Electronic Visit Verification (EVV)

PURPOSE

An EVV system is required to document the actual time a provider begins and ends providing services. This policy contains information about what services require and do not require EVV, EVV requirements and how to comply with these requirements.

APPLICABILITY

- EVV is a federal requirement for providers of Medicaid long-term services and supports and state plan home health services.
- EVV coverage is required for:
  - Medicaid-covered personal care and related services as of January 1, 2021.
  - Medicaid-covered home health services as of July 1, 2023.
  - EVV Policy Effective Date 11/1/2024

DEFINITIONS

(Reference applicable program policy manuals for extended definitions)

- *Activities of Daily Living (ADL) supported services* – Includes but not limited to: movement, bathing, dressing, toileting, transferring, personal hygiene

- *Client/Recipient/Individual* – Individual receiving the service

- *Data Aggregator* – A system that collects and compiles EVV data from various EVV systems, produces uniform data and reports, supports claims payment by validating all required data elements are present when claims are processed in ND Health Enterprise Medicaid Management Information System (MMIS).

- *Electronic Visit Verification* – Systems that verify by a phone, fixed device or computer-based system that personal care, home health and other home and community-based services (HCBS) are being provided.

- *Fixed Object Device (FOD)* – Generates unique codes at check-in and check-out. Service providers can enter codes into the EVV system. The device is secured in the individual's home where the service provider begins and ends the service, in one specific location to verify the service provider was with the individual for the service.

- *Instrumental Activities of Daily Living (IADL) supported services* – Includes but not limited to meal preparation, money management, shopping, telephone use.

- *Interactive Voice Response* (IVR) – An automated telephone system technology that enables callers to receive or provide information or make requests using voice or menu inputs, without speaking to a live agent.

- *Mobile Application* – Providers check-in and check-out through a mobile application, usually on the provider's personal or agency-provided smartphone. The application connects to the internet and location services with GPS.

- *ND Health Enterprise MMIS* – ND Medicaid claims payment system.

- *Personal Care Services* – Provision of services consisting of a range of human assistance, provided to an individual with disabilities or conditions, that allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of hands-on assistance or cuing so that the individual can perform a task without direct assistance.

- *Qualified Service Providers (QSPs)* – Individuals or agencies that provide services to clients who receive services funded by North Dakota Health and Human Services. QSPs are independent contractors that have met certain competency standards required to provide services to eligible clients.

- *Sanction* – An action taken by the Department against a provider for noncompliance with a federal or state law, rule, policy or with the provisions of the Medicaid and children's health insurance program provider agreement.

- *Sandata Technologies* – The current data aggregator vendor for North Dakota.

- *Telephonic* – Providers check in and out by dialing the EVV solution from a landline and using interactive voice response (IVR).

- *Tertiary* – Paper attached to the electronic record.

- *Therap* – The current contracted vendor for North Dakota. Providers may use other vendors who agree to use the state data aggregator. Therap serves as the default system.

- *Veridian Fiscal Solutions* – The current contracted vendor for self-directed EVV in-home supports and respite services. The vendor is responsible to train and support individuals using EVV for self-directed services.

COVERED SERVICES AND LIMITS

Programs Subject to EVV

- 1915(c) Medicaid waivers:
  - Autism Spectrum Disorder
  - Children's Hospice 1915(c)
  - HCBS – Aged & Disabled
  - Medically Fragile Children's 1915(c)
  - Traditional IID/DD Home and Community Based Services
- 1915(i) State Plan Amendment
- Home Health
- Medicaid State Plan - Personal Care - Unit rate
- Service Payments to Aged and Disabled (SPED) Program
- Expanded Service Payments to the Elderly and Disabled (EXSPED) Program

Service Types Requiring an In-Home Visit

Personal Care Services (PCS)

- Activities of Daily Living (ADL) supported services: movement, bathing, dressing, toileting, transferring, personal hygiene
- Instrumental Activities of Daily Living (IADL) supported services: meal preparation, money management, shopping, telephone use

Providers Subject to EVV

- Agency Qualified Service Providers (QSPs)
- Individual QSPs
- Licensed Developmental Disabilities (DD) Providers
- Children's Medically Fragile, Autism Spectrum, Children's Hospice respite and In-home support providers
- Self-Directed Providers
- 1915(i) Respite Providers
- Home Health Agencies
- Traditional IID/DD HCBS Waiver Self-Directed In-Home Support and Respite Providers

