

AHCCCS E.V.V.

ELECTRONIC VISIT VERIFICATION

Frequently Asked Questions (FAQ)

Scheduling | February 2021

Why is AHCCCS requiring scheduling for EVV when it is not required under the 21st Century Cures Act or the Centers for Medicare and Medicaid Services (CMS)?

The scheduling requirement helps the provider agencies, health plans and MCOs to document when and why service visits didn't happen according to the original plan. This information helps to support AHCCCS' EVV goals to track and monitor access to care, inform workforce development and provider network adequacy. Specifically, this information helps to tell the story of service delivery. It will help to understand if the reason why the visit didn't occur as originally planned was the result of reasons that are not concerning (i.e. the member didn't want service at that time) or did not occur because of concerning reasons (i.e. caregiver did not show up).

Are provider agencies serving ALTCS members still required to submit the Non-Provision of Services (NPS) logs to the Health Plans?

EVV is replacing the need for Gap reporting for the providers and Health Plans serving the ALTCS population. The AHCCCS Contractors Operations Manual, Policy 413 - Gap in Critical Services Policy will be reserved effective 01/01/21. AHCCCS encourages providers to reach out to the Health Plans for guidance on final reporting submission requirements.

How can an agency enforce late or missed visits when members are in an area with no landline, cell coverage or internet service or for those instances when the use of paper timesheets is allowed?

Members need to understand that if the DCW is using the paper timesheet and FOB device option, the provider agency is unable to know in "real-time" if the DCW does not show up on time. Provider agencies are expected to counsel members on how to contact the agency in the event the DCW is late or does not show up at all to provide care as part of the contingency plan discussion. The member will need to communicate these circumstances to the provider agency directly.

If a member has an unplanned support need or prefers services at a different time than originally planned, how can we make sure that scheduling requirements don't create access to care issues?

Even with a scheduling requirement, it is still allowable for visits to:

- Start before the scheduled start time,
- Start after the scheduled time, and
- Occur without a schedule.

How can Agencies comply with scheduling requirements for service in which the client has the right to adjust their own schedule?

Provider agencies are expected to develop a standard/recurring schedule in partnership with members (and as appropriate with their families and service planning/treatment teams) based upon the medical necessity requirements outlined in the service/treatment plan. Schedules may be modified based upon the member/family preferences following processes established by the provider agency. If scheduling arrangements are made between the member/family and the Direct Care Worker, the provider agency will be able to explain the variance of the schedule using a reason code(s) that documents the schedule change was at the member's request. Provider agencies will be expected to counsel members and DCWs on these arrangements to make sure the DCW is providing care within the authorization limits and tasks performed are consistent with the medically necessary needs and preferences outlined in the service/treatment plan.

Are there any exemptions from the scheduling requirements for members with live-in caregivers or members managing their care under the Self-Directed Attendant Care service model?

Yes. AHCCCS does not require scheduling for members who employ their DCWs under the Self-Directed Attendant Care model. Additionally, AHCCCS does not require scheduling for members with live-in or onsite Caregivers that often provide services on demand. These visits will trigger an "unscheduled visit" exception and the provider agency will need to apply the appropriate reason codes to document why the visit was unscheduled. Please reference the "Live-In/Onsite Caregiver" FAQ on the EVV webpage (www.azahcccs.gov/EVV).

How far in advance must a schedule be made?

Schedules must be recorded in the system before the visit is scheduled to start.

Can schedules created in advance be changed/edited?

Schedules may be edited up until the visit is scheduled to start. The schedule cannot be edited retroactively. If a DCW no-shows or is late (at least 60 minutes from the start time), the provider agency is expected to reschedule the visit based upon the member's contingency plan preferences. A visit is considered late if the DCW has not signed in within 60 minutes of the scheduled start time. The new visit should be marked as a reschedule.

Can multiple visits be applied to one schedule?

No, only one visit can be applied to a schedule.

How do provider agencies document visits that don't occur as originally planned?

There are four instances that trigger exceptions in the EVV system regarding the schedule. These include instances whereby the:

- DCW does not show up to provide care
- Visit is unscheduled
- Visit is shorter in duration than originally planned
- Visit starts more than 60 minutes after originally planned

Provider agencies will use reason codes to explain why these instances happened and use resolution codes to document what the agency did to ensure the member's needs were met when a DCW no-showed or was late.

How are missed, late and short visits defined?

- Missed Visit - The DCW does not show up at all for the visit
- Late Visit - The DCW shows up more than 60 minutes after the scheduled start time.
- Short Visit - The DCW provides services less than the scheduled length of time

What are some examples of reasons for missed, late or short visits that may or may not be concerning?

Generally, it is going to be concerning if the reasons why these circumstances occur are not directed by the member or member preferences. For example, it generally won't be concerning if the member chooses not to have services that day unless this is occurring regularly and the medically necessary services are not being provided. Examples of reason codes that could be applied to a missed, late or short visit that indicate member direction include:

- Member No Show
- Member Refused Service
- Member Preference

How are AHCCCS and the Health Plans going to use the data reported about scheduling?

AHCCCS will look at the data to help inform workforce development and network adequacy planning. The scheduling data helps to identify why visits are not occurring as originally planned while the data on the contingency planning helps to highlight what the agency was able to do to accommodate the member when a visit was late or missed.

Will provider agencies be penalized for instances when visits are late or missed?

Provider agencies will be able to bill for late, short or unscheduled visits when:

- Reason and resolution codes are applied to document why the visit did not occur as originally planned and
- Resolution codes document what the agency did to ensure the member's needs were met when a DCW no-showed or was late.

AHCCCS and the Health Plans will monitor the data during a baseline period in an effort to develop performance metrics that may be used to incentivize performance through vehicles such as value-based purchasing arrangements, Differential Adjusted Payment initiatives or quality monitoring reviews.

AHCCCS anticipates the baseline period to start after the claim and policy grace period ends.