





OFFICES OF LONG -TERM LIVING AND DEVELOPMENTAL PROGRAMS BULLETIN

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SUBJECT
Electronic Visit Verification (EVV) for Personal Care Services (PCS)

BY

Jamie Buchenauer, Deputy Secretary
Office of Long-Term Living

BY

Kristin Ahrens, Deputy Secretary
Office of Developmental Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into the Medicaid Management Information System (MMIS) to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at:
http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

PURPOSE:

The purpose of this bulletin is to inform providers enrolled in the MA Program of the requirement to use Electronic Visit Verification (EVV) for personal care services (PCS) visits effective with dates of service on or after January 1, 2020.

SCOPE:

This bulletin applies to providers enrolled in the MA Program, including Agency with Choice (AWC) providers and Vendor Fiscal/Employer Agent (VF/EA) providers, who provide PCS to MA participants who are enrolled in an Office of Developmental Program (ODP) or Office of Long-Term Living (OLTL) waiver, the Act 150 Program, or a Community HealthChoices (CHC) managed care organization.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Provider Assistance Center: 800-248-2152 or email papac1@dxc.com
Community HealthChoices providers should address any questions regarding EVV to the applicable MCO.

Visit the DHS EVV site at: <https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx>

BACKGROUND:

Section 12006(a) of the 21st Century Cures Act (Cures Act), signed into law on December 13, 2016, added section 1903(l) to the Social Security Act, 42 U.S.C § 1396b(l), which mandates that states require EVV use for Medicaid-funded PCS visits by a provider. States must implement EVV for PCS by January 1, 2020.

EVV is a technology solution which electronically verifies the provision of PCS by providers of home and community-based services using multiple technologies such as telephonic, mobile application and web portal verification inputs to help electronically validate PCS services and prevent fraudulent PCS claims. The Cures Act requires that EVV systems must collect and verify the following:

1. The type of service provided
2. The name of the individual receiving the services
3. The date of service delivery
4. The location of service delivery
5. The name of the individual providing the service
6. The time the service begins and ends

Providers of OLTL's CHC 1915(c) Waiver, OBRA Waiver and Act 150 Program services must use EVV for the following services:

- Personal Assistance
- Respite (unlicensed settings only)
- Participant-Directed Community Supports

Providers of ODP's Consolidated Waiver, Person/Family Directed Support Waiver, Community Living Waiver, and Intellectual Disabilities/Autism Base services must use EVV for the following services:

- Companion
- In-Home and Community Support
- Respite (unlicensed settings only), excludes Respite Camp
- Homemaker

Providers of ODP's Adult Autism Waiver services must use EVV for the following services:

- Specialized Skill Development – Community Support
- Respite (unlicensed settings only)

DISCUSSION:

This bulletin includes the minimum requirements for providers of ODP and OLTL waiver services and Act 150 Program services (fee-for-service (FFS) programs) and providers of CHC managed care services. Managed Care Organizations (MCOs) may have other requirements for network providers, which are imposed by the MCO agreements with the Department of Human Services (Department) and contracts with individual network providers. Providers should contact their applicable CHC-MCOs with any questions regarding EVV billing and procedures.

The Department solicited stakeholder feedback and reviewed best practices regarding implementation of the Cures Act requirements. Based on stakeholder feedback, the Department established an open EVV system model that enables providers and MCOs to choose an EVV system that best suits their operations and needs. While the Department implemented the Open Choice Model, configuration requirements, rules, and policies, are set by the Department. Therefore, a provider may use any EVV vendor of their choice, so long as the vendor can satisfy the configuration requirements, rules and policies.

The open model requires the use of an EVV Aggregator to consolidate data from all EVV systems, apply standard business rules to ensure PCS visits are properly and consistently verified, and generate alerts when PCS visit data does not conform to these standards. The EVV Aggregator, which collects data from an Alternate EVV system (also referred to as third-party EVV systems) and the Department's EVV system, facilitates payments for claims.

Providers may choose to use their own EVV system as long as their system captures the elements required under the Cures Act and meets the required technical specifications to interface with the EVV Aggregator and/or the CHC-MCO EVV system.

1. Providers using an Alternate EVV system in the FFS programs administered by ODP or OLTL will need to complete the certification process with the Department's EVV Aggregator.
2. Providers using an Alternate EVV system in the CHC program will need to establish an interface with the CHC-MCOs.
3. Providers using an Alternate EVV system in both FFS programs and CHC will need to comply with 1 and 2 above.

The EVV Aggregator and the Department's EVV system integrate with the Department's existing MMIS. Technical specifications for the EVV Aggregator and a list of PCS service codes and modifiers are found on the Department's EVV website at:

<https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx>.

