# Virginia Department of Medical Assistance Services
# Electronic Visit Verification (EVV)
# Frequently Asked Questions (FAQs)
# Revised October 17, 2022

**Contents**



## Home Health Care Services

Question: When will the use of an EVV system be required for Home Health Care Services?

Answer: The Centers for Medicaid and Medicare Services (CMS) allows states to apply for a one-year Good Faith Extension for the implementation of Electronic Visit Verification (EVV) requirements for Home Health Care Services (HHCS). The Department of Medical Assistance Services (DMAS) has applied for the Good Faith Extension and is working toward a July 2023 implementation date. DMAS will collaborate with provider representatives, associations, and DMAS contracted vendors to develop and implement a technical specification guide to support a transition to these requirements.

Implementation will involve modifying the 837I to accommodate the additional EVV fields. A technical specification guide is published at https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/electronic-visit-verification. The guide is called, "MES EDI 837I Companion Guide 100622 Revised".

Question: Which Home Health Care Services billing codes are required to use EVV?

Answer: The 837I uses revenue codes for billing Home Health Care Services (HHCS) Virginia Medicaid services. The following revenue codes will require EVV information:

- 0550 Skilled Nursing Assessment
- 0551 Skilled Nursing Care, Follow-Up Care

- 0559 Skilled Nursing Care, Comprehensive Visit
- 0571 Home Health Aide Visit (no PA required)
- 0424 Physical Therapy, Home Health Assessment
- 0421 Physical Therapy, Home Health Follow-Up Visit
- 0434 Occupational Therapy, Home Health Assessment
- 0431 Occupational Therapy, Home Health Follow-Up Visit
- 0444 Speech-Language Services, Home Health Assessment
- 0441 Speech-Language Services, Home Health Follow-Up Visit

Question: Will Virginia Medicaid accept paper claims or claims through the Direct Data Entry portal that requires EVV information?

Answer: For Home Health Care Services, Virginia Medicaid will not accept paper claims or Direct Data Entry (DDE) claims for dates of service beginning October 1, 2023. The DDE portal will not been modified to accept the additional fields required for EVV claims. Claims submitted through the DDE portal with an October 1, 2023 date of service or later will not allow the entry of the additional EVV fields that are required for payment. Providers must submit electronic data interchange (EDI) 837I claims.

Question: Will Hospice or Private Duty Nursing claims requires EVV information?

Answer: No.

## EVV Personal Care, Respite Care, Companion Services Timeline

Question: When will the use of an EVV system be required?

Answer: The federal 21st Century CURES Act requires states to implement Electronic Visit Verification (EVV). The original law required states to comply for Medicaid in-home personal care by January 1, 2019, and home health services by January 1, 2023. The Virginia Appropriations Act expanded the use of EVV to include respite and companion services. In July 2018, federal legislation extended the deadline for states to comply with the EVV requirement without penalty for Medicaid personal care services to January 1, 2020. There was no change in the date for home health services. Virginia Medicaid began accepting EVV claims on October 1, 2019. **Virginia Medicaid requires EVV information before payment for Agency Directed personal care, and respite and companion services beginning September 1, 2020.** The effective date of the EVV criteria is based on the date the service was provided, ***not*** the date the claim was submitted. For example, if the service was provided in August 2020, but the claim was submitted in September 2020, the claim is processed with the EVV requirements as being informational. See the August 14, 2020, Medicaid Bulletin for more information.

Question: Will Virginia Medicaid accept paper claims or claims through the Direct Data Entry portal that requires EVV information?

Answer: For Agency Directed personal care services, respite care, and companion services, Virginia Medicaid does not accept paper claims or Direct Data Entry (DDE) claims for dates of service beginning September 1, 2020. The DDE portal has not been modified to accept the additional fields required for EVV claims. Claims submitted through the DDE portal with a September 1, 2020 date of service or later will not allow the entry of the additional EVV fields that are required for payment. Providers must submit electronic data interchange (EDI) 837P claims.

## General Questions

Question: Where can I find the Virginia Medicaid requirements for EVV systems?

Answer: The EVV regulations provide basic system requirements. The EVV regulations were published in the Virginia Register of Regulations on July 19, 2021 with an effective date of August 18, 2021. They are available 12VAC30-60-65 Electronic Visit Verification. They will be updated to include EVV requirements for Home Health Care Services.

Question: Will Virginia Medicaid provide a list of approved EVV vendors?

Answer: Virginia Medicaid does not and will not approve EVV vendor systems. To facilitate the adoption of an EVV system by the provider community, Virginia Medicaid may, from time-to-time, refer inquiries to a list of EVV systems compiled by a third party. There are several resources available for you to help identify potential EVV vendors. The best resource is to discuss with your colleagues and provider associations the EVV systems they use or recommend. This will give you the advantage of learning from their experiences. Nationally there are several resources, including the National Electronic Visit Verification Association. More information about this group is available at https://nevva.org. Also, Applied Self Direction at http://www.appliedselfdirection.com/resources/directory-evv-vendors-interested-serving-self-direction-programs has a list of vendors. Remember, it is the responsibility of the provider to ensure that their system meets Virginia Medicaid's requirements.

Question: Our aides have difficulty understanding technology, and they are unable to consistently comply with using the EVV app to clock in and clock out. Even using telephony to clock in or clock out has been challenging. Are there other options?

