Electronic Visit Verification (EVV) Provider Questions and Answers

Information

Where can we find information on recordings and information on EVV?
Visit Partners EVV webpage, https://providers.partnersbhm.org/electronic-visit-verification/ to view recordings and presentations.

What is the contact information for HHAeXchange?
North Carolina HHAeXchange Client Support information:

- NCSupport@hhaexchange.com
- 866-242-2465

Where can I find the slide deck from the provider session?
Visit https://providers.partnersbhm.org/electronic-visit-verification/

Codes, Modifiers and Billing

Do we know when the T2012 service code will be ready to use?
Partners is working expeditiously to enter associated codes in time for the June 30, 2021 EVV launch. These codes will be added to provider contracts where you already have the base code. No action is required by providers. In addition, we are working to ensure that providers have ease in requesting services regardless of who is providing and where that service is being provided. We will communicate more closer to June 30, 2021.

Will there be a modifier for T2012GC for RADSEs using Appendix K?
Partners will be adding modifiers to T2012 GC to ensure Appendix K flexibilities are available.

What do we do if T2012 will not go through HHAeXchange?
Answer: Please refer to Joint Communication Bulletin #J395 https://www.ncdhhs.gov/media/12757/download?attachment and the Electronic Visit Verification Guidance Document that was revised June 23, 2021, to determine whether specific situations meet the EVV exclusion criteria. https://providers.partnersbhm.org/wp-content/uploads/electronic-visit-verification-design-guidance-document.pdf

Will T2012 will be billed outside of HHAeXchange?
The new T2012 codes do not go through HHAeXchange. EVV is not required. Please refer to:

- Joint Communication Bulletin #J395 https://www.ncdhhs.gov/media/12757/download?attachment
- Electronic Visit Verification Guidance Document that was updated June 23, 2021, to determine whether specific situations meet the EVV exclusion criteria.

https://providers.partnersbhm.org/wp-content/uploads/electronic-visit-verification-design-guidance-document.pdf

Will we required to separate just community portion of Community Living and Support from Personal Care due to T2012 code?

Please refer to:

- Joint Communication Bulletin #J395 https://www.ncdhhs.gov/media/12757/download?attachment
- the Electronic Visit Verification Guidance Document that was updated June 23, 2021, to determine whether specific situations meet the EVV exclusion criteria. https://providers.partnersbhm.org/wp-content/uploads/electronic-visit-verification-design-guidance-document.pdf

Do we need to request authorizations for T2012 codes? Some of our individuals will be EVV and some will be receiving services from live-in caregivers. How will Partners know unless we request authorization?

Partners is working toward a unified authorization for Community Living and Support. Instructions on how to access the new Community-Only and Live-in Caregiver codes will be communicated in a separate provider alert.

When we bill in AlphaMCS for a caregiver, will we enter T2012GG instead of T2013 TF?

You would bill one of the new codes T2012 codes once they have been added.

Do we have an updated document with the corrected modifier?

Updated EVV Guidance Document dated June 23, 2021. https://providers.partnersbhm.org/wp-content/uploads/electronic-visit-verification-design-guidance-document.pdf

For Community Living & Support – Individual: When the caregiver lives in the home with the client, do we have to create a profile and schedule for them in HHAeXchange?

When services meet the exclusion criteria for EVV, those services are billed directly to Partners and no validation is required through HHAeXchange. Please refer to Joint Communication Bulletin #J395 https://www.ncdhhs.gov/media/12757/download?attachment and the Electronic Visit Verification Guidance Document that was revised June 23, 2021, to determine whether specific situations meet the EVV exclusion criteria. https://providers.partnersbhm.org/wp-content/uploads/electronic-visit-verification-design-guidance-document.pdf

If a participant is bedridden and all services are in the home, (not in the community), how does EVV work? (Example: services are provided by relatives in the home with one parent as RADSE, and the uncle works evenings with him in the home).

Caregivers who live in the member's home are exempt from EVV. Caregivers who do not live in the member's home are held to EVV requirements. In the example, the uncle would be required to comply with EVV requirements.

