pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Developmental Programs

Comprehensive Guide to Electronic Visit Verification

VERSION 3.0

This resource provides Office of Developmental Programs (ODP) specific Electronic Visit Verification (EVV) information for stakeholders

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***New** – added to this version of guidance

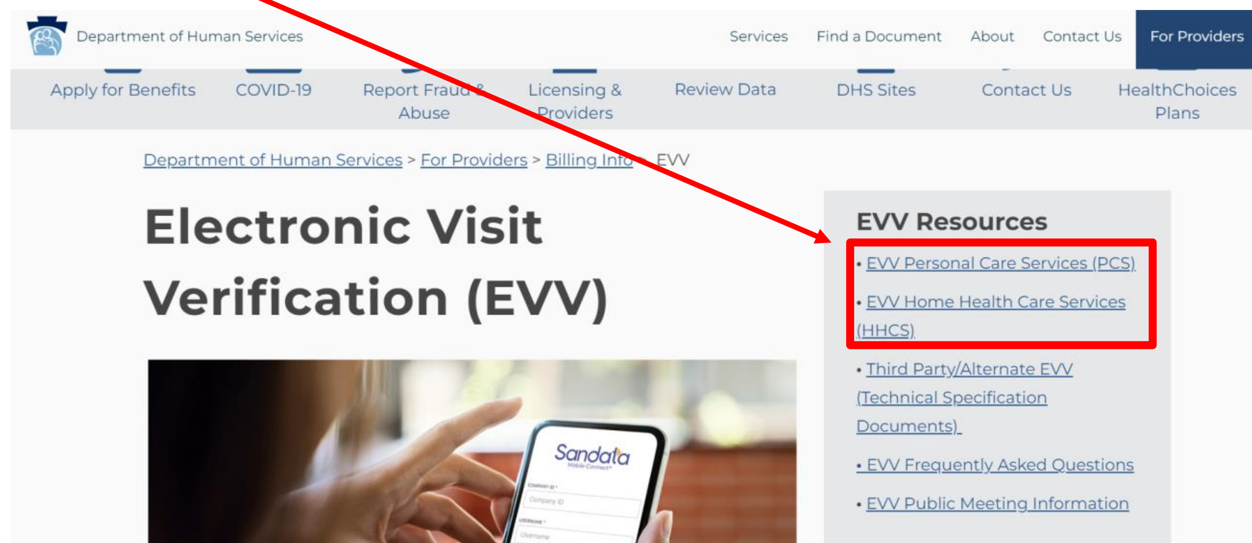
INTRODUCTION

This document is technical in nature and provides detailed information to support EVV (billing/claims, EVV errors and EVV calculation logic). The DHS EVV website contains the majority of other information that IS NOT contained in this document including public meeting notices, EVV listserv communications, contact information, training and Frequently Asked Questions (FAQs) that address general, provider, technology, and training questions: *https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx*

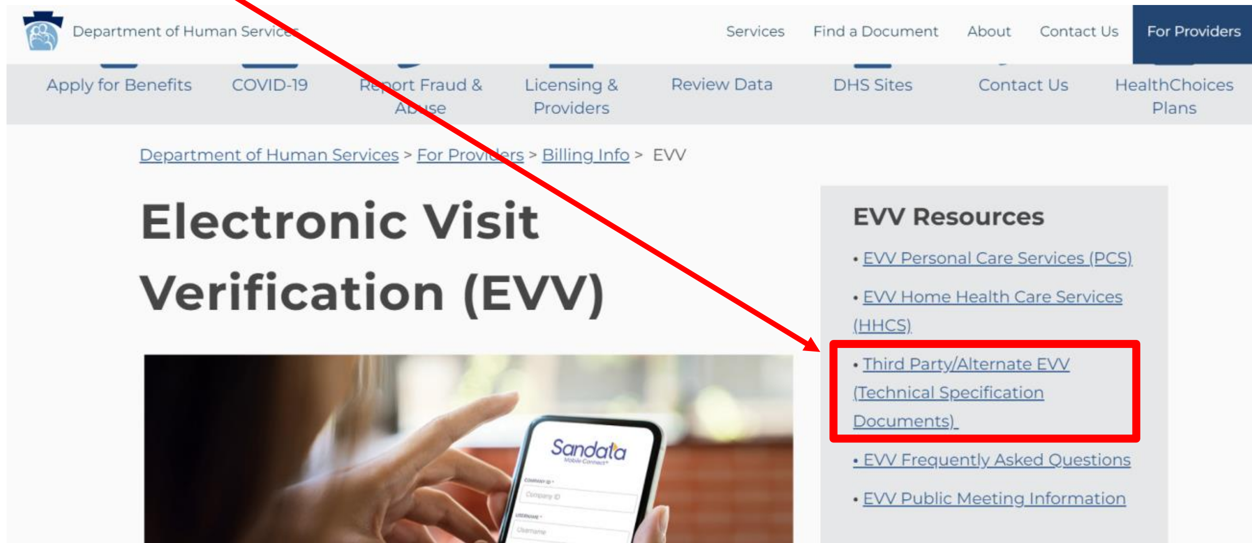
Effective January 1, 2020, Section 12006 of the 21st Century Cures Act required that care workers, providers, provider agencies, Agency with Choice (AWC) and Vendor Fiscal (VF)/Employer Agents (EAs) use an EVV system to electronically capture Personal Care Service (PCS) visits and corresponding visit data. Pennsylvania also requires these provider entities to electronically send these captured visits to the DHS EVV aggregator as the source of record and for them to be validated against during claims processing. On January 1, 2021, EVV for PCS was fully implemented to be in compliance with the 21st Century Cures Act.

In addition, Section 12006 of the 21st Century Cures Act requires that DHS implement a statewide EVV system for providers rendering Home Health Care Services (HHCS) by January 1, 2023.

For a list of ODP personal care and home healthcare services subject to EVV, visit the DHS EVV website at: https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx under EVV Resources.



Pennsylvania uses an open EVV system model. This means that providers, provider agencies, AWCs and VF/EAs may choose to use the DHS EVV system, at no cost to the provider, **OR** they may utilize an alternate EVV vendor system to capture the six data elements required under the 21st Century Cures Act. Alternate EVV users are required to meet the EVV technical specifications for interfacing with the DHS Aggregator. To view this document, go to: https://www.dhs.pa.gov/providers/Billing-Info/Pages/Alternate-EVV.aspx under EVV Resources.



The Consolidated Waiver, Person Family Directed Supports (P/FDS) Waiver, Community Living Waiver, Adult Autism Waiver and the Base program all offer personal care and home health care services that are subject to EVV. All EVV systems must capture the following data points:

- Type of service(s)
- Individual receiving the service(s)
- Date of the service(s)
- Location of the service(s) delivery
- Care worker(s) providing the service(s)
- Time the service(s) begins and ends.

In addition to the six (6) required data points, providers, provider agencies, AWCs, VF/EAs using a third party/alternate EVV vendor system, are required to transmit additional visit related data elements to the EVV aggregator[1] for the record to successfully be accepted into and be stored in the DHS EVV aggregator for claims validation. For providers using an alternate EVV solution,

[1] The DHS EVV Aggregator is a system that receives and stores data from third-party systems (also referred to as Alternate EVV) and the DHS EVV system into a single uniform platform to facilitate payments of claims. The DHS Aggregator allows providers to use a third-party system (also referred to as Alternate EVV) for visit verification. The DHS EVV aggregator **DOES NOT** submit claims.

see the Alternate EVV Technical specifications on the DHS EVV website (see screenshot above for document web location).

NOTE:

- The DHS EVV aggregator only stores EVV data captured during the visit and is validated against during claims processing when an EVV service is found on a claim transaction. No edits/visit changes can physically be performed by the provider in the aggregator environment. In other words, the aggregator does not allow providers to physically go into it and make changes to previously captured EVV visits. Edits to previously captured visits can only be made in the EVV source system where the visit was captured. The DHS EVV aggregator is view only and DOES NOT submit claims.

- If an EVV record is sent by an alternate EVV vendor system to the DHS EVV aggregator and is missing required data or the format is incorrect, as specified in the Alternate EVV technical specifications, the record will be rejected and, therefore, the record will not be stored in the DHS EVV aggregator. Rejected and missing records in the DHS EVV aggregator will set an EVV claim validation edit error status code (ESC) 928, *"NO MATCHING PCS EVV VISIT FOUND" or ESC 938, "NO MATCHING EVV HHCS VISIT FOUND"), when this scenario presents itself and the claim detail line will deny. Providers should ensure that errors and exceptions are corrected in the EVV source system they use and resubmitted to the EVV aggregator as an update to an existing visit BEFORE claim transactions are submitted to the Medicaid Management Information System (MMIS), currently referred to as PROMIS*e*™.

ODP PERSONAL CARE SERVICES (PCS) SUBJECT TO EVV

The Centers for Medicare & Medicaid Services (CMS) states that PCS consists of services supporting activities of daily living (ADL), such as movement, bathing, toileting, transferring, and personal hygiene or services that offer support for instrumental activities of daily living (IADL), such as meal preparation, money management, shopping, and telephone use.

There are six ODP services that are considered personal care services and are subject to EVV. The DHS EVV system and EVV aggregator, provided by Sandata, will ONLY support the six ODP services below.

PCS Services Subject to EVV for Consolidated Waiver, Person/Family Directed Support Waiver (P/FDS), Community Living Waiver (CLW), and Base Services (Applies to Care workers, Provider, Provider Agency, AWC and VF/EA)

- Companion
- In-Home and Community Support
- Unlicensed Respite (excludes respite camp)
- Homemaker

PCS Services Subject to EVV for
Adult Autism Waiver (AAW)

- Specialized Skill Development: Community Support
- Unlicensed Respite (In-Home Only)

ODP HOME HEALTH CARE SERVICES (HHCS) SUBJECT TO EVV

There are five ODP services considered HHCS and are subject to EVV. The DHS EVV system and EVV aggregator will ONLY support the five ODP HHCS below.

HHCS Services Subject to EVV for
Consolidated Waiver, Person/Family Directed Support Waiver (P/FDS), Community Living Waiver (CLW), and Base Services
(Applies to Provider, Provider Agency, AWC and VF/EA)

- Shift Nursing (1:1 and 2:1)
- Physical Therapy
- Occupational Therapy
- Speech/Language Therapy

HHCS Services Subject to EVV for
Adult Autism Waiver (AAW)

- Therapy – Speech/Language

IMPORTANT DATES AND EXPECTED ACTION

Per the 21st Century Cures Act mandate, Pennsylvania first implemented EVV for personal care services (PCS) on January 1, 2020, and again for Home Health Care Services (HHCS) on January 1, 2024.

