCCS E.V.V.

ELECTRONIC VISIT VERIFICATION

EVV Billing Checklist

This document is intended to serve as a self-assessment tool for providers to use in order to mitigate issues when billing for EVV services. Information provided in this guidance includes steps a provider can take to make sure the EVV visit is verified before submitting a claim. Additionally, this guidance provides steps a provider can take if a soft/hard claim rejection is sent by the health plan or AHCCCS for Fee-for-Service (FFS) members after a claim has been submitted.

Claims Validation

EVV includes a claims validation process where Sandata will confirm a visit is in “verified” status before the health plan is allowed to pay a claim. A visit is considered “verified” when it contains all of the required information under the 21st Century Cures Act noted below.

1. Member
2. Provider Agency
3. Employee/staff providing the service
4. Service provided
5. Date/time service began
6. Date/time service ended
7. Location of service delivery

REMINDER: The claim being submitted must match either the health plan or AHCCCS FFS prior authorization or information entered by the provider in the AHCCCS Service Confirmation Portal; otherwise, it will not pass validation and the claim will be denied. Please refer to the AHCCCS Service Confirmation Portal guidelines and the appropriate health plan or AHCCCS FFS authorization guidelines for additional details.

Note: *During the soft edit claim period, the health plan(s) or AHCCCS FFS will continue to pay the claim even if it does not pass claims validation. Providers are **strongly encouraged** to utilize this time to follow through on all steps (including steps to update visit data after a soft claim denial) in this checklist to ensure readiness for the hard edit claim period.*

Resources:

- [Billing FAQ](#)
- [Sandata EVV Workflow](#)
- [Alternate Vendor EVV Workflow](#)

BEFORE Submitting a Claim for EVV Services

Step One: Check your EVV Portal visit maintenance information to ensure the visit(s) you plan to bill for have no exceptions for missing or incomplete information.

EVV systems are required to trigger exceptions and require visit maintenance when specific information is missing or incomplete for a visit. Providers will use a standard set of reason/ resolution codes and, in some cases, be required to enter a note into the EVV system in order to get the visit into a verified state. Sandata users will confirm whether or not a visit is in a verified state through visit maintenance.

Providers using an Alternate EVV System can confirm whether or not a visit is in a verified state by accessing the Sandata Aggregator. The Sandata Aggregator is read-only and visits cannot be updated directly in the Aggregator. Visits must be updated in your alternate EVV vendors portal and resent to Sandata.

***Note:** Wait at least one business day before billing for visits that have been updated and now in a verified status. Claims that are billed on the same day as the visit update or change may not pass claims validation.*

Resources:

- Sandata users can access training on Visit Maintenance [here](#).
- Alternate EVV System users can access training on the Sandata Aggregator [here](#).

Step Two: Check to make sure the units on the claim do not exceed the EVV visit(s).

In order to mitigate any billing issues, a best practice is to ensure the billed units on the claim match the combined total billable units of the EVV visits for the associated dates of service.

Sandata checks to make sure the visits associated with the claim result in one of these scenarios:

- 1) If the units in the EVV Visit(s) is greater than the units reported in the Claim (**passes** claims validation)
- 2) If the units in the EVV Visit(s) are equal to the units reported in the claim (**passes** claims validation)
- 3) If the units in the EVV Visit(s) are fewer than the units in the claim (**does not** pass claims validation)

AFTER Submitting the Claim for EVV Services

Step Three: Check the results of the EVV claim validation process in the Sandata Portal or Aggregator.

Processed status means the visit has passed claims validation.

Unmatched information status means the EVV system was unable to find an exact match for the visit complete with all the required elements (payer, provider, member, service, date of service, and units).

No visit found status means the EVV system could not find a visit, data is incomplete or is different from what is submitted on the claim.

Step Four: Monitor the explanation of benefits (EOB) or explanation of payment (EOP) from your health plan for denial reasons and begin the process with Step One to resolve any exceptions.

***Note:** During the hard edit claim period, providers will be permitted to re-bill for denied services at least one day after verifying correct visit data and resolving exceptions. In order to prevent duplicate and/or additional claim denials, please refer to the appropriate health plan or AHCCCS FFS billing guidelines for details on submitting corrected claims.*