Guidance for UPMC Community HealthChoices Personal Assistance Services Providers Regarding Record Keeping and Electronic Visit Verification Requirements

Personal assistance services (PAS) are a home- and community-based services benefit that are covered through the Community HealthChoices Long-Term Services and Supports (LTSS) program. PAS primarily include hands-on assistance for participants, as specified in a person-centered service plan (PCSP), to enable a participant to more fully integrate into their community and ensure their health, welfare, and safety. PAS are intended to help participants complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that the participant would perform on their own if they did not have a disability.

> **Activities of daily living:** These include eating, drinking, ambulating, transferring in to and out of a bed or chair, toileting, bladder and bowel management, personal hygiene, self-administering medication, and proper turning and positioning in a bed or chair.
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> **Instrumental activities of daily living:** These include the following activities when done on behalf of a participant: laundry, shopping, securing and using transportation, using a telephone, making and keeping appointments, caring for personal possessions, writing correspondence, using a prosthetic device, and housekeeping.

See Application for 1915(c) HCBS Waiver: PA.0386.R04.07 - Jan 01, 2022 (as of Jan 01, 2022) (the "Waiver") and 55 Pa. Code § 52.3 for more information. These definitions should be regarded as general guidance for scope of services, tasks, and duties encompassed by PAS; however, the examples are not exhaustive. As the Waiver indicates, "this service will be provided to meet the participant's needs, as determined by an assessment, in accordance with Department requirements and as outlined in the participant's service plan."

For each participant, UPMC CHC develops a person-centered service plan (PCSP) that addresses how the participant's health needs will be managed under their Community HealthChoices plan. The PCSP includes an LTSS service plan, which is designed to "identify and address how LTSS needs will be met and how services will be provided in accordance with the Person-Centered Service Planning (PCSP)." See the 2022 Community Healthchoices Agreement for more information.

PCSPs document the type, scope, amount, duration, and frequency of services needed by the participant. These plans are furnished to the participant and, can be shared directly with the PAS provider through the UPMC Health Plan Provider OnLine website in order for the PAS provider to develop a plan of care to meet the daily needs of the participant. In addition, the elements of the scope of work—the tasks that are identified in the PCSP for completion with and for the participant—are outlined in the Service Authorization through HHAeXchange. PAS providers must provide services in accordance with this scope of work.

Documentation Requirements for PAS Providers

PAS providers must complete and maintain documentation that records all services provided to a participant, and those services must be in accordance with the type, scope, amount, duration, and frequency found in the PCSP and the details of the Service Authorization. Specifically, provider records should

note all ADL/IADL tasks performed during the PAS encounter and demonstrate how each service was related to needs identified on the PCSP. Additional guidance can be found in 55 Pa. Code § 52.14 (Ongoing responsibilities of providers), § 52.15 (Provider records), and § 52.43 (Audit requirements). (Please note that the responsibilities listed in those regulations are not exhaustive.) Providers must complete documentation as contemporaneously with service delivery as possible.

Electronic Visit Verification Requirements for PAS Providers

Under Section 12006(a) of the 21st Century Cures Act (Cures Act) and Pennsylvania DHS Medical Assistance Guidance, PAS providers are required to implement Electronic Visit Verification (EVV) for all PAS services. In order to fulfill the EVV requirement, the following data must be captured and provided to UPMC Health Plan via its EVV vendor, HHAeXchange:

- Type of service performed
- Participant receiving the service
- Individual providing the service
- Date of the service
- Location of service delivery
- Time the service begins and ends

See the UPMC Health Plan Provider Manual, UPMC Community HealthChoices (Medical Assistance) – Chapter N, for further guidance on EVV.

The minimum threshold for use of EVV is electronic verification of 50 percent of all PAS encounters. Any use of EVV below this threshold is grounds for imposition of a Compliance Plan and may be grounds for termination of a PAS provider's participating provider agreement with UPMC CHC. See OLTL Bulletin 07-20-04 for more information.

The EVV requirement **is separate from and in addition to the record-keeping requirements described above.** Compliance with the EVV requirements does not abrogate a PAS provider's responsibility to keep records of all ADL/IADL tasks performed during a PAS encounter and how each service relates to needs identified on the PCSP.

Additional Requirements for PAS Providers

Finally, 28 Pa. Code § 611.57 ("Consumer protections") states that the following information must be provided by PAS providers to consumers: "A listing of the available home care services that will be provided to the consumer by the direct care worker and the identity of the direct care worker who will provide the services." This participant-facing documentation is independent of either the provider's record keeping or EVV requirements.

