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ELECTRONIC VISIT VERIFICATION

Frequently Asked Questions (FAQ)
Visit Maintenance and Audit Documentation
October 2022

What is visit maintenance and why is it needed?

Visit maintenance is required to explain why a visit didn't go according to the original plan and/or to add or document missing/incomplete data required to bill for EVV services. For more information on billing and EVV, visit the Billing FAQ on the EVV web page.

How does visit maintenance work?

Visit maintenance is a process by which providers document required information. This process may look different depending on the EVV system the provider is utilizing. All EVV systems are required to trigger visit maintenance when the following exceptions or events occur. When these triggers are identified, providers will use a standard set of reason/resolution codes and, in some cases, will be required to enter a memo into the EVV system prior to getting paid for the visit. Members and caregivers are prohibited from performing visit maintenance with one exception; members enrolled in the ALTCS-EPD program who are using the Self Directed Attendant Care model may elect to perform visit maintenance in the EVV system.

Table 1: Standard Exceptions Descriptions

Standard Exceptions	
Name	**Description**
Unknown Clients	Exception for a visit that was performed for a client that is not yet entered or not found in the EVV system.
Unknown Employees	(Telephonic only) Exception for a visit that was performed by a caregiver who was not yet entered or not found in the EVV system (at the time the visit was recorded).
Invalid Service	Exception when the service selected for a visit is not valid for the program/recipient of care.
Missing Service	Exception when the service provided during a visit is not recorded or present in the system.
Visits Without In Calls	Exception triggered when a visit is recorded without an "in" call that began the visit.
Visits Without Out Calls	Exception triggered when a visit is recorded without an "out" call that

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Standard Exceptions	
Name	**Description**
	completed the visit.
Unmatched Client ID / Phone	(Telephonic only) Exception when the visit was recorded from a phone number that was not matched to a recipient of care in the EVV system.
Employee Speaker Verification	(Telephonic only) Only used when the Employee Speaker Verification feature is enabled. This exception indicates that the speaker verification evaluation did not match the voice making the call with a known caregiver in the EVV account that the phone number is associated with.
Service Verification Exception	Exception is triggered when the client indicates that the SERVICE RECORDED in the EVV visit does not reflect the actual activity performed during that visit.
Visit Verification Exception	Exception occurs when the client indicates that the DURATION of the EVV visit does not reflect the amount of time that care was actually provided for.
Client Signature Exception	Exception occurs when the visit does not have a signature or client voice recording captured at the time of service.
No Show	This exception occurs when a visit has been scheduled, but no calls have been received for that visit.
Unscheduled Visit	This occurs when a visit is started or completed without a schedule in place for that member+service+caregiver.
Late In Call	This occurs when the start of a visit is received and recorded as having begun more than 60 minutes AFTER the scheduled start time for that visit.

What information is required for billing versus what information is needed to comply with AHCCCS policy?

Table 2 outlines which exceptions are required per the 21st Century Cures Act (billing) and exceptions that are required to comply with AHCCCS policy. All exceptions will require documentation before the visit can be billed. The claims validation process monitors compliance with the billing requirements and visits will not be paid if the information is missing or incomplete. AHCCCS and the Health Plans will monitor provider compliance with the policy requirements. It is important to note that the documentation of the location of service delivery is also required to bill and get paid for a visit. Per AHCCCS policy, the location is not listed as a standard exception because the location of service does not have to be pre-approved or occur in a predetermined location.

Note: For providers of DES/DDD HCBS, locations of service delivery outside of the member's home or a community setting require Life Safety Inspection (LSI) certification by DES/Office of Licensing, Certification and Regulation (OLCR), AAC6-18-701. This process is separate and apart from the EVV requirements.