If the caregiver lives in the home, do we bill for Community Living and Support through AlphaMCS or HHAeXchange?
Providers will have the ability to bill Community Living and Support in AlphaMCS using the T2012CG codes. Please refer to Joint Communication Bulletin #J395 https://www.ncdhhs.gov/media/12757/download?attachment and the Electronic Visit Verification Guidance Document that was revised June 23, 2021 to determine whether specific situations meet the EVV exclusion criteria. https://providers.partnersbhm.org/wp-content/uploads/electronic-visit-verification-design-guidance-document.pdf

Is there an exemption for Innovations Community Living and Support T2013TF that is provided in the community only (not in member's home)?
Please refer to Joint Communication Bulletin #J395 https://www.ncdhhs.gov/media/12757/download?attachment and the Electronic Visit Verification Guidance Document that was revised June 23, 2021, to determine whether specific situations meet the EVV exclusion criteria. https://providers.partnersbhm.org/wp-content/uploads/electronic-visit-verification-design-guidance-document.pdf

How is Partners handling the authorizations for individuals who have a combination of services with RADSE and regular staff?
Partners is working toward using the "all services" option for Community Living and Supports. This option is contributing to the delay we are experiencing with the codes.

We have a member receiving Community Living and Support services that is not in the HHAeXchange system. Will they be included?
Only members with current/active authorizations for EVV required services will be included in the provider profile in HHAeXchange.

Will member authorizations be updated in response to the new codes/modifiers? How will it work? When will it happen?
Current authorizations will be updated to reflect the new process. Once they are complete, you will receive a notification to bill against the new authorizations. We ask that any services on or after June 30, 2021 are billed to the new authorizations.

Will Partners have the codes and the contracts completed before June 30, 2021?
Partners is working diligently to ensure the codes and contracts are updated prior to June 30, 2021. Partners will add these codes to provider contracts with no action by providers.

The new codes will impact testing because many members receive services from RADSE and staff. If we do EVV billing through HHAeXchange, then we will get denial for duplicate claims denial for the RADSE that we bill to AlphaMCS?
You will not get a denial for duplicates, unless you bill EVV services to AlphaMCS that should be going to HHAeXchange first. The logic is in place in AlphaMCS to edit the EVV codes (that go through HHAeXchange) separately than codes that you bill directly to AlphaMCS.

What we do if we cannot test until the new codes are entered?
Authorizations for EVV required services have been sent to HHAeXchange for members who have active/current authorizations. Testing for those services should continue all the way through to having the claim processed by Partners. Services that do not require electronic visit verification should not be submitted using HHAeXchange. In order to confirm that providers are ready to bill for services at launch starting with dates of service June 30, 2021, all providers should be submitting test claims for EVV required services now. The new codes that are being added are codes that will be billed directly to Partners and do not require electronic verification. These codes should not impact testing.

What will the process be for denied claims?
Claims will need to be resubmitted correctly through HHAeXchange if using EVV required procedure codes.

Is there a requirement for how often data is to be sent? If using EDI option, can the data be sent weekly, every two weeks, or does it have to be daily?
It would depend on how often you want claims to process.

What are the timelines for filing claims?
We recommend that providers have claims submitted to HHAeXchange by 5 p.m. on Monday to meet Partners 5 p.m. checkwrite cutoff that occurs on Tuesdays.

How will we be paid if everything is not ready regarding codes, contracts, etc.?
Partners is working toward a solution that will allow providers to continue to bill the codes necessary (new and current) while we work toward a unified authorization.

When we complete the EVV verification process, is HHAeXchange going to submit billing for all scheduled services that pass the six EVV required components?
The six requirements listed on the Partners EVV webpage are:

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

If you are using the free EVV tool solution for billing, please refer to HHAeXchange Provider EVV Welcome Packet. If you are using an existing solution for, please refer to your HHAeXchange Provider EDI Welcome Packet.

