Electronic Visit Verification (EVV) for Medicaid Services

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Abbreviations/Terms

DDE – Direct Data Entry

EDI – Electronic Data Interchange

EVV – Electronic Visit Verification

GPS – Global Positioning System

MCOs – One of Medicaid's contracted insurance plans: Aetna, Anthem, Magellan, OptimaHealth, United Healthcare, or Virginia Premier

Member – An individual who has Medicaid

Trading Partner – The entity that submits the claim to DMAS or the MCO. This may be the EVV vendor or the clearinghouse.

Implementation Dates

The federal 21st Century CURES Act of 2016 requires states to implement Electronic Visit Verification (EVV). Subsequent legislation extended the EVV requirement for Medicaid personal care services to January 1, 2020.

The Virginia Appropriations Act mandates EVV for Companion Care, and Respite Services.

DMAS will require EVV for both Consumer and Agency Directed Services beginning October 1, 2019. That includes: Personal Care Services, Companion Care, and Respite Services.

Home Health will begin on January 1, 2023.

Provider Choice

Virginia is a provider choice state for Agency Directed services. Providers may choose an EVV system that best meets their needs as long as it meets DMAS requirements.

Major types of technology systems

- Telephony, Interactive Voice Response (IVR)
- Web-based verification/one-time password generator
- GPS
- Biometrics

EVV Services

The EVV systems must electronically identify the location and times when the service begins and ends and store the results!

Choosing a system involves some work, because you have to pick an EVV system that supports your business needs. Some of the factors include:

- ease of use, training, technical support, contract/purchase cost, claims submission, connectivity, data storage, etc.

EVV Services

The following HCPCS codes that require EVV information:

- Personal Care: T1019, S9125
- Respite Services: T1005
- Companion Services: S5135

Each code is a separate clock in and clock out.

Consumer Directed services use a different set of billing codes.

Have the nurse take the EVV app to the member's home to identify reasonableness of GPS location.

Identify in the care plan the normal locations where service is provided.

Two Important Changes

For services performed on or after October 1, 2019

How claims are submitted

EVV reporting requirements

Submitting Claims

If a member has covered by Virginia Medicaid

Paper

Directed Data Entry (DDE)

Electronic Data Interchange (EDI) – 837P Claims

The claim must be sent in an electronic format to DMAS or the one of Medicaid's Health Plans.