NOTE: Providers serving individuals enrolled in a FFS program may choose to use the Department's EVV system at no cost. The CHC-MCOs are also offering their own internal EVV systems for providers enrolled in CHC-MCO networks.

The implementation of EVV should not impact the provision of PCS. The Department's policies and procedures regarding the provision of PCS remain the same and PCS delivery should continue as it did before the implementation of these EVV requirements. EVV does not change the method and location for PCS delivery.

PROCEDURE:

Effective with dates of service on or after January 1, 2020, providers must meet the federal requirements of EVV to capture and submit the EVV data to the Department's EVV Aggregator for visit verification of PCS.

As of January 1, 2021, the Department will deny all PCS visit claims and CHC-MCO PCS encounters that do not have corresponding visit verifications recorded in the Department's EVV Aggregator.

Training

- If a provider elects to use the Department's EVV system, the provider must complete mandatory training for the system. The Department will issue login credentials to the provider to access the Department's EVV system and EVV Aggregator once the provider completes the mandatory training.
- If a provider or vendor elects to use their own third party or alternate EVV system, the provider must complete system certification and EVV Aggregator training. The Department will issue login credentials to access the Department's EVV system or the EVV Aggregator once a provider or vendor completes the mandatory training.
- A provider must ensure that its staff (including direct care staff and attendants) who provide services for which EVV is required, receive training and comply with all processes required to verify service delivery through the use of EVV.
- Providers must train office and administrative staff members on the use of the EVV System to enter all of the required data elements, enter schedules (as applicable), and verify service delivery through visit maintenance and the use of reason codes.

EVV Billing and Compliance Requirements

1. Providers Billing FFS Through MMIS:

- Beginning with dates of service on or after January 1, 2020, edits matching EVV visit data to information submitted on claims will occur during claims adjudication.
- For claims that contain PCS services subject to EVV with dates of service between the period January 1, 2020 through December 31, 2020, MMIS will perform validation against the EVV Aggregator to determine if the information submitted on the claim matches the EVV PCS visit data stored in the EVV Aggregator. However, EVV Error Service Codes (ESCs) will set without impacting claim payment. During this period, the claim will continue to successfully pass DHS EVV validation and process through the normal claim's adjudication process. The expectation is that providers will take the initiative to note what EVV edit(s) set and actively make

corrections, if applicable, either to the data stored in the DHS EVV Aggregator or the claim itself before future PCS claims submit, to ensure errors do not repeat.

- For dates of service on or after January 1, 2021, when MMIS identifies a claim that contains a service subject to EVV, MMIS will perform validation against the EVV Aggregator to determine if the information submitted on the claim matches the EVV PCS visit data stored in the EVV Aggregator. EVV ESCs will set and potentially impact claim payment. See Appendix A, “EVV Error Status Codes,” for a list of EVV ESCs, the conditions in which the ESCs will set, and whether or not the ESC will cause the claim to pay, deny, or suspend.
- For visit corrections on an EVV transaction that has already billed, and is within the required billing timeframes, the provider must:
 - follow the billing process for the specific visit;
 - make the necessary changes in the applicable EVV system for that visit:
 - if updates are made in the DHS EVV solution, the updates will flow into the Aggregator for claims processing;
 - if using an Alternate EVV system, it is important that updates to visits are sent to the Aggregator to ensure EVV validation is successful;
 - re-bill for the corrected visit if within the required FFS billing timeframes.
- Provider agencies must ensure service claims are supported by service delivery records that have been verified and confirmed in an EVV System. The provider must complete any necessary visit corrections prior to submitting a claim associated with the EVV transaction. Claims are subject to denial or recoupment if they are submitted before all required visit corrections are completed in the EVV System.

2. Calculating Time for Billing Procedures

- The EVV system applies billing guidelines consistent with the Department’s established program billing policies.
- Please refer to ODP Bulletin 00-18-04 “Interim Technical Guidance for Claim and Service Documentation” and its attachments for references to billing guidelines.
- Please refer to OLTL Bulletin 05-13-02, 51-13-02, 54-13-02, 55-13-02, 59-13-02 “Billing Instructions - Home and Community Based Waiver Provider's Billing of Procedure Codes Based on Authorized Service Plans through PROMISe™” for billing guidance that pertains to OLTL programs.

