

540 – ELECTRONIC VISIT VERIFICATION

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I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), DES DDD (DDD), Contractors; Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), Tribal ALTCS, TRBHA, and all FFS populations, excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100).

This Policy establishes requirements for Contractors and providers regarding the mandated use of an Electronic Visit Verification (EVV) system for personal care and home health services pursuant to 42 USC 1396b(l).

II. DEFINITIONS

Refer to the [AHCCCS ACOM and AMPM Dictionary](#) for common terms found in this Policy.

For purposes of this policy, the following terms are defined as:

AGGREGATOR	The AHCCCS Electronic Visit Verification (EVV) System that allows the state to compile all data and present it in a standardized format for review and analysis.
DESIGNEE	An individual who is 12 years of age or older and who is delegated by the member or Health Care Decision Maker (HCDM) the responsibility of verifying service delivery on behalf of the member.
DIRECT CARE WORKER (DCW)	A DCW is an individual receiving payment to provide one or more of the services subject to Electronic Visit Verification (EVV). A DCW may also be referred to as a “caregiver” and, therefore, include a live-in caregiver who is paid to provide EVV services.
ELECTRONIC VISIT VERIFICATION (EVV)	A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

MANUAL EDIT

Any change to the original visit data captured at the point of care including missing or inaccurate data that has to be manually added or adjusted to correct the data. All edits shall include an appropriate audit trail.

III. POLICY

AHCCCS is required to comply with the EVV requirements in the 21st Century Cures Act, 42 USC sec 1396b(l). Contractors and providers are required to utilize an EVV System capable of sharing data with the AHCCCS Aggregator. AHCCCS is using EVV to help ensure, track, and monitor timely service delivery and access to care for members.

The list of provider types and services that are mandated to use EVV can be found on the AHCCCS website.

A. SERVICE VERIFICATION

1. All providers who are subject to EVV shall utilize an EVV System to electronically capture and submit to the AHCCCS Aggregator the defined data per the specifications available on the AHCCCS website.
2. The member/Health Care Decision Maker (HCDM), or Designee, shall verify hours worked by the Direct Care Worker (DCW) at the point of care or within 14 days of the visit. The member/HCDM, or Designee shall also verify Manual Edits to visits.
3. If a member/HCDM, is unable or not in a position to verify service delivery on an ongoing basis, they shall arrange for a Designee to have the verification responsibility. In those instances, the member/HCDM is required to sign a standardized AHCCCS attestation specified in Attachment A, at a minimum on an annual basis, attesting that they have communicated the requirements of the verification responsibility to the Designee to whom they are delegating the verification responsibility. The provider shall assist the member/ HCDM to make an informed decision about verification delegation. The member/HCDM can change decisions about verification delegation at any time by completing a new attestation.
4. Exceptions to the Designee age requirement shall be discussed with the treatment and/or planning team and documented in Attachment A prior to the delegation of service delivery verification responsibility.
5. Neither the HCDM nor a Designee is allowed to verify service delivery for the services that they have personally rendered. If this situation presents barriers to verification, the member or HCDM shall document in Attachment A.

B. PAPER TIMESHEETS

The use of paper timesheets is allowable when the actual date, start and end time of the service provision is independently verified, for example, a code that represents a time and date stamp through the EVV System and under the following circumstances:

1. The DCW and the member live in geographic areas with limited/intermittent or no access to landline, cell, or internet service.
2. Individuals for whom the use of electronic devices would cause adverse physical or behavioral health side effects/symptoms.
3. Individuals electing not to use other visit verification modalities on the basis of moral or religious grounds.
4. Individuals with a live-in caregiver or DCW accessible on-site 24 hours and for whom the use of other visit verification modalities would be burdensome.
5. Individuals who need to have their address and location information protected for a documented safety concern (i.e. witness protection or domestic violence victim).

The member/HCDM and provider are required to sign a standardized AHCCCS attestation as specified in Attachment B and utilize the standardized paper timesheet specified in Attachment C. Attachment B is utilized to justify the allowance of the use of paper timesheets. The attestation is specific to the member and the services they receive from a single provider. The provider agencies shall review Attachment B with the member/HCDM at least annually to ensure the member's circumstances and EVV decision has not changed. The member can make a change to begin using a different EVV device at any time without waiting for the annual review. Contractors shall review annually and monitor the use of these attestations to ensure they are utilized for allowable instances only. It is permissible for provider agencies to utilize their own paper timesheet as long as the minimum data elements are captured.

The provider shall enter the paper timesheet into their EVV System no more than 21 days after the date of service rendered as long as timeliness filing standards, as found in ACOM Policy 203 or the provider's contract with the Health Plan, are also met. The signature does not have to be recorded in the EVV System, but Agencies shall have the original, wet copy of the signature on file for audit purposes. A faxed copy of the signature is permissible for billing purposes.

C. ELECTRONIC VISIT VERIFICATION MODALITIES

1. The member/HCDM may choose, at a minimum on an annual basis, the device that best fits their lifestyle and the way in which they manage their care. At least two different types of visit verification modalities shall be available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service. The provider shall assist the member/HCDM to make an informed decision about the choice of data collection modality. The member/HCDM shall be permitted to change the modality at any time.

2. It is allowable for provider agencies to allow DCWs to utilize personal devices such as a smartphone. If the provider elects this option, the provider is responsible for having a back-up plan for EVV if the device becomes inoperable.
3. If the provider chooses to allow for Global Positioning System (GPS) tracking while the DCW is on the clock, the provider shall disclose to members how and why the DCW is being tracked. The disclosure should be documented and on file.
4. The members shall be offered the opportunity to change their preference for the visit verification device the DCW will use.

For members who receive service(s) on an intermittent basis, such as respite care or home health services, the choice of a modality may be limited.