Table 2: Standard Exceptions

Standard Exceptions			
Name	**Manual Edits Required**	**Cures Act Requirement**	**Policy Requirement**
Unknown Clients	Y	Y	
Unknown Employees	Y	Y	
Invalid Service	Y	Y	
Missing Service	Y	Y	
Visits Without In Calls	Y	Y	
Visits Without Out Calls	Y	Y	
Unmatched Client ID / Phone	Acknowledge Only	Y	
Employee Speaker Verification	Acknowledge Only	Y	
Service Verification Exception	Acknowledge Only		Y
Visit Verification Exception	Acknowledge Only		Y
Client Signature Exception	Acknowledge Only		Y
No Show	Acknowledge Only[1]		Y
Unscheduled Visit	Acknowledge Only		Y
Late In Call	Acknowledge Only[2]		Y

Note: The provider can simply acknowledge the exception if manual edits are not required to clear the exception. In both cases, reason/resolution codes are required to document why the exception occurred and, in some cases, describe what happened as a result of the event (i.e., caregiver no show) that caused the exception. While to clear an exception may not require manual edits, under some circumstances the reason for the exception may require manual edits.

[1] Some circumstances resulting in a no show exception may warrant the manual entry of a timesheet.
[2] Some circumstances resulting in a late in call exception may warrant the manual edit of the DCWs start time.

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What are the reason and resolution codes used to clear exceptions?

The provider should choose the appropriate reason code to explain why the visit did not go according to the original plan and/or document missing required EVV data, including the provider's response to the situation. Table 3 outlines the reason codes along with the applicable resolution codes and whether a memo is also required to meet audit documentation requirements. Some examples of common events/scenarios that may result in an exception have been listed in this FAQ, along with an outline of the audit documentation requirements.

Table 3: Reason/Resolution Codes

Reason Code	Applicable Resolution Code(s)	Memo
Caregiver Error	None	Y
Member/Designee Unable to Verify	• None • Designee Attestation on File	Y
Mobile Device Issue	None	Y
Telephony Issue	None	Y
Member/Designee Refused Verification	None	
Unsafe Environment	• Contacted Case Manager and/or Reconvened Treatment/Planning Team • Reschedule within 2 hours • Reschedule within 24 hours • Reschedule within 48 hours • Next Scheduled Visit • Non-Paid Caregiver	Y
Member Refused Service	None	
Member No Show	None	
Caregiver No Show	• Reschedule within 2 hours • Reschedule within 24 hours • Reschedule within 48 hours • Next Scheduled Visit • Non-Paid Caregiver	
Clinical Need	Non-EVV Service Provided	Y
Live In/Onsite Caregiver	None	
Member Preference	None	
Other	Timesheet with Signature on File	Y

For Alternate EVV Vendors: Table 3 represents the pairing options of the reason/resolution codes as presented in the Sandata system. Alternate EVV Vendors must provide the options for the reason/resolution codes and memos, but they are not required to pair them in the same way they are represented in the Sandata system. In October 2022, AHCCCS released updated specifications for the Alternate EVV Vendors. Therefore, if a provider is using an Alternate EVV Vendor, some of the reason/resolution codes may not yet be available. Until then, the providers should use the reason/resolution codes that best describe the circumstances.

For Sandata Users: There is a difference between a reason note and a memo. Both the reason note and the memo are accessible when reviewing visit data. The reason note can only be added while performing visit maintenance. The memo can be added after visit maintenance. There are 1,024 characters allowable in the memo field as opposed to 256 characters in the Reason Notes field. Memos are only needed to validate the service delivery if it did not occur at the point of care.

What are some common scenarios that result in exceptions and how should they be documented for audit purposes?

Table 4 lists some common scenarios that may occur along with an example of how to clear the exception with documentation that would support an audit or monitoring by AHCCCS or a Health Plan. This guidance is not intended to be exhaustive as there will be scenarios that occur which are not outlined below. This does provide general guidance so that providers can make informed determinations regarding how to document scenarios that are not listed. It is intended to serve as a desk/reference aid for those responsible for visit maintenance.

