CHAPTER 62 ELECTRONIC VISIT VERIFICATION

EFFECTIVE DATE: September 22, 2021
REFERENCES: AMPM Policy 540, Electronic Visit Verification

PURPOSE

This Policy applies to DES DDD Qualified Vendors and establishes requirements regarding the mandated use of an Electronic Visit Verification (EVV) system for personal care and home health services pursuant to 42 U.S.C. 1396(b)(l).

DEFINITIONS

Aggregator - A function of the AHCCCS EVV Vendor System that allows the state to compile all data and present it in a standardized format for review and analysis.

Ahcccs Electronic Visit Verification (EVV) Vendor - The AHCCCS selected Statewide EVV vendor to comply with the 21st Century Cures Act (Cures Act).

Alternate Electronic Visit Verification (EVV) System - Any EVV system(s) chosen by a provider as an alternate to the AHCCCS selected Statewide EVV vendor.

Designee - For the purposes of this Policy, an individual who is 12 years of age or older and who is delegated by the member or Health Care Decision Maker the responsibility of verifying service delivery on behalf of the member.

Direct Care Worker (DCW) - For the purposes of this Policy, a DCW is an individual providing one or more of the services subject to EVV.

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.

Electronic Visit Verification (EVV) System Chapter 500 – Care Coordination Requirements - The AHCCCS procured system or an AHCCCS approved alternate EVV system.

Health Care Decision Maker - An individual who is authorized to make health care treatment decisions for the patient (member). As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231, or 36-3281.

Manual Edit - Any change to the original visit data. All edits shall include an appropriate audit trail.

Prior Authorization - For the purposes of this Policy, a process by which it is determined in advance whether a service that requires prior approval will be covered, based on the initial information received. Prior Authorization may be granted provisionally (as a

temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. Prior Authorization is not a guarantee of payment.

Qualified Vendor: For the purposes of this policy, means the same as Provider in AHCCCS AMPM 540.

Service Plan - A complete written description of all covered health services and other informal supports that includes individualized goals, peer-and-recovery support and family support services, care coordination activities, and strategies to assist the member in achieving an improved quality of life.

POLICY

AHCCCS is required to comply with the EVV requirements in the 21st Century Cures Act, 42 U.S.C. 1396(b)(l). The Division and Qualified Vendors are required to utilize AHCCCS's single statewide EVV System for data collection. Qualified Vendors may use the EVV Vendor or choose an AHCCCS approved alternate EVV System capable of sharing data with the Aggregator. AHCCCS and the Division are 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 and include but are not limited to Attendant Care, Habilitation Nursing, Homemaker, and Respite.

A. Service Verification

1. All Qualified Vendors who are subject to EVV must utilize the EVV Vendor or an AHCCCS approved alternate EVV System to electronically track the defined data specifications available on the AHCCCS website.

2. The member/Health Care Decision Maker, or Designee, shall verify hours worked by the DCW at the point of care or within 14 days of the visit. The member/Health Care Decision Maker, or Designee shall also verify Manual Edits to visits.

3. If a member/Health Care Decision Maker 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/Health Care Decision Maker is required to sign a standardized attestation specified in Electronic Visit Verification (EVV) – Designee Attestation form (DDD-2102A), 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 Qualified Vendor shall assist the member/Health Care Decision Maker to make an informed decision about verification delegation. The member/Health Care Decision Maker can change decisions about verification delegation at any time by completing a new attestation. The Qualified Vendor shall keep the attestation on file, following the Divisions record retention requirements outlined in the Qualified vendor Agreement.

4. Exceptions to the Designee age requirement shall be discussed with the treatment and/or planning team and documented on the DDD-2102A form prior to the delegation of service delivery verification responsibility.

5. Neither the Health Care Decision Maker 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 Health Care Decision Maker shall document on the DDD-2102A form.

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. Members for whom the use of electronic devices would cause adverse physical or behavioral health side effects/symptoms.

3. Members electing not to use other visit verification modalities on the basis of moral or religious grounds.

4. Members with a live-in caregiver or caregiver accessible on-site 24 hours and for whom the use of other visit verification modalities would be burdensome.

5. Members who need to have their address and location information protected for a documented safety concern (i.e., witness protection or domestic violence victim or members in the Address Confidentiality Program as outlined in DES Policy VR-2.2-v1).

The member/Health Care Decision Maker and Qualified Vendor are required to sign a standardized attestation as specified in the Electronic Visit Verification – Paper Timesheet Attestation form (DDD-2101A) and utilize the standardized paper timesheet specified in the DDD Electronic Visit Verification Paper Timesheet form (DDD-2100A). The DDD-2101A form 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 Division will review the records of the Qualified Vendor annually and monitor the use of these attestations to ensure they are utilized for allowable instances only. It is permissible for Qualified Vendors to utilize their own paper timesheet as long as AHCCCS minimum data elements are captured.

The Qualified Vendor shall enter the paper timesheet into their EVV System no more than 21 days past the date of service rendered as long as timeliness filing standards, as found in Division of Developmental Disabilities Provider Manual, Chapter 12-Billing and Claim Submission are also met. The signature does not have to be recorded in the EVV System, but Qualified Vendors 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. EVV Modalities

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

2. It is allowable for Qualified Vendors to allow DCWs to utilize personal devices such as a smartphone. If the Qualified Vendor elects this option, the Qualified Vendor is responsible to have a back-up plan for EVV if the device becomes inoperable.

3. If the Qualified Vendor chooses to allow for GPS tracking while the DCW is on the clock, the Qualified Vendor shall disclose to members how and why the DCW is being tracked. The disclosure should be documented and on file.