Home and Community Based Services (HCBS) Subject to EVV

Program	Service Name	Code	Modifier
Medical Services	Respite (provider managed)	S5150	
Autism Spectrum Disorder	Respite (self-directed)	S5126	
Children's Hospice 1915(c)	Respite (provider managed)	G0156	
Medically Fragile Children's Waiver 1915(c)	In-home Support (self-directed)	T2041	
Traditional IID/DD Home and Community Based Services	Adult Family Foster Care – Respite Care	S5150	
	Extended Home Health Care	G0300	
	Homemaker	S5130	
	Independent Habilitation	T2017	
	In-Home Supports (provider managed)	S5125	
	In-Home Supports – secondary staff (provider managed)	S5125	XP
	In-home Supports (self-directed)	T2041	
	Respite (provider managed)	S5150	
	Respite – secondary staff (provider managed)	S5150	XP
	Respite – self directed	S5151	
1915(i) State Plan Amendment	Respite Care	T2027	
Home Health	Home Health Aide	G0156	
	Physical Therapy	G0151	
	Physical Therapy Maintenance	G0159	
	Physical Therapy PTA	G0157	
	Occupational Therapy	G0152	
	Occupational Therapy Maintenance Program	G0160	
	Occupational Therapy OTA	G0158	
	Speech Therapy	G0153	
	Speech Therapy Maintenance Program	G0161	
	Skilled Nursing (LPN)	G0300	
	Skilled Nursing (RN)	G0299	
	RN Care Training/Education	G0495	

Program	Service Name	Code	Modifier
Aging Services (Medicaid State Plan – Personal Care – Unit Rate) Service Payments to Aged and Disabled (SPED) Expanded Service Payments to the Elderly and Disabled (EXPSPED)	Chore Labor	S5120	
	Chore Labor (two person assist)	S5120	XP
	Companionship	S5135	TF
	Extended Personal Care	S5115	
	Extended Personal Care (Nurse)	S5115	TD
	Homemaker	S5130	
	Homemaker (two person assist)	S5130	XP
	Non-Medical Transportation	T2001	
	Non-Medical Transportation (Escort)	T2001	UC
	Nurse Education	S5108	
	Personal Care (unit rate)	T1019	
	Personal Care (unit rate) (two person assist)	T1019	XP
	Personal Care HCBS Waiver (unit rate)	S5100	
	Personal Care HCBS Waiver (unit rate) (two person assist)	S5100	XP
	Respite Care	S5150	
	Respite Care (two person assist)	S5150	XP
	Supervision	S5135	
	Supervision (two person assist)	S5135	XP
	Transitional Living	T2021	

SERVICE SETTINGS NOT SUBJECT TO EVV

- Personal Care Services (PCS) provided to inpatients or residents in the following settings are excluded from EVV requirements:
  - Hospital
    - With the exception of DD services:
      In accordance with Section 601(d) of the Social Security Act as added by Section 5001 of the Cares Act: In-Home Supports and Respite may be authorized in an acute care hospital to meet the needs of the service recipient that are not met through the provision of hospital services and/or to ensure the smooth transitions between acute care settings and home and community-based setting and to preserve the service recipient's functions. This service will not be authorized to substitute services that the hospital is obligated to provide under Federal or State law
  - Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IID)
  - Institution of Mental Diseases (IMD)
  - Nursing Facility
  - Congregate residential settings where 24-hour service is available, this includes specialized basic care facilities, licensed assisted living, and residential habilitation.

- Live-in Providers:
  - Personal care services (PCSs) rendered by an individual living in the same residence as the member no longer require EVV. The live-in provider EVV exemption applies only to daily rate live-in providers; EVV requirements still apply to unit rate live-in providers. This change occurred on March 1, 2024.
  - DD-provided live-in services: For DD-provided services; an in-home support or respite provider may live in the same home, but may not be the primary caregiver, legal guardian, or legally responsible person.

EVV SYSTEM REQUIREMENTS

Section 1903(l)(5)(A) indicates the EVV system must be able to electronically verify the following visit information, as part of personal care services or home health care services:

- Individual receiving the service
- Individual providing the service
- Date of the service
- Location of service delivery
- Time the service begins and ends
- Type of service performed

Individuals Receiving Care - Non-Compliance Penalties

Individuals must agree to participate with approved EVV data collection methods for services to continue.

Providers should work with the individual and their case manager (CM) or developmental disability program manager (DDPM) to find the best EVV data collection method for each consumer. If an individual refuses services because of EVV please contact the individual's CM or DDPM.