DHS EVV Sandata Solution Users

Providers, Provider Agencies and AWCs who are new to EVV and are interested in using the DHS Sandata EVV solution to electronically capture visits for PCS or HHCS should reach out to the Provider Assistance Center papac1@gainwelltechnologies.com or 1-800-248-2152 to express interest, obtain more information and request a Welcome Kit. Please note, that Providers, Provider Agencies and AWCs will be instructed by the PAC line to attend self-paced mandatory training first to use and access the DHS Sandata EVV system. The training may be accessed at https://sandatalearn.com/?KeyName=PAEVVAgency.

Alternate EVV System Users

Providers, Provider Agencies, AWCs and VF/EAs who choose to use an Alternate (Third Party) EVV system for either PCS or HHCS should go to the DHS EVV website to understand the requirements for using an alternate EVV system. To locate this information, go to the main landing page of the DHS EVV website https://www.dhs.pa.gov/providers/Billing-Info/Pages/EVV.aspx, find and click on the hyperlink in the red box shown in the screenshot on the following page.

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Department of Human Services > For Providers > Billing Info > EVV
Electronic Visit Verification (EVV)
Sandata
EVV Resources
• EVV Personal Care Services (PCS)
• EVV Home Health Care Services (HHCS)
• Third Party/Alternate EVV (Technical Specification Documents)
• EVV Frequently Asked Questions
• EVV Public Meeting Information

EVV MANUAL THRESHOLD COMPLIANCE AND MONITORING

ODP and OLTL's EVV Bulletin (Electronic Visit Verification (EVV) for Personal Care Services (PCS), number 07-20-04, 54-20-04, 59-20-04, 00-20-03), issued September 10, 2020, contains information about manual edits and compliance rate expectations that begins on page 6 of the Bulletin and can be found here: MAB2020091001.pdf (pa.gov).

*Medical Assistance Bulletin number 05-22-09, 07-22-03, 54-22-01, 59-22-01, 00-22-06," Electronic Visit Verification Requirements for Home Health Care Services in the Fee-for-Service Delivery and Managed Care Delivery Systems", was issued on August 10, 2022. This bulletin applies to OMAP, ODP and OLTL. It contains information about manual edits and compliance rate expectations that begins on page 6 of the Bulletin. This information is consistent with the information communicated in the aforementioned Bulletin number 07-20-04, 54-20-04, 59-20-04, 00-20-03 and can be found here: MAB2022081001.pdf (pa.gov).

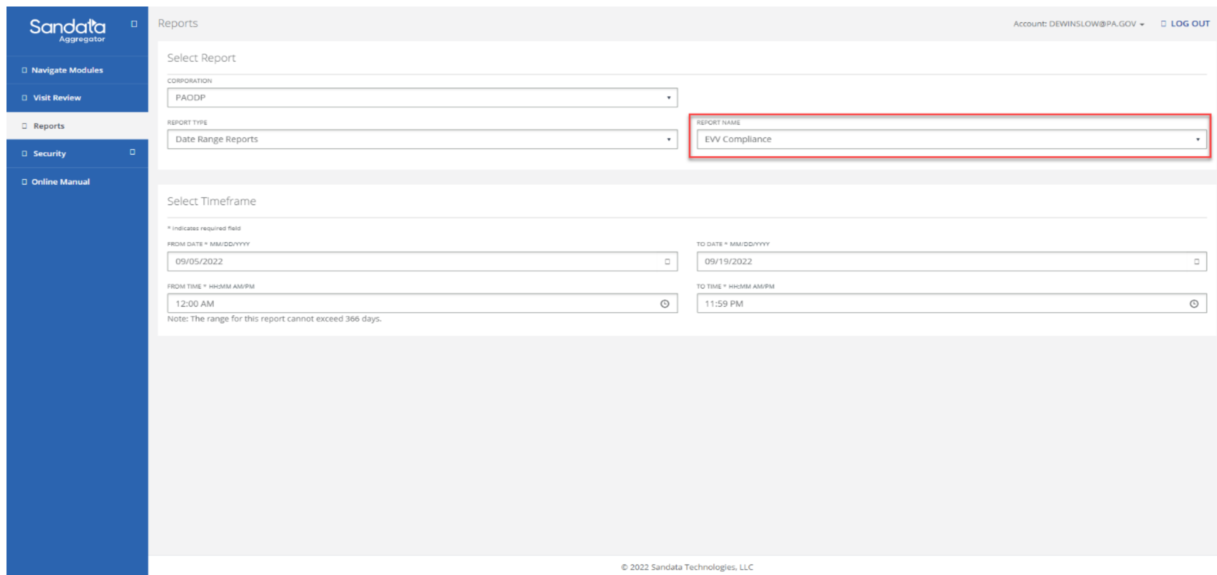
CMS requires that states actively assess EVV manual compliance. ODP Electronic Visit Verification team regularly monitors EVV manual compliance rates and emails quarterly progress notices from the ODP EVV resource account, ra-pwodpevv@pa.gov.

It is a sound business practice and strongly encouraged that the providers, provider agencies, AWCs and VF/EA ensure they have documentation demonstrating the service was rendered as specified in the waivers, that the service rendered meets the anticipated needs of the individual, as defined in the ISP, and any manual updates made to the EVV record corroborates with any claims submitted.

The EVV Compliance report is currently available in the EVV Aggregator. To access the EVV Compliance Report you need to log into the Aggregator and perform the following steps:

1. Choose Reports from the menu on the left.
2. In the Report Type drop down, choose Date Range Reports.
3. In the Report Name drop down, choose EVV Compliance.
4. Choose Run Report.

You will have the ability to choose dates to run the report. You can also narrow the report down by Account (if you have more than one), Client Name or Employee Name. The report provides detail information based on visit date, client, and employee for each account. The last page of the report shows summary information including the percentages of compliance.



ODP has incorporated EVV Manual Threshold compliance into their Claims Documentation review process, which is a component of ODP's Quality Assessment and Improvement (QA&I) process. For more information on claim documentation requirements see Bulletin 00-02-03, Technical Guidance for Claim and Service Documentation.

EVV ASSISTANCE/CONTACT INFORMATION

ODP EVV Claim Inquiries: ODP EVV claim inquiries should be made to the ODP Claims Resolution Section: ra-odpclaimsres@pa.gov 1-866-386-8880
Hours of operation: Monday - Thursday, 8:30 AM -12 PM & 1 PM - 3:30PM

ODP Providers who wish to inquire about EVV Compliance Monitoring quarterly progress notices should reach out to ra-pwodpevv@pa.gov

For technical issues such as DHS Sandata account assistance, Welcome Kit reissuance, account unlock issues for DHS Sandata EVV, please contact Provider Assistance Center (PAC) – papac1@gainwelltechnologies.com or 1-800-248-2152.

For general EVV program issues or requests to be added to the EVV Listserv, please contact EVV Resource Account at: RA-PWEVVNOTICE@pa.gov

ODP Providers that use a 3rd party EVV system and are experiencing technical issues should contact the Sandata Alternate EVV team at PAAltEVV@sandata.com.

The Sandata Online Customer Service/Ticket Portal (also referred to as the Knowledge Center) is available as a resource for providers experiencing EVV issues. For information on how to access this portal and the EVV resources within it, go to the slide deck from the July 30, 2021

Public Meeting. See the first and second screen shot below for the resource location that explains how to access the Sandata Online Customer Service portal.

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Department of Human Services > For Providers > Billing Info > EVV

Electronic Visit Verification (EVV)

The 21st Century CURES Act requires Electronic Visit Verification (EVV) systems for Medicaid-funded personal care services (PCS) and home health care services. To learn more, check out the EVV overview presentation.

Additional Resources

- Third Party/Alternate EVV (Technical Specification Documents)
- EVV Public Meeting Information

Previous Meeting Dates

2021

Date	Video	Additional Materials	Additional Resources
Tues, April 23, 2021	Watch	View Materials	Questions and Answers
Fri, July 30, 2021	Watch	View Materials	

EVV AGGREGATOR

The DHS EVV Aggregator is a system that receives and stores data from third-party EVV systems and the DHS EVV Sandata system into a single uniform platform to facilitate payments of claims. The DHS EVV aggregator allows providers to use a third-party system (also referred to as Alternate EVV) for visit verification. The DHS EVV aggregator **DOES NOT** submit claims.

If a claim detail line passes EVV validation, the Internal Control Number (ICN) associated with the claim is passed to and stored in the DHS EVV aggregator. When viewing EVV records in the DHS EVV aggregator, please note that the presence of an ICN does not mean the claim was paid. It only means that the claim passed EVV validation and was allowed to continue through the usual claim's adjudication process. After EVV validation occurs against the DHS EVV

aggregator, the claim will still need to go through HCSIS plan validation and may set edits during this process. An EVV record in the DHS EVV aggregator will show a "Processed" status after EVV validation occurs and passes while a "Verified" status in the aggregator means EVV claims validation has not yet occurred against the visit record.

The DHS EVV Aggregator is a read-only web portal for the provider, provider agency, AWC or VF/EA to view their EVV data, search and run reports. Aggregator reports are downloadable in Excel or CSV format.

VISIT SIGN OFF/SIGNATURE

Provider Agency Using the DHS Sandata EVV System: If the provider agency is using the DHS Sandata EVV system, this system does not require sign-off/signature on the visit. This feature was disabled in the DHS Sandata EVV system.

Provider Agency Using an Alternative EVV System: If the provider agency is using an alternative EVV system, then the provider agency may require a signature.

If a signature is required by the provider agency and if the participant is unable to sign or voice verify for EVV, the Supports Coordinator should:

a. Document the reason the participant cannot verify EVV in the Individual's care plan.

b. Document who, if anyone, will verify the service for the participant.

VF/FMS Model: If the participant is using the ODP Vendor Fiscal/Financial Management Service model, currently managed by Public Partnership LLC (PPL) the EVV system PPL uses requires a signature. The Common Law Employer, NOT the participant, is required to sign the timesheet.

AWC Model: If the participant is in the Agency with Choice (AWC) model, regardless of whether the AWC is using the DHS Sandata EVV system or an alternate EVV system, the Managing Employer (ME) is NOT required to approve time sheets for services subject to EVV, however, the AWC provider is still required to ensure service delivery was provided.

CHECK-IN/CHECK-OUT REQUIREMENTS

EVV does not affect or change access to care or the policy and provision of services. Service provision should support/align with the service definition found in the approved waiver(s) and the services' duration, frequency and scope as described in the individual's approved plan.

There will be no change in service delivery as a result of EVV. However, it is the responsibility of the provider, provider agency, AWC and VF/EA to ensure DSPs (Direct Support Professionals)/SSPs (Support Service Professionals):

- Are informed of which EVV solution they are required to use to capture PCS and HHCS visit information,
- Are trained on the agency's EVV system or DHS's EVV solution, and
- Understand and comply with the organization's expectations regarding their business practices to support EVV.

COMBINING PARTIAL UNITS

NOTE: <u>ODP is a fee-for-service program that does not round time or individual units of service.</u> The rate methodology for ODP personal care and home health care services is designed to take into consideration the time differential that may occur normally with service delivery.

