Electronic Visit Verification Provider Help Aid

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PURPOSE

Electronic Visit Verification (EVV) is a mechanism to capture and validate information about a visit to a Medicaid participant's home and is intended to curb fraud, waste, and abuse. All Personal Assistance Agencies (PAAs) are required to comply with rules and regulations outlined in IDAPA 16.03.26.054.

This document outlines EVV requirements for PAAs as well as the process for identifying agencies with EVV data transmission that has been manually.

> **Manually Verified Visit** – the visit was not verified electronically; the agency has manually overridden either all or a portion of the visit data.

Oversight of manually verified visits is important to ensure that the provider is delivering services according to the service plan and EVV criteria. Optimally, all visit data should be transmitted and verified electronically with no manual manipulation of the data. However, if the provider has identified instances when manually overridden data is necessary it should be outlined in their EVV policies and procedures.

EVV REQUIREMENTS

All PAAs must have a compliant EVV system that captures and validates the following six (6) data elements for **each visit**:

1. Type of service performed
2. Individual receiving the service
3. Date of service
4. Location of service delivery
5. Individual providing the service
6. Time the service begins and ends

All visits for the following services must be captured and validated by the agency's EVV system:

- Personal Care Services (T1019)
- Attendant Care (S5125)
- Homemaker Services (S5130)
- Respite (T1005)

All PAAs must complete testing with the state's aggregator and receive production credentials confirming successful data submission to the aggregator. The technical guide for all EVV requirements is available at www.idmedicaid.com.

For more information about EVV requirements and additional resources, please visit the Long Term Care Provider Resources website.

ADDITIONAL RECORD REQUIREMENTS

Agencies with compliant EVV systems will capture most of the required elements described in IDAPA 16.03.26.543.02 and 16.03.26.553.04. However, agencies **must** also capture the below elements. The agency may elect to use their EVV platform to do so.

> **Service delivery documentation must be maintained on all participants who receive State Plan Personal Care Services (PCS) or Aged & Disabled (A&D) Waiver services.**

All agencies must maintain documentation of every visit made to a participant's home. Each service delivery record must contain the following elements as outlined in IDAPA:

- **Date and time of visit:** the time of day services are delivered must be identified by A.M. or P.M. unless military time is utilized
- **Length of visit:** must include the total time for Attendant Care and Homemaker services
- **Services provided:** care tasks provided during each visit made to the participant
- **Narrative:** summary comments entered by the Direct Care Professional regarding the participant's response to the service(s), any changes noted in the participant's condition, or any deviations from the service plan
- **Participant signature and date:** this may be captured with a written or electronic signature, unique login, or voice signature
- **Direct Care Professional signature and date:** this this may be captured with a written or electronic signature, unique login, or voice signature

When submitting documents during a Bureau of Long Term Care (BLTC) Quality Assurance (QA) Audit, agencies that elect to use voice signatures **MUST** provide a report from their EVV platform that validates voice signature data.

PARTICIPANT ACCESS TO RECORDS

Record Availability

A copy of the service delivery documentation, including all information as outlined above, must be available to the participant on at least a weekly basis. This may be in either a printed format and placed in the participant's home or available to the participant and/or legal representative by an electronic record (email, login, website, etc.). If the documentation is not in a printed format and kept in the participant's home, the agency must document the participant's preference on how the service delivery documents are received by an attestation which must be kept on file by the agency.

The agency's service delivery policies and procedures should be updated accordingly to outline this process.

Service Delivery Documentation Acknowledgement

If a participant declines to receive paper copies of their service delivery documentation, the agency must document this refusal with a participant acknowledgement including the participant or legal guardian signature and date. This acknowledgement must clearly indicate the method by which service delivery documentation was offered to the participant (print, electronic, email, etc.), and acknowledge that service delivery documentation is available to the participant on at least a weekly basis.

The acknowledgement must be kept on record with the agency and made available to the BLTC if requested. A template acknowledgement is available on the Long Term Care Provider Resources website.

EVV Informed Consent

An Informed Consent is required for all PAAs implementing an EVV system. The BLTC has developed a template consent form for agencies to utilize. It is not required that agencies use this template however the BLTC recommends it as a best business practice.

The BLTC Informed Consent template is available on the Long Term Care Provider Resources website. If the agency chooses not to use the BLTC template, the agency is responsible for developing and using an appropriate Informed Consent form.