Self-Directed EVV Supports

Veridian Fiscal Solutions is the current contracted vendor for self-directed EVV in-home supports and respite services. The vendor is responsible for supporting individuals using EVV for self-directed services, which may include training for EVV. Visit https://www.veridianfiscalsolutions.org/nd/forms-resources.aspx for ongoing training materials. Veridian's contact information is available on the "Contact Us" tab at the website listed above.

Veridian provides two options to collect EVV data:

- A Web application (on a web browser, requires internet connection)
- Interactive Voice Response (IVR) (does not require an internet connection)

Open EVV Model

- Therap LLC is the current contracted EVV vendor for the state of North Dakota. Providers may use other vendors who must agree to use the state's data aggregator. Therap serves as the default system.

- There is no charge to any provider or individual to use the Therap EVV system; however, costs may be incurred by agency providers who choose to use an alternate EVV system or vendor, for the technology or other devices required to collect data during a visit. Providers must work with their vendor to resolve issues related to the collection or submission of EVV data. North Dakota Department of Health and Human Services is not responsible for claims payment issues resulting from failed third party EVV integration with the State's aggregator.
- Sandata Technologies is the current data aggregator vendor for ND.
    - This system aggregates EVV data from all third-party vendors, including Therap.
    - Providers are responsible for working with the aggregator vendor to ensure they meet all requirements, and for any interface costs charged by the vendors if they choose to use their own system.
    - Providers are responsible for reviewing the state Alternate Vendor EVV specifications/addendum to ensure all valid data is provided to the aggregator for processing. to ensure all valid data is provided to the aggregator for processing.
- QSPs must choose an EVV vendor upon enrollment. If a QSP changes their EVV vendor after enrollment, they must notify Adult and Aging Services at dhshcbs@nd.gov and allow at least three (3) weeks for the change to be implemented in the state system.

Data Collection Methods for EVV Data (Therap)

- Mobile application (Online and/or offline) – primary data collection method
- Web application on computer (online only)
- Interactive Voice Response (IVR)
- Fixed Visit Verification (FVV) Device - pre-approval from state is required.
- Tertiary (Paper attached to electronic record) - pre-approval from state is required.

Approval Requirements

Fixed Visit Verification (FVV) Device

- A signed user agreement is required for this option.
- When a FVV is requested to be used as the EVV data collection method, approval must be requested from the party listed on the left by the appropriate Administrator or Liaison listed on the right below:

Requesting Party	Approving Administrator/Liaison
HCBS case manager (CM)	Aging Services Provider Liaison
ASD Service Manager (SM)	Children's Waiver Administrator
DD Program Manager (DDPM)	DD Section Program Administrator
1915(i) Respite Provider (RP)	1915(i) Program Administrator
Medically Fragile (MF)	MF Waiver CM
Children's Hospice	Children's Hospice CM

- A user agreement must be completed granting permission for the eligible individual to have the FVV placed in their home and must be submitted with the request.
- Once an FVV is no longer needed, the provider must notify the CM, SM, DDPM, or the 1915(i) Program Administrator and return the FVV to Aging Services who stores the FVVs.

Tertiary (paper is attached to electronic record)

- Providers who want to use a tertiary method to collect EVV data must submit a written request.
- Approval must be requested from the party listed on the left by the appropriate Administrator or Liaison listed on the right below:

Requesting Party	Approving Administrator/Liaison
HCBS case manager (CM)	Aging Services Provider Liaison
ASD Service Manager (SM)	Children's Waiver Administrator
DD Program Manager (DDPM)	DD Section Program Administrator
1915(i) Respite Provider (RP)	1915(i) Program Administrator
Medically Fragile (MF)	MF Waiver CM
Children's Hospice	Children's Hospice CM

- The request must list the reasons why an electronic method of data collection cannot be used. Tertiary methods of data collection may be used as a last resort or if other methods are not feasible, such as when:
  - There is an extended period that the EVV system is down for repair or system maintenance or there is a natural disaster or other event that makes electronic collection of required data impossible, or
  - The provider has no other means to collect data and not approving the use of a tertiary method will create an access issue or jeopardize health and safety of the eligible individual.

<u>Manual Corrections of EVV Visit (check in/check out) Data</u>

- Manual adjustments to EVV data may require a reason code entry on the EVV data. See the "Manual correction exception codes & descriptions " section below for a list of reason codes and explanations.
- The EVV standards and policy requirements do not replace or supersede program or licensure requirements. Providers must follow all program and licensure rules and policies in addition to EVV policies.
- Agency provider guidance
  - The Therap LLC EVV system allows agency administrators to manually update a visit when necessary.
  - All changes to visits are tracked by the data aggregator. The state has access to data of all manually corrected visits. Frequent or high percentage of manual corrections are subject to review and may lead to provider sanctions.

