AHCCCS E.V.V. ✓
ELECTRONIC VISIT VERIFICATION
Frequently Asked Questions (FAQ)
Billing| Updated October 2022

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 overall timeliness of prior authorizations by the Health Plans.

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 available on the EVV website (www.azahcccs.gov/EVV) for more information on that process.

What can I do if we are experiencing missing members or authorizations in our Sandata agency account? (added July 2022)

If the agency is experiencing missing members or authorizations, please use the Missing Authorization and Member Checklist available on the EVV web page (www.azahcccs.gov/EVV) to research and determine what steps should be taken to exhaust other remedies prior to contacting Sandata (refer to the section entitled "Sandata EVV System Resources and Technical Assistance").

What is a soft claims edit period? (updated October 2022)

AHCCCS is allowing for a soft-claim edit period for claims for dates of service beginning January 1, 2021 thru December 31, 2022. 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. Consistent with practices prior to the EVV mandate, 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 web page (www.azahcccs.gov/EVV).

When will the hard claim edits begin? (updated October 2022)

The hard claim edits will be in effect for dates of service starting January 1, 2023. AHCCCS undertook a number of activities in partnership with CMS, Sandata, and Managed Care Organizations (MCOs) to inform the plans and timeline to make the transition from the soft claim edits to the hard claim edits period. Once the hard claim edits begin, providers will not get paid unless all the required EVV visit data is present. AHCCCS has been tracking various provider readiness milestones that represent a continuum of compliance. MCOs are using that data to inform provider engagement and outreach plans to ensure that providers have the support they need to fully implement EVV. If providers are contacted by their contracted MCO(s), providers are strongly encouraged to respond and connect to ensure readiness for the hard claim edits.

Will EVV create a delay in the health plan's process to approve claims for payment? (updated July 2022)

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.

Beginning January 1, 2023, 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 that are compliant with EVV.

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
- Direct Care Worker (DCW)
- Service
- Date and time the service began and ended
- Location of the service
- Authorization for the service

Is there a way I can make sure that the visit will get paid before I submit a claim? (added July 2022).

Yes. AHCCCS has created a EVV Billing Checklist 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. The EVV Billing Checklist is available on the EVV web page (www.azahcccs.gov/EVV) under the section entitled "Sandata EVV System Resources and Technical Assistance."

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.

Are there any service delivery scenarios that don't require EVV? (Added July 2022)

In response to input and in partnership with the MCOs and the provider community, AHCCCS has decided that the following service delivery scenarios do not require EVV. This means that MCOs will not require EVV specific edit checks before paying a claim for services rendered under these circumstances.

- **Telehealth and Telephonic services** - Services billed with the FQ or GT modifier do not require EVV.
- **Medicaid as last payer** - Services that are paid in full, partially paid or otherwise covered by another non-Medicaid payer do not require EVV.
- **Prior Period Coverage** - If a member is not AHCCCS eligible at the time of service delivery, EVV is not required for those service visits. EVV will be required for services rendered if/when the member becomes AHCCCS eligible.

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 EVV 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? (updated July 2022)

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 should 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. Adjusting the visit minutes to simply accommodate the authorization limits is not allowable because it violates documentation requirements for audits. Time adjustments should only be made to accurately document the service duration and with the appropriate documentation regarding the reasons why adjustments were made to the call in/out times.

Does the EVV edit check/claims validation process accommodate for bundled billing? (added July 2022)

Yes. The claims validation process allows for either scenario in which the provider:
- Submits multiple claims for multiple visits of the same service on the same day, or
- Submits one claim for multiple visits of the same service on the same day (i.e., bundled billing).

Does Sandata have a claim date span limit for claims validation? (added July 2022)

Yes. While it is a rare occurrence that line items on claims exceed 31 days (e.g., encompass more than 31 days of visits), Sandata is only able to perform validation for line items on claims that have a date span of 31 or less days from the date of service. Claims older than 31 days old are not impacted by this limitation.

Will the Sandata EVV system automatically split overnight visits for billing purposes? (added July 2022)

Sandata does not split visits for billing purposes, but rather captures the total duration of the visit and accommodates overnight visits for claims validation. Providers should follow the billing rules for the payer as it pertains to split or overnight visits.

The following is an example of a scenario in which an employee provides care to a client that starts before midnight one day and ends after midnight the following day.

- The employee calls in upon arriving (12/2 @ 10 p.m.) and calls out when leaving (12/3 @ 4 a.m.).
- Claims are matched based on the date the service began. During claims validation, Sandata will look for a claim with the start date of 12/2 for a total of 24 units.