BILLING 15-MINUTE TIMED CODES

The purpose of the EVV system is to capture ACTUAL TIME worked by the Direct Care Professional based on the clock in and clock out times. **There is NO rounding of time or units.**

Example

Clock In: 6:58 AM
Clock Out: 10:04 AM
Total Actual Time: 3 hours, 6 minutes **Total Billable Units** = 12

All PAAs must bill procedure codes for the services they delivered using the appropriate codes and the appropriate number of units of service. **Only time spent directly working with the participant is counted.**

For any single code, **agencies may bill a single 15-minute unit that is greater than or equal to eight (8) minutes and less than 23 minutes in a day.**

The pattern remains the same for service times in excess of two (2) hours. **Agencies should NOT bill for services performed for less than eight (8) minutes.** The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If an agency has a practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

When more than one service measured in 15-minute increments is performed on a single date of service, the total number of minutes for all services billed in 15-minute increments should be totaled to determine the total number of units that can be billed for that date of service.

Additional References

For additional information, agencies may refer to the following resources:

- **Idaho Medicaid Provider Handbook:** General Billing Instructions, Medicaid Billing Policies, 1.3
- **Medicaid Information Release MA08-11:** "Billing for 15 Minute Units" (5/1/2008)
- **MedicAide Newsletter, August 2019**: "Billing Time-Based Codes: 15 Minute Units, and Other Timed Codes in Fee-For-Service Medicaid"
- **MedicAide Newsletter, March 2023**: "Billing 15-Minute Time Based Codes"

These resources are available on the provider portal website located at: www.idmedicaid.com.

CLAIMS LOGIC

EVV Data Element	Affects Claims	How?
Person **Receiving** Service	Yes	Medicaid ID# (MID) for the participant receiving the service matches the MID on claim
Person **Delivering** Service	**No**	*This information should be captured in the service plan or narrative*
Date	Yes	Date of service on the claim matches the date of the EVV visit
Start and End Time	Yes	Start and end time difference does not exceed total authorized and billed units
Location	**No**	*This information should be capture in the service plan or narrative*
Service(s) Provided	Yes	Procedure code on the EVV visit line matches the procedure code on the claim

If one (1) or more of the required data elements is missing and no manual entry/reason code has been keyed, the associated claim will deny.

Duals Claims

Duals claims will be paid by the appropriate health plan. PAAs must collect EVV data for all EVV applicable services regardless of the payor.

CLAIMS PROCESSING ISSUES ESCALATION PROCESS

If you have unexpected claims processing results in the Gainwell system that you are unable to troubleshoot on your own, please follow the steps outlined below.

1. Contact your Gainwell Provider Relations Consultant (PRC)
2. If you do not get resolution at this step, please contact Gainwell at:
    a. Gainwell Provider Relations (866) 686-4272
    b. Email providerfeedback@gainwelltechnologies.com
    c. Email idproviderservices@gainwelltechnologies.com

