Electronic Visit Verification Program Manual

Official guidance for the Colorado Electronic Visit Verification (EVV) Program

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Version 1.2

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Policy & Financing

I. EVV Program Glossary

A. Participants

1. Member

Member is an actively enrolled Health First Colorado recipient of EVV-required services. The member is referred to as the 'Client' in both the State EVV Solution and Provider Choice System.

2. Direct Care Worker

Direct Care Worker, also known as Caregiver, is the person providing a service to a member. The Direct Care Worker is often an employee of a Provider.

3. Provider

Provider is an actively enrolled Health First Colorado provider billing for EVV-appropriate services.

B. General

1. The 21st Century Cures Act

The 21st Century Cures Act, also known as the Cures Act, is Federal statute "to accelerate the discovery, development, and delivery of 21st century cures, and for other purposes." Section 12006 of the Cures Act mandates State Medicaid agencies to use Electronic Visit Verification.

2. Electronic Visit Verification (EVV)

EVV means the use of technology, including mobile device, telephony, or manual visit entry, to verify the required data elements related to the delivery of Health First Colorado Services as mandated by the 21st Century Cures Act and CCR 2505-10 Section 8.001.

3. Colorado "Open Choice" or "Hybrid" Model

An Open Choice or Hybrid EVV model means that in Colorado a provider agency may choose to use the State EVV Solution at no cost or utilize a Provider Choice System. Providers who choose to utilize a Provider Choice System must ensure that their system is configured to Colorado EVV rules and requirements.

4. State EVV Solution

State EVV Solution means the portion of the Colorado hybrid implementation model that is made available by the Department. The State EVV Solution includes the Mobile Visit Verification (MVV) Application, Telephonic Visit Verification (TVV) System, the Provider EVV Portal, and the optional Scheduling module (see Technical Definitions). The Department utilizes Sandata for the State EVV Solution and the solution is offered at no cost to providers.

5. Provider Choice System

Provider Choice System means the portion of the Colorado hybrid implementation model chosen by providers to submit EVV data. In some cases, providers may choose to add an EVV component to an administrative technology already in use. All contracted technologies must complete interface testing with Sandata and providers must complete Data Aggregator training. Provider Choice Systems are paid for by the Provider, satisfy all requirements as defined in rule, are compatible with the State EVV Solution interfacing, and are consistent with Federal and State law.

6. Verification Data Points

Verification Data Points mean the essential points of data that all EVV records must have to be considered a viable EVV. The federally required points and their corresponding definitions in Colorado are:

Federally Required Point of Data	Corresponding Definition in Colorado
The type of service performed	EVV Type of Service is a designation given to a group of appropriate codes for a type of service delivered. Full information is in the EVV Type of Service section of this manual
The individual receiving the service	The individual receiving the service is the Member as clarified in the Participant Definitions of this manual
The date of the service	The date of the service
The location of service delivery	A location may be a mailing address, GPS coordinates, or a uniquely identified location. A uniquely identifiable location example is "Colorado State Capital Building"; recording "Doctor's office" is not uniquely identifiable and is therefore not an acceptable location record.
The individual providing the service	The Direct Care Worker as clarified in the Participant Definitions of this manual. Direct Care Workers are affiliated with a Provider as clarified in the Participant Definitions of this manual.
The time the service begins and ends	The time that a service begins and the time the time that a service ends, as recorded utilizing EVV technology at the time of service.

EVV records also contain additional points, like sequence identifiers which indicate the order in which records are updated. All Verification Data Points are listed in the Technical Specification Documents section of the Provider Choice Systems web page on the Electronic Visit Verification web page.

7. Threshold

Threshold means the Department-defined acceptable limit of modified and manual EVV records determined as a percent of paid claims.

C. Operational Use

1. Sandata Welcome Letter

Welcome email from Sandata sent to the provider's Service Email Address after training has been complete. The Sandata Welcome Letter includes Sandata credentials for entry into the State EVV Solution Provider EVV Portal or Provider Choice EVV Solution Data Aggregator.