D. LIVE-IN CAREGIVERS

Within 30 days of hire, the provider shall use the EVV system to identify DCWs who are live-in caregivers and the specific relationship to the member. The EVV system shall also be updated within 30 days of any changes (i.e., applying an end date to the relationship). The live-in caregiver must be identified for each unique client, relationship, and service combination. The EVV System must electronically capture and submit the defined data to the AHCCCS Aggregator per the specifications available on the AHCCCS website. The list of the acceptable relationship types is limited to:

1. Spouse.
2. Adult children/Stepchildren.
3. Son-in-law/Daughter-in-law.
4. Grandchildren.
5. Siblings/Step siblings.
6. Parents/Adoptive Parents/Legal Guardians.
7. Stepparents.
8. Grandparents.
9. Mother-in-law/Father-in-law.
10. Brother-in-law/Sister-in-law.
11. Other.

The category of “other” is to be used for live-in caregiver relationships not otherwise defined in the list of options (i.e., roommate).

E. CONTINGENCY/BACK-UP PLAN

The provider agencies shall use the standardized AHCCCS Contingency/Back-Up Plan form as specified in Attachment D to plan for missed or late service visits and discuss the member's preference on what to do should a visit be late or missed. The preferences shall be noted for each service the provider is rendering. It is allowable for members to choose different preference options based upon the service. The Contingency/Back-Up Plan shall be reviewed and signed by the member and the provider agency, at least annually, as the outcome of a conversation to understand the member's needs and preferences. In the event a visit is late or missed, the provider is required to follow up with the member to discuss what action needs to or can be taken to meet the service need. The member/HCDM can change decisions about these preference levels and the Contingency/Back-Up Plan at any time. Should the member not choose a preference, a default preference may be applied based upon the service.

F. REPORTING

The Contractors shall utilize EVV data to monitor and analyze the following to support provider compliance with EVV as well as inform network adequacy and workforce development planning, including but not limited to:

1. Member access to care, including:
 - a. Late and missed visits and adherence to contingency planning preferences, and
 - b. Timeliness of new services from the date it was determined medically necessary to the date the service was provided for newly enrolled and existing members. Additional information on this requirement is specified in AMPM Policy 1620-A, AMPM Policy 1620-D, AMPM Policy 580, and AMPM Policy 310-B.
2. The Provider Performance, including, but not limited to:
 - a. Unscheduled visits,
 - b. Manual Edits,
 - c. Device utilization,
 - d. EVV modality types in use,
 - e. Live-in caregiver relationships are identified with appropriate use of the "other" category,
 - f. Visits that follow the member's Contingency/Back-Up Plan, and
 - g. Monitoring of service hours authorized compared to service hours actually provided.
3. The Provider shall self-monitor and analyze the following including, but not limited to:
 - a. Performance, including but not limited to:
 - i. Location discrepancies,
 - ii. Documentation of the reconciliation of visit exceptions including those requiring manual edits, and
 - iii. Auto versus manually verified visits.
 - b. Service Delivery that monitors service hours authorized compared to service hours actually provided, and
 - c. Live-in Caregiver identification:
 - i. Ensuring live-in caregiver relationships are identified within 30 days of hire or change in the relationship, and
 - ii. Monitoring appropriate use of "other" category.

G. PROVIDER REQUIREMENTS AND CONTRACTOR OVERSIGHT

The Contractors, including AHCCCS Division of Fee-for-Service Management (DFSM), shall monitor all provider responsibilities specified in this Policy as part of annual monitoring to ensure compliance for the following roles and responsibilities of providers required to utilize EVV, including but not limited to:

1. Notifying AHCCCS of all new users and user terminations and all data security incidents.
2. Collecting and maintaining records for the audit period of at least six years from the date of payment, applicable attestations regarding verification delegation, paper timesheet allowances, and contingency/back-up plans as specified in this Policy.
3. Counseling the member/HCDM on the scheduling flexibility based on the member's Service Plan or provider plan of care and what tasks can be scheduled and modified depending on the DCWs scheduling availability at least every 90 days.
4. Developing a general weekly schedule for each service. The EVV System shall record the schedule for each service. The system is prohibited from canceling a scheduled visit; however, visits may be rescheduled. The EVV System shall denote what scheduled visits are rescheduled visits. Scheduling is not required for members that have live-in caregiver or DCW onsite.
5. Ensuring that all associated EVV System users have access to training on the EVV System.
6. Submitting data timely to AHCCCS as a condition of reimbursement as specified in technical requirement documents available on the [AHCCCS Electronic Visit Verification website](#).
7. The providers shall comply with member responsiveness including requirements that provider agencies shall answer the phone 24/7 or return a phone call within 15 minutes for members who are reporting a missed or late visit.
8. Ensuring the provider has at least two different types of visit verification devices available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service.
9. Ensuring any device used to independently verify start and end times without the use of GPS is physically fixed to the member's home to ensure location verification.
10. Ensuring any providers that permit DCWs to utilize personal devices such as a smartphone have an alternate verification method or option if the device becomes inoperable.
11. Ensuring that member devices are not used for data collection unless the member has chosen a verification modality that requires use of their device (e.g., landline telephone).

12. Contacting the member to validate any visit exceptions including instances when the member indicates the service or duration does not accurately reflect the activity performed during the visit. The documentation of exceptions should be consistent with CMS's Medicare signature and documentation requirements for addendums to records. The changes as a result of the exceptions process are considered an addendum to the record and do not change the original records. The Documenting Manual Edits to visits, after contacting the member, within the system and/or maintaining hard copy documentation. The documentation should follow requirements detailed on the [AHCCCS EVV website](#) and includes:

- a. Appropriate reason and resolution codes, and
- b. Memos that follow the defined format with all required information present.