THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Electronic Visit Verification
Monitoring in-home health care service delivery

Frequently Asked Questions
April 2021

1. **What date does the State require compliance with the Electronic Visit Verification (EVV) system?**
   The State and all certified personal care agencies were required by CMS to be in compliance with the 21st Century Cures Act regarding EVV implementation as of **January 1, 2021**. The February 21, 2021 effective date of the Alaska regulations changes to 7 AAC 105.230(f), 7 AAC 125.070, and 7 AAC 127.053 is secondary to the federal timeline.
   Documentation requirements of PCS services have not changed significantly with the implementation of EVV requirements. The added requirements are location of the service (7 AAC 105.230(f)) and capturing the data electronically through an EVV system. Each personal care services agency, whether using a third-party system or Therapy, is required by the Cures Act to electronically capture six elements by January 1, 2021. Those six elements are:

   (1) the identity of the rendering provider;

   (2) the identity of the recipient;

   (3) the location of the service;

   (4) the date of the service;

   (5) the start and stop times of the service; and

   (6) the type of service provided.

   The Department will continue to apply a reasonable perspective to audit and recoupment efforts regarding the ability to capture the visit electronically. It is the Department's expectation that providers collect all required data elements beginning January 1, 2021 regardless of the EVV system preference.

   The Department has given providers time to manually enter visits into the EVV system if they were not able to capture the data electronically beginning January 1. Currently SDS is not mandating a requirement to upload supportive documentation with manual entries. However, performing this step is highly recommended as a best practice, as it will save both provider and State resources when responding to records requests for this information, in the event of an audit or selection in a post payment review.

2. **Will SDS consider a "soft rollout" for providers using Therap since the system was not available until right before January 1, 2021?**

   As of EVV implementation on 1/1/21, the State is allowing agencies to continue efforts to test workflows, monitor EVV adoption with their agencies and, most importantly, ensure staff are properly trained and equipped to meet the new mandate. The State recognizes the tremendous impact of EVV on business practices for both providers and the State, so has implemented strategies

to allow for some flexibility and growth. These strategies will ensure providers, the State and Therap can work out the bumps together and successfully move forward. Soft rollout strategies that have been implemented include the following:

a) The State did not hold up or begin denying claims on January 1, 2021 if providers were not able to fully use the EVV system through Therap, recognizing the need to assist in bringing providers into compliance and making this a soft launch. Providers can currently submit claims and receive reimbursement without interruption. Since implementation, there have been no claim denials due to EVV data requirements.
b) The State has not set the expectation for 100% compliance with real time electronic visit matching data and has offered providers using Therap the opportunity to manually enter data if unable to get their employees trained in time for rollout. The State expects to see the number of manual entries declining as providers and employees become familiar with the system.
c) The State has not required providers using Therap to pre-schedule visits, though it is a tool offered.
d) The State has not implemented claim denials if GPS coordinates do not match the pre-scheduled visit. The State recognizes it may take a while to set benchmarks and find out if or where geo fencing is problematic in Alaska.
e) The State has not started a post payment review of providers yet, allowing them time to manually enter information into the system.
f) In collaboration with providers, the State has developed a set of exception codes for use to reasonably explain when there was an issue with a "slot" time or visit.
g) The State has not set a compliance benchmark measurement at implementation for the use of exception codes at this time. The Department will evaluate EVV data and outcomes post-implementation to determine a benchmark that is reasonable. This benchmark and other performance measurements will be shared with the provider community once established.
h) The EVV aggregator is expected to be launched in April 2021. Providers and the State will have an opportunity to test and review aggregator data together to determine quality assurance measures and benchmarks that are reasonable and meaningful while upholding the integrity of the EVV system and required data elements. Therap system users will begin populating data in the system first, followed by the 3rd Party system users.
i) The EVV data integration with the Medicaid Management and Information System (MMIS) is expected to be launched in January 2022. The State is currently working with vendors to develop the requirements to exchange data between the two systems. Edits set in the system to deny claims based on EVV data will be developed and tested prior to implementation, if feasible. Until that time, the State may conduct post payment reviews as needed.
j) The state regulation (7 AAC 105.230(d)(7)) requiring contemporaneous documentation for services rendered remains suspended per the Governor's order, which effectively allows providers more time to document services during the pandemic.

The State has determined that the soft rollout will continue for a minimum of 90 days post-implementation of the aggregator. During this time, the State will be reviewing and evaluating the EVV data to set performance benchmarks. Stakeholders will be offered opportunities to participate in and offer feedback through an advisory board beginning in Summer 2021.

3. **Will the State suspend or eliminate recoupment efforts during the soft rollout?**

   No. The State will continue its established practice of compliance oversight by reviewing data and documentation to assure the service occurred during the soft rollout period and for all future dates.

   Providers have always been required to have proper service documentation in place prior to submitting a claim, regardless of new EVV requirements effective 1/1/21. If documentation does not support the claim submitted, which now includes the six required EVV data elements, claims are subject to recoupment.

4. **Is audit liability greater for providers using the Therap system than for third party users?**

   From the State perspective, the audit liability is the same. Regardless of the system, each provider must be able to electronically capture the data elements and match them to supportive documentation. The State has the fiduciary responsibility to monitor all providers, not just those using Therap.