2. Unmodified EVV

Unmodified EVV is an EVV captured by a caregiver with all Verification Data Points at the time of service and remains unmodified in any way.

3. Modified EVV

Modified EVV is an EVV record with one or more of the Verification Data Points captured or modified after the time of service.

4. Exception

Exception means an alert identifying a missing Verification Point of Data. All Exceptions must be fixed for an EVV record to be a verified visit.

Exceptions may be fixed in the Visit Maintenance module of the State EVV Solution. For Provider Choice functionality contact your vendor.

5. Alternate Location

An Alternate Location means a modification that corrects the location recorded at the time of service or enters an otherwise unrecorded location. See Alternate Locations Guidance for more information.

6. Manual Visit Entry (Manual EVV)

Manual Visit Entry means an EVV record input in the Provider EVV Portal after the time of service delivery by administratively entering all Verification Points of Data.

7. Verified Visit

A verified visit does not contain any exceptions, meaning either no exceptions exist, or they have been fixed, making the visit eligible for claim matching.

8. Matched Visit

A matched visit is an EVV record that has matched to a billed claim. A matched visit requires a verified visit EVV record and a billed claim that has no other claim errors that has paid correctly. EVV records that are not yet a verified visit will not match. Billed claims that have not paid (for any reason, not just EVV matching) will not match.

D. Program Integration

1. Remittance Advice (RA)

The RA contains a weekly summary of all claims submitted and is available the Monday following the end of the claim submission cycle. For more information on reading and downloading your Remittance Advice, refer to the Provider Web Portal Quick Guides web page.

2. Service Email Address

Email contact located in the DXC Provider Portal titled "Service Email Address". The Service Email Address is utilized for sending the Sandata Welcome Letter containing Sandata credentials for entry into the system. Refer to the Provider Maintenance Provider Web Portal Quick Guide, available on the Quick Guides web page, for guidance on updating this email in the DXC Provider Web Portal.

3. Mailing Email Address

Email contact located in the DXC Provider Portal titled "Mailing Email Address". The Mailing Email Address is utilized for sending DXC communications including updates on the EVV Program. Refer to the Provider Maintenance Web Portal Quick Guide, available on the Quick Guides web page, for guidance on updating this email in the DXC Provider Web Portal.

4. Explanation of Benefits (EOB) 3054

Informational message on provider specific Remittance Advice (RA) designating that a claim billed with an EVV-applicable code does not have a corresponding visit recorded through an EVV system. See Remittance Advice (RA) for more information on viewing claim lines that have received this message.

E. Technical Definitions

1. Direct Care Worker ID

Direct Care Worker ID, or Employee ID, identifies the Direct Care Worker providing services and is automatically generated for the State EVV Solution. See Colorado Addendum for specific value for Provider Choice systems. See Training Participant Guide for usage.

2. Exception ID

Exception IDs identify Exceptions that are created in the EVV systems. Specific Exception IDs are located in the supplemental training materials for the State EVV Solution and in the Colorado Addendum for Provider Choice Systems.

3. Provider EVV Portal

The Provider EVV Portal is the web-based administrative tool used to manage EVV activity, add Manual Visit Entry data elements, and to monitor all activity recorded in the EVV System. For Provider Choice Systems, please contact EVV vendor for specific information.

4. Data Aggregator

Data Aggregator is the read-only portal for Provider Choice System users. Visit data will be reflected from the Provider EVV Portal. Information in the Data Aggregator can only be updated by submitting new EVV information to the Department.

5. Mobile Visit Verification (MVV App/SMC App)

Mobile Visit Verification is a smart phone or mobile device application used by the Direct Care Worker to record visit data at the start and end of the visit.

6. Reason Code

Reason Codes are standard codes established by the Department used to explain (or, as stated in the Sandata training manuals, "acknowledge") an Exception. Reason Codes are located in the supplemental training materials for the State EVV Solution and in the Colorado Addendum for Provider Choice Systems.