EVV Reporting Requirements

6 Federal Minimum Requirements

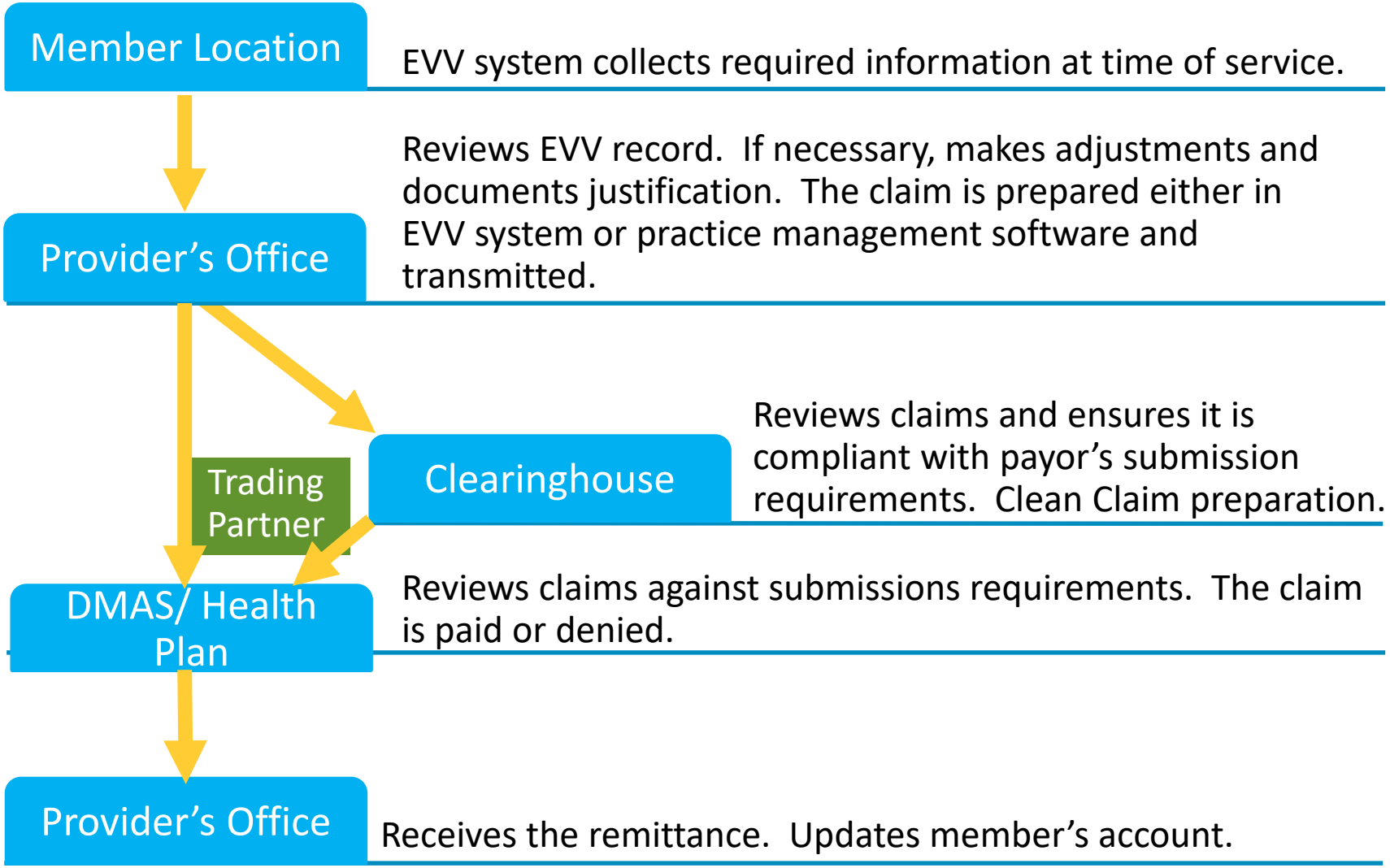
- First three are already on claim forms:
  - The individual receiving the service(s);
  - Date of service; and
  - Type of service(s) performed (personal, respite, companion, home health).

- Additional claim information via technical guide:
  - Individual providing the service;
  - Location of service delivery (beginning and ending); and
  - Time the service begins and ends.

EVV System Requirements

- ADA and HIPAA compliant
- Electronic recording of required data, able to produce data upon demand, and safeguard data both physically and electronically.
- Accessible for input or service delivery 24 hours per day, 7 days per week.
- Data backups for emergencies, disasters, natural, and system malfunctions.

EVV Process


Member Location
EVV system collects required information at time of service.
Provider's Office
Reviews EVV record. If necessary, makes adjustments and documents justification. The claim is prepared either in EVV system or practice management software and transmitted.
Trading Partner
Clearinghouse
Reviews claims and ensures it is compliant with payor's submission requirements. Clean Claim preparation.
DMAS/ Health Plan
Reviews claims against submissions requirements. The claim is paid or denied.
Provider's Office
Receives the remittance. Updates member's account.

Lifeline Telephone Support

Lifeline is a program to assist eligible consumers with purchasing landline telephone or cellphone service at a reduced cost. If the member, aide, or attendant qualifies for the Lifeline program, the phones may be used to support the Electronic Visit Verification (EVV) initiative.

Several telephone or wireless companies participate in Lifeline. If you are covered by a Virginia Medicaid Managed Care Organization, contact them directly. If not, you can select your own.

Companies that participate provide discounted rates, the minimum you would save is $9.25 per month on your service. Choose wisely. Different plans offer different numbers of minutes, different refill options, and serve different geographic areas. Some offer free phones.