Answer: It is the provider's responsibility to ensure the member's care is reported in an EVV system by the aide. Providers are encouraged to develop a training program for new aides. It may be necessary to provide refresher training periodically. Your EVV vendor may be able to assist with a training program. Some vendors offer online training and or documentation. If you continue to experience significant difficulty, you may want to look at alternative systems. There are hundreds of EVV vendors that offer different designs and capabilities. You may find a different system that is easier to use and meet your business needs and meets DMAS requirements.

Question: Will Virginia Medicaid handle our grievances with EVV vendors who are creating challenges for smooth operations?

Answer: Agency Directed providers may choose an EVV vendor that best meets their needs as long as it meets DMAS requirements. There are hundreds of EVV vendors with many differences between them. If your current vendor is not meeting your needs, you may want to consider changing systems. DMAS and the MCOs receive claims from numerous vendors. Providers are encouraged to do their due diligence when selecting a system.

Question: I decided to switch EVV vendors. The EVV system may contain more information than just the EVV records. What is the requirement for records?

Answer: It is the provider's responsibility to maintain the required member records. Depending on the EVV system used, the system may contain more than just EVV claim information. It is

important to review the information collected and maintained in the previous EVV. It is the provider's responsibility to keep the records that may be required in the event of an audit. Please see the question below "How long must records be maintained?".

Question: One of our members is concerned about confidentiality and does not want the aide to use the EVV app. Is this justification for a manual entry?

Answer: No. Explain to the member the information is necessary to bill the service. When any medical service is billed, it has always contained confidential information such as name, address, date of birth, date of service, and the type of service received. All information collected is required to be kept confidential according to the Health Insurance Portability and Accountability Act (HIPAA) and state regulations. The EVV requirement only adds the aide's name and the time and location the aide performs the service. The purpose of EVV is to ensure the aide is on sight. An EVV Notice for Members brochure is available on the DMAS website that may be useful in explaining its purpose to members.

Question: What happens if I don't use an EVV system?

Answer: Personal care services, respite care, and companion services require the use of an EVV system. If a provider does not submit the required EVV information, the claim will be denied.

Question: What must be in the EVV electronic record?

Answer: The EVV electronic record must contain the six data elements required by the CURES Act. This includes (i) the type of service performed; (ii) the individual receiving the service; (iii) the date of the service; (iv) the beginning and ending location of service delivery; (v) the individual providing the service, and; (vi) the time the service begins and ends.

Question: Is telephony an acceptable method of EVV?

Answer: All EVV systems, including telephony, must be capable of electronically capturing and storing the location of the Medicaid member, the type of service performed, the date and time of the call, and the aide's information. For telephony, the landline phone number associated with the member is acceptable to verify the location. If there is no landline phone, a 'fixed object,' device sometimes known as a key FOB or just FOB may be used. Telephony verification with the aide dialing in from a cell phone, regardless of whom it belongs to, without any associated fixed in-home device (FOB), does not meet the requirements. If you are not familiar with FOBs, please review the FAQ addressing that topic.

Question: Is a fixed object device (FOBs) an acceptable method of EVV?

Answer: Fixed object device (FOBs) are devices that allow verification that the aide was in the specified location when they clock in and clock out. FOBs are assigned or registered to the member and are placed in their home. The FOB is attached to something in the house, like a drawer pull. It is often affixed with a plastic zip tie. The most common type of FOB has a button that, when pushed, displays an encrypted date/time/machine code. Aides push the button on the FOB when they arrive and leave the visit, and record the displayed number. The number can generally be entered on the EVV app or used in telephony to record the visit.

Question: To what extent can the EVV system be a manual process?

Answer: EVV is intended to be an electronic process for all personal care, respite care, and companion services that require EVV. The provider is responsible for having a system that captures the EVV elements in an electronic record when the visit occurs and that it is maintained

for audit. The electronic process should start with the aide reporting the time and location when the visit begins and ends as it occurs as well as information about the aide. Manual entries and manual adjustments are expected to decrease over time. Please see the FAQs under the heading "Adjusting the EVV Record" for more information.

For example, telephony, which tends to be one of the lower-tech systems, should be capable of capturing and storing the telephone number associated with the location of the member, the type of service performed, the date and time of the call, and the aide's ID.

Question: My agency provides one of the services that require EVV. Will the Managed Care Organizations (MCOs) allow me to select an EVV system?

Answer: Agency Directed providers can choose a system that best meets their own business needs that is compliant with Virginia Medicaid's and the MCO's reporting requirements. The MCO will be responsible for collecting the required EVV claim information.

Question: Will Virginia Medicaid require aides to have a unique identifier (ID), or will the first and the last name suffice?

Answer: The claim must contain the aide's ID, first name, and last name. Neither Virginia Medicaid nor the MCOs will be issuing aide IDs. The aide ID is established by the provider and must be unique for each aide. The aide ID can be a mixture of both alphabetical and numeric characters.

Question: How long does the agency have for service authorizations?

Answer: Service authorizations do not change with EVV. The time period for a service authorization is provided on the authorization form. There are several factors that can affect an authorization period, such as member eligibility. The normal authorization period for personal care or companion services is one year, while the normal authorization period for respite care is two years through fee-for-service Medicaid. The health plans may have a different authorization period.

Question: For agencies involved with both Consumer Directed and Agency Directed caregivers, will the agency need to have the Fiscal/Employer Agent (F/EA) system and their own EVV system?

Answer: Yes. 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. If the agency is involved with Consumer Directed, the Fiscal/Employer Agent (F/EA) will provide access to an EVV system and coordinate training for both the attendant and the Medicaid member. The two programs have different methods of reimbursement.

Question: How will EVV work for Consumer Directed services?