ODP PCS and HHCS EVV services are associated with the following units of service:

- Respite (unlicensed and agency managed), In-Home and Community Supports, Companion and Specialized Skill Development: Community Support (Adult Autism Waiver), Nursing (including Speech/Language and Occupational Therapy): 15 minutes.
- Homemaker Services: 1 Hour
- Respite (unlicensed): 24 Hours/Day Unit. (Does not include respite camp and respite in a Life Sharing setting)

ODP rounding rules for 15-minute units of service that are applied in the EVV Aggregator:

- 14 minutes = 0 units
- 15 minutes to 29 minutes = 1 unit
- 30 minutes to 44 minutes = 2 units
- 45 minutes to 59 minutes = 3 units

ODP rounding rules for 1-hour units of service that are applied in the EVV Aggregator:

- 59 minutes = 0 Units
- 1 hour to 1 hour and 59 minutes = 1 unit
- 2 hours to 2 hours and 59 minutes = 2 units

ODP rounding rules for 24 hours/day units of service that are applied in the EVV Aggregator:

- 16 hours = 0 units
- 16 hours and 1 minute to 24 hours = 1 unit
- 24 hours and 1 minute to 40 hours = 2 units

This section is intended to provide additional clarification on combining partial units when billing for Personal Care and Home Health Care Services subject to EVV. The ODP announcement can be found here: ODP Announcement 22-098

All ODP PCS and HHCS subject to EVV are permitted to bill units on one claim detail line that are based on the total accumulated continuous or non-continuous service time across an individual calendar day or across multiple calendar days not to exceed 31 days. The 31-day restriction is based on a limitation associated with the EVV aggregator. If 31 days are exceeded, error status code (ESC) 933 will set and deny the claim detail line. **Please note that procedure codes may have restrictions for billing that are less than 31 days which supersedes the aggregator limitation.**

The begin and end date submitted on a claim detail line informs the system what date range to use when locating visit time in the EVV Aggregator that will be used by the system to calculate units for the same provider, same individual and same service, regardless if the service delivery time was rendered continuous or non-continuously. Once all service time in the aggregator is located, the system totals all the time found and use the total time to calculate units. The total calculated units in the EVV aggregator are then assessed against the units submitted on the claim when determining to pass or fail the claim detail line.

As long as the total calculated units found in the EVV aggregator ***is equal to or greater than*** the units submitted on the claim detail line, the claim will pass EVV validation and continue moving through the claims adjudication process where it is subject to individual support plan validation and additional Medical Assistance and ODP specific edits and audits in the Medicaid Management Information System (PROMIS*e*™).

ROUNDING

ODP issued Bulletin 00-22-05 Individual Support Plans on August 9, 2022. Please refer to the most recent update found here Individual Support Plan Manual.pdf (pa.gov) to review how ODP defines units of service. Rounding is not permitted.

ODP conforms with the Office of Medical Assistance Fee for Service Programs regarding rounding. The rate methodology for ODP personal care and home health care services is designed to take into consideration the time differential that may occur normally with service delivery.

Please note that seconds electronically captured during a visit are not considered in the unit calculation. In other words, if a service delivery visit is 7 minutes and 55 seconds, the EVV system would consider this visit 7 minutes in duration.

Rounding Versus Adding Partial Units

Rounding (not allowed)

Approximating the minutes of service rendered to bill a full unit

Example: Billing for a 15-minute unit of service when 12 minutes of service were rendered.

Adding Partial Units (allowed)

Adding minutes of service rendered together to bill a full unit

Example: Adding 12 minutes of service rendered on Monday and 18 minutes of service rendered on Tuesday to bill two 15-minute units of service.

PLACE OF SERVICE CODES (POS)

Several data points represent the "location of service delivery".

- The first point is the place of service code (POS) on a claim transaction. During normal claims processing, the POS code on the claim detail line is always validated to ensure the location in which the service was rendered is permissible as specified in the waiver.

  ODP EVV services are associated with 6 possible place of service codes:

  - 02: Telehealth Provided Other than in Patient's Home
  - 10: Telehealth Provided in the Home
  - 11: Office
  - 12: Home
  - 21: Inpatient Hospital
  - 99: Other Place of Service

    -Please consult the ISP Manual for IDA Waiver Services and the Adult Autism Waiver Provider Information Table for further clarification on POS codes

- The second data point that represents the location of service delivery is on the EVV record itself. For DHS Sandata EVV users, the "VisitLocationType" is anticipated to be enforced/required when submitting EVV transactions. The user will be required to select either "Home" or "Community" for the record to be considered complete. If the service is/will be rendered in both the home and community during the service visit period, the user should select the value where the service was primarily rendered.

- When a third-party/alternate vendor EVV transaction is submitted to the EVV aggregator, the aggregator will validate that the "location of service delivery" is present in the transaction. If it is not present in the alternate EVV transaction or the field is blank, the EVV record will be rejected and will need to be resubmitted to the Aggregator with the "location of service delivery" included.

For PCS and HHCS, the GPS location where service delivery was provided is stored in the EVV aggregator. This information is accessible to AWC, VF/EA, provider, provider agencies and DHS who may review this information or perform audits as needed. While in the community, DSPs/SSPs have the option to turn off GPS to alleviate any privacy concerns about tracking community locations.

If the same service was rendered consecutively in multiple places within a 24-hour period, the visit may be electronically captured as one visit or two separate visits each representing a different place of service. It is at the discretion of the provider, provider agency, AWC and VF/AE to prescribe business rules as it applies to checking-in/checking-out when the same service is delivered consecutively during a 24-hour period in different locations. Billing should align with the check-in/check-out rules defined by the provider/provider agency.

Visit Capture Guidance When Location Changes Within a 24-hour Period: *In-home and community supports* services were rendered in the home from 8am – 12:00pm then in the community from 12:00pm - 2:00pm. For DHS EVV compliance, the location is only required to be captured at check-in and check-out for each service provided to the individual. The service may start at one location and end at another location; however, the locations visited by the caregiver and the individuals receiving support in-between check-in and check-out for the service are not required to be captured. In the noted example, the caregiver would need to check in at 8:00 am and check out at 2:00 pm, with the location being captured at check-in as the home and the location for the check-out captured as the community. Agencies may establish policies to capture the location where the service was rendered, including check-in and check-out based more accurately on when the service delivery location changes. Agencies are encouraged to instruct DSPs/SSPs on their rules for checking-in/checking-out when the same service is delivered in different settings consecutively in a 24-hour period.

<u>Place of Service Billing Instructions</u>:

Option 1: For the above scenario, if the DSP/SSP checked-in/checked-out for each location in which the same service was delivered to the same individual within a 24-hour period, the provider has two (2) billing options:

1. Bill one claim detail with units that reflect the period 8am – 2pm and use the place of service code that was most prominent during the time span of service delivery.

2. Bill two (2) claim detail lines with **different place of service codes** while entering the same service, date of service and same recipient ID. If this method is used, Error Status Code (ESC) 5000, "Detail is a suspected duplicate-modifier", will set for informational purposes only and the claim detail line will be approved for payment, assuming no other edits set for other reasons. No additional action is needed by the provider when ESC 5000 sets.

Option 2: If the same service was delivered consecutively in different settings from 8am to 2pm and the DSP/SSP checked-in at 8am and checked-out at 2pm, the provider would bill one (1) claim detail line, enter units that reflect the period 8am – 2pm and enter the place of service code that was most prominent during the time span of service delivery.

Choosing a place of service code to enter on a claim detail line when billing the same service that is rendered non-consecutively in multiple locations (i.e., home and community) during a 24-hour period. If there is a break in service and the setting changed for the same provider, same service, and same consumer during a 24-hour period, the service's visit check-in/check-out time and locations should be individually captured by the EVV application and will be stored as multiple records in the EVV aggregator. When billing, the claim detail line(s) should align with the date, service (procedure code and modifier(s), if applicable), location and number of units stored in the EVV records. If the same service was rendered non-consecutively in different locations throughout a calendar day and the visits were electronically captured in this manner, all accumulated units rendered in the community should be entered on one claim detail line while all accumulated units rendered in the home should be entered on a second claim detail line.

A claim with multiple claim detail lines that contain different place of service codes, will cause Error Status Code (ESC) 5000 to set, "Detail is a suspected duplicate-modifier". This ESC is an informational edit and will not prevent the claim from continuing to process. No additional action is needed by the provider when this ESC sets.

Place of Service Billing Rule: The place of service code is a required field on a claim and only one code is permitted on each claim detail line to specify where the service was rendered.

2:1 STAFFING RATIOS

2:1 Staff to Individual Ratio (Applies to Respite and In-Home and Community Supports Services)

For Personal Care Services subject to EVV with 2:1 staff to individual ratios, **both** DSPs/SSPs **MUST** check-in/check-out for the same individual/same service/same date/time and same location. ODP recognizes that it may sometimes be challenging for both DSPs/SSPs to check-

in/check-out at the exact same time and has designed system logic to account for potential check-in/check-out time differences associated with 2:1 staff to individual ratios. It is important to understand this logic to train staff appropriately and minimize/eliminate claim payment issues.

For personal care services with 2:1 staff to individual ratios, at least two (2) instances (records) for the same service/same individual/same date of service/same provider must be present in the EVV aggregator in order for the claim to pass EVV validation. The total unit calculation for the service itself is based on logic that is designed in the system to look at the earliest common time and the latest common time between both DSPs/SSPs. The minutes associated with this time will then be converted to units, stored in the aggregator and compared to the units found on the claim.

For example, DSP/SSP "A" checks in at 4:55 PM and checks out at 5:10 PM, and DSP/SSP "B" checks in at 5:00 PM and checks out at 5:15 PM. The common check-in time between both DSPs/SSPs is 5:00 PM, and the common check-out time between both DSPs/SSPs is 5:10 PM. In this example, only 10 minutes will be calculated as the common time in which the service was delivered by both DSPs/SSPs, which equates to zero (0) units. For this example, if a claim is billed for 1 unit, it will deny in the system.

*If a check-in or check-out time was not accurately captured or not electronically captured at all for one or both care workers, EVV systems allow for the visit to be manually entered or manually adjusted to reflect the time-of-service delivery. If there are time disparities between the care workers rendering a 2:1 service due to device or connectivity at the point of care limitations and both care workers were, in fact, present at the exact same time to render services, a manual adjustment to the EVV record is justified. Manual adjustments should always contain notes documenting why the adjustment was made.

*RULE: For 2:1 services, the DHS EVV System expectation is that only two caregivers are clocked in at the same time. **IF** a 2:1 service has more than two caregivers at the point of care at the same time, this results in overlapping check in times for the same provider, participant, service, and date of service. This scenario will cause ESC 927 to set and the claim will be denied. To correct this issue, it is recommended the provider manually adjusts the EVV record of the third caregiver, whose shift overlaps with the original two caregivers who began the visit then resubmit the EVV record to the DHS Aggregator. When making the manual EVV record adjustment, the start time of the third caregiver's visit should be no earlier than the exact time the shift is intended to begin. To avoid this issue altogether and prevent the need for a manual EVV record adjustment, it is recommended that the third care worker not check in until after the care worker they are replacing checks out.