- ✓ Access Wireless (888-900-5899)
- ✓ Assurance Wireless (888-321-5880)
- ✓ Safelink Wireless (800-378-1684)

For more information go to the DMAS EVV webpage.

EVV in Virginia

http://www.dmas.virginia.gov/#/longtermprograms

EVV System Record Requirements

- Retain EVV data for 6 years. If there is an audit, the records shall be retained until the audit is completed and exceptions resolved.
- If a minor, keep records 6 years after reaching 18 years of age.
- Record retention applies even if the provider discontinues operation.
- Produce archived EVV data timely and electronically when requested by DMAS or its designee.
- If electronic verification is not available, the provider shall document the reason the aide/attendant did not use EVV.

Have a policy on who has the authority to adjust the EVV record.

Licensed Settings Where EVV Is Not Required

Department of Behavioral Health and Developmental Services (DBHDS) licensed site such as a group home, sponsored residential home, supervised living, supported living or similar licensed facility, the Reach Program, or in a school setting.

FAQs

Question: Will the Virginia Medicaid system have edit checks?

- Answer: There will be several system edits. At this point, the following edits will be included:
  - Standard edit processes such as member and provider eligibility,
  - Verifying the charges with the service authorization (SA);
  - Payment consistent with the procedure code); and
  - Verifying EVV billing codes contains information in all EVV fields.

  Additional claim information:
  - Individual providing the service;
    - All three fields: ID, First Name, Last Name
  - Location of service delivery (beginning and ending); and
    - All three fields: Street, City (alpha), Zip (numeric)
  - Time the service begins and ends.
    - Military Time - There is a check that the end time is later than the start time. If the shift is overnight, there is a check that the date range includes two consecutive dates.

FAQs

Question: There was an old rule of thumb to not submit a claim with the same date of service on more than one line. With EVV, a Medicaid member may receive services from more than one aide working multiple shifts during the same day. Is it ok to submit a claim with multiple lines for the same date of service?

- Answer: An EVV 'line of billing' includes the date, type of service, service start and end time, attendant name, and beginning and ending location. There may be more than one aide shift per day and a shift may cross from one day to the next.

FAQ

Question: How are the billing of units handled when a full hour is not worked?

- Answer: The CCC Plus Waiver Manual. "Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed.

  Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS."

Units billed should always be within 30 minutes if you bill monthly or 59 minutes if you bill weekly or biweekly of the EVV time.

Billing Units Example

For example, a provider that bills weekly may have an aide that works 2 hours 20 minutes the first week, 2 hours 45 minutes the second week, 2 hours 5 minutes the third week, and 1 hours and 15 minutes the fourth week.

Calendar Week	Worked	Billed	Extra Time Carried Forward
Week 1	2 hours 20 minutes	2 hours	20 minutes
Week 2	2 hours 45 minutes	3 hours	5 minutes
Week 3	2 hours 5 minutes	2 hours	10 minutes
Week 4	1 hours 15 minutes	1 hours	25 minutes
Total	8 hours 25 minutes	8 hours	25 minutes not billed

- Note: Rounding occurs only once at the end of the calendar month. The intent is that billing each week should be never vary more than one hour from actual during the calendar month.

- The claim must contain the actual time clocked in and clocked out.

Optional
Provider Aide Record (DMAS-90 Form)

- The DMAS-90 form captures:
  - Dates and times of various activities; and
  - Changes in the individual's physical or emotional condition, daily activities or services provided.

- The record of care must contain the individual's/family member's signature. If the EVV system is the record of care, the EVV system must be capable of electronically capturing and storing the individual's/family member's signature. The EVV system must also be capable of reproducing a representation of the DMAS-90 form in a paper format.

- The DMAS-90 form is not sent to DMAS or one of Medicaid's health plans, but must be kept accessible in the event the documentation is requested.

Have a policy on electronic signatures.

Submit a test claim.

Questions, Comments, & Answers

DMAS EVV Contacts

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