Answer: The Fiscal/Employer Agent (F/EA) will provide access to an EVV system and coordinate training for both the aide and the Medicaid member.

Question: Are there any settings where EVV will not be required?

Answer: Yes. EVV will not be required for individuals in a group home licensed by the Department of Behavioral Health and Developmental Services (DBHDS), a sponsored residential home, supervised living, supported living, or similar licensed facility/location licensed to provide respite services, the Regional Educational Assessment Crisis Response and Habilitation (REACH) Program, or in a school where the personal care is rendered under the authority of an

Individualized Education Program (IEP), or for live-in caregivers. Please see Chapter V of the Commonwealth Coordinated Care Plus Waiver Manual, Chapter V, page 3, or the EPSDT (Personal Care Services) Supplement B, page 23 on how to bill claims provided in these settings. The use of the UB modifier for care provided that does not meet this criterion is not allowed. DMAS and the MCOs may verify claims without EVV information to ensure compliance with Medicaid's and the health plan's policies and procedures.

Question: What does it mean to have a data backup? What is the system requirement?

Answer: The proposed regulations state "all EVV systems shall provide for data backups in the event of emergencies, disasters, natural or otherwise, and system malfunctions both in the location services are being delivered and the backup server location." The regulations further state at a minimum, the system must have a daily backup of the most recent data that has been entered. Most commercial EVV vendors have redundant backups. It is the provider's responsibility when selecting an EVV system to inquire and ensure the system has this capability.

Question: How long must records be maintained?

Answer: Providers are be required to retain EVV data for at least six years from the last date of service. Records of minor individuals must be kept for at least six years after the minor individuals have reached 18 years of age. If an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception is resolved. Retention of records applies even if the provider discontinues operation. Providers will be required to produce archived EVV data in a timely manner and in an electronic format when requested by DMAS or its designee.

Question: The EVV regulations state providers will be required to produce archived EVV data in a timely manner and in an electronic format. What is meant by electronic format?

Answer: EVV data is part of the medical record. Providers may keep the EVV data within the EVV vendor's application or download the EVV data and store it in a different format that is readily accessible. For example, the EVV data may be stored in a pdf format.

Question: Who pays for the EVV system?

Answer: For Agency Directed services, the provider is required to obtain and pay for the use of their own EVV system.

Question: Will Virginia Medicaid measure providers in a new way?

Answer: Virginia Medicaid will continue to measure providers as they do today. The only additional measurement when EVV is required is the reporting of the additional information with the claim.

Question: When will MCO audits start? What will each audit look like?

Answer: The MCO audit will be conducted according to the health plan's policies and procedures for conducting audits and fraud, waste, and abuse reviews. One of the primary purposes of the audit is to provide a level of assurance the service was performed according to Virginia Medicaid and the plan's requirements.

Question: How does Virginia plan to aggregate the data?

Answer: CMS requires states to receive six (6) EVV data elements electronically. The first three are already on claim forms: individual receiving the service(s); date of service; and type of service(s) performed (personal care, respite care, and companion services). Added to the claim, as required by the technical specification guide, are the additional fields: location of service delivery (beginning and ending); individual providing the service; and the time the service begins and ends. Virginia does not use the term aggregator because it has different meanings depending on its context. Virginia will receive all required EVV information and maintain it in the Medicaid Management Information System (MMIS).

## Location

Question: Can a Medicaid member receive services in the community with EVV?

Answer: Yes. The use of EVV does not change the services or location in which services are provided. Members are permitted to receive services in accordance with their care plan, existing program rules, and wherever the provider can safely accommodate. EVV should not interfere with the member's ability to travel.

Question: Is GPS tracking required?

Answer: No. The physical address is required for submission.

Question: What is the EVV requirement on location?

Answer: Virginia Medicaid requires electronic verification that the aide is in proximity with the individual. EVV systems verify location using one or more methods, including landline, a fixed in-home device such as a fob, GPS, or member biometrics. For Agency Directed services, a system capable of verifying location through one of these methods will be acceptable.

Telephony verification with the aide dialing in from a cell phone without any associated fixed in-home device does not meet the requirements.

Most EVV vendors have the capability or the option to capture an EVV event manually in the event cell service is not available or if the member does not have a telephone or will not let the aide use their telephone. For example, most systems capture and record information offline. The location feature on most smartphones continues to work without cell service.

It is the provider's responsibility to ensure the recorded location where the service begins and ends is reasonable according to the care plan. The accuracy of the location of the smartphone may vary by device and surrounding structures. As a result, the physical 911 street address captured by the EVV application may not correspond precisely with the member's address, but it should be reasonably close.

Question: The clock in or clock out location is different from the address on the scheduled address. For example, the clock in was at the Medicaid member's doctor's office instead of their home address. What location should be reported on the claim?

Answer: The clock in and clock out address should be the actual where the shift begins or ends. Understandably the service may be provided in a location other than the member's place of

residence. It has always been the provider's responsibility to ensure the care is provided in a safe location desired by the member.

Question: The EVV system shows the clocked in or clocked out from an address that is slightly different from the actual address. Should there be a manual adjustment to correct the address?

Answer: The clock in and clock out address should be the actual unadjusted address pinpointed by the smartphone when the shift begins. It is understandable that occasionally it may be different than the member's street address. Variations occur depending on the make and model of the smartphone or tablet and the connection it is making to satellites and cell towers.

It is the provider's responsibility that the aide is providing the service when they clock in until they clock out. It is a good practice that when the care plan is developed, the nurse takes the EVV app to the member's home to verify the reasonableness of the location identified in the app.