Table 4: Scenarios

#	Scenario	Exception	Manual Edit	Reason Code	Resolution Code	Memo
1	Visit is recorded for a member that hasn't been loaded into the system	Unknown Clients	Y	Other	None	N/A
2	DCW put in the wrong ID when using telephony	Unknown Employees	Y	Caregiver Error	None	N/A
3	Using telephony, entered service that was not authorized for the member	Invalid Service	Y	Caregiver Error	None	N/A
4	Visit was recorded without the	Missing Service	Y	Other	None	N/A

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#	Scenario	Exception	Manual Edit	Reason Code	Resolution Code	Memo
	authorization loaded					
5	DCW forgets to clock in	Visits Without In Calls	Y	Caregiver Error	None	Entered manual date and time after confirming with the [member/designee's name] via [Communication Method] on XX/XX and [caregiver name] via [Communication Method] on XX/XX. Communication method = verbal, email or portal
6	DCW's phone is not working	Visits Without In Calls	Y	Device Issue	None	Entered manual date and time after confirming with the [member/designee's name] via [Communication Method] on XX/XX and [caregiver name] via [Communication Method] on XX/XX. Communication method = verbal, email or portal.
7	DCW forgets to clock out	Visits Without Out Calls	Y	Caregiver Error	None	Entered manual date and time after confirming with the [member/designee's name] via [Communication Method] on XX/XX and [caregiver name] via [Communication

#	Scenario	Exception	Manual Edit	Reason Code	Resolution Code	Memo
						Method] on XX/XX. Communication method = verbal, email or portal.
8	Member won't let the DCW user their landline or cell phone	Visits Without Out Calls	Y	Telephony Issue	None	Entered manual date and time after confirming with the [member/designee's name] via [Communication Method] on XX/XX and [caregiver name] via [Communication Method] on XX/XX. Communication method = verbal, email or portal
9	Using telephony, call in from a phone number that is not recorded as a member phone number	Unmatched Client ID / Phone		Caregiver Error	None	Confirm the location of service delivery with the [member/designee's name] via [Communication Method] on XX/XX and [caregiver name] via [Communication Method] on XX/XX. Communication method = verbal, email or portal
10	Using telephony, voice recognition didn't verify the DCW (i.e., DCW has a cold or there is background noise)	Employee Speaker Verification		Telephony Issue	None	Confirmed identity of the caregiver for the visit with the [member/designee's name] via [Communication

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#	Scenario	Exception	Manual Edit	Reason Code	Resolution Code	Memo
						Method] on XX/XX.
11	Member/Guardian/Designee refuses to verify service delivery	Client Signature Exception, or Service Verification Exception		Member/ Designee Refused Verification	None	N/A
12	Guardian/Designee was not home when the service ended to verify service delivery	Client Signature Exception, or Service Verification Exception		Member/ Designee Unable to Verify	None	Confirmed date/time of service delivery with the [member/designee's name] via [Communication Method] on XX/XX. Communication method = verbal, email or portal
13	The member can't verify service delivery and the guardian is the paid caregiver. There is no one else to verify service delivery	Client Signature Exception, or Service Verification Exception		Member/ Designee Unable to Verify	Designee Attestation on File	N/A
14	DCW arrives and due to the environment in the home is unable to provide services that day. The environmental safety concern is anticipated to NOT be immediately solvable.	No Show		Unsafe Environment	Contacted Case Manager and/or Reconvened Treatment/ Training Team	Suspending service until service planning team reconvenes
15	DCW arrives and is unable to provide services due to an environmental condition that	No Show		Unsafe Environment	-Reschedule within 2, 24 or 48 hours -Next Scheduled	N/A

#	Scenario	Exception	Manual Edit	Reason Code	Resolution Code	Memo
	uniquely impacts the DCW. For example, the DCW has asthma and a family member is visiting the member and smoking inside of the house.				Visit -Non-Paid Caregiver	
16	DCW arrives, but Member sends them home	No Show		Member Refused Service	None	N/A
17	DCW cancels and the agency **can't** provide a relief caregiver to meet the member's contingency plan	No Show		Caregiver No Show	-Reschedule within 2, 24 or 48 hours -Next Scheduled Visit -Non-Paid Caregiver	N/A
18	DCW cancels and the agency **can** provide a relief caregiver to meet the member's contingency plan	No Show		Caregiver No Show	-Reschedule within 2, 24 or 48 hours -Next Scheduled Visit -Non-Paid Caregiver	N/A
19	DCW and member decide to cancel service delivery for the day, but don't tell the agency	No Show		Member Preference	None	N/A
20	Caregiver uses a timesheet and the FOB device is broken	No-Show	X[3] Manual Entry of the timesheet	Other	Timesheet with Signature on File	FOB Device was broken. Manual entry of visit in accordance with the timesheet documentation.