Linking 2 to 1 visits with the Group Code Field

AltEVV- According to our PA-DHS [Alternate EVV Technical Specifications](), the "GroupCode" field is optional.

DHS EVV- For those using the Sandata system and capturing visits using the SMC app (as opposed to a telephony visit)

- If the service being rendered is a group service which is a 2:1 service, then, the Group Code must be assigned otherwise the claim would deny once billed in PROMIS*e*™.
- If the service being rendered is a 1: Many service (e.g., 1:2, 1:3, 1:4), then the Group Code is optional (lack of the code would not cause a claim to deny once billed in PROMIS*e*™.

1:2, 1:3 and 1:4 STAFFING RATIOS

DSPs/SSPs that provide support services to more than one individual concurrently, must check-in/check-out for each individual for the service/visit to be accurately captured and stored in the EVV aggregator. If a DSP/SSP fails to check-in/check-out for each individual, related claims will deny during EVV validation because no record will be found in the Sandata aggregator.

VALIDATE HCSIS AUTHORIZATION PRIOR TO EVV AND BILLING

Providers, provider agencies, AWCs and VFs/AEs should regularly review Service Authorization Notices and/or the Provider Service Detail Report in HCSIS prior to service delivery and billing to ensure the service(s), date span associated with the authorized service line on the plan (service begin and end-date), the provider authorized on the plan is accurate and sufficient units and dollars are authorized on the individual's plan. Service Authorization Notices can be run and re-run to view changes made to the plan within a specific period by entering a date in the "*Date Last Changed From:*" field and "To:" field.

Regularly reviewing Service Authorization Notices and/or the Provider Service Detail report will minimize and/or prevent claim/claim detail line denials.

BILLING FOR 15 MINUTE SERVICES

Same logic applies for 1-hour units of service.

1. **Bill a single date of service delivery (that does not cross midnight) on one calendar day for the same service, same participant, and same provider/provider agency.**

Bill Single Visit on Single Calendar Day				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**11:00 am**	**11:50 am**	**50 min**	**3**

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	12	W1726					1	3.00	3.00

- **<u>Claim 1</u>:** If "Units Alwd" on claim <u>are less than or equal to</u> the units found in the EVV aggregator, the claim detail line will pass EVV validation in the aggregator and continue processing.

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	12	W1726					1	2.00	2.00

- **<u>Claim 2</u>:** If "Units Alwd" on claim <u>are greater</u> than the units in the EVV aggregator, the claim detail line will be denied and stop processing.

2. **Bill two non-consecutive visits (that do not cross midnight) in one calendar day by the same or two different DSPs/SSPs for the same service, same participant (RID) and same provider/provider agency.**

Bill Two Visits on the Same Day				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**11:00 am**	**11:16 am**	**16 minutes**	**1**
01/01/2019	**11:00 pm**	**11:18 pm**	**18 minutes**	**1**

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	12	W1726					1	2.00	2.00

- <u>**Claim 1:**</u> Detail line will pass EVV validation and continue processing because "Units Alwd" are equal to units found in the EVV aggregator records.

3. **Bill a single date of service delivery (that does not cross midnight) over two calendar days by the same or two different DSPs/SSPs for the same service, same participant, and same provider/provider agency. The provider can bill 2 separate detail line, one for each day OR span bill.**

Bill Two Claim Detail Lines One for Each Day				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**11:00 am**	**11:16 am**	**20 minutes**	**1**
01/03/2019	**11:00 am**	**11:40 am**	**40 minutes**	**2**

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	12	W1726					1	1.00	1.00
2019/01/03	2019/01/03	12	W1726					1	2.00	2.00

- <u>Claim 1</u>: Two separate claim detail lines where the EVV aggregator would calculate units strictly with <u>no rounding</u> applied for each day. In other words, one unit would be calculated for 01/01 and two units calculated for 01/03.

Bill One Claim Detail Line and Date Span				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**11:00 am**	**11:55 am**	**55 minutes**	**3**
01/03/2019	**1:00 pm**	**1:40 pm**	**20 minutes**	**1**
Total accumulated time for date span 1/1/2019 - 1/3/2019			**75 minutes**	**5**

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/02	99	W1726					1	5.00	5.00

- Claim 2: one claim detail line for both dates of service using span dating on one claim detail line. The EVV aggregator will add up all the minutes for the two dates of service then convert the total accumulated minutes to units.

4. **Bill multiple non-consecutive service deliveries (that do not cross midnight) over two calendar days by the same or two different DSPs/SSPs for the same service, same participant and same provider/provider agency. The provider can bill 2 separate detail line, one for each day OR span bill.**

Bill Two Claim Detail Lines One for Each Day						
Date	Time In	Time Out	Time In	Time Out	Total Time	Total Units
01/01/2019	11:00 am	11:09 am	1:00 pm	1:07 pm	16 minutes	1
01/03/2019	11:00 am	11:25 am	1:00 pm	1:15 pm	40 minutes	2

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	12	W1726					1	1.00	1.00
2019/01/03	2019/01/03	12	W1726					1	2.00	2.00

- Billing two claim detail lines where the EVV aggregator would calculate units strictly with no rounding applied for each day. In other words, one unit would be calculated for 01/01 and two units calculated for 01/03.

Bill ONE Claim Detail Line and Span Date						
Date	Time In	Time Out	Time In	Time Out	Total Time	Total Units
01/01/2019	11:00 am	11:20 am	1:00 pm	1:20 pm	40 minutes	2
01/02/2019	11:00 am	11:20 am	1:00 pm	1:20 pm	40 minutes	2
Total accumulated time for date span 1/1/2019 - 1/3/2019					80 minutes	5

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/02	99	W1726					1	5.00	5.00

- Billing one claim detail line for both dates of service using span dating on one claim detail line. The EVV aggregator will add up all the minutes for the two dates of service then convert the total accumulated minutes to units.

5. **Bill a single date of service delivery that DOES cross midnight on one calendar day for the same service, same participant, and same provider/provider agency (when service delivery is less than 24 hours)**

Bill Single Visit that Crosses Midnight and is LESS THAN 24 hours				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**11:50 pm**	**12:40 am**	**50 min**	**3 units**

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	12	W1726					1	3.00	3.00

- **<u>Claim 1</u>:** For this scenario to pass EVV validation against the aggregator, the claim MUST have a "From DOS" and "To DOS" that is equal and reflects the date in which the service began.

Bill Single Visit that Crosses Midnight and is GREATER THAN 24 hours				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**11:00 pm**	**11:30 pm**	**24 hours 30 min**	**98 units**

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef
2019/01/01	2019/01/02	99	W1726					1

- **<u>Claim 2</u>**: For this scenario to pass EVV validation against the aggregator, the claim MUST have a "From DOS" and "To DOS" that reflects the actual start date and end date of service delivery.

6. **Bill multiple non-consecutive service deliveries that DO cross midnight over two calendar days but less than 24 hours by the same or two different DSPs/SSPs for the same service, same participant, and same provider/provider agency.**

Bill Multiple Visits that Cross Midnight LESS THAN 24 hours				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**11:30 pm**	**12:22 am**	**52 Minutes**	**3**
01/02/2019	**10:00 am**	**10:30 am**	**30 Minutes**	**2**

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	12	W1726					1	3.00	3.00
2019/01/02	2019/01/02	99	W1726					1	2.00	2.00

- **Claim 1**: Bill 2 individual lines considering less than 24 hours for visit occurring over midnight in which "From DOS" and "To DOS" that is equal and reflects the date in which the service began.

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/02	99	W1726					1	5.00	5.00

- **Claim 2:** Span bill in which the EVV aggregator will add up all the minutes for the two dates of service then convert the total accumulated minutes to units.

7. **Bill multiple consecutive service deliveries for same service event over two consecutive calendar days in excess of 24 hours by the same or two different DSPs/SSPs for the same service, same participant and same provider/provider agency.**

Bill Multiple Visits that Cross Midnight GREATER THAN 24 hours				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/02/2021	**10:00 am**	**9:00 pm**	**11 Hours**	**44 Units**
01/02/2021	**8:47 pm**	**7:01 pm**	**22 Hours 14 Min**	**88 Units**
			33 Hours 14 Minutes	**132 Units (> 96 Units so dates on claim should reflect 1/2/2021 - 1/3/2021)**

BILLING FOR UNLICENSED RESPITE DAY SERVICES

For unlicensed respite day services, providers/provider agencies should ensure the visit record in the EVV aggregator shows at least 16 hours and one minute of continuous service delivery to align with the ISP Manual, which indicates that "day respite must be provided for periods of more than 16 hours". From a visit capture perspective, DSPs/SSPs should ensure that their clock-in and clock-out time reflects at least 16 hours and one minute of consecutive service delivery. Please remember that seconds captured are not considered when calculating units in the system so the care worker should ensure they capture at least an additional minute either at check-in or check-out to ensure more than 16 hours is captured. For unlicensed respite day services, there cannot be a break in service for a single service delivery event. For this service, the provider/provider agency has the option to bill for a single care event or multiple care events (span dating) on one claim detail line.

1. **Bill a single continuous care event by the same service, same provider, same DSP on one claim detail line that was rendered within one calendar day for unlicensed respite day 1:1, 1:2, 1:3 and 1:4 staff to individual ratios.**

    - To bill for unlicensed respite day services delivered continuously for at least 16 hours within one calendar day, the "From DOS" and "To DOS" on a single claim detail line should reflect the same date with "Units Billed" as "1".

Single Respite Day Visit				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**6:00 am**	**11:00 pm**	**17 hours**	**1**

From DOS	To DOS	POS	Proc Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	11	W9799					1	1.00	1.00

2. **Bill multiple nonconsecutive visits for the same service, same provider, same (or multiple) DSPs on one claim detail line that was rendered within one calendar day for unlicensed respite day 1:1, 1:2, 1:3 and 1:4 staff to individual ratios.**
   - As long as the total time of service delivery is greater than 16 hours the claim will pass EVV validation and continue processing.

Multiple Non-Consecutive Visits Within a Day				
Date	**Time In**	**Time Out**	**Total Time**	**Total Units**
01/01/2019	**5:00 am**	**2:00 pm**	**9 hours**	**1**
01/01/2019	**3:00 pm**	**11:00 pm**	**8 hours**	

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	11	W9799					1	1.00	1.00

3. **Bill a single continuous service event on one claim detail line that overlaps into another calendar day (crosses midnight) for unlicensed respite day 1:1, 1:2, 1:3 and 1:4 staff to individual ratios:**
   - For this billing scenario, the "From DOS" and "To DOS" of service on the single claim detail line should reflect the same date. This scenario assumes the care worker **<u>did not</u>** check-in and out at midnight and one EVV record is stored in the EVV aggregator reflecting this care event.