Question: Our member lives in a remote location where there is no cell signal and they do not have a landline? How can we comply with the EVV requirement?

Answer: EVV requires the collection of six data elements. Check to see if you EVV application has offline or GPS capabilities. Also, perhaps your EVV vendor offers a FOB feature. If you are not familiar with telephony or an FOB option, please review the FAQ "Question: Is a fixed object device (FOBs) an acceptable method of EVV?"

If your EVV system does not work at a member's location because of connectivity, and your vendor does not offer offline capabilities, GPS, telephony, or FOB, the visit can be documented manually. Please refer to the FAQ, "Question: If a manual entry to record the visit or an adjustment to the EVV record is needed, what are the requirements to document the adjustment or visit?"

Question: If the clock out is immediately followed by a clock in within a minute of each other, must the location be the same?

Answer: The clock out and clock in address should be the actual unadjusted address pinpointed by the smartphone when the shift begins and ends. The two addresses should be within the same reasonable location. There may be some slight variation (e.g., a different smartphone) if the location is an adjacent address.

Question: The location the service begins and ends has a field for the name of the location, such as 'Sunny Day Park' or 'Maple Doctor's Office'? Can the first field of the address be left blank?

Answer: Yes, the first field can be blank. The next field must contain the physical 911 street address. The additional fields capture the city, state, and five or nine-digit zip code.

Question: In an instance where there was no location at clock in or clock out, what address should be used on the claim? Should the location be left blank, or should it be the member's address or wherever the services were supposed to be provided?

Answer: If the address field is left blank when the claim is submitted, the claim will be denied. If the clock in or clock out time needs to be adjusted, the location should be adjusted to reflect the location where the service began or ended. Please see the next FAQ under Adjusting the EVV Record section on who has the authority to adjust the time.

## Adjusting the EVV Record

Question: If a manual entry to record the visit or an adjustment to the EVV record is needed, what are the requirements to document the adjustment or visit?

Answer: EVV requires the collection of six data elements. Every provider must have a system that collects and stores an electronic record of the visit that contains the six data elements. The expectation is that EVV is used and that manual adjustments are the exception rather than the norm.

In the event there is a need to enter a manual EVV visit or to adjust an EVV record, please ensure you are compliant with the following. First, just a reminder it is the provider's responsibility that the aide is providing the service during the duration of the visit from when they clock in until they clock out. If there is an ongoing need to perform a manual entry for the member, it is a good idea to document it in the member's care plan with the explanation such as the member lives in a remote location with no cell signal, GPS, or landline to verify the location, etc. Each manual entry should be made and documented by someone who has the authority to adjust the aide's hours of pay as to the reason why the visit was not electronically verified. The adjustment may be made by an RN, a supervisor, the agency owner, or a designee who has the authority to make independent verification. In no case should coworkers be allowed to adjust each other's time. It is a good practice for the provider to have a policy on who has the authority to adjust the EVV record. Please refer to the DMAS-90 section of the FAQs for documenting the DMAS-90 visit information.

Question: If the EVV system is not working, how should the visit be documented?

Answer: The provider is responsible for working with the EVV vendor they have selected to ensure the system is operational. The proposed regulations state, "All EVV systems shall be accessible for input or service delivery 24 hours per day, seven days per week." In the event the EVV system is not used to record a visit, the visit becomes a manual entry and must be documented. Please see the FAQ on who has the authority to adjust the EVV record.

Question: What reasons are allowed in the event EVV is not available or accessible, and how/where are they documented?

Answer: Each provider should establish reasonable allowances for the need to make adjustments. For example, it is a good practice that if the provider's EVV system requires an active connection that the provider assesses the location of the member's home for the potential of a loss in connectivity when a care plan is developed. If it is known there is a problem with connectivity at any location where a regular clock in or clock out is performed, the provider should retain this documentation on file, and they can refer to their due diligence check when an adjustment is made. If the documentation is made in the EVV system, the system must be capable of storing and producing it in a timely manner and in an electronic format when requested by DMAS or its designee.

Question: Where should the documentation be kept when adjustments are made to the EVV Record?

Answer: The documentation can be made in the EVV system or on a paper document. Record of the change must be maintained the length of time required to maintain the EVV record.

Question: Is there a threshold on the number of manual adjustments a provider can make to an EVV record?

Answer: Virginia Medicaid has not established a threshold for the number of manual adjustments to the EVV record, but it is anticipated the number of adjustments for each provider should decrease over time as workers become more familiar with their system.

Question: In the event the EVV system is not used to record a visit, is there a certain amount of time the provider has to get the information in the system?

Answer: The EVV system should be kept reasonably current, but the update frequency depends on how quickly the provider will bill for services.

## Billing

Question: Which personal care, respite care, and companion service billing codes are required to use EVV?

Answer: The following Agency Directed HCPCS codes will require EVV information:

Personal Care: T1019
Respite Services: T1005
Companion Services: S5135

Update: The billing code S9125 skilled respite has been excluded. If a previous claim was submitted with S9125 and it was denied because of an EVV requirement, please resubmit.

Question: Where can I find the technical specifications to submit an EVV claim?

Answer: The technical specification guide to submit Agency Directed fee-for-service claims can be found on https://www.virginiamedicaid.dmas.virginia.gov. On the top blue banner, click on 'EDI Support' and select 'EDI Companion Guides.' Select '837 - Professional Health Care Claim or Encounter (5010)'. The technical specification guide to submit Agency Directed claims to a DMAS contracted MCO can be found at https://eps.dmas.virginia.gov. Select 'Resources' and click on 'Click here to download Companion Guides', then click on 'MES EPS 837P Companion Guide'.