4. Members shall be afforded 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. Contingency/Back-Up Plan

Qualified Vendors are responsible for Contingency/Back-Up planning and shall use the standardized Contingency/Back-Up Plan as specified in Electric Visit Verification (EVV) Member Contingency/Back-Up Plan form (DDD-2099A) 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 Qualified Vendor is providing. It is allowable for members to choose different preference options based upon the service. The Contingency/Back-Up Plan shall be reviewed by the Qualified Vendor with the member at least annually, and a current copy provided to the assigned Support Coordinator. In the event a visit is late or missed, the Qualified Vendor 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/Health Care Decision Maker 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 shall be applied based upon the service.

E. Reporting

The Division will monitor and analyze the Qualified Vendor's EVV data including the following:

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 AHCCCS AMPM Policy 1620-A (Initial Contact/Visit Standard), AMPM Policy 1620-D (Placement/Service Planning Standard), AMPM Policy 580 (Behavioral Health Referral and Intake Process), and AMPM Policy 310-B (Title XIX/XXI Behavioral Health Service Benefit).

2. Qualified Vendors Performance, including:

a. Unscheduled visits,

b. Manual Edits,

c. Device utilization,

d. EVV modality types in use,

e. Visits that follow the member's Contingency/Back-Up Plan, and

f. Monitoring of service hours authorized compared to service hours actually provided.

3. The Qualified Vendors shall self-monitor and analyze the following:

a. Performance, including:

i. Location discrepancies, and

ii. Visit exceptions.

b. Devices

i. Monitor and maintain the list of AHCCCS EVV Vendor devices assigned to the provider, as applicable.

c. Service Delivery

i. Monitor service hours authorized compared to service hours actually provided.

F. Qualified Vendor Requirements

1. Comply with annual EVV monitoring.

2. Collect and maintain 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. Counsel the member/Health Care Decision Maker 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. Develop 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 or onsite caregivers; however, the Qualified Vendor shall facilitate a conversation with the member, their family, case managers (if applicable) to make a determination whether or not the exemption from the scheduling requirement is the best decision to support the member.

5. Ensure that all associated EVV Systems users are trained on the EVV System.

6. For providers using an Alternate EVV System, submit data timely as a condition of reimbursement as specified in technical requirement documents available on the AHCCCS website.

7. Comply with member responsiveness including requirements that Qualified Vendors shall answer the phone 24/7 or return a phone call within 15 minutes to members or responsible persons who are reporting a missed or late visit.

8. For Qualified Vendors using the AHCCCS EVV Vendor, develop and implement policies to account for and ensure the return of devices issued by Qualified Vendors to DCWs.

9. Have 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.

10. Ensure 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.

11. Ensure that DCWs who utilize personal devices, such as a smartphone, have an alternate verification method or option if the device becomes inoperable.

12. Ensure 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).

13. Contact 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. Changes as a result of the exceptions process are considered an addendum to the record and do not change the original records.

14. Document Manual Edits to visits within the system and/or maintaining hard copy documentation.

G. Qualified Vendor Attestation

Qualified Vendors shall complete an attestation verifying agreement to comply with the requirements of Electronic Visit Verification. This attestation shall be incorporated as a requirement of the Division's credentialing and recredentialing process.

H. After-Hours Telephone Survey

The Division conducts a telephone survey of the after-hours response of Qualified Vendors (Vendors) contracted to provide services subject to Electronic Visit Verification (EVV) to ensure calls made to the Vendor after business hours are answered immediately or returned within 15 minutes. In addition to the After-Hours Survey, the Division also monitors member grievance information about Vendor's after-hour responsiveness.

In order to ensure access to care for Division members, the Vendor's telephone system shall have a recorded message providing information to callers including the Vendor name and how to reach staff after hours. The message shall indicate to the caller the timeframes the caller can expect to receive a return phone call, not to exceed 15 minutes. The current after-hour contact information shall be maintained in the Division's CAS system.

Survey Process

A. The Division randomly selects the Vendor to participate in the After-Hours Telephone Survey and calls the Vendor, using the Vendor's after-hours telephone number(s) identified in Focus.

B. If the Vendor answers the call immediately or returns the call within 15 minutes, the Division documents the Vendor response and requires no additional survey-related action from the Vendor.

C. If the Vendor does not answer the call and does not return the call within 15 minutes:

1. Corrective Action Plan (CAP)

a. The Division will send a CAP letter to the Vendor, requiring the Vendor to submit a CAP to the Division within 14 calendar days from the date of the CAP letter.

b. If the Vendor does not submit a CAP to the Division within 14 calendar days from the date of the CAP letter, the Division shall send a second CAP letter to the Vendor, requiring that the

Vendor respond to the Division within five calendar days from the date of the second CAP letter.

c. If the Vendor does not respond to the Division within five calendar days from the date of the second CAP letter, the Division may follow progressive contractual action.

2. CAP Review and Verification

a. After review, the Division sends a letter to the Vendor, accepting or rejecting the CAP.

b. If the CAP is not accepted, the Division shall schedule a meeting with the Vendor and offer technical assistance to support the vendor's resubmission.

c. After Acceptance:

i. Division Network staff shall conduct three follow-up calls to the Vendor on different dates/times over three consecutive months.

ii. If the Vendor answers each after-hours follow-up phone call within 15 minutes or returns the call within 15 minutes, the Division staff shall send a letter to the Vendor indicating:

- Vendor is in compliance
- CAP is closed

iii. If the Vendor is not successful in answering the follow-up after-hours calls, the Division may follow progressive contractual action.