Single Respite Day Visit Across Midnight				
Date	**Time In**	**Time Out**	**Total Time**	**Total Unit**
01/01/2019	6:00 pm	11:00 am	17 hours	1

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	11	W9799					1	1.00	1.00

4. **Bill a single service event on one claim detail line that crosses midnight where the provider/provider agency required the care worker(s) to check-out at midnight and check-in after midnight for unlicensed respite day 1:1, 1:2, 1:3 and 1:4 staff to individual ratios:**

  - Because the provider/provider agency requires the care worker to check-out and check back in at midnight, this creates two (2) EVV records in the EVV aggregator that represents one continuous care event. To account for this, the "From DOS" should reflect the date the service began and the "To DOS" should reflect the date the service was completed with "Units Billed" as "1". This will tell the system to look for and add up all time found in the aggregator that is associated with the same service/same individual/same provider for all dates in the date range submitted on the claim detail line then the system will use the total time found that is tied to those EVV records to calculate units.

Single Respite Day Visit Clock Out/In at Midnight				
Date	Time In	Time Out	Total Time	Total Units
12/08/2023	**6:00 pm**	**12:00am**	**6 hours**	1
12/09/2023	**12:00am**	**11:00am**	**11 hours**	

From DOS	To DOS	POS	Proc Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Diag XRef	Units Billed	Units Alwd
2023/12/08	2023/12/09	99	W9798					1	1.00	1.00

5. **Bill multiple nonconsecutive visits for the same service, same provider, same (or multiple) DSPs on one claim detail line that crosses two different calendar days in excess of a 24-hour period unlicensed respite day 1:1, 1:2, 1:3 and 1:4 staff to individual ratios.**
  - When billing for services associated with a day unit that are rendered overnight and cross calendar days (**<u>even if period exceeds 24 hours</u>**), the claim detail line **<u>MUST</u>** contain only one date of service. The "From DOS" and "To DOS" **<u>MUST</u>** be the same and equal the first day the service was delivered in order to pass EVV validation and continue processing, as seen below.

Single Respite Day Visit Across 2 Calendar Days				
Date(s) of Service	Time In	Time Out	Total Time	Total Unit(s)
01/01/2019	**6:00 am**	**2:00 pm**	**8 hours**	**1**
01/01/19 – 01/02/19	**11:00 pm**	**8:00 am**	**9 hours**	

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2019/01/01	2019/01/01	11	W9799					1	1.00	1.00

6. **Bill a single service event on one claim detail line that was rendered within one calendar day for unlicensed respite day <u>2:1 staff</u> to individual ratio:**

   - To bill for unlicensed respite day services delivered by two care workers within a calendar day, the "From DOS" and "To DOS" on the single claim detail line should reflect the same date.
   - During claims validation against the EVV aggregator for 2:1 day unit services, the system will look for at least two (2) EVV records that contain the same service/same individual/same date of service/same provider for the claim to pass EVV validation. The total unit calculation for the service itself looks at the earliest common time and the latest common time between both care workers. The common minutes associated with this time are then converted to units and compared to the units found on the claim.

Single Respite Day Visit 2:1					
Employee	**Date**	**Time In**	**Time Out**	**Total Time**	**Total Units**
Care worker A	**01/26/2024**	**6:00 am***	**12:00am**	**18 hours**	**1**
Care worker B	**01/26/2024**	**5:45am**	**11:45pm***	**18 hours**	

*Common time begins when Care Worker A clocks in at 6:00am and ends when Care Worker B clocks out at 11:45pm. The common time is 17 hours and 45 minutes which passes the verification for an unlicensed respite day unit of 16 hours and 1 minute.

Detail No.	Stat	From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
001	P	2024/01/26	2024/01/26	99	W9801					1	1.00	1.00

7. **Bill a single continuous service event <u>with no break in service</u> that overlaps into another calendar day (crosses midnight) on one claim detail line for unlicensed respite day services with a <u>2:1</u> staff to individual ratio:**

   - For this billing scenario, the "From DOS" and "To DOS" of service on the single claim detail line should reflect the same date. This scenario assumes the care worker **<u>did not</u>** check-in and out at midnight and one EVV record is stored in the EVV aggregator reflecting this care event.
   - During claims validation against the EVV aggregator for 2:1 unlicensed respite day service, the system looks for at least two (2) EVV records that contain the same service/same individual/same date of service/same provider for the claim to pass EVV validation. The total unit calculation for the service itself looks at the earliest common time and the latest common time between both

care workers. The minutes associated with the common time are then converted to units and compared to the units found on the claim.

Single Respite Day Visit 2 to 1 Across Midnight					
Employee	**Date**	**Time In**	**Time Out**	**Total Time**	**Total Units**
Care worker A	01/26/2024	6:00 pm	12:00 pm	18 hours	1
Care worker B	01/26/2024	6:00 pm	12:00 pm	18 hours	

Detail No.	Stat	From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
001	P	2024/01/26	2024/01/26	99	W9801					1	1.00	1.00

8. **Bill a single continuous service event with a break in service on one claim detail line that overlaps into another calendar day (clock out/in at midnight) for unlicensed respite day <u>2:1</u> staff to individual ratio:**

- Because the provider/provider agency required the care worker(s) to check-out and check back in at midnight amid a continuous service delivery, this action generated and stored four EVV records (and possibly more if shift changes also occurred) in the EVV aggregator that actually represents one continuous care event. To account for this, the "From DOS" should reflect the date the service began and the "To DOS" should reflect the date the service was completed with "Units Billed" as "1". This will tell the system to look for and add up all common time found in the aggregator that is associated with the same service/same individual/same provider and same dates in the date range submitted on the claim detail line then use the total common time found that is tied to those EVV records to calculate units.

- During claims validation against the EVV aggregator for 2:1 unlicensed respite day services, the system looks for at least two (2) EVV records that contain the same service/same individual/same date of service/same provider for the claim to pass EVV validation. The total unit calculation for the service itself looks at the earliest common time and the latest common time between both care workers. The minutes associated with this time are then converted to units and compared to the units found on the claim.

Single Respite Day Visit 2: 1 Clock Out/In at Midnight					
Employee	**Date**	**Time In**	**Time Out**	**Total Time**	**Total Unit**
Care worker A	12/08/2023	6:00pm	12:00am	6 hours	1
Care worker B	12/08/2023	6:00pm	12:00am	6 hours	
Care worker A	12/09/2023	12:00am	11:00am	11 hours	
Care worker B	12/09/2023	12:00am	11:00am	11 hours	

From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
2023/12/08	2023/12/09	99	W9798					1	1.00	1.00

A special note on Shift Changes: For 2:1 unlicensed respite day services, if the aggregator contains overlapping time for three or more care workers, the system is unable to determine which care worker visit time to use when calculating units; and as a result, the claim detail line will deny. While this scenario can occur for other EVV services, it occurs most frequently when multiple DSPs are providing care to one individual. This typically occurs during shift changes:

Overlapping Shifts					
Employee	**Date**	**Time In**	**Time Out**	**Total Unit**	**Total Time**
Care worker A	06/30/2023	6:00 pm	12:00 pm		18 hours
Care worker B	06/30/2023	6:00 pm	11:06 pm*	?	5 hours
Care worker C	06/30/2023	11:00 pm*	12:00 pm		13 hours

*To resolve this issue, the provider should the manually adjust the new shift care worker's EVV visit time to a time that does not overlap with the care worker's time whose shift is ending. Due to this system limitation, a manual edit for this scenario is acceptable by DHS.

9. **Bill for multiple care events on one claim detail line (<u>span dating</u>) rendered over two or more calendar days for unlicensed respite day 1:1, 1:2, 1:3 or 1:4 services where each care event occurred within a calendar day and did not cross midnight.**

    - To bill for multiple unlicensed respite day service care events that crossed into one or more calendar days (referred to as span dating), the claim detail line must show a date span with a "From DOS" that reflects a date when the first service began and a "To DOS" that reflects a date when the last service delivery ended.

Multiple Respite Days Span Date				
Date	Time In	Time Out	Total Unit	Total Time
12/17/2023	6:00am	10:30pm	1	16.5 hours
12/23/2023	6:00am	10:15pm	1	16.15 hours

Detail No.	Stat	From DOS	To DOS	POS	Proc Code	Modifiers 1	2	3	4	Diag XRef	Units Billed	Units Alwd
001	P	2023/12/17	2023/12/23	99	W9798					1	2.00	2.00

10. **Billing for multiple care events on one claim detail line (<u>span dating</u>) for unlicensed respite day <u>2:1</u> services where each care event occurred within a calendar day and did not cross midnight.**

Multiple 2:1 Respite Days Span Date					
Employee	Date	Time In	Time Out	Total Unit	Total Time
Care worker A	08/01/2023	6:00am	11:00pm		17 hours
Care worker B	08/01/2023	6:00am	12:00am		18 hours
Care worker A	08/02/2023	2:00am	07:00pm		17 hours
Care worker B	08/02/2023	2:00am	07:00pm		17 hours
Care worker A	08/03/2023	6:00am	11:00pm		17 hours
Care worker B	08/03/2023	6:00am	12:00am		18 hours
Care worker A	08/04/2023	6:00am	11:00pm		17 hours
Care worker B	08/04/2023	6:00am	12:00am		18 hours
Care worker A	08/05/2023	6:00am	11:00pm		17 hours
Care worker B	08/05/2023	6:00am	12:00am		18 hours
Care worker A	08/0/2023	2:00am	07:00pm		17 hours
Care worker B	08/06/2023	2:00am	07:00pm		17 hours

Detail No.	Detail Stat	From DOS	To DOS	POS	Proc Code	Modifiers 1	Modifiers 2	Modifiers 3	Modifiers 4	Diag XRef	Units Billed	Units Alwd
001	P	2023/08/01	2023/08/06	12	W9800						6.00	6.00

Please note: When date spanning, a claim detail line should not contain any more than 31 days in a date span. In other words, the "From DOS" and "To DOS" should not exceed 31 days. The 31-day restriction is based on a limitation associated with the EVV aggregator. If 31 days are exceeded, error status code (ESC) 933 will set and deny the claim detail line.

APPENDIX A: EVV Error Status Codes (ESCs)

The claims adjudication process will flow as it currently does today, EXCEPT when an EVV service is found on the claim, PROMIS*e*™ will make a "call" to the EVV aggregator to validate a record(s) is present and ensures the EVV record(s) found in the EVV aggregator matches what is specified on the claim. If the claim detail line passes EVV validation, the claim will continue processing and next validate against the plan in HCSIS before completing the claims processing adjudication cycle. No EVV validation call will be made when a claim is voided. The ESCs below describe the EVV validation logic. **All error resolution corrections should be made in the original system. Once a correction is made, the corrected EVV record should be resent to the aggregator <u>before a claim is resubmitted</u>**. No corrections can be made in the EVV aggregator itself. The EVV aggregator is read only.