Question: The aide worked a shift that started before midnight and ended after midnight. The claim was denied with an error code of 2100, "EVV SRVC END TIME IS INVALID." How do we prevent this from happening?

Answer: A shift that begins one day and continues past midnight into the next day must be reported as two separate services. The first service should end no later than 11:59 pm (reported as 2359 on the claim); however, the system will allow 2400. The next service should start at midnight (reported as 0000 on the claim), which is the start of a new day. The aide should clock out at 11:59 and clock back in at midnight, reported as 0000.

Question: Before EVV, I submitted personal care claims directly to DMAS and Medicaid health plans. Will I be able to continue to submit EVV claims the same way?

Answer: The DMAS portal and the health plan portals are not being modified to allow the keying of direct data entry of EVV claims. However, some clearinghouses may adjust their portal to key the information into their website.

Question: Do I have to change how frequently I bill?

Answer: The billing frequency does not need to change because of EVV.

Question: There is some confusion about the use of clearinghouses. DMAS uses Conduent, and Virginia's MCOs use other clearinghouses to exchange EDI transactions. Please clarify?

Answer: Most clearinghouses have the capability to transmit claims to all six of the Virginia Medicaid MCOs. Among the clearinghouses, there is a wide variety of services and costs. You may use any clearinghouse that meets your business needs. Usually, your EVV vendor has selected a clearinghouse. You need to check to make sure the clearinghouse you select offers the capability to transmit claims to the MCOs that you bill. A list of the clearinghouses used by the MCOs can be found on the DMAS webpage at MCO Clearinghouses and Payer IDs [pdf].

Question: Is it possible to send EVV claims directly to DMAS instead of going through a clearinghouse?

Answer: Yes, it is possible. Several providers submit their own claims directly; **however, it is much easier for providers that do not have IT program development capabilities to work through an EVV vendor to submit claims.**

Question: Where can I find the technical specifications to submit an EVV claim?

Briefly, to submit claims directly, the electronic claim needs to be formatted according to the technical specification guide for fee-for-service claims, enroll with Conduent as a service center, and successfully submit a test file before being approved to submit an actual claim. The technical specification guide to submit Agency Directed fee-for-service claims can be found on https://www.virginiamedicaid.dmas.virginia.gov. On the top blue banner, click on 'EDI Support' and select 'EDI Companion Guides.' Select '837 - Professional Health Care Claim or Encounter (5010)'. The technical specification guide to submit Agency Directed claims to a DMAS contracted MCO can be found at https://eps.dmas.virginia.gov. Select 'Resources' and click on 'Click here to download Companion Guides', then click on 'MES EPS 837P Companion Guide'. Additional information is available on the DMAS EVV webpage https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/electronic-visit-verification. Scroll down to the banner labeled "Resources." You will need to email the Conduent Service Center at Virginia.EDISupport@Conduent.com and ask for an enrollment packet. They will communicate the process to enroll and for sending a test file. Be aware this process takes time!

Question: If an aide provides two services, such as personal care and respite care, in one visit, how should EVV be recorded?

Answer: If two billing/HCPCS codes are billed by the same aide, each code is considered a separate service, and each code must have a clock in and clock out. In other words, each billing line on the claim form stands on its own.

Question: There is an old rule of thumb not to 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. Will it be okay to submit a claim with multiple lines for the same date of service?

Answer: The short answer is yes! An EVV 'line of billing' includes the date, type of service, service start and end time, aide's name, and beginning and ending location. For EVV, a claim can contain multiple 'lines of billing' for the same day. Each 'line of billing' can only be for one

aide and one shift. There may be more than one aide shift per day, and a shift may cross from one day to the next. For example, if there are three aides for the same date of service, there would be three' lines of billing', each with a different aide. If the same aide performs services at three different times on the same date of service, there would be three' lines of billing' for each separate time of service.

Question: Will a second claim for the same service on the same day be denied?

Answer: When a provider submits a claim with the same HCPCS/CPT code for the same day of service, a modifier of 76 must be added to the second-billed claim. Even if different aides work on the same day, it is still considered a second claim. Modifier 76 is widely used to indicate that a procedure or service was repeated subsequent to the original procedure or service. Remember, each line of billing can have up to four modifiers if there is a need to add another modifier. DMAS and the MCOs may verify claims without EVV information to ensure compliance with Medicaid's and the health plan's policies and procedures.

Question: Do all shifts for the same day need to be on the same claim, or can they be submitted on separate claims forms?

Answer: Shifts that occur on the same day can be on separate claims. The 76 modifier must be added to the second visit even if the second claim is submitted on a separate claim form. DMAS and the MCOs may verify claims without EVV information to ensure compliance with Medicaid's and the health plan's policies and procedures.

Question: We submitted a claim for a visit that began at 8 am to 8 pm and now need to submit for a visit that occurred from midnight to 8 am the same day.

Answer: There is a distinction between the order the service is provided and the order in which the service is billed. Normally, the order in which the service occurs and the order in which the service is billed is the same. However, if the second visit provided is billed and paid, then later the first visit provided is billed, the first visit becomes the second visit billed for that date of service, and the 76 modifier must be used.

Question: Does Virginia use reason codes when a manual adjustment is made?

Answer: Virginia does not require reason codes; however, providers are encouraged to identify trends within their practice on the need to make manual adjustments.

Question: Will the Virginia Medicaid system have edit checks?