- Individual provider guidance
  - The Therap LLC EVV system allows individual self-employed contractors enrolled as QSPs to manually correct their visit time when necessary.
  - All changes to visits are tracked by the data aggregator. The state has access to data of all manually corrected visits. Frequent or high percentage of manual corrections are subject to review and may lead to provider sanctions.
- Self-Directed provider guidance
  - If the self-directed employee fails to clock in and clock out of the EVV system, the self-directed employer of record must work with the employee to enter the visit into the EVV system and manually edit the visit. Manually entered visits may negatively impact EVV compliance.
  - All changes to visits are tracked. The state has access to data of all manually corrected visits. Frequent or high percentage of manual corrections are subject to review and may lead to provider sanctions.

<u>Manual entry/correction/exception reason codes & descriptions</u>

- Providers completing manual entries or corrections in the EVV system may be required, based on the table below; to enter additional notes to describe why they are manually changing their clock in/out times.
- Descriptions listed below indicate which codes require an additional, manual entry/exception note.
- Failure to include the required note matching the exception code reason will result in claims denial or recovery.

Therap Exception Code	Sandata Exception Code	Sandata & Therap Description Combined	Exception Note Required?
	100	Member No Show	**YES**
06	110	Member/Individual Unavailable	**YES**
04	120	Member/Guardian Refused Verification	**YES**
	130	Member Refused Service	**YES**
	140	Member Incapable, Designee Unavailable	No
	150	Caregiver Failed to Call In – Verified Services Were Delivered	No
	160	Caregiver Failed to Call Out – Verified Services Were Delivered	No
09	170	Caregiver Failed to Call In and Out – Verified Services Were Delivered	No
	180	Caregiver Called Using an Alternate Phone	**YES**
	190	Caregiver Change	No
05	200	Mobile App Issue/Inoperable	No
01	210	Telephony Issue/Inoperable	No
	220	FVV Issue/Inoperable	No
03 & 08	230	Service Outside the Home/Individual displaced	**YES**
	240	Unsafe Environment	**YES**
02 & 07	999	Other/Staff Error	**YES**

DOCUMENTATION

- In addition to EVV requirements, providers are also required to maintain matching program / service documentation to support the service billed.
- Billed EVV data must match documented services.
- QSPs using the Individual Service Plan (ISP) data documentation features correctly within Therap are not required to maintain separate documentation of services provided outside of Therap.

Client Signatures

Client signature or voice verification is not required; however, clients will have the option to verify via either method if they so choose.

BILLING AND REIMBURSEMENT

Rounding Rules Used to Calculate Units - EVV Data Collection

- 15-minute unit rates
- At least 8 minutes of service must be performed before providers can bill for the first 15-minute unit, do not bill for services performed less than 8 minutes.
- For providers working more than one EVV shift per day, per individual, the EVV system does not round each clock in or clock out time; the system rounds the total duration of the actual time worked for all shifts throughout the day, using the unit rounding rules listed below.
- The program provider may never increase billed hours beyond actual hours worked.
- The program provider may downward adjust billed hours if the actual hours worked and captured in the EVV system are incorrect or, if the program provider or fiscal agent intends to bill Medicaid for less time than actual hours worked in the EVV system.
- Program providers and fiscal agents must follow program rules and policies, including requirements regarding rounding.
- See below for required times to bill timed 15-minute units. The pattern remains the same for allowable tasks performed in excess of 8 units (2 hours).

# Units	At Least
2	23 minutes
3	38 minutes
4	53 minutes
5	68 minutes
6	83 minutes
7	98 minutes
8	113 minutes

Or

Actual Time Worked	Quarter Hour Increment	Bill Hours
0 - 7 minutes	0 minutes	0.00
8 - 22 minutes	15 minutes	0.25
23 - 37 minutes	30 minutes	0.50
38 - 52 minutes	45 minutes	0.75
53 - 67 minutes	60 minutes or 1 hour	1.00

- Examples:
  - Provider works two hours and 53 minutes of actual hours for a shift; billed hours round up to 3 hours.
  - Provider works two hours and 52 minutes of actual hours for a shift, billed hours round down to 2.75 hours.
  - Provider works four hours and 10 minutes of actual hours for a shift, billed hours round up to 4.25 hours.
  - The EVV system does not round each clock in or clock out time; the system rounds the <u>total duration</u> of the actual time worked for all shifts throughout the day.