EVV ERROR STATUS CODES (ESC)			
EVV ESC CODE	**EVV ESC DESCRIPTION**	**WHY IS THIS ESC SETTING?**	**RESOLUTION ACTIVITY**
ESC 925	EVV PCS Visit Verified	Providers will see these ESCs each time PROMISe™ determines a service subject to EVV is found on the claim and the claim detail line passed EVV validation against the EVV Aggregator record(s).	These two edits set for informational purposes only. They serve to inform the provider, provider agency, AWC, and VF/EA, 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 935	EVV HHCS Visit Verified		
ESC 926	Duplicate Matching EVV PCS Visits Found	A duplicate EVV record exists in the aggregator.	When two exact EVV records exist in the aggregator, the claim validation call does not know which record to match with, so it will set either ESC 926 or ESC 936 and deny.

EVV ERROR STATUS CODES (ESC)			
EVV ESC CODE	**EVV ESC DESCRIPTION**	**WHY IS THIS ESC SETTING?**	**RESOLUTION ACTIVITY**
ESC 936	Duplicate Matching EVV HHCS Visits Found		To correct this issue for alternate EVV users, the EVV record should contain “BillVisit” set to “False”. This will tell the aggregator to set the duplicate record to “Omit” so it is not considered during EVV validation against the aggregator. In addition, alternate EVV users should ensure when sending records for omission that they submit the same “VisitOtherID” that was assigned to the original record they wish to omit/remove.
ESC 927	PCS Units Billed Exceed Units Verified in EVV	When the provider sees either 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.	Provider, provider agencies, AWC and VF/EA, 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. Providers 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. While performing claims resolution analysis, providers are encouraged to review the rounding rules and/or the calculation rules, make corrections accordingly and resubmit claim. 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. Example: Fiscal year unit limitations or weekly unit limitations may “cutback” units submitted on a claim which would make the units on the claim less than what was submitted on the actual claim.
ESC 937	HHCS Units Billed Exceed Units Verified in EVV		
ESC 928	No Matching PCS EVV Visit Found	When the provider sees either ESC set, the claim detail line denied for one of the following reasons: 1. No EVV record was found in the Aggregator, OR	1. Submit EVV record to the Aggregator then resubmit the claim. 2. Verify if the claim was submitted and processed BEFORE the visit information was successfully sent to the EVV Aggregator. If not, resubmit claim. 3. If the EVV record in the Aggregator is in an “Incomplete” status, there is an exception(s) associated with the record that will need a manual update made. Go

EVV ERROR STATUS CODES (ESC)

EVV ESC CODE	EVV ESC DESCRIPTION	WHY IS THIS ESC SETTING?	RESOLUTION ACTIVITY
ESC 938	No Matching HHCS EVV Visit Found	2. The EVV record was submitted to the aggregator AFTER the claim was submitted and processed, OR 3. The status of the EVV record in the EVV Aggregator is in an "Incomplete" status OR 4. 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 5. 2:1 service with overlapping time in the aggregator for 3 or more care workers (typically due to shift changes)	into the source EVV system you use, correct the data, ensure the record is in a "Verified" status then resubmit the visit to the EVV Aggregator. Resubmit the claim once you are sure the EVV record status has been sent to the Aggregator and in a "Verified" status. 4. If the EVV record that is found in the Aggregator 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 technical specifications found on the DHS EVV website. A frequently seen error is when the EVV record contains a 9-digit MA ID # instead of the 10-digit Recipient ID number (RID) that is contained on the claim. If you experience this issue, update your client/participant number from 9 to 10-digits in your source system that feeds the alternate EVV system records that are sent to the aggregator. 5. For 2:1 services specifically, the system is unable to determine which care worker visit to use when calculating units if the aggregator contains overlapping time for 3 or more care workers. This scenario will typically occur during shift changes. To resolve this issue, the provider should manually adjust the 3rd care worker's EVV visit to a time that does not overlap with the care worker's time whose shift is ending. Due to this system limitation, a manual edit for this scenario is acceptable by DHS.
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, Gainwell, will resolve the error and reprocess the claim within a 24-hour period. **No action is needed by the provider.** If a provider, provider agency, AWC or VF/EA 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.

EVV ERROR STATUS CODES (ESC)			
EVV ESC CODE	**EVV ESC DESCRIPTION**	**WHY IS THIS ESC SETTING?**	**RESOLUTION ACTIVITY**
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, Gainwell, will resolve the error and reprocess the claim within a 24-hour period. **No action is needed by the provider.** If a provider, provider agency, AWC or VF/EA 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	ESC sets when there is a technical issue related to the interface.	When this ESC sets, the claim will suspend and the PROMISe™ technical vendor, Gainwell, will resolve the error and reprocess the claim within a 24-hour period. **No action is needed by the provider.**

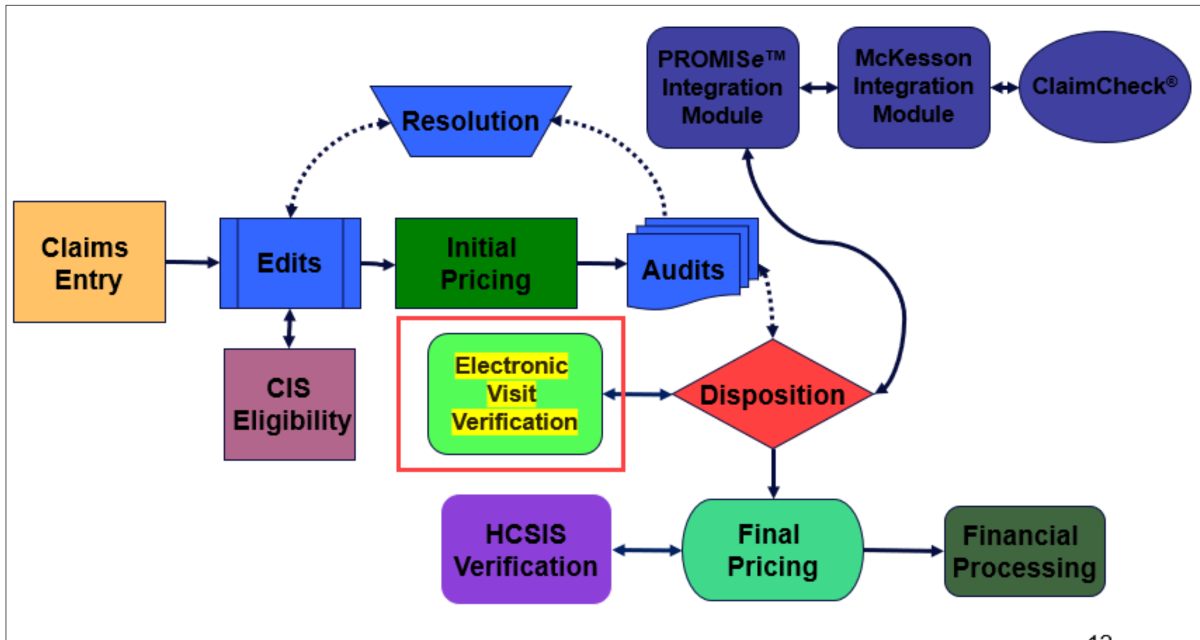
EVV ERROR STATUS CODES (ESC)			
EVV ESC CODE	**EVV ESC DESCRIPTION**	**WHY IS THIS ESC SETTING?**	**RESOLUTION ACTIVITY**
ESC 933 (Previously ESC 926)	EVV Internal Record Format Error	This ESC will set when PROMISe™ sends an incorrectly formatted record to the EVV Aggregator during the EVV record validation process **OR** when a provider bills a claim with a date span on one claim detail lines that is equal to or greater than 31 calendar days.	This ESC sets and will suspend the claim detail line for one of two reasons: 1. If an incorrectly formatted record is sent to the aggregator during the claim's validation process, this ESC sets, the claim will suspend and the PROMISe™ technical vendor, Gainwell, will resolve the error and reprocess the claim within a 24-hour period. **No action is needed by the provider**. 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. 2. This ESC will also set if a claim detail line is billed with a date span that is equal to or greater than 31 days. To resolve this issue, the date span on the claim detail line will either need to be split onto two separate claim detail lines and resubmitted or split and resubmitted on two separate claims.

APPENDIX B: ABBREVIATIONS/DEFINITIONS/TERMS

ACRONYM/ABBREVIATION/ TERM	DEFINITION/TRANSLATION
AAW	Adult Autism Waiver
Aggregator	The DHS EVV Aggregator is a system that integrates data from third-party systems (also referred to as Alternate EVV systems) and the DHS EVV system into a single uniform platform to facilitate payments of claims. The DHS Aggregator allows providers to use a third-party system (also referred to as Alternate EVV) for visit verification.
AWC	An Agency with Choice is one option a participant can use when self-directing their own services.
Claim	A transaction submitted requesting provider-rendered service payment. ODP providers use the 837 Professional format for claim transactions/billing.
CMS	Federal entity that translates to the Centers for Medicare and Medicaid Services
Community Support	An AAW service that assists a participant to gain skills needed to live in the community. The intent of this service is to reduce the need for direct assistance by improving a participant's ability to live independently in the community.
Companion	A service offered by the Consolidated, P/FDS, Community Living Waiver and Base program to provide supervision and assistance focused on health and safety of the individual. Not available to those in licensed residential settings.
DHS	Pennsylvania Department of Human Services
DOS	Date of Service abbreviation in PROMIS*e*™
DSP/SSP	Direct Service Professional/Support Service Professional
ESC	Stands for Error Status Code. ESCs set during claims processing to inform the biller of what action took place while processing a claims transaction. When an ESC sets, it will either deny, pay or suspend an entire claim or just a claim detail line.
EVV	Electronic Visit Verification
FAQs	Frequently Asked Questions
HCSIS	Home and Community Services Information System
HHS	Home Healthcare Services
Homemaker	A service offered by the Consolidated, P/FDS, Community Living Waiver and Base program. Service includes household cleaning/maintenance and homemaker activities such as meal preparation, laundry, or services to keep the home clean and in safe condition.
IHCS	**In-Home and Community Supports:** A service offered by the Consolidated, P/FDS, Community Living Waiver and Base program. This service assists individuals with acquiring, retaining, and improving self-help, socialization, and adaptive skills. Service