Answer: The Virginia Medicaid claims submission system will have several system edits. At this point, the following edits will be included:

- Standard edit processes such as member and provider eligibility;
- Verifying the claim or encounter is supported by and consistent with EVV data;
- Verifying the claim is supported by and consistent with a service authorization (SA);
- Pricing the claim using the appropriate rate for the procedure code submitted; and
- Checking for duplicate services.

Question: What are the Explanation of Benefit (EoB) EVV error codes?

Answer: The full updated list of error codes, including the new EVV edits, has been posted to the DMAS Medicaid website at https://dmas.virginia.gov/for-providers/general-information/claims-and-billing. Click on the Excel spreadsheet under Financial and Billing Information labeled 'Error Code Crosswalk Listing.' Below are the codes related to EVV errors.

| DMAS Edit | EOB Description |
|---|---|
| 2094 | ELECTRONIC VISIT VERIFICATION DATA MISSING |
| 2095 | EVV BEGINNING ADDRESS IS INVALID |
| 2096 | EVV ENDING ADDRESS IS INVALID |
| 2097 | EVV ATTENDANT FIRST OR LAST NAME IS MISSING |
| 2098 | EVV ATTENDANT'S ID IS MISSING |
| 2099 | EVV SRVC BEGIN TIME IS INVALID |
| 2100 | EVV SRVC END TIME IS INVALID |

Question: Are overlapping times between two aide shifts allowed? For example, our system records EVV time to the second. An aide can clock out and clock in within the same minute, but the EVV system shows the times do not overlap by several seconds.

Answer: The Virginia reporting requirement is at the minute level. It is understandable that a clock out and clock in could occur within the same minute.

Question: Some of the claims are being rejected because of taxonomy codes. What is the requirement?

Answer: The requirement is identified in the Commonwealth Coordinated Care Plus Waiver Manual, Chapter V, page 26. If the provider's NPI can represent more than one service type, a taxonomy code must be submitted with the claim. The table below identifies the taxonomy codes that are required for the EVV procedure. The appropriate taxonomy code must be on the claim in order for payment to occur.

| Type of Waiver Service | Taxonomy Code | Procedure Code (CPT) | Modifier | Units |
|---|---|---|---|---|
| Personal Care | 3747P1801X | T1019 | N/A | Hour |
| Respite Care | 385H00000X | T1005 | N/A | Hour |
| Private Duty Nursing Respite | 163WC2100X | S9125 | For RN =TD<br>For LPN = TE | Hour |

Question: The respite services were provided in a group home, and the claim was denied for not having EVV information.

Answer: EVV will not be required for services in Department of Behavioral Health and Developmental Services (DBHDS) licensed facilities, such as a group home, sponsored residential home, supervised living, supported living or similar licensed facility, the REACH Program, or in a school setting where the personal care is rendered under the authority of an Individualized Education Program (IEP), or for live-in caregivers. The Commonwealth Coordinated Care Plus Waiver Manual, Chapter V, page 3, or the EPSDT (Personal Care Services) Supplement B, page 23, provides information on how to bill claims provided in these settings. Providers **may** use a modifier of UB in association with the Agency Directed service procedure code when the service is provided in an exempt setting. The modifier will exempt the claim from the additional reporting requirements. The claim will accommodate up to four modifiers. The use of the UB modifier for care provided that does not meet this criterion is not allowed.

Question: We are one of the few Agency Directed providers that have a live-in caregiver. Is EVV required in this situation?

Answer: Beginning January 1, 2021, EVV is not required for live-in caregivers. Providers **MUST** use a modifier of UB in association with the Agency Directed service procedure code when the service is provided in an exempt setting. The modifier will exempt the claim from the additional reporting requirements. DMAS and the MCOs may verify claims with the UB modifier to ensure compliance with Medicaid's and the health plan's policies and procedures.

Question: What is the definition of a live-in caregiver?

The Virginia Administrative Code, 12VAC30-120-900, provides the following definition. "Live-in caregiver" means a personal caregiver who resides in the same household as the individual who is receiving waiver services.

Question: We are a DBHDS licensed provider; are we exempt from the EVV requirement?

Answer: If the EVV service is provided within a DBHDS licensed facility such as a group home, then the service is exempt from the EVV requirements. If you are a DBHDS licensed provider, but providing the service is provided in a setting that is nonexempt, such as the member's home, the service is subject to EVV. The important part of the exemption is where the service is provided, not who is providing it.

## Unit of Service

Question: The current unit of service billed is one hour. Will there be a change?

Answer: There will be no change to the one hour unit of service.

Question: Our EVV system calculates the units of service based on the actual clock in and clock out time, but the claims have been denied.

Your EVV system may allow the unit of service to be calculated by subtracting the stop time from the start time and allowing that amount to populate the units of services. If unadjusted, the calculated unit of service may result in partial units e.g.: decimals. Only whole units are allowed by DMAS. Please see the FAQs below which describe how units of services should be billed.

Question: Do I have to wait until the end of the month to bill the additional time providing a service?

Answer: Additional minutes occur when the EVV time providing care to a Medicaid member exceeds the whole unit(s) that can be billed. The additional minutes spent providing care, in excess of 60 minutes provided during a visit, can be accrued per member. Once the total sum of accrued minutes equals a whole hour, that whole hour can be billed. That hour can be billed immediately or later during the month. It would be advisable to review the authorization and to time the billing within the authorized service period. Accrued minutes are different than rounding. Rounding occurs only once at the end of the calendar month per member.

The time providing the service and the units billed is based on the member. One or more aides may provide services to the same member that can be added together to equal one hour.

