AHCCCS E.V.V.
ELECTRONIC VISIT VERIFICATION

Frequently Asked Questions (FAQ)
Billing

Will EVV create a delay in the health plan's process to approve claims for payment?

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.

Hard claims edits were implemented on January 1, 2023. Providers 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 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

Is there a way I can make sure that the visit will get paid before I submit a claim?

Yes. AHCCCS has created an 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 or approved before submitting a claim.

Additionally, this guidance provides steps a provider can take if a 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 "General Resources and Frequently Asked Questions."

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 the AHCCCS Aggregator 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.

Are there any service delivery scenarios that don't require EVV?

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. This includes services that are paid for with state only dollars.
- **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. EVV is only required for services rendered to Medicaid members (Title 19 or Title 21 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?

The EVV system must record the exact time the DCW works. The EVV System reports the visit minutes to the AHCCCS 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 AHCCCS aggregator edit check/claims validation process accommodate for bundled billing?

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).

Will the AHCCCS Aggregator automatically split overnight visits for billing purposes?

The AHCCCS Aggregator 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.