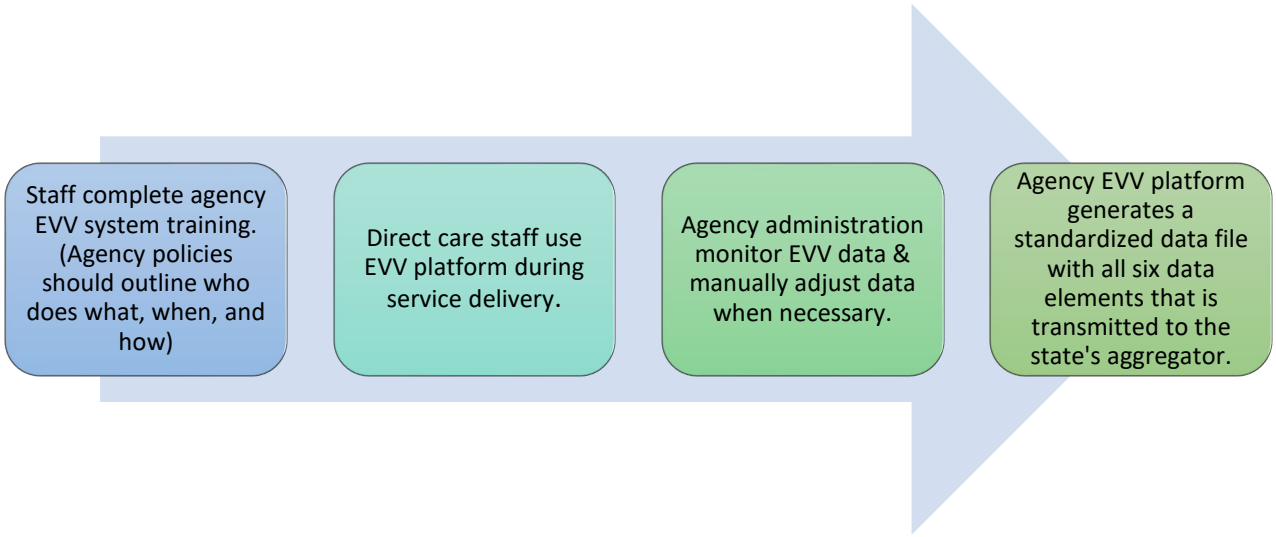
QUALITY ASSURANCE OVERSIGHT

The BLTC, QA team will retain oversight of EVV data to verify that services are delivered according to the service plan and level of care assessment. All PAAs will continue to be audited on a biennial basis using existing criteria as well as EVV data.

Policies and Procedures

- All PAAs are required to develop and maintain policies and procedures outlining agency implementation and use of EVV technology, including strategies for the safeguarding of participant information and privacy. Policies should include the compliance threshold for manually verified visits
- A template for EVV policies and procedures is available on the Long Term Care Provider Resources website

- During the quality assurance audit, the agency's EVV policy will be required for review. All new PAAs are required to submit their EVV policies and procedures prior to approval of their Medicaid provider enrollment application



MANUALLY VERIFIED VISIT

A manually verified visit is visit data that has been manually adjusted for either all or a portion of the visit.

If the agency manually edits one (1) or more of the six (6) required data elements or the agency's EVV system automatically adjusts any of these data elements, it will result in a manually verified visit.

MANUALLY VERIFIED VISIT COMPLIANCE THRESHOLD

To be compliant with the Centers for Medicare & Medicaid Services (CMS) guidelines, the BLTC requires that all PAAs meet a threshold of 85% compliance for manually verified visits.

This means all PAAs with manually verified visits above a 15% threshold are out of compliance and will require improvement.

Threshold Improvement Process

On a quarterly basis, the BLTC, QA team will review manually verified visit data. All agencies below the required 85% compliance threshold will receive email notification informing the agency they are below the compliance threshold. The email notification will outline an improvement process dependent upon certain criteria.

Threshold Deficiencies

EVV Action Plan

If the agency is deficient and below the compliance threshold, the email notification will include a request for an **EVV Action Plan**. The agency must complete the action plan and outline at a minimum the following:

1. Cause for the excessive manually verified visits. *The following list is not inclusive of all possible issues but provides some possible root causes:*

a. Direct care staff trends i.e., forgetting to enter time in/out, signature, etc.
b. Agency administration is manually overriding visit data inadvertently while reviewing or verifying EVV data.
c. The agency's EVV software is automatically overriding data within the system i.e., automatically adjusting/rounding time in/out.

2. Outline the detailed action plan the agency will take to meet the manually verified visit compliance threshold moving forward. *Some actions to consider may include:*
    a. Provide a detailed training and disciplinary plan for staff who do not follow all EVV operational processes which result in a manually verified visit.
    b. If automatic adjustments within the agency's EVV software are determined, provide a detailed report of the research and issue(s) identified with the EVV vendor.
        i. Outline the solution and actions the EVV vendor and/or agency will take to discontinue and prevent the EVV system from automatically adjusting visit data.
        ii. Outline how the agency will monitor their EVV system to ensure automatic adjustments have stopped.

The agency must submit the completed action plan via email to BLTCQA@dhw.idaho.gov.

If no response is received from the agency, the BLTC, QA team will initiate a Medicaid claims payment hold and notify the Duals providers who will also initiate a claims payment hold.

EVV Action Plan Review

The BLTC, QA team will review the submitted EVV Action Plan and notify the agency if the action plan is approved or denied.