Example: An aide clocks in at 9:00 am, and clocks out at 10:20 am; the 20 extra minutes cannot be billed on that service line until an additional 40 minutes are accrued. If, at the end of the

month, the number of accrued minutes does not reach a full hour, then rounding can be applied. See the next FAQ for information on rounding.

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

Answer: The answer is provided in the Commonwealth Coordinated Care Plus Waiver Manual, Chapter V, page 13. "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."

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 hour and 15 minutes the fourth week.

The first-week provider should bill 2 hours with 20 minutes carried forward. The second week 3 hours should be billed with 5 minutes carried forward. The third week 2 hours should be billed with 10 minutes carried forward. The fourth week 1 hour should be billed. Since the remaining total number of accumulated unbilled minutes is only 25 minutes, applying the rounding requirement, these additional minutes cannot be billed.

| 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 hour 15 minutes | 1 hour | 25 minutes |
| Total | 8 hours 25 minutes | 8 hours | 25 minutes not billed |

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

**Summary of EVV Units of Service**

1) During the month, only whole hours where 60 minutes of service is provided for each unit can be billed.
2) If there are minutes of service provided leftover from a previous visit in excess of 60 minutes, those accrued minutes can be added to the subsequent visit to help make a whole hour of service. That is, previous unbilled minutes of service can be added together to equal one completed hour of service, and then one whole unit can be billed.
3) If a visit occurs that is less than one hour, and there are no previous unbilled minutes of service that can be added to equal one whole hour, the visit cannot be billed. The provider is required to retain a record of the visit to substantiate the total units worked. Only whole hours worked can be billed.
4) Rounding occurs only once at the end of the month. The extra minutes that have not been used to make up a whole unit can be added together. If the previously unbilled minutes are more than 30 minutes, the minutes can be round up to an hour, and an additional unit can be billed.

If the previously unbilled minutes are less than 30 minutes, the time is rounded down and cannot be billed.

See the table below. If an aide works an hour and 15 minutes during the first visit and only 45 minutes during the second visit, the provider can bill one unit for the first visit and one unit for the second visit. The extra 15 minutes from the first visit can be added to the 45 minutes of the second visit to equal one complete hour unit of service. If the third visit is only 50 minutes, the visit should not be billed. Fifty minutes is less than one hour, and there are no previous unbilled minutes that can be added to equal one completed hour of service. If the final visit for the month is one hour long, the units billed can be two. The fifty minutes from the previously unbilled service can be rounded up since it is over 30 minutes. Remember, rounding occurs only once at the end of the month.

| # | Date | Start Time | End Time | Duration | Minutes | Units billed |
|---|---|---|---|---|---|---|
| 1 | 07/01/2020 | 8:15 am | 9:30 am | 1 hour 15 mins | 75 | 1 |
| 2 | 07/02/2020 | 9:30 am | 10:15 am | 45 minutes | 45 | 1 |
| 3 | 07/03/2020 | 10:00 am | 10:50 am | 50 minutes | 50 | 0 |
| 4 | 07/31/2020 | 11:00 am | 12:00 pm | 1 hour | 60 | 2 |

Question: A claim was submitted with no time to obtain payment for 45 minutes of service that was provided earlier in the month, which remained unbilled at the end of the month. The claim was denied. How should the claim be submitted for the additional unit of service that can be rounded up?

Answer: Claims with zero time will be denied. The provider should submit the 45-minute time and the additional unit of service, in accordance with the end of the month rounding protocol, on the date the service was provided. Don't forget to use the 76 modifier if billing a second claim for a previously billed date of service.

Question: During the month, the aide provided care for less than an hour. Since the aide is scheduled to return later in the month, should the claim be billed to show the time with no unit of service claimed?

Answer: No. However, the provider should maintain a record of the visit to substantiate the visit, care provided, and the accumulated hours billed for the month.

Question: Can the billed time be the scheduled time instead of the actual clock in and clock out time?

Answer: No.

Question: The EVV system will round each visit time to whole hours. Is this okay? For example, the aide will work 5 hours and 51 minutes. The system will round to six hours.

Answer: No. Many EVV systems have an option to round or not. Please ensure your system is configured to comply with the requirements above.

Question: Can the time reported on the claim form be rounded? For example, our EVV system allows rounding to the nearest hour or 15 minutes.

Answer: No. The claim, and if the DMAS-90 Provider Aide Record is captured by the EVV system, should report the actual clock in and clock out time.

## Signatures

Question: Will a Medicaid member's signature or voice verification be required on an electronic device upon completion of the assignment?

Answer: The Medicaid member does not need to sign the EVV record if the system is used to collect only the EVV claim required fields. There is a separate requirement for the provider to have a signed authorization by the member to submit a claim for services.

Question: If we go paperless, do we have to use the original DMAS approved forms, DMAS-97A/B, Agency or Consumer Direction Provider Plan of Care or DMAS-99, Community-Based Care Recipient Assessment Report in order to stay compliant, or can we make sure that the required information is inputted into our system?

Answer: EVV does not change the requirements for any existing DMAS forms. If the provider's EVV system captures all of the components of the DMAS-97A/B form and or the DMAS-99 form and the system is capable of replicating the DMAS form layout, the information can be captured electronically. Providers shall be able to produce the forms when requested by DMAS or its designee that meets the requirements of the paper form. The EVV system must be capable of electronically capturing the individual's/caregiver's signature. Additionally, a hard copy of the DMAS-97A/B form and or the DMAS-99 form are required to be kept with the Medicaid member.