[3] Manual entry of the entire timesheet would be required.

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#	Scenario	Exception	Manual Edit	Reason Code	Resolution Code	Memo
21	DCW arrives and member is not at home	No Show		Member No Show	None	N/A
22	DCW lives with the member	Unscheduled Visit		LiveIn/ Onsite Caregiver	None	N/A
23	DCW and member decide on a schedule change, but don't tell the agency	Unscheduled Visit		Member Preference	None	N/A
24	DCW is a neighbor that provides on-call respite services	Unscheduled Visit		Member Preference	None	N/A
25	DCW forgets to clocks until after starting work	Late In Call		Caregiver Error	None	Entered manual date and time after confirming with the [member/designee's name] and [caregiver name] via [Communication Method] on XX/XX. Communication method = verbal, email or portal.
26	DCW arrives 60 minutes or later after the scheduled start time because they had a flat tire	Late In Call		Caregiver Error	None	[State why the DCW as late]
27	DCW arrives 60 minutes or later after the scheduled start time because the family called and asked them to come later	Late In Call		Member Preference	None	N/A
29	DCW is scheduled to provide a service and when they arrive the	Unscheduled Visit		Clinical Need	Non-EVV Service Provided	Specify the service that was provided.

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#	Scenario	Exception	Manual Edit	Reason Code	Resolution Code	Memo
	member is in need of a service that is not subject to EVV					

Authorizations

What if we have received a referral to serve a new member and are still awaiting prior - authorization by the Health Plan, but services must be initiated right away?

Under these circumstances, providers must use a documentation standard that validates the provision of service delivery, including methods used previously to EVV (i.e., paper timesheet, EHR/EMR record). The record must be manually entered into the EVV system in order to receive payment for services. Timesheets must be entered in the EVV system within 21 days from the date of services if the provider can still meet the timeliness filing standards.

What if there is no authorization on the day when the visit starts?

For Sandata Users: To continue providing services and recording EVV visit information for a missing member or missing service authorization, the caregiver will use the "Start Unknown Visit" feature. Recorded training sessions on the "Start Unknown Visit" are available here:

- Start Unknown Visit
- Complete Unknown Visit

It is important to note that when starting a visit for an unknown member, the user will type the name of the member when they start the Unknown Client Visit. The name they enter is transposed to the memo field of the recorded visit in EVV.

An exception for the authorization will flag on the visit. Once the authorization issue is fixed or you have a new authorization issued, you can clear the exception and link the authorization to the visit in order to bill for the visit. The member's name will be available in the Memo tab of the visit in Visit Maintenance. You can find a recorded training session on clearing exceptions for an Unknown Client here.

Claims Payment

If I do submit a claim and it is rejected for payment because of missing/incomplete EVV information, do I still have an opportunity to still get paid for those services?

Yes. For more information on preparing for claims submission or addressing claims rejections, visit the Billing Checklist on the EVV web page.

Is there a deadline for manual edits or completion of visit maintenance before or after billing?

No. Providers will not get paid until the visit has all the required data or documentation. Standard timeliness filing requirements do apply. For more information on preparing for claims submission or addressing claims rejections, visit the Billing Checklist on the EVV web page.

Paper Timesheets

With the introduction of EVV, does a signed paper timesheet still need to be collected to verify service delivery?

EVV replaces the need for paper timesheets unless the member (Health Care Decision Maker) qualifies for one of the allowable circumstances and has chosen to use the paper timesheet option, which must be utilized in conjunction with a device that can independently verify the date/time of the service. The paper timesheet must be manually entered into the EVV system in order to receive payment for services.