Frequently Asked Questions:

Aren't type, scope, amount, duration, and frequency included in the EVV encounter? Why do I need to keep separate records of task details?

The six required EVV data elements (see above) do not include all required details of the service delivery. EVV only accounts for the type (PAS or Respite and with the applicable CPT code), amount (based on the overall units of the shift between the clock in/clock out), duration (based on the elapsed time between clock in/clock out), and the frequency (based on the appropriate interval for service delivery per the PCSP and POC).

Scope (i.e., tasks, duties, ADLs, IADLs) is not part of the EVV requirements but it is a requirement based on both Pennsylvania Code (see above) and your participating provider agreement with UPMC CHC. This requirement helps ensure that participants are receiving the right care, in the right way, at the right time, every time.

How much scope detail should the direct care worker record?

The direct care worker should provide as much scope detail as possible, generally adhering to the ADL and IADL tasks noted in the definitions above and in the PCSP. All tasks for a date of service should be

recorded. Keep in mind that tasks identified on the PCSP and plan of care should be recorded if they are performed during a visit, even if they are not specified in the CMS and Pa. Code service definition.

Remember, only tasks truly completed during the encounter date of service should be recorded.

What if the provider's EVV system does not record scope of work (i.e., tasks, duties, ADLs, IADLs)?

If the provider is not recording tasks (ADLs/IADLs) in a digital system, the direct care worker should produce a document—digital or paper—that includes the scope of work performed during the visit and the direct care worker's signature.

My tasks are recorded digitally but the data is not integrated with (transferred into) HHAeXchange. What should I do?

The electronic scope detail (tasks, duties, ADLs, IADLs) should be retained according to the timeline specified in your participating provider agreement. It should be made available during an audit or a documentation request by Quality Monitoring.

If there is a missing EVV clock in OR clock out, does the provider need to have a reference document with a direct care worker sign-off that indicates the time of the clock in or out?

Yes. It does not have to be a physical copy—it could be a digital document if the provider has the technology for electronic signature attestation—but it does need to be a reference document (not necessarily a complete time sheet) for auditing purposes.

If there is both a missing EVV clock in AND clock out, what documentation should be recorded?

The provider would need a full time sheet (digital or paper) with the direct care worker's signature. Again, it could be a digital document if the provider has the capacity to record all applicable timesheet details with a direct care worker's electronic signature/attestation. It should include all the task details that were not otherwise recorded in the digital system.

If the EVV encounter was performed, do we need a direct care worker's signature on documentation?

If the EVV system captures the required scope information, a direct care worker's signature is not needed on documentation. However, if the scope of work—all the tasks performed during an encounter shift—is separately recorded in the provider's preferred system, those records would require the direct care worker's signature.

If we need to correct a minor EVV error—such as a geofence adjustment because of a participant address mismatch or a direct care worker's clock out in the community—how would we address the manual edit documentation?

The provider administrator should note the circumstances in the linked HHAeXchange note or their system of record. No direct care worker signature is required.

Can we substitute an administrator's signature for a direct care worker's signature in any of the above scenarios? What if the direct care worker no longer works for our agency?

No. The direct care worker signature is required regardless of the circumstances.

Does manual documentation require a participant's signature?

No. For agency-model services (that is, services provided by a direct care worker employed by an agency and not directly by the participant), the participant is not expected to sign the provider's time sheets or other forms of manual encounter documentation. However, the provider may choose to require a participant's signature for these circumstances based on their business practices.

Is there a recommended time frame for manual documentation completion?

Manual documents should be completed immediately, on the date of service. The provider should train the employed direct care worker to

immediately document missed clock in and clock out when identified, and to record scope (tasks, duties, ADLs, IADLs) upon completion of the task or upon the close of the encounter/shift. This should be acknowledged within a provider's internal policies.

Do I need to have a record-keeping policy/ procedure and an EVV policy/procedure for my organization?

Yes, and the direct care worker should be trained on record keeping and EVV to ensure successful utilization.

As indicated in OLTL Bulletin 07-20-04, "Providers are to establish policy on documentation required to meet auditing requirements and standards, as well as organizational needs."

UPMC CHC will regularly monitor and review provider EVV policies. At minimum, policies should set clear guidelines on EVV requirements, the effective use of the provider's EVV solution of choice, and contingency planning in the event that a visit (or a portion of a visit) was not captured using EVV or requires an edit and/or correction, etc. All stakeholders—administrators, direct care workers, participants, and Support Team members—should be trained on a provider's EVV process respective of their roles.