Question: What is an acceptable electronic signature for DMAS forms incorporated within the EVV application?

Answer: DMAS records must be fully signed and dated (month, day, and year), including the title or affiliation of the signer on the date of service delivery. An electronic signature that meets the following criteria is acceptable for clinical documentation:

- identifies the individual by name and whether they are the member, family member, caregiver, aide or RN;
- assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Providers must have written policies and procedures in effect regarding the use of electronic signatures. In addition to complying with security policies and procedures, providers who use electronic signatures must sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use must be maintained and available at the provider's location.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records.

Question: What is the requirement for signing or applying a unique identification number that can serve as a signature on the DMAS-90, Provider Aide Record?

Answer: The Commonwealth Coordinated Care Plus Waiver Manual, Chapter IV, page 41, references the personal care aide and individual/family receiving services having a unique personal identification number that can serve as a signature. This is an alternative option to sign the DMAS-90, Provider Aide Record electronically. In the previous page of the manual, Chapter

4, page 40 says, the records contained in the chart must be current within two (2) weeks at all times of the date of service delivery. This form can only be signed by the member after the completion of the DMAS-90 form by the aide. The member receiving services must take action after the completion of the form to enter their signature or unique personal identification number.

The manual also states, in instances where the individual is unable to sign and there is no family member or other legal representative to do so, the reason for the absence of this signature must be thoroughly documented on the DMAS-90. If the individual is unable to sign his/her signature on the DMAS-90, the individual may make an "X". The RN Supervisor must document on the DMAS-99 that the "individual is unable to sign the DMAS-90".

## DMAS-90 Provider Aide Record

Question: Will the DMAS-90 form, Provider Aide Record, continue to be required with EVV?

Answer: DMAS will continue to require the collection of information required on the DMAS-90 form. The DMAS-90 form collects additional information that is not reported to DMAS, such as the activity of service performed and observations of the individual's condition. If the provider's EVV system captures the components of the DMAS-90 form and can reproduce the DMAS-90 form in a paper format, automation may be beneficial for the provider.

The record of care must contain the individual's/family member's signature. If the EVV system is capable of electronically capturing and storing the individual's/family member's signature, the electronic EVV file can be the record of care.

Question: If the DMAS-90 form, Provider Aide Record, is captured in the EVV system, how is this information made available to DMAS or one of the MCOs?

Answer: The DMAS-90 form is not part of the claim submission process. It is to be retained by the provider. If the EVV system is the record of care, the system must be capable of producing it in a timely manner either in a hard copy or an electronic format when requested by DMAS or its designee.

Question: The DMAS-90 form, Provider Aide Record, covers a week and collects the four comments only once along with the individual's/family member's signature. Some EVV applications that incorporate the DMAS-90 form collect the four comments by shift. It is burdensome to collect both with each shift.

Answer: The requirement is that the four comments and the individual's/family member's signature are to be recorded weekly. In converting the DMAS-90 form to an electronic record, the EVV vendor may require the information by shift.

Question: Should the total time on the DMAS-90 form, Provider Aide Record, match the EVV recorded time or the units of service billed?

Answer: The time reported on the DMAS-90 form should equal the amount of time captured using the EVV system. There is no requirement to report the amount of time spent on each individual activity.

Question: Is the Medicaid member required to sign the EVV at the end of each shift?

Answer: A claim that requires EVV information does not require a signature other than the member's signature required to be on file to submit a claim. If your EVV system collects information on the DMAS-90 form, the DMAS requirement is a weekly signature.

Question: Our EVV vendor has automated the DMAS-90, Provider Aide Record. There is an option to have the system provide default responses. Is this allowed?

Answer: No

## Additional Information

Question: Where can I find additional resources?

Answer: Additional information on EVV is available at the following link: https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/electronic-visit-verification. Click on 'Electronic Visit Verification' in the top banner.

Question: We are having difficulty with our claims. Can you explain where the problem may be occurring?

Answer: We have received numerous inquiries lately from personal care providers about problem claims. We understand that many providers may have adopted new vendors to submit EVV claims, and many are approaching the one-year requirement for their claim submission. It may be helpful to understand the process to diagnose where the problem with the claim submission may be occurring.

For background information, when a claim is submitted to DMAS, it is checked against Medicaid's normal claim processing requirements before the EVV system edits are applied. The process involves several checks comparing the information we have in the provider file (such as NPI or API number) with the information received. The service center file is checked with the trading partner file authorized to send the claim. The member file, such as member ID, eligible dates of service, etc., is compared with the claim. Then the procedure file is compared proper billing information is correct and authorized.

If the provider is **not** able to receive acknowledgement from DMAS that a claim has been submitted:

1) Check how the provider information and claim requirements are set up in your system. This is where a majority of the difficulty appears to occur.
2) Check with your clearinghouse that they are receiving the claim according to their format. Make sure they are aware of DMAS' claims technical specifications guide.
3) If the clearinghouse believes the claim format is correct, email Conduent EDI Helpdesk at Virginia.EDISupport@Conduent.com.

If the provider receives acknowledgement from DMAS about an error that is not that an EVV code:

1) Review the error code and correct.
2) If unable to identify the error, call the Provider HELPLINE Monday–Friday 8:00 am-5:00 pm 1-804-786-6273 or 1-800-552-8627.

If the provider receives an EVV error on the EOB, we can assist through the EVV mailbox.

For a complete list of provider contact information, click on this link https://www.virginiamedicaid.dmas.virginia.gov/wps/PA_VAProviderServices/VAPdfRenderServlet?selectedCode=Contct and a PDF will download.