Does the provider have to provide proof if the member falls under one of the allowable circumstances for paper time sheets?

A signed, and annually updated, AHCCCS standard attestation will suffice as documentation for the allowable use of paper timesheets. The allowable use of paper timesheets will be audited by the Health Plans to ensure compliance with the AHCCCS policy.

Is there going to be a limit of how many paper time sheets a provider can have?

No. However, AHCCCS plans to monitor the use of paper timesheets to determine whether or not a provider agency falls within or outside the normal threshold for paper timesheet utilization.

Do paper timesheets need to be stored in the EVV system, or can it just be stored within the EMR?

The paper timesheet must be manually entered into the EVV system in order to receive payment for services. Timesheets must be entered in the EVV system within 21 days from the date of services if the provider can still meet the timeliness filing standards. Providers must have the original timesheet with a wet copy of the signature on file.

What if we receive a timesheet and need to make edits before manually entering into the EVV system? How do we document the changes from the hard copy version to the manually entered version?

The provider should enter the corrected visit information in the EVV system and document the changes (including verification of the changes by the member and caregiver) and note in the EVV system memo field “Manual entry of visit in accordance with timesheet documentation.”

If we capture service events via a paper timesheet and save as a pdf image, is this pdf document considered sufficient support that a wet signature was obtained from the client?

The provider agency must have the original, wet copy of the signature on file for audit purposes. A PDF or faxed copy of the signature is permissible for billing purposes.

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Exceptions

If a provider has a visit that has an exception (i.e. late in call), will the provider get a claim kicked back if they don't put the appropriate reason or resolution code to document why the visit was late?

Providers must resolve exceptions in order to get paid for the visit. To mitigate billing issues, providers should confirm that the visit is in a verified status prior to submitting a claim. For more information on preparing for claims submission or addressing claims rejections, visit the Billing Checklist on the EVV web page.

How many exceptions will be allowed per member?

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 provider 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 claim enforcement period (January 1, 2023). AHCCCS does not anticipate having performance metrics at the member level, but will monitor overall provider compliance to determine whether or not a provider agency may fall within or outside the normal threshold for exceptions.

Location

Do service delivery locations need to be pre-approved or predetermined?

While the documentation of the location of service delivery is required in order to bill and get paid for a visit, the location is not listed as a standard exception because the location of the service does not have to be pre-approved or occur in a predetermined location.

Note: For providers of DES/DDD HCBS, locations of service delivery outside of the member's home or a community setting require Life Safety Inspection (LSI) by DES/Office of Licensing, Certification and Regulation (OLCR), please see AAC6-18-701f. This process is separate and apart from the EVV requirements.

Are providers expected to validate the service location addresses?

With respect to a mobile device, the system is required to capture the location when the caregiver is logging in and logging out. The GPS coordinates are required to be submitted with the visit data. For all other devices, depending upon the device and the EVV system that is utilized, the location may be captured in various electronic or manual ways. Providers are expected to audit the locations to ensure that they are either in the member's home or community locations appropriate for service provision supporting the member's lifestyle, the circumstance of the service delivery and overall needs specified in the service/treatment plan.

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Verification

Is it allowable for staff to have verbal conversations with members and caregivers to record verbal approval of service delivery?

Yes. If verification is not captured at the point of care, an exception will be applied to the visit. In order to clear the exception, the provider will need to acknowledge it with the appropriate reason code (i.e., member/Designee Unable to Verify) and provide confirmation of the verification of the member and caregiver following the format provided below.

> Confirmed date/time of service delivery with the [member/designee's name] via [Communication Method] on XX/XX.
>
> Communication method = verbal, email or portal

Is there a deadline for the verification of service delivery by the member?

The EVV System must record the member/Health Care Decision Maker or Designee verification at the point of care or within 14 days of the rendered service.

Can providers use a PIN for an electronic signature?

PINs are permissible in lieu of a signature if the system has an authentication process to set up the PIN and has procedures to reset the PIN on a regular cadence.