3. Manual Edits and Compliance Rates

- If an EVV visit is missing information or the EVV visit information was entered incorrectly and requires any type of edit or correction, this is deemed a manual edit. If a provider has to manipulate data or add missing data or change data in any way after the service is delivered, this is deemed a manual edit.
 - Manual edits in EVV are accepted but should never be the primary source of visit capture information. Manual edits should be done on an exception basis only and should be kept to a minimum.
 - Acceptable reasons for a manual edit are the following:
 1. Providers are missing one or more data elements of required visit information, or
 2. Providers need to make a correction or change to one or more data elements because it was incorrect.
 - Examples of acceptable manual edits may include, but are not limited to, the following:
 1. A caregiver misses a clock-in or clock-out and the visit needs to be edited to add the appropriate time of service.
 2. The visit is unable to be electronically captured at the point of care because the mobile application and/or telephony are not available. (The EVV system is down.)
 3. The visit is unable to be electronically captured because a device cannot be used at the point of care.
 4. A visit is captured electronically but causes an exception to be generated; the record would be classified as a manual edit.
- In order to meet compliance with The Centers for Medicare and Medicaid Services (CMS), the Department expects providers to achieve 50% of EVV records for verified visits without manual edits from January 1, 2021 and moving forward. The Department will review manual edit data on the federal fiscal year quarterly basis for providers providing services through a FFS program. For providers enrolled in the CHC managed care delivery system, the CHC-MCO will conduct the review of manual edit data on a federal fiscal year quarterly basis and contact the provider regarding any needed quality improvement plan.
- For those providers not achieving the 50% threshold for manual edits on a quarterly basis, the Department will work with providers to develop corrective action plans as part of the standard monitoring process when necessary.
- The Department will provide technical assistance to those providers identified by the Department with a large number of manual edits in their EVV records.

4. Visit Corrections and Documentation for Manual Corrections

- If EVV visits require manual corrections or edits due to missing or incorrect data elements, providers must maintain hard copy documentation of the manual corrections for auditing purposes. Hard copy documentation is a paper copy.
- Providers are to establish policy on documentation required to meet auditing requirements and standards, as well as organizational needs.

5. Service Authorization

- Providers are to review Service Authorization Notices and/or the Provider Service Detail Reports prior to service delivery and billing to ensure the provider, the PCS, the date span for PCS, and sufficient units for PCS are authorized on the Individual Support Plan or Person-Centered Service Plan. This practice will minimize claim denials.

ATTACHMENTS:

Appendix A: EVV Error Service Codes

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EVV ESC CODE	EVV ESC DESCRIPTION	WHY IS THIS ESC SETTING?	RESOLUTION ACTIVITY
ESC 925	EVV Visit Verified	Providers will see this ESC each time PROMISE™ determines a Personal Care Service is found on the claim and it passed EVV validation against the EVV Aggregator record(s).	This edit sets for informational purposes only. It serves to inform the AWC, VF/EA, provider or provider agency that the claim passed EVV validation in the Aggregator. No action is needed by the provider. When a claim passes EVV validation, it continues processing through the claims adjudication process as it currently does today.
ESC 926	EVV Internal Record Format Error	This ESC will set when PROMISE™ sends an incorrectly formatted record to the EVV Aggregator during the EVV record validation process.	When this ESC sets, the claim will suspend and the PROMISE™ technical vendor, DXC, will resolve the error and reprocess the claim within a 24-hour period. No action is needed by the provider. Errors of this nature will be recycled/reprocessed in PROMISE™ by the technical vendor, DXC, within a 24-hour period. If an AWC, VF/EA, provider or provider agency sees this ESC while performing claims reconciliation activities, DO NOTHING to the claim and check back later in the day or the following day to confirm the claim was reprocessed on its own. If this ESC continues to be present 24 hours after claim submission, contact the Provider Assistance Center (PAC).
ESC 927	Units Billed Exceed Units Verified in EVV	When the provider sees this ESC set, the claim detail line denied because the allowed units on the claim detail line are greater than the units found on the EVV record in the Aggregator.	<p>AWC, VF/EA, provider and provider agencies should determine if the units on the claim detail line or the units found in the EVV record need to be corrected. PROMISE™ is not designed to cut back units on the claim for an EVV service if the allowed units on the claim are greater than the total units found in the Aggregator. The AWC, VF/EA, provider or provider agency should make corrections as applicable and resubmit the claim, ensuring the units found in the EVV Aggregator are equal to or greater than the units submitted on the claim.</p> <p>While performing claims resolution analysis, AWC, VF/EA, provider and provider agencies are encouraged to review the rounding rules and/or the calculation rules found in Appendix B, make corrections accordingly and resubmit claim.</p> <p>Note: “Allowed” units on a claim detail line are not always equal to the exact units submitted on the claim because other edits/audits are performed before the units on the claim are validated against the units found in the EVV Aggregator record.</p> <p>Example: Fiscal year unit limitations or weekly unit limitations may “cutback” units</p>

