

EVV Billing Checklist



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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 the AHCCCS aggregator 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

Resources:

- [Billing FAQ](#)

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.

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Providers using an EVV System can confirm whether or not a visit is in a verified state by accessing the AHCCCS Aggregator. The AHCCCS 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 the AHCCCS Aggregator.

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:

- Provider Agencies can access information on the AHCCCS Aggregator by following the guides below:
 - Step 1
 - [EVV Service Now Registration](#)
 - Step 2 – Not Available for Use Until October 6, 2025
 - [EVV Aggregator Provider User Manual](#)

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.

The AHCCCS Aggregator 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 AHCCCS Aggregator.

Processed status means the visit has passed claims validation.

Unmatched information status means the AHCCCS aggregator 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 AHCCCS aggregator 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

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plan for denial reasons and begin the process with Step One to resolve any exceptions.

Note: 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.

Step Five: If the issue is still unresolved, please use the information and directions below to reach out to the member's Health Plan to resolve a billing issue. **Please be sure to mention EVV to ensure your request is routed appropriately.**

Health Plan	Preferred Contact Method for EVV Services/Providers
Arizona Complete Health	AzCHProviderEngagement@azcompletehealth.com
Banner- University Family Care	800-582-8686
Banner- University Family Care LTC	833-318-4146
Care1st	1-602-778-1800 or 1-866-560-4042 (options in order 5, 7)
DDD	For authorization issues, please first contact the assigned support coordinator or if necessary, the Division's Customer Service Center, at DDDCustomerServiceCenter@azdes.gov or Toll Free (844) 770-9500. TTY/TDD 711. Fax: (602) 542-6870
Health Choice Arizona	480-968-6866 or 800-322-8670 – follow prompts for provider assistance
Molina Complete Care	800-424-5891
Mercy Care	Please contact the Claims Inquiry Claims Research Department (CICR) by calling 602-263-3000 or 800-624-3879 toll-free.
Mercy Care Long Term Care	Please contact the Claims Inquiry Claims Research Department (CICR) by calling 602-263-3000 or 800-624-3879 toll-free.
UnitedHealthcare Community Plan	800-445-1638 Additional contact information and resources: https://www.uhcprovider.com/az-evv

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UnitedHealthcare Community Plan Long Term Care	Please call 800-293-3740 for Therapy services (Physical, Occupational, Speech). For all other services, please call the member's case manager. Additional contact information and resources: https://www.uhcprovider.com/az-evv
American Indian Health Program (AIHP) and the following Tribal ALTCS Programs: • Gila River Indian Community • Hopi • Navajo Nation • Pascua Yaqui • San Carlos Apache • Tohono O'Odham Nation • White Mountain Apache • Native American Community Health Center	In Maricopa County: 602-417-7100 Outside Maricopa County: 1- 800-962-6690