7. Telephonic Visit Verification (TVV)

TVV is a functionality for Direct Care Workers to record an EVV visit calling in with a telephone. Each provider agency using the State EVV Solution is provided with two toll-free telephone numbers for use by Direct Care Workers to record visit data at the start and end of a visit. For Provider Choice System functionality please contact your vendor.

Colorado allows the use of both landlines and cell phones to submit TVV records. EVV systems (either State Solution or Provider Choice System) must automatically record a specific address as the telephone is used and locations must be updated to reflect the actual location of service delivery as needed.

II. EVV Program Overview

A. Colorado EVV

Electronic Visit Verification (EVV) is mandated (effective August 3, 2020) in Colorado by 10 CCR 2505-10 Section 8.001 and Section 12006(a) of the 21st Century Cures Act. Federal guidance requires EVV for Home and Community Based Services (HCBS) that include an element of Personal Care Services and State Plan Home Health Care Services. Colorado requires the use of EVV for several other services that are similar in nature and delivery to the federally mandated services. These additional services are included to enhance care coordination, promote quality outcomes for members, and to streamline requirements for providers. Specifically, EVV will be required for the following:

- Behavioral Therapies
- Consumer Directed Attendant Support Services (CDASS)
- Home Health
- Homemaker
- Hospice
- Independent Living Skills Training (ILST) and Life Skills Training (LST)
- In-Home Support Services (IHSS)
- Occupational Therapy
- Pediatric Behavioral Therapies
- Pediatric Personal Care
- Personal Care
- Physical Therapy
- Private Duty Nursing
- Respite and Youth Day
- Speech Therapy

EVV requirements are the responsibility of providers billing services to the Department of Health Care Policy & Financing (the Department). The impact to most members is minimal, however members who utilize CDASS and employ attendants will be required to complete training and comply with EVV requirements.

The Colorado EVV Program has implemented an Open Choice Model, meaning that providers may use the State EVV Solution or a Provider Choice EVV System.

- **State EVV Solution**: The Department provides an EVV system for provider use at no cost. The State EVV Solution is built specifically to collect EVV records and may be (optionally) used for scheduling care.
- **Provider Choice EVV System**: Providers may choose to use a Provider Choice EVV system that interfaces their choice of technology with the State EVV Solution. This is especially useful for providers that already use an administrative suite of technology that can incorporate EVV records into existing records and practices. Any costs associated with using a different EVV system will be borne by the provider.

The Department has worked with providers and other stakeholders throughout the design of the EVV Program and has made several changes both to the system and policy to incorporate stakeholder feedback. The Department established an Electronic Visit Verification web page to share policy and system updates and engagement opportunities, held multiple stakeholder meetings from September 2017 through the present, and held specific engagement sessions for Code of Regulations feedback. Additional information on stakeholder engagement can be found on the Electronic Visit Verification web page.

B. Colorado EVV Exclusions

EVV is intended to be used for the services mentioned above when provided in a visit-based fee-for service setting. While EVV records *may still be* collected (meaning the Department does not prohibit the collection of records in these circumstances), EVV records *are not required when services are delivered through the following ways*:

- **Child Health Plan *Plus* (CHP+):** CHP+ is public low-cost health insurance for certain children and pregnant women. It is for people who earn too much to qualify for Health First Colorado (Colorado's Medicaid Program), but not enough to pay for private health insurance.
- **Live-in Caregivers**: The Department recognizes the unique nature of service delivery for Live-in Caregivers. For an EVV exemption, Live-in Caregivers must meet all requirements as stated in the Department Operational Memo 20-051 "Electronic Visit Verification Live-In Caregiver Exception" and the Live-in Caregiver Attestation Form, available on the Electronic Visit Verification web page in English and Spanish.
- **Non-Fee for Service:** Members receiving care through capitated payment models including through the Regional Accountable Entities (RAEs), Managed Care Organizations (Denver Health Medicaid Choice and Rocky Mountain Health Plan's Prime), or capitated behavioral health benefits administered by the RAEs.
- **Program of All-Inclusive Care for the Elderly (PACE):** The PACE program provides comprehensive medical and social services to certain frail individuals 55 years of age and older. The goal of PACE is to help individuals live and stay in their homes and communities through comprehensive care coordination.
- **State Supported Living Services (State SLS):** State SLS services mirror SLS waiver services for normally ineligible members and do not use normal billing methodology.