   In cases where providers have manually entered visit data and have supportive documentation to support the claim, the State would not be required to recoup.

   Failure to comply with EVV requirements may result in overpayments or sanctions, up to and including termination.

   Third party vendors must also comply with post payment reviews and audits.

5. **When the direct service professional's time collected in the EVV system does not match their timesheet information, how should providers adjust information?**

   Each agency determines their quality assurance process in review of EVV data and timesheets. The EVV system is the system of record for service delivery. Adjustments to EVV data are allowable if reasons for exceptions are documented. Records support all submitted claims and must be available upon audit or request. It is the provider's responsibility to verify the authenticity of the documentation that supports the claim.

   Please refer to 7AAC 105.230 for requirements for provider records.

6. **Will SDS offer technical support on how to manage the verification of claims?**

   SDS has offered over three years of outreach and technical assistance in advance of the January 1 implementation date and will continue to do so post-implementation. SDS expects that existing providers are already knowledgeable about EVV requirements and have practices in place to capture required data on service delivery and submitted claims in a compliant manner. DHSS does not dictate business operations to providers, including how to set up a provider's system to collect the EVV data elements. SDS has been very clear on what the federally required EVV data elements are and that they should be verified.

7. EVV is in minutes, yet billing is for 15-minute increments. Should employees now be writing the exact minute on the timesheet?

EVV is the system of record, meaning it is capturing the actual time that an employee checked in and checked out. The requirement to submit start and stop times has not changed. Submitting a claim to Medicaid should be based on the duration of the visit. Please refer to 7 AAC 105.230.

8. Should claims be submitted based on the length of time an employee is scheduled?

Scheduling an employee at a certain time should never influence a provider's decision to submit a claim based on duration. The EVV start and stop times, and the duration between start and stop, are the basis for Medicaid claims.

For example, if an employee is scheduled between p.m. and p.m. but the EVV data indicated a duration of six minutes, the provider agency should NOT submit a claim to Medicaid. If the agency verifies a log in error and the employee delivered a service with a longer duration (maybe they logged out by accident), the employee should use an exception code and explain the error. The employee's documentation and explanation should be verified by the provider agency.

Using this same example, if the only duration the agency can verify with the employee is nine minutes, then one billing unit may be legitimate. If the employee is scheduled for two hours and only delivers nine minutes, the agency must not bill for more than one unit, no matter the intended schedule. If the time cannot be verified except for the EVV visit data that indicated six minutes of duration, then the provider should not submit a claim to Medicaid.

7 AAC.105.230 (d)(5)(a) states "a provider may only bill for a unit of service if the actual direct service time spent is in excess of 50 percent of the time value of the procedure code billed."

9. Will the State pay for extra units if the duration times fall short of 15-minutes?

Please refer to 7 AAC 105.230 in its entirety. The State will not pay for extra units. However, the State has provided a standardized acceptable method for calculating units in regulation.

The following is excerpted from 7 AAC 105.230 (NOTE: providers should be applying the regulation in its entirety to their billing practices):

> (5) start and stop times for time-based billing codes;
>
> > (A) a provider may only bill for a unit of service if the actual direct service time spent is in excess of 50 percent of the time value of the procedure code billed;
> >
> > (B) direct service time associated with a particular procedure code shall be calculated in the aggregate by the direct service provider for each date of service when determining the appropriate number of units that may be billed;
> >
> > (C) a provider may not use pre-populated clinical notes or timesheets to document actual start and stop times;
> >
> > (D) a provider may not bill for services without proper start and stop times documentation;

(E) the use of documentation that does not specify both start and stop times will result in an overpayment;

(F) the following table shall be used when billing for time-based billing codes under this section and identifies the appropriate number of units to bill using a 15-minute time-based code:

Units	Number of Minutes of Direct Service Time
1	> 8 minutes through 22 minutes
2	> 23 minutes through 37 minutes
3	> 38 minutes through 52 minutes
4	> 53 minutes through 67 minutes
5	> 68 minutes through 82 minutes
6	> 83 minutes through 97 minutes
7	> 98 minutes through 112 minutes
8	> 113 minutes through 127 minutes

Example:

A recipient receives 39 minutes of T1019 PCS service in the morning and additional 24 minutes of T1019 in the afternoon from their PCS agency. Total duration of service delivery of T1019 for the day is 63 minutes. When combined and rounded per the regulation and table above, these time in/time out segments convert to four (4) billable units of service for the day, not five (5) billable units if the segments were converted individually. Direct service time associated with a particular procedure code shall be calculated in total for each date of service when determining appropriate number of units that may be billed.

10. Will the Alaska Department of Labor and Workforce Development's Wage and Hour Administration be available at future Town Halls to answer questions?

The Department encourages providers to contact Wage and Hour directly with specific questions about how to pay employees or direct their time.

If providers have questions regarding EVV, or when to submit claims to Medicaid based on employees' time beyond what is addressed in this FAQ resource, DHSS would be happy to respond.

The Department recognizes that using an EVV system is new to many providers and encourages providers to participate in existing Town Halls and to submit questions to the EVV mailbox at: DHSSEVV@alaska.gov.