Appendix A: EVV Error Service Codes

EVV ESC CODE	EVV ESC DESCRIPTION	WHY IS THIS ESC SETTING?	RESOLUTION ACTIVITY
			submitted on a claim which would make the units on the claim less than what was submitted on the actual claim.
ESC 928	EVV Visit Not Found	<p>When the provider sees this ESC set, the claim detail line denied due to one of the following reasons:</p> <ul style="list-style-type: none"> • No EVV record was found in the Aggregator, or • The status of the EVV record in the EVV Aggregator is in a status other than “Verified” or “Processed,” or • Mismatch was found between either the date of service, RID (10 digits), procedure code/modifier and/or MPI (9 digit) code that is found on the claim versus what is found in the EVV record, or • The EVV record was submitted to the aggregator after the claim was submitted and processed. 	<p>To correct this error, verify if the claim was submitted and processed BEFORE the visit information was successfully sent to the EVV Aggregator. If so, Providers should ensure the EVV record is found in the EVV Aggregator, it contains valid data and resubmit claim.</p> <p>If the EVV record in the Aggregator is in a status other than “Verified” or “Processed”, there is an exception(s) associated with the record that will need a manual update made. Go to the dashboard in the EVV application you use and correct the missing data, ensure the record is verified then resubmit to the EVV Aggregator. Resubmit the claim once you are sure the EVV record status has been updated to verified.</p> <p>If the EVV record that is found in the Aggregator but contains a mismatch between one or more data elements on the claim, review the EVV record in the Aggregator and manually validate if the data elements found in the Aggregator record(s) contains the appropriate values as specified in the Alternate EVV interface requirements, technical specifications and addendums found on the DHS EVV webpage: https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx.</p> <p>If the EVV record is accurate, validate the information that was sent on the claims transactions is accurate, make corrections as needed and resubmit the claim.</p> <p>If the EVV record is accurate, validate if the claim was submitted before the EVV record was sent to the aggregator. If so, resubmit the claim.</p>

Appendix A: EVV Error Service Codes

EVV ESC CODE	EVV ESC DESCRIPTION	WHY IS THIS ESC SETTING?	RESOLUTION ACTIVITY
ESC 929	EVV Web Service Timeout	When this ESC sets, PROMISe™ received a web service timeout when communicating with the EVV Aggregator.	When this ESC sets, the claim will suspend and the PROMISe™ technical vendor, DXC, will resolve the error and reprocess the claim within a 24-hour period. No action is needed by the provider. Errors of this nature will be recycled/reprocessed in PROMISe™ by the technical vendor, DXC, within a 24-hour period. If an AWC, VF/EA, provider or provider agency sees this ESC while performing claims reconciliation activities, DO NOTHING to the claim and check back later in the day or the following day to confirm the claim was reprocessed on its own. If this ESC continues to be present 24 hours after claim submission, contact the Provider Assistance Center (PAC).
ESC 930	EVV Internal Error	When this ESC sets, PROMISe™ received an internal error when communicating with the EVV Aggregator.	When this ESC sets, the claim will suspend and the PROMISe™ technical vendor, DXC, will resolve the error and reprocess the claim within a 24-hour period. No action is needed by the provider. Errors of this nature will be recycled/reprocessed in PROMISe™ within a 24-hour period by the technical vendor, DXC. If an AWC, VF/EA, provider or provider agency sees this ESC while performing claims reconciliation activities, DO NOTHING to the claim and check back later in the day or the following day to confirm the claim was reprocessed on its own. If this ESC continues to be present 24 hours after claim submission, contact the Provider Assistance Center (PAC).
ESC 931	EVV-PROMISe Internal Error	This ESC sets when there is a technical issue related to the interface OR when a provider bills a claim with a date span on one claim detail line that exceeds 31 calendar days	When this ESC sets, the claim will suspend and the PROMISe™ technical vendor, DXC, will resolve the error and reprocess the claim within a 24-hour period. No action is needed by the provider. Errors of this nature will be recycled/reprocessed in PROMISe™ within a 24-hour period by the technical vendor, DXC. HOWEVER , this ESC will also set if a claim detail line is billed with a date span that is greater than 31 days. To resolve this issue, the date span on the claim detail line will need to be split onto two separate claim detail lines and resubmitted or split and resubmitted on two separate claims. If a provider, provider agency, AWC or VF/EA, sees this ESC while performing claims reconciliation activities, validate if a date span was submitted that exceeds 31 days and, if so, correct and resubmit the claim(s). If not, then DO NOTHING to the claim and check back later in the day or the following day to confirm the claim was

Appendix A: EVV Error Service Codes

EVV ESC CODE	EVV ESC DESCRIPTION	WHY IS THIS ESC SETTING?	RESOLUTION ACTIVITY
			reprocessed on its own. If this ESC continues to be present 24 hours after claim submission, contact the Provider Assistance Center (PAC).