Direct care workers should always be prepared for circumstances in which there could be manual entry circumstance for the encounter.

What happens if the GPS coordinates are in the community when the shift starts/ends but that is where the participant wants to start?

If a visit (encounter) begins or ends in the community in an atypical location (a location that is not identified as the primary residence in the managed care organization [MCO] system of record) the encounter is regarded as a noncompliant manual exception under the DHS PCS EVV Bulletin, Cures Act, and the UPMC Health Plan Provider Manual, UPMC Community HealthChoices (Medical Assistance)—Chapter N.

In these circumstances, the GPS location of the start/end location recorded on the caregiver's smartphone EVV app will not align with the customary service delivery location, or the telephone modality will be unavailable.

In best practice, the direct care worker should clock in and clock out in the community where visits begin and end using an EVV solution if/when available but notate manual exceptions per the above.

Additionally, it is allowable to revert to recording the missing EVV visit/encounter details in an alternative format (i.e., paper or a digital document) that should be signed by the attending caregiver. However, please note that this will be regarded as a manual exception, not a compliant EVV encounter.

Can a secondary service location be added to support EVV encounter recording?

Yes. A secondary service address can be added if the participant customarily receives PAS in a non-primary location (for example, if a participant receives ongoing agency PAS at their daughter's home twice a week).

Providers can request the addition of this address for the purposes of EVV compliance tracking by contacting their Network representative via CHCProviders@upmc.edu. (Participants should contact their service coordinator with all requests.)

All secondary address additions must be reviewed by the participant's service coordinator and approved in the PCSP before they are entered into the HHAeXchange system. Normal GPS geofence restrictions apply.

Can additional landlines be added to support EVV encounter recording?

Yes. Additional landlines can be approved for participants who receive services at locations other than their home. Like additional locations, additional landlines must be reviewed and approved per the above guidelines.

What if the participant only has a cell phone and the direct care worker does not have a cell phone?

Using a participant's cell phone is not acceptable for telephonic verification unless there is a way to capture location, such as a fixed visit verification device.

Telephonic verification must include validation through a GPS or location system.

EVV policies for providers incorporating a landline telephone modality should include a process for verifying the participant's phone type, ideally during new participant intake and annually.

Providers are advised to closely monitor landline telephone use, ensuring that Interactive Voice Response (IVR) call-in/call-outs associated with visits are initiated from a landline at the participant's registered service locations.

Direct care workers should be advised to provide notification of any changes that impact EVV capture.

Visits not recorded using EVV tools and entered as manual visits are regarded as noncompliant manual exceptions with the EVV for Personal Care Services, (PCS) Bulletin (#07-20-04), Cures Act, and the UPMC Health Plan Provider Manual (Chapter N).

Can my organization use fixed object devices to track EVV?

Yes. Fixed object devices (FOBs) are an allowable alternative to EVV tools. All FOBs must be permanently affixed at the primary service location.

For providers using only the free HHAeXchange system, FOBs can be requested by contacting the UPMC Health Plan Network team at CHCProviders@upmc.edu. Providers are required to complete a short survey to verify whether an FOB is the best fit for each circumstance.

How does UPMC CHC monitor for EVV compliance?

The UPMC Provider Monitoring team refers providers to the waiver citation regarding acceptable EVV methodology: "The methods used to capture visits include mobile phone applications, telephonic entry via a landline telephone, and fixed verification devices."

The Provider Monitoring team must validate a PAS visit via compliant means to ensure the location of the visit.

Noncompliant manual exceptions to EVV are factored into the aggregate EVV Compliance percentage.

For example, if a provider completes 100 visits per quarter and 25 of the 100 visits were noncompliant manual exceptions, the provider is considered to be 75 percent EVV compliant.

UPMC Health Plan monitors EVV compliance on a quarterly basis and will request Compliance Plans for providers that fail to meet a 50 percent EVV compliance threshold for all reported encounters, effective Jan. 1, 2023.

Often, situations with GPS coordinates outside the home are identified by the Monitoring and Audit teams. These teams take into consideration a participant's address history (GPS coordinates possibly tie to prior address, causing a mismatch of the caregiver and participant pins), the marked tasks/duties for the PAS visit, and manual edits in provider's participant record.

CHC EVV RCRD KP GD PAS PRVDR 23PV3480053 (MG) 3/2/23 PDF