ACRONYM/ABBREVIATION/ TERM	DEFINITION/TRANSLATION
	can be provided in home and community settings. This service may be made available to individuals in their own home or in other residential of community settings not subject to licensing regulations. Recreation is not an eligible service. Camp day or overnight can only be provided under respite/family aid. Entrance fees to events are not covered.
MMIS	Medicaid Management Information System (currently known as PROMIS*e*™)
ODP	Office of Developmental Programs
OLTL	Office of Long-Term Living
OMAP	Office of Medical Assistance Programs
PCS	Personal Care Services
POS	Place of Service terminology used in PROMIS*e*™
PROMIS*e*™	Claims processing and management information system for the Commonwealth of Pennsylvania, Department of Human Services.
QA and I	Quality Assessment and Improvement. ODP Quality Assessment process designed to conduct a comprehensive quality management review of providers delivering services and supports to individuals with intellectual disabilities and autism spectrum disorders
Respite	A service offered by the Adult Autism Waiver, Consolidated, P/FDS, Community Living Waivers and Base program. This service is provided on a short-term basis to relieve those persons normally providing care to the individual.
Sandata	DHS EVV solution
VF/EA	Vendor Fiscal/Employer Agent

APPENDIX C: DETAILED PROCESS FLOW OF PROMISeTM CLAIMS ENGINE



APPENDIX D: SANDATA SERVICE ID CROSSWALK TO PROCEDURE CODE/MODIFIER COMBO AND SERVICE DESCRIPTION

Payer	Program	Sandata Service	HCPCS	Modifier1	Modifier2	Modifier3	Service Description
PAODP	ODP	T2025_03	T2025	TD	UN		Nursing (1:2) RN
PAODP	ODP	T2025_04	T2025	TD	UN	U1	Nursing (1:2) RN - ECS
PAODP	ODP	T2025_05	T2025	TD	U1		Nursing - (1:1) RN-15 Mins -ECS
PAODP	ODP	T2025_05	T2025	TD	U1		Nursing - (1:1) RN-15 Mins - ECS
PAODP	ODP	T2025_06	T2025	TE			Nursing - (1:1) LPN-15 Mins
PAODP	ODP	T2025_07	T2025	TE	UN		Nursing (1:2) LPN
PAODP	ODP	T2025_08	T2025	TE	UN	U1	Nursing (1:2) LPN - ECS
PAODP	ODP	T2025_09	T2025	TE	U1		Nursing - (1:1) LPN-15 Mins - ECS
PAODP	ODP	T2025_10	T2025	GN			Speech/Language Therapy-15 Mins
PAODP	ODP	T2025_11	T2025	GN	U2		Speech/Language Therapy - 15 Mins - AAW
PAODP	ODP	T2025_11	T2025	GN	U2		Speech/Language Therapy - 15 mins - AAW
PAODP	ODP	T2025_12	T2025	GN	U1		Speech/Language Therapy-15 Mins - ECS
PAODP	ODP	T2025_13	T2025	GO			Occupational Therapy-15 Mins
PAODP	ODP	T2025_14	T2025	GO	U1		Occupational Therapy-15 Mins - ECS

PAODP	ODP	T2025_18	T2025	GP			Physical Therapy-15 Mins
PAODP	ODP	T2025_19	T2025	GP	U1		Physical Therapy-15 Mins - ECS
PAODP	ODP	W1724	W1724				Companion Basic (1:3)
PAODP	ODP	W1724_02	W1724	U1			Companion Basic (1:3) - ECS
PAODP	ODP	W1725	W1725				Companion Level 1 (1:2)
PAODP	ODP	W1725_02	W1725	U1			Companion Level 1 (1:2) - ECS
PAODP	ODP	W1726	W1726				Companion Level 2 (1:1)
PAODP	ODP	W1726_02	W1726	U1			Companion Level 2 (1:1) - ECS
PAODP	ODP	W1726_03	W1726	U4			Companion Level 2 (1:1) – No Benefit Allowance
PAODP	ODP	W1726_04	W1726	U4	U1		Companion Level 2 (1:1) - No Benefit Allowance - ECS
PAODP	ODP	W1726_04	W1726	U4	U1		Companion Level 2 (1:1) – No Benefit Allowance - ECS
PAODP	ODP	W7058	W7058				IHCS Basic (1:3)
PAODP	ODP	W7058_01	W7058				IHCS Basic (1:3)
PAODP	ODP	W7058_02	W7058	U1			IHCS Basic (1:3) - ECS
PAODP	ODP	W7059	W7059				IHCS Level 1 (1:2)
PAODP	ODP	W7059_01	W7059				IHCS Level 1 (1:2)
PAODP	ODP	W7059_02	W7059	U1			IHCS Level 1 (1:2) - ECS
PAODP	ODP	W7060	W7060				IHCS Level 2 (1:1)
PAODP	ODP	W7060_01	W7060				IHCS Level 2 (1:1)

PAODP	ODP	W7060_02	W7060	U1			IHCS Level 2 (1:1) - ECS
PAODP	ODP	W7060_03	W7060	U4			IHCS Level 2 (1:1) - No Benefit Allowance
PAODP	ODP	W7060_04	W7060	U4	U1		IHCS Level 2 (1:1) - No Benefit Allowance - ECS
PAODP	ODP	W7061	W7061				IHCS Level 2 (1:1) Enhanced
PAODP	ODP	W7061_01	W7061				IHCS Level 2 (1:1) Enhanced
PAODP	ODP	W7061_02	W7061	U1			IHCS Level 2 (1:1) Enhanced - ECS
PAODP	ODP	W7061_03	W7061	TE			IHCS Level 2 (1:1) Enhanced - LPN
PAODP	ODP	W7061_04	W7061	TE	U1		IHCS Level 2 (1:1) Enhanced - LPN - ECS
PAODP	ODP	W7061_05	W7061	TE	U4		IHCS Level 2 (1:1) Enhanced - LPN - No Benefit Allowance
PAODP	ODP	W7061_06	W7061	TD			IHCS Level 2 (1:1) Enhanced - RN
PAODP	ODP	W7061_07	W7061	TD	U1		IHCS Level 2 (1:1) Enhanced - RN - ECS
PAODP	ODP	W7061_08	W7061	TD	U4		IHCS Level 2 (1:1) Enhanced - RN - No Benefit Allowance
PAODP	ODP	W7061_09	W7061	U4			IHCS Level 2 (1:1) Enhanced - No Benefit Allowance

PAODP	ODP	W7061_10	W7061	U4	U1		IHCS Level 2 (1:1) Enhanced - No Benefit Allowance - ECS
PAODP	ODP	W7061_11	W7061	TE	U4	U1	IHCS Level 2 (1:1) Enhanced - LPN - No Benefit Allowance - ECS
PAODP	ODP	W7061_12	W7061	TD	U4	U1	IHCS Level 2 (1:1) Enhanced - RN - No Benefit Allowance - ECS
PAODP	ODP	W7068	W7068				IHCS Level 3 (2:1)
PAODP	ODP	W7068_01	W7068				IHCS Level 3 (2:1)
PAODP	ODP	W7068_02	W7068	U1			IHCS Level 3 (2:1) - ECS
PAODP	ODP	W7068_03	W7068	U4			IHCS Level 3 (2:1) - No Benefit Allowance
PAODP	ODP	W7068_04	W7068	U4	U1		IHCS Level 3 (2:1) - No Benefit Allowance - ECS
PAODP	ODP	W7069	W7069				IHCS Level 3 (2:1) Enhanced
PAODP	ODP	W7069_01	W7069				IHCS Level 3 (2:1) Enhanced
PAODP	ODP	W7069_02	W7069	U1			IHCS Level 3 (2:1) Enhanced - ECS
PAODP	ODP	W7069_03	W7069	TE			IHCS Level 3 (2:1) Enhanced - LPN
PAODP	ODP	W7069_04	W7069	TE	U1		IHCS Level 3 (2:1) Enhanced - LPN - ECS
PAODP	ODP	W7069_05	W7069	TE	U4		IHCS Level 3 (2:1) Enhanced - LPN - No Benefit Allowance

PAODP	ODP	W7069_06	W7069	TD			IHCS Level 3 (2:1) Enhanced - RN
PAODP	ODP	W7069_07	W7069	TD	U1		IHCS Level 3 (2:1) Enhanced - RN - ECS
PAODP	ODP	W7069_08	W7069	TD	U4		IHCS Level 3 (2:1) Enhanced - RN - No Benefit Allowance
PAODP	ODP	W7069_09	W7069	U4			IHCS Level 3 (2:1) Enhanced - No Benefit Allowance
PAODP	ODP	W7069_10	W7069	U4	U1		IHCS Level 3 (2:1) Enhanced - No Benefit Allowance - ECS
PAODP	ODP	W7069_11	W7069	TE	U4	U1	IHCS Level 3 (2:1) Enhanced - LPN - No Benefit Allowance - ECS
PAODP	ODP	W7069_12	W7069	TD	U4	U1	IHCS Level 3 (2:1) Enhanced - RN - No Benefit Allowance - ECS
PAODP	ODP	W7201	W7201				Specialized Skill Development (1:1)
PAODP	ODP	W7204	W7204				Specialized Skill Development (1:2)
PAODP	ODP	W7205	W7205				Specialized Skill Development (1:3)
PAODP	ODP	W7205	W7205				Specialized Skill Development (1:3)
PAODP	ODP	W7213	W7213				Respite - Agency Managed In Home
PAODP	ODP	W7283	W7283				Homemaker-1 Hour
PAODP	ODP	W7283_01	W7283				Homemaker-1 Hour

PAODP	ODP	W7283_02	W7283	U4			Homemaker - Permanent - 1 Hour - No Benefit Allowance
PAODP	ODP	W7283_03	W7283	UA			Homemaker - Temporary - 1 Hour
PAODP	ODP	W7283_04	W7283	UA	U4		Homemaker - Temporary - 1 Hour - No Benefit Allowance
PAODP	ODP	W8095	W8095				Respite Unlicensed Level 4 (2:1) Enhanced-15 Mins
PAODP	ODP	W8095_01	W8095	U4			Respite-Unlic Level 4 (2:1) Enh-No Benefit Allowance-15 Mins
PAODP	ODP	W8095_02	W8095				Respite Unlicensed Level 4 (2:1) Enhanced-15 Mins
PAODP	ODP	W8095_03	W8095	U1			Respite – Unlicensed Level 4 (2:1) Enhanced) – ECS – 15 Mins
PAODP	ODP	W8095_04	W8095	U4	U1		Respite–Unlic Level 4 (2:1) Enh-No Benefit Allow–ECS–15 Mins
PAODP	ODP	W8095_05	W8095	TD	U1		Respite Unlicensed Level 4 (2:1) RN ECS-15 Mins
PAODP	ODP	W8095_06	W8095	TD	U4	U1	Respite Unlicensed Level 4 (2:1) RN-No Benefit Allowance-ECS-15 Mins