- Overnight Visit Requirements
  - Provider cannot span bill between two days. The shift must be split before billing is submitted.
  - If the provider uses Therap as their third-party vendor:
    - Therap automatically splits the shift at 11:59 pm and the new shift begins at 12:00 am.
    - Process is automatically completed for the provider.
    - *Example:*
      Shift begins at 9:00 pm on Wednesday and ends at 6:00 am on Thursday:
      - Available hours on Wednesday: 9:00 pm – 11:59 pm: 3 hours (12 units)
      - Available hours on Thursday: 12:00 am – 6:00 am: 6 hours (24 units)
      - Shift is automatically split for provider; no additional action is necessary.
  - If the provider uses a third-party vendor other than Therap:
    - If a shift spans overnight between two days, it is the third-party vendor's responsibility to ensure the shift is split at 11:59 pm and the new shift begins at 12:00 am.
    - *Example*:
      Shift begins at 9:00 pm on Wednesday and ends at 6:00 am on Thursday:
      - Available hours on Wednesday: 9:00 pm – 11:59 pm: 3 hours (12 units)
      - Available hours on Thursday: 12:00 am – 6:00 am: 6 hours (24 units)
      - Provider must ensure their third-party vendor system splits this shift at midnight on Wednesday to ensure appropriate billing.

<u>Common Claim Denial Codes</u>

- No EVV Visit Found (16/N281)
  - EVV data is tied to billing; it is reviewed and matched by the state once claims are sent.

  - If claim denied for this reason code, providers must work with Therap or EVV vendor of record to ensure all EVV visits are inputted and match claims data.
  - Review Therap data to make sure all visits for the day are in an “accepted status” and sent to the aggregator. If the data is “rejected”, fix any errors that may have occurred and resend the EVV visit.
- Unmatched Units (16/N280)
  - EVV data is tied to billing; it is reviewed and matched by the state once claims are sent.
  - If claim denied for this reason code, provider must work with Therap or EVV vendor of record to ensure all EVV visits and units are appropriately documented and match claims data.
  - If billing outside of Therap, review how you round the total time of all visits for the day.
  - Review Therap data to ensure all visit data is in an “accepted status” and sent to the aggregator. If data is “rejected”, fix any errors that may have occurred and resend the EVV visit.

NON - COMPLIANCE

Providers (agency, independent & self-directed) who refuse, or fail to use an approved EVV system appropriately:

- May be considered non-compliant of EVV system policy if:
  - Manual or corrected entries consist of 20% or more of submitted claims during an identified review period.
- May be denied payment if:
  - Not compliant with EVV standards
  - Submit a claim without a matching EVV transaction.
  - When an approved EVV system is not used to document service delivery for required programs and services.
  - Data from the EVV system does not correspond with the claim line item or match to a current approved service authorization.
  - Billed claims do not match service documentation.
- May be subject to sanctions such as but not limited to:
  - Audit and recovery
  - No new referrals or authorizations
  - Payment suspension
  - Pre-payment review
  - A corrective action plan
  - Referral for investigation of fraud, waste, and abuse and/or
  - Termination of provider status

REPORTING FRAUD, WASTE AND ABUSE

Providers or Individuals who suspect Medicaid fraud, waste or abuse may report the information to:

- Medicaidfraud@nd.gov, call 1-800-755-2604 or complete the Suspected Fraud Referral form (SFN 20) and submit to the Department.

FAQs

- For more information, please visit the Electronic Visit Verification webpage on the NDHHS website.

LEGAL AUTHORITY

- Section 12006(a) of the 21st Century Cures Act mandates states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS)

  that require an in-home visit by a provider. This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or a waiver.

- ND 0273 – Home and Community-Based Medicaid Waiver Program (serves older adults and adults with physical disability)
- ND 0037 – Traditional Individuals with Intellectual Disability/Developmental Disabilities (IID/DD) HCBS waiver
- ND 0568 – ND Medicaid Waiver for Medically Fragile Children
- ND 0834 – Children's Hospice
- ND 0842 – Autism Spectrum Disorder (ASD) Birth through Seventeen
- NDAC 75-03-23 – Home and Community-Based Services (HCBS) under the Service Payments for the Elderly and Disabled Program (SPED)
- NDAC 75-03-24 – Expanded Service Payments for Elderly and Disabled (EXSPED)