With the Appendix K situation and family members providing services, how will Partners discern or authorize claims with a modifier?
Once all codes are updated in the system, Partners will issue a provider alert to give providers the base codes and modifier codes to be used for billing.

Will the EVV Service Codes for June dates of service need to be submitted by the Monday at 5 p.m. cutoff date or is it just May 2021 services and prior?
You will submit all claims with dates of service June 30, 2021, and after with your first EVV submission. All dates of service prior to June 30, 2021, should be submitted directly to Partners as normal.

Will an ERA be submitted to providers from the claims sent to HHAeXchange as they are now in AlphaMCS?
The claims should appear on your AlphaMCS Remittance Advice as they do now.

How shall we handle the RADSE Community Living and Supports modifier? The state has told us to use to allow RAPs to avoid EVV clock in/out requirements.
The following codes are currently being added to Partners' service matrix and will be used to bill services directly to Partners when EVV exclusion criteria is met.

- T2012 Community Living and Supports Community only
- T2012-HQ Community Living and Supports Community only Group
- T2012-GG Community Living and Supports provided by a live-in caregiver (RADSE)
- T2012-GC HQ- Community Living and Supports Group provided by a live-in caregiver (RADSE)

Processes

The other Personal Care Services (PCS) services went live, but with report and pay for a while. Can that be done now?
That would be at the State level. Partners does not process claims as report and pay. The claims approve or deny based on adjudication edits.

What if rates are incorrect in HHAeXchange?
Providers now have the ability to update rates inside HHAeXchange. Claims will pay based on rates maintained by Partners inside AlphaMCS.

If a member has an incorrect address listed in the HHAeXchange, can the Partners assigned Care Manager make the update instead of going through the Department of Social Services?
Member addresses are populated based on the global eligibility file. Providers have the ability to add additional service locations inside the portal. Please refer to the following link for instructions.
https://hhaxsupport.s3.amazonaws.com/SupportDocs/ENTF/Process+Guides/ENTF+Process+Guide+-+Patient+Placement+and+Management.pdf

For members with discrepancies concerning their addresses in HHAeXchange, if DSS has the correct address and Partners updates daily, why would a correct address not show in HHAeXchange? Our understanding is that this is initiated by DSS.
Member addresses are managed by DSS and come to Partners via a global eligibility file on a daily basis. Member address and service location may be different depending on the individual circumstances of that member. Directions for setting up additional member service locations/addresses can be found at https://hhaxsupport.s3.amazonaws.com/SupportDocs/ENTF/Process+Guides/ENTF+Process+Guide+-+Patient+Placement+and+Management.pdf.

How do we have a client added to HHAeXchange?
Members are populated inside HHAeXchange based on authorizations. If you have a current authorization for an EVV required service, then you should see that member in HHAeXchange. If not, then the member would not show up. Authorizations are sent over to HHAeXchange from Partners electronically and are updated daily. If a member who is currently authorized is not showing up please send list of those member names to EVVSupport@partnersbhm.org. For a list of required services please visit https://providers.partnersbhm.org/electronic-visit-verification.

When entering service locations within authorizations, can you provide a list for each EVV required service and the service location for those?
Partners maintains sites and services inside of AlphaMCS. Partners sends site information to HHAeXchange through an automated feed. The list of services requiring EVV can be found at the following link: https://providers.partnersbhm.org/electronic-visit-verification/

Authorizations are also maintained inside of AlphaMCS. Authorizations are sent over to HHAeXchange through an automated feed and are attached to the corresponding sites in the provider profile inside of HHAeXchange.

You should be able to log into your profile inside of HHAeXchange to see all of the sites and current/active authorizations associated with your agency. Only members with current/active authorizations will be included inside the provider's profile.

Is the aggregator/HHAeXchange being used for referrals, authorizations, and ongoing communications for the non-mandated codes/services? Our question is about the non-applicable services also need to be billed through HHAeXchange. Can you advise?
Only the required EVV services will be billed through HHAeXchange. Authorizations for required EVV services will be processed inside of AlphaMCS and then sent over to HHAeXchange through an automated feed from Partners to HHAeXchange. The provider will still submit authorizations to us with no change in that process for both EVV and non-EVV services.