PAODP	ODP	W8095_07	W8095	TD	U4		Respite Unlicensed Level 4 (2:1) RN-No Benefit Allowance-15 Mins
PAODP	ODP	W8095_08	W8095	TD			Respite Unlicensed Level 4 (2:1) RN-15 Mins
PAODP	ODP	W8095_09	W8095	TE	U1		Respite Unlicensed Level 4 (2:1) LPN-ECS-15 Mins
PAODP	ODP	W8095_10	W8095	TE	U4	U1	Respite Unlic Level 4 (2:1) LPN-No Benefit Allowance-ECS-15 Mins
PAODP	ODP	W8095_11	W8095	TE	U4		Respite Unlic Level 4 (2:1) LPN-No Benefit Allowance-15 Mins
PAODP	ODP	W8095_12	W8095	TE			Respite Unlicensed Level 4 (2:1) LPN-15 Mins
PAODP	ODP	W8096	W8096				Respite -15 Mins Basic (1:4)
PAODP	ODP	W8096_01	W8096				Respite -15 Mins Basic (1:4)
PAODP	ODP	W8096_02	W8096	U1			Respite -15 Mins Basic (1:4) - ECS
PAODP	ODP	W9596	W9596				Respite - Agency Managed Out of Home - 15 Mins
PAODP	ODP	W9795	W9795				Respite Unlicensed Basic (1:4)-Day
PAODP	ODP	W9795_01	W9795				Respite Unlicensed Basic (1:4)-Day
PAODP	ODP	W9795_02	W9795	U1			Respite Unlicensed Basic (1:4)-ECS-Day

PAODP	ODP	W9796	W9796				Respite Unlicensed Level 1 (1:3)-Day
PAODP	ODP	W9796_01	W9796				Respite Unlicensed Level 1 (1:3)-Day
PAODP	ODP	W9796_02	W9796	U1			Respite Unlicensed Level 1 (1:3)-ECS-Day
PAODP	ODP	W9797	W9797				Respite Unlicensed Level 2 (1:2)-Day
PAODP	ODP	W9797_01	W9797				Respite Unlicensed Level 2 (1:2)-Day
PAODP	ODP	W9797_02	W9797	U1			Respite Unlicensed Level 2 (1:2)-ECS-Day
PAODP	ODP	W9798	W9798				Respite Unlicensed Level 3 (1:1)-Day
PAODP	ODP	W9798_01	W9798				Respite Unlicensed Level 3 (1:1)-Day
PAODP	ODP	W9798_02	W9798	U1			Respite Unlicensed Level 3 (1:1)-ECS-Day
PAODP	ODP	W9798_03	W9798	U4			Respite Unlicensed Level 3 (1:1)-No Benefit Allowance-Day
PAODP	ODP	W9798_04	W9798	U4	U1		Respite Unlicensed Level 3 (1:1)-No Benefit Allowance-ECS-Day
PAODP	ODP	W9799	W9799				Respite Unlicensed Level 3 (1:1) Enhanced-Day
PAODP	ODP	W9799_01	W9799				Respite Unlicensed Level 3 (1:1) Enhanced-Day

PAODP	ODP	W9799_02	W9799	U1			Respite Unlicensed Level 3 (1:1) Enhanced-ECS-Day
PAODP	ODP	W9799_03	W9799	U4			Respite Unlic Level 3 (1:1) Enhanced-No Benefit Allowance-Day
PAODP	ODP	W9799_04	W9799	U4	U1		Respite Unlic Level 3 (1:1) Enhanced-No Benefit Allowance-ECS-Day
PAODP	ODP	W9799_05	W9799	TD	U1		Respite Unlicensed Level 3 (1:1) - Enhanced - RN - ECS - Day
PAODP	ODP	W9799_06	W9799	TD	U4	U1	Respite Unlic Level 3 (1:1) Enh-RN-No Benefit Allowance-ECS-Day
PAODP	ODP	W9799_07	W9799	TD	U4		Respite Unlicensed Level 3 (1:1) -Enh-RN-No Benefit Allowance-Day
PAODP	ODP	W9799_08	W9799	TD			Respite Unlicensed Level 3 (1:1) - Enhanced - RN - Day
PAODP	ODP	W9799_09	W9799	TE	U1		Respite Unlicensed Level 3 (1:1) - Enhanced - LPN - ECS - Day
PAODP	ODP	W9799_10	W9799	TE	U4	U1	Respite Unlic Level 3 (1:1) Enh-LPN-No Benefit Allowance-ECS-Day

PAODP	ODP	W9799_11	W9799	TE	U4		Respite Unlicensed Level 3 (1:1) Enh-LPN-No Benefit Allowance-Day
PAODP	ODP	W9799_12	W9799	TE			Respite Unlicensed Level 3 (1:1) - Enhanced - LPN - Day
PAODP	ODP	W9800	W9800				Respite Unlicensed Level 4 (2:1)-Day
PAODP	ODP	W9800_01	W9800				Respite Unlicensed Level 4 (2:1)-Day
PAODP	ODP	W9800_02	W9800	U1			Respite Unlicensed Level 4 (2:1) ECS-Day
PAODP	ODP	W9800_03	W9800	U4			Respite Unlicensed Level 4 (2:1) No Benefit Allowance-Day
PAODP	ODP	W9800_04	W9800	U4	U1		Respite Unlicensed Level 4 (2:1) No Benefit Allowance-ECS-Day
PAODP	ODP	W9801	W9801				Respite Unlicensed Level 4 (2:1) Enhanced-Day
PAODP	ODP	W9801_01	W9801				Respite Unlicensed Level 4 (2:1) Enhanced-Day
PAODP	ODP	W9801_02	W9801	U1			Respite Unlicensed Level 4 (2:1) Enhanced - ECS - Day
PAODP	ODP	W9801_03	W9801	U4			Respite Unlic Level 4 (2:1) Enhanced-No Benefit Allowance-Day

PAODP	ODP	W9801_04	W9801	U4	U1		Respite Unlic Level 4 (2:1) Enhanced-No Benefit Allowance-ECS-Day
PAODP	ODP	W9801_05	W9801	TD	U1		Respite Unlicensed Level 4 (2:1) Enhanced - RN - ECS - Day
PAODP	ODP	W9801_06	W9801	TD	U4	U1	Respite Unlic Level 4 (2:1) Enh - RN-No Benefit Allowance-ECS-Day
PAODP	ODP	W9801_07	W9801	TD	U4		Respite Unlic Level 4 (2:1) Enh – RN - No Benefit Allowance - Day
PAODP	ODP	W9801_08	W9801	TD			Respite Unlicensed Level 4 (2:1) Enhanced - RN - Day
PAODP	ODP	W9801_09	W9801	TE	U1		Respite Unlicensed Level 4 (2:1) - Enhanced - LPN - ECS - Day
PAODP	ODP	W9801_10	W9801	TE	U4	U1	Respite Unlic Level 4 (2:1) Enh-LPN-No Benefit Allowance-ECS-Day
PAODP	ODP	W9801_11	W9801	TE	U4		Respite Unlic Level 4 (2:1) - Enh - LPN-No Benefit Allowance-Day
PAODP	ODP	W9801_12	W9801	TE			Respite Unlicensed Level 4 (2:1) - Enhanced - LPN - Day

PAODP	ODP	W9860	W9860				Respite Unlicensed Level 1 (1:3)-15 Mins
PAODP	ODP	W9860_01	W9860				Respite Unlicensed Level 1 (1:3)-15 Mins
PAODP	ODP	W9860_02	W9860	U1			Respite Unlicensed Level 1 (1:3)-ECS-15 Mins
PAODP	ODP	W9861	W9861				Respite Unlicensed Level 2 (1:2)-15 Mins
PAODP	ODP	W9861_01	W9861				Respite Unlicensed Level 2 (1:2)-15 Mins
PAODP	ODP	W9861_02	W9861	U1			Respite Unlicensed Level 2 (1:2)-ECS-15 Mins
PAODP	ODP	W9862	W9862				Respite Unlicensed Level 3 (1:1)-15 Mins
PAODP	ODP	W9862_01	W9862				Respite Unlicensed Level 3 (1:1)-15 Mins
PAODP	ODP	W9862_02	W9862	U1			Respite Unlicensed Level 3 (1:1)-ECS-15 Mins
PAODP	ODP	W9862_03	W9862	U4			Respite Unlicensed Level 3 (1:1)-No Benefit Allowance-15 Mins
PAODP	ODP	W9862_04	W9862	U4	U1		Respite Unlicensed Level 3 (1:1)-No Benefit Allowance-ECS-15 Mins

PAODP	ODP	W9863	W9863				Respite Unlicensed Level 3 (1:1) Enhanced-15 Mins
PAODP	ODP	W9863_01	W9863				Respite Unlicensed Level 3 (1:1) Enhanced-15 Mins
PAODP	ODP	W9863_02	W9863	U1			Respite Unlicensed Level 3 (1:1) Enhanced-ECS-15 Mins
PAODP	ODP	W9863_03	W9863	U4			Respite Unlic Level 3 (1:1) Enhanced-No Benefit Allowance-15 Mins
PAODP	ODP	W9863_04	W9863	U4	U1		Respite Unlic Level 3 (1:1) Enh-No Benefit Allowance-ECS-15 Mins
PAODP	ODP	W9863_05	W9863	TD	U1		Respite Unlicensed Level 3 (1:1) Enhanced RN-ECS-15 Mins
PAODP	ODP	W9863_06	W9863	TD	U4	U1	Respite Unlic Level 3(1:1)Enh-RN-No Benefit Allowance-ECS-15 Mins
PAODP	ODP	W9863_07	W9863	TD	U4		Respite Unlic Level 3 (1:1) Enh-RN-No Benefit Allowance-15 Mins
PAODP	ODP	W9863_08	W9863	TD			Respite Unlicensed Level 3 (1:1) Enhanced – RN - 15 Mins

PAODP	ODP	W9863_09	W9863	TE	U1		Respite Unlicensed Level 3 (1:1) Enhanced – LPN -ECS -15 Mins
PAODP	ODP	W9863_09	W9863	TE	U1		Respite Unlicensed Level 3 (1:1) Enhanced - LPN -ECS -15 Mins
PAODP	ODP	W9863_10	W9863	TE	U4	U1	Respite Unlic Level 3(1:1)Enh-LPN-No Benefit Allow-ECS-15 Mins
PAODP	ODP	W9863_11	W9863	TE	U4		Respite Unlic Level 3(1:1)Enh-LPN-No Benefit Allowance-15 Mins
PAODP	ODP	W9863_12	W9863	TE			Respite Unlicensed Level 3 (1:1) Enhanced-LPN-15 Mins
PAODP	ODP	W9864	W9864				Respite Unlicensed Level 4 (2:1)-15 Mins
PAODP	ODP	W9864_01	W9864	U4			Respite Unlicensed Level 4 (2:1)-No Benefit Allowance-15 Mins
PAODP	ODP	W9864_02	W9864	U4	U1		Respite Unlic Level 4 (2:1)-No Benefit Allowance-ECS-15 Mins
PAODP	ODP	W9864_03	W9864				Respite Unlicensed Level 4 (2:1)-15 Mins

PAODP	ODP	W9864_04	W9864	U1			Respite Unlicensed Level 4 (2:1)-ECS-15 Mins