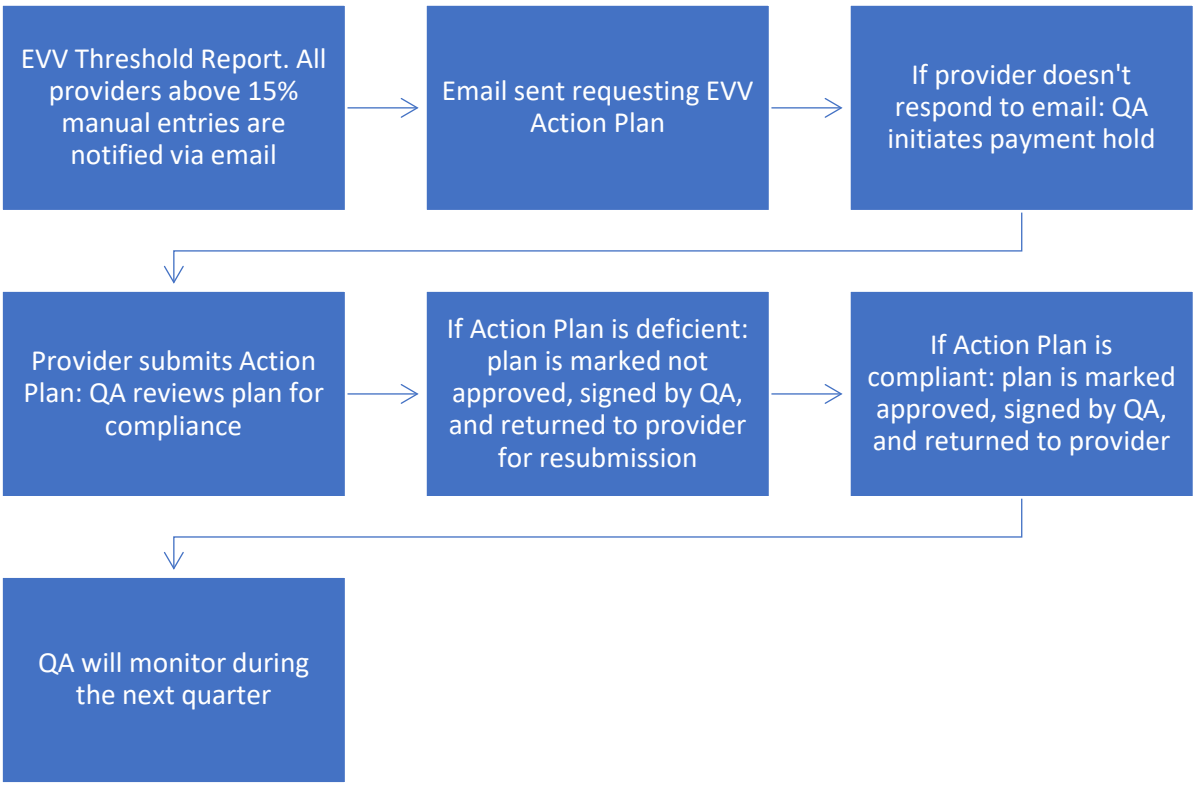
Denied EVV Action Plan

If the QA team determines the EVV Action Plan is deficient, it will be denied and returned to the agency for editing and resubmission. The agency must modify and resubmit the action plan for approval.

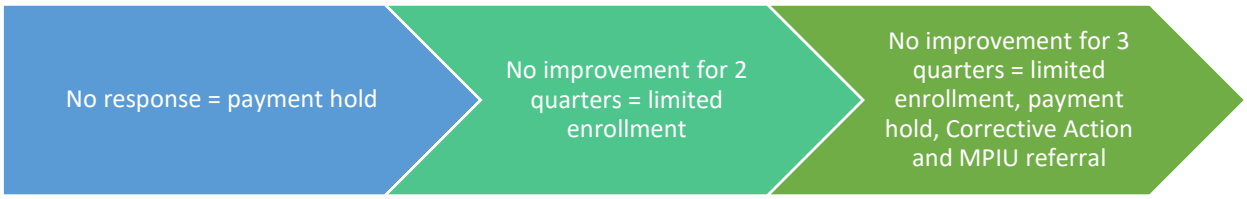
Approved EVV Action Plan

If the QA team determines the EVV Action Plan is sufficient, it will be approved and returned to the agency for implementation. The QA team will monitor the agency's manually verified visit data during the next quarter.

WORKFLOW



No Response or Improvement



Version History

Date	Version	Comments
2/2026	v2.3	Added version history, accessibility update, IDAPA update.

The information outlined herein is not new law but is an agency interpretation of existing law, except as authorized by law or as incorporated into a contract. To seek additional information or provide input on the agency guidance document please reach out to BLTCQA@dhw.idaho.gov.