Is the deadline for utilizing the EVV System when billing B3 still June 30, 2021?
All claims for EVV required services must be processed through HHAeXchange starting with dates of service June 30, 2021.

Do we have to submit on June 30, 2021? Or just be ready?
Providers must have appointments set up inside of HHAeXchange, have caregivers set up inside of HHAeXchange, clock in and out of visits inside of HHAeXchange starting on June 30, 2021. Claims for dates of service June 30, 2021 forward will validate inside of HHAeXchange prior to processing with Partners but do not have to be submitted on June 30, 2021.

Within the HHAeXchange platform, under contracts, if we see offices that are no longer operating, should we reach out to HHAeXchange on, or the LME/MCO?
Provider sites are managed by Partners. If sites are no longer in operation or if new sites need to be added, please email Natalie Mooneyham at nmooneyham@partnersbhm.org

Your clarification on EVV testing does not address if a member gets some Community Living and Supports from a RADSE and some from staff. If we submit claims to HHAeXchange for T2013 for the EVV staff, will we get denials for the claims that get billed in AlphaMCS for the RADSE which will be billed as T2013 because the codes are not in yet?
Partners is offering the following solution for testing until June 30, 2021 for providers who are offering Community Living and Supports where a portion of the service is provided by live in caregivers and a portion of the service is provided by caregivers who live outside of the member's home:

- Providers should continue to test in the live HHAeXchange system all the way up to submitting the 837 file.
- When providers are ready to submit their 837 claims, they should notify Rhonda Colvard, Claims Manager at rcolvard@partnersbhm.org.
- After contacting Rhonda, providers should only submit **three claims** and our Claims Department will monitor those claims inside of AlphaMCS to determine whether or not they process.
- Once they have processed our Claims Department will revert those claims.
- Provider will then be able to submit the complete 837 directly to us through AlphaMCS in order to avoid denials for duplicate claims.

Should we go through the process of trying to bill through HHAeXchange until dates of service June 30, 2021?
Partners is encouraging providers to complete the testing process inside HHAeXchange up to and including submitting 837 files. Partners is offering the following solution for testing until June 30, 2021, for providers who are offering Community Living and Supports where a portion of the service is provided by live in caregivers and a portion of the service is provided by caregivers who live outside of the member's home:

- Providers should continue to test in the live HHAeXchange system all the way up to submitting the 837 file.
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- Once they have processed our Claims Department will revert those claims.
- Provider will then be able to submit the complete 837 directly to us through AlphaMCS in order to avoid denials for duplicate claims.

Where are the rules from the government that state that a caregiver has to be within a 200 mile radius to clock in and out? Where are the timeline rules that state "by when goals/tasks have to be completed" on the mobile app after a caregiver clocks out?
Section 12006(a) of the 21st Century Cures Act mandates that 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. https://www.congress.gov/bill/114th-congress/house-bill/34/text

We previously had the ability to change/assign coordinator to patients, and now this option is locked. HHAeXchange seemed to think this was controlled by Partners. Does the LME/MCO control this feature?
Partners received clarification from HHAeXchange related to this question. Each provider should have an assigned "administrator" within their organization who should have the ability to then assign permissions to other users and would have "coordinator" privileges.

How do you input two different addresses into the system for the geo locate? (example: a member under 18 who lives with two parents at two different locations)
Member address and service location may be different depending on the individual circumstances of that member. Directions for setting up additional member service locations/addresses link: https://hhaxsupport.s3.amazonaws.com/SupportDocs/ENTF/Process+Guides/ENTF+Process+Guide+-+Patient+Placement+and+Management.pdf.

When a participant goes to a caregiver home, do they use EVV?
If Community Living and Support starts in the member's home or if Community Living and Support ends in the member's home, then EVV is required.

Do we have to request an authorization, or will that come from the Care Coordinator?
Innovations authorizations are managed by Care Managers. If the service is not an Innovations service, then the provider is responsible for the authorization.