B. Colorado EVV Restrictions

EVV assures that care is delivered at the time of service by collecting six points of data. The Department, in coordination with stakeholders, has developed restrictions enforced in both system design (the State EVV Solution can not violate these restrictions and Provider Choice Systems must be set up to not violate these restrictions) and policy (these restrictions are specified in 10 CCR 2505-10 8.001, known as the "EVV Rule"). Providers or technology systems are encouraged to contact the Department (evv@state.co.us) for clarifications around these restrictions. Restriction violators should be reported to the Department for enforcement. The following practices are prohibited in the Health First Colorado EVV Program:

- The Department will not allow or accept biometric data, pictures, video, or voice recordings to identify members or substantiate Health First Colorado visit data.
- The Department will not allow or accept visit data that includes continual GPS tracking during a visit and will only accept location information at the beginning and/or end of a Health First Colorado visit.
- The Department will not utilize geo-fencing to restrict location of Health First Colorado service delivery.

III. Enrollment

A. Member Enrollment

Members receiving services that require EVV must be administratively entered into the Provider EVV Portal for each Provider Agency collecting EVV records. Members and Providers must work together to ensure that information is correct and viable. Providers Agencies are responsible for the maintenance of all caregiver information. CDASS members should work directly with their FMS vendors.

B. Caregiver Enrollment

Caregivers utilizing EVV must be administratively entered into the Provider EVV Portal by each Provider Agency collecting EVV records for services rendered. Caregivers and providers must work together to assure that information is correct and viable. Providers Agencies are responsible for the maintenance of all caregiver information.

B. Provider Enrollment

Providers billing for EVV-services must be enrolled with the EVV program for each unique Provider Health First Colorado ID (Medicaid ID). EVV enrollment may be automatically included in your new Medicaid enrollment depending on the nature of the codes regularly billed by the provider type and specialty. Provider types and specialties who do not have EVV enrollment automatically included in their Medicaid enrollment but are planning to bill, or are already billing EVV codes (see EVV Types of Service - Service Code Inclusions), may submit an Electronic Visit Verification Attestation Form to have EVV enrollment added to their Medicaid enrollment. Providers may use this Electronic Visit Verification Attestation Form during initial enrollment or as a maintenance update to their current enrollment. The Electronic Visit Verification Attestation Form can be found under Provider Enrollment & Update Forms drop-down section of the Provider Forms web page. For more information on Provider Maintenance to a current enrollment, refer to the Provider Maintenance Web Portal Quick Guide, available on the Quick Guides web page.

1. Multiple EVV enrollments

Agencies with multiple Health First Colorado Provider (Medicaid) IDs can bypass additional training for each ID associated with the agency. This can be done if one Health First Colorado Provider (Medicaid) ID has fully completed training and received credentials for the State EVV Solution or the Sandata Data Aggregator (Provider Choice EVV Solution Training).

For those who would like to bypass additional training and have already completed training for one Provider Health First Colorado ID (Medicaid ID), additional credentials can be requested by contacting Sandata at cocustomercare@sandata.com or (855) 871-8780.

2. Training

Providers enrolled in the EVV program must complete necessary training to receive EVV credentials. Training must be completed for both the State EVV Solution and Provider Choice EVV Solution. For more information on training visit the Electronic Visit Verification web page.

IV. Provider Guidance

The following guidance may be used to implement EVV successfully:

A. Alternate Locations

A modification that corrects the location recorded at the time of service or enters an otherwise unrecorded location is defined as an **Alternate Location**. Alternate Locations are used in the following situations:

- Correcting any method of EVV collection that recorded the location incorrectly.
- Modifying an existing EVV record to update a previously entered location.
- Entering a Manual Visit into the Provider EVV Portal.

Provider Responsibilities

Provider agencies must ensure the location for an EVV record is correct. A location may be a mailing address, GPS coordinates, or a uniquely identified location. (A uniquely identifiable location example is “Colorado State Capital Building”; recording “Doctor’s office” is not uniquely identifiable and is therefore not an acceptable location record.)

Provider agencies must maintain records supporting both the validity and appropriate use of Alternate Location.

Alternate Location in State EVV Solution

Providers may refer to “Appendix A: Alternate Location Guidance for State EVV Solution” in this document for detailed methodology.

Alternate Location in Provider Choice EVV Solutions

Providers utilizing a Provider Choice EVV Solution must ensure that a correct location of service delivery is submitted to the Department. Providers should ask their EVV vendor how to correct or input location of service delivery within their EVV system. Providers are responsible for reviewing and ensuring accuracy of EVV data submitted to the Department through the Data Aggregator.

B. Billing Integration

EVV records do not bill the Department directly. Claims should still be submitted to the Department according to Department guidance. EVV records collected by the State Solution or transmitted to the State Solution by a Provider Choice system will be transmitted to the Department’s fiscal agent to match against claims during adjudication. EVV records will then match to claims lines submitted to the Department as an additional requirement for claims to process correctly.

If an EVV record is modified after a claim line is matched for payment, the provider is responsible for voiding the matched claim and resubmitting for payment to ensure the correct EVV matches to the billed claim. For information on how to void and resubmitting a claim, please refer to Department guidance.

Visit records in the State Solution are transmitted nightly. Visits are available for matching in the DXC Claims System the day after a visit is recorded and verified. Please be aware that claims must be billed after service has been completed and a visit has been recorded to ensure proper matching.

For more information on the DXC payment processing schedule please refer to the Billing Training Resources drop-down section on the Provider Training web page.

Providers may review Remittance Advice for EOB 3054 to assure that claims will pay as intended after January 1, 2021. For more information on reading and downloading your Remittance Advice, refer to the Provider Web Portal Quick Guide on the Quick Guides web page.

B. Compliance Timeline

The Colorado EVV Program both made the State EVV Solution available and allowed providers to use Provider Choice Systems to submit EVV records beginning on October 1, 2019.

On August 3, 2020, the use of EVV was mandated by Colorado Code of Regulation. As required by the 21st Century Cures Act and according to the plan approved by the Colorado Joint Budget Committee, on **January 1, 2021, all claims requiring the use of EVV will encounter a pre-payment review process. Claims without corresponding EVV records will deny during claims adjudication**.

The Department is utilizing a tiered implementation strategy to familiarize providers with the use of EVV before incorporating claims adjudication to minimize long-term administrative burden and reduce the financial impact when claims require EVV records on January 1, 2021. The Department has issued guidance through Operational Memo 20-079 advising providers of the following stages of EVV implementation:

August 3, 2020 – Compliance Monitoring:

- The EVV Rule (10 CCR 2505-10 8.001.3.E.1.a) states: "Providers that fail to comply with this rule after August 3, 2020, may be subject to Compliance Monitoring and a Request for Written Response in accordance with Section 8.076."
- Beginning August 3, 2020, all claims submitted to the Department that require EVV records will be reviewed for corresponding EVV.
- Providers that are not using EVV after August 3, 2020, must submit a written plan to the Department outlining their intent to utilize EVV and when compliance is expected.

October 1, 2020 – Over-Payment Review:

- The EVV Rule (10 CCR 2505-10 8.001.3.E.1.b) states: "Providers that fail to comply with this rule after October 1, 2020, may be subject to Compliance Monitoring, Request for Written Response, or Overpayment Recovery."
- Beginning October 1, 2020, in addition to the August 3, 2020 enforcement requirements, all claims submitted to the Department that require EVV records will be reviewed for corresponding EVV.
- All claims subject to EVV requirements will pay initially, even if no EVV record is on file to match to the claim.

- Paid claims that do not have valid matching EVV records may be subject to Department review and recoupment as Over-Payment Recovery.

January 1, 2021 – Pre-Payment Claim Adjudication:

- The EVV Rule (10 CCR 2505-10 8.001.3.E.1.c) states: "Providers that fail to comply with this rule after January 1, 2021, may be subject to Compliance Monitoring, Request for Written Response, Overpayment Recovery, Denial of Claims, Suspension, Termination, or Nonrenewal of their Colorado Medicaid Provider Agreement in accordance with Section 8.076."
- Beginning January 1, 2021, in addition to the October 1, 2020, enforcement, all claims submitted to the Department that require EVV records must be matched to valid EVV records to pay.
- *Due to the unique federally-mandated payment structure for Hospice services, Hospice services are exempt from Pre-Payment Claim Adjudication. Hospice services are subject to Compliance Monitoring and Over-Payment Review only.*

Provider Options for Compliance

Providers may utilize multiple strategies to assure compliance at appropriate times and are advised of options that may be useful in implementing EVV in a timely manner.

- State EVV Solution interim option: If a Provider Choice System is not fully interfacing with Sandata to transmit EVV records to the Department, providers may use the State EVV Solution until the interface is complete to ensure compliance. If a Provider Choice system will not be fully interfaced with Sandata before January 1, 2021, the State EVV Solution interim option may be used to ensure no interruption in payments. Providers will not be exempt from using EVV while going through the interface process with Sandata. Providers can only use one system (either the State EVV Solution or their Provider Choice System) at a time. Providers may switch from using the State EVV Solution to the Provider Choice System when they are ready; there is no time limit for using the State EVV Solution. Providers must notify Sandata of the transition and complete all necessary training to use the State EVV Solution or Data Aggregator view for Provider Choice Systems.

- Switching to a different EVV vendor: Providers may switch to a different EVV vendor, to the State EVV Solution, or away from the State EVV Solution at any time for any reason. Providers must notify Sandata of the transition, ensure proper interfacing, and complete all necessary training to use the State EVV Solution or Date Aggregator view for Provider Choice systems.

- CDASS vendor switching: Each Financial Management Service (FMS) vendor is utilizing a Provider Choice System. If a CDASS member or their authorized representative, would like to utilize a different EVV system, they may change FMS vendors during quarterly open enrollment periods.

D. Live-in Caregivers

The Department does not require EVV from Live-in Caregivers for many services. However, individual Provider Agencies may choose to require EVV for Live-in Caregivers.

Live-in Caregiver Definition

The Department has developed the following definition based on federal precedent and stakeholder engagement:

> *Live-in Caregiver means a caregiver who permanently or for an extended period of time resides in the same residence as the Medicaid member receiving services. Live-in caregiver status is determined by meeting requirements established by the U.S. Department of Labor, Internal Revenue Service, or Department-approved extenuating circumstances.*

Types of Services Eligible or Ineligible for Live-in Caregiver Exemption

Services provided by Live-in Caregivers are often delivered incrementally and without clearly defined start and end times. The Department recognizes the unique challenges of collecting EVV for this type of care and allows providers to exempt the appropriate EVV Types of Service from EVV if provided by a documented Live-in Caregiver. The EVV Types of Service that are eligible to use the Live-in Caregiver exemption are:

EVV Type of Service	Live-in Caregiver
Behavioral Therapies	Eligible
Consumer Directed Attendant Support Services (CDASS) (and CDASS SLS Health Maintenance)	Eligible
Home Health (including CNA, Nursing, OT, PT, and ST)	Eligible
Homemaker	Eligible
Hospice (including In-Home and Inpatient)	Eligible
Independent Living Skills Training (ILST) and Life Skills Training (LST)	Eligible
In-Home Support Services (IHSS)	Eligible
Occupational Therapy	Ineligible
Pediatric Behavioral Therapies	Ineligible
Pediatric Personal Care	Eligible
Personal Care	Eligible
Physical Therapy	Ineligible
Private Duty Nursing	Eligible
Respite and Youth Day	Eligible
Speech Therapy	Ineligible

Provider Responsibilities

Billing providers are responsible for compiling, maintaining, and validating all records justifying the status of each Live-in Caregiver for Department verification and auditing. The Live-in Caregiver Attestation Form and all supporting documentation must be collected and validated prior to utilizing the Live-in Caregiver exemption. Documentation must be valid during the time of service and billing dates if EVV is not collected. Providers should review instructions and requirements outlined in the Live-in Caregiver Attestation Form and Live-in Caregiver Memo for additional details.

Billing providers are responsible for using correct billing methodology that designates Live-in Caregiver services by claim line. Claims adjudicated as provided by a Live-in Caregiver without required Live-in Caregiver documentation or EVV records are subject to recoupment.

Consumer Directed Attendant Support Services (CDASS) Responsibilities

CDASS Employers of Record (EOR) are responsible for compiling, maintaining, and validating all records justifying the status of a Live-in Caregiver for Department verification and auditing. The Live-in Caregiver Attestation Form and all supporting documentation must be completed by the EOR and collected by the Financial Management Service (FMS) Vendor prior to utilizing the Live-in Caregiver exemption. FMS vendors must maintain records designating the status of Live-in Caregivers. Documentation must be valid during the time of service and billing dates if EVV is not collected. EOR and FMS vendors should review instructions and requirements outlined in the Live-in Caregiver Attestation Form for additional details.

FMS vendors are responsible for using correct billing methodology that designates Live-in Caregiver services by claim line. This process is described in the Live-in Caregiver Memo. Claims adjudicated as provided by a Live-in Caregiver without required Live-in Caregiver documentation or EVV records are subject to recoupment. EOR are responsible for the validation of Live-in Caregiver documentation. If information is incorrect or falsified, recoupment liability is with the EOR. If Live-in Caregiver documentation is not collected by the FMS vendor, and EVV is not submitted, liability is with the FMS vendor.

Operational Methods of Billing for Live-in Caregiver Services

Billing providers may submit claims including both Live-in Caregiver services and services requiring EVV records at the same time. Each claim line must appropriately indicate if the service was provided by a Live-in Caregiver. If the same service is provided by both a Live-in Caregiver and a non-Live-in Caregiver, the units billed to each should be billed on separate claim lines and indicated correctly.

For claims billed using the CMS 1500 billing methodology, Place of Service (POS) 99 must be designated **for all lines where a Live-in Caregiver has delivered the service.**

For claims billed using the UB-04 billing methodology, Condition Code 23 must be designated on the **claim where all lines are services delivered by a Live-in Caregiver.**

Lines representing services **not** delivered by a Live-in Caregiver must use the appropriate Place of Service or Condition Code as outlined in Department billing manuals, which may not include Place of Service 99 or Condition Code 23. Providers who have previously used POS 99 to indicate information other than Live-in Caregiver designation are advised that this POS has been repurposed to identify services provided by Live-in Caregivers. Utilizing of POS 99 will require proof of Live-in Caregiver status.

E. Manual Entry Guidance

Manual Visit Entry means an EVV record input in the Provider EVV Portal after the time of service delivery by administratively entering all Verification Points of Data.

Providers utilizing the State EVV Solution can find information on entering a Manual Visit Entry in the Provider EVV Portal in the EVV Agency Provider Participant Training Guide on the Electronic Visit Verification State Solution Provider Information web page.

Providers utilizing Provider Choice EVV Systems should reach out to vendors for information on entering a Manual Visit Entry. Provider Choice EVV Systems submit new data to the Department which updates

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existing records. Providers utilizing a Provider Choice System can see the latest version of data in the Data Aggregator.

C. Minimum Necessary

EVV records are used to verify that services have been delivered in as real-time a method as possible. EVV technologies are not prohibited from integrating into other technologies (such as service scheduling, payroll, or electronic health records), however only information required for the collection and submission of EVV records is necessary. Many EVV technology solutions have the capacity to collect much more information than is needed to collect and submit EVV records. The Department recognizes that some business practices may find this capacity useful but cautions that doing so may end up creating additional administrative burden in keeping all information correct.

The Department only receives EVV-related data through the EVV program. If providers choose to use EVV technology for other uses, that information will not be sent to the Department through the EVV Program.

D. Modification Thresholds

Visit details added or modified after the time of service are considered visit modifications. Although the Department recognizes the practical need for visits to be modified, doing so should only be done as an exception to normal practice, and the majority of all EVV records should remain unmodified. Threshold means the Department-defined acceptable limit of modified and manual EVV records determined as a percent of paid claims each month.

Modified and manually entered EVV records will allow claims to pay, however exceeding manual or modified thresholds persistently and intentionally could imply fraudulent, abusive, or wasteful practices that would make providers subject to Department audit. Providers should hold records showing the need for records to be manually entered or modified. Thresholds will drive quality improvement by identifying providers that require the Department's involvement for re-training and quality improvement strategies.

E. Telemedicine/Telehealth and EVV

Telemedicine and Telehealth are remote delivery options for Health First Colorado services that utilize interactive audio, interactive video, or interactive data communication instead of in-person contact.

Providers delivering services requiring EVV through Telemedicine or Telehealth are responsible for the capture and reporting of EVV to the Department, regardless whether the provider is utilizing a Provider Choice System or the State EVV Solution. Providers utilizing Telemedicine or Telehealth should refer to the EVV Types of Service – Service Code Inclusion list, available on the Electronic Visit Verification Resources web page under the Department Guidance section to determine if EVV is required.

Many EVV-required services have expanded to include Telemedicine and Telehealth designated by a Place of Service 02 (for CMS 1500 methodology), or a Modifier GT (for UB-04 methodology). All EVV-appropriate services delivered through Telemedicine or Telehealth require EVV to be collected by the caregiver. Many EVV technologies automatically record the location of the caregiver providing services

through Telemedicine or Telehealth; the location in the EVV record must indicate the location of the member receiving services through Telemedicine or Telehealth. Provider Agencies may utilize Alternate Location methodology as needed.

Telemedicine and Telehealth are emerging fields and continue to develop in Colorado. Future guidance will be posted in Telemedicine resources, posted on the EVV website, and sent to affected providers as needed.

V. EVV Types of Service

Similar services are grouped into Colorado EVV Types of Service to reduce administrative burden during service delivery. Rather than having caregivers record each billing code at the time of service, only the “Type of Service” is needed. This drastically reduces the administrative burden for both caregivers working with Medicaid Members as well as provider administrators responsible for maintaining EVV records.

Caregivers and Administrators interested in each type of service should refer to the “EVV Types of Service Summary Table” on the next page.

Billing providers interested in which billing codes are included in each Type of Service, as well as the specific circumstances in which they apply, should refer to the next section “EVV Types of Service Billing Conditions and Code Inclusions.”

A. Colorado EVV Types of Service Summary Table

The following Types of Service are used by caregivers at the time of service and administrators maintaining EVV records:

TVV Code	Group Code	Telephony Prompt for Readback	Service Text Selection for Mobile
101	CDASS	Consumer Directed Attendant Support Services (CDASS)	CDASS
102	SLSHM	Consumer Directed Attendant Support Services SLS Health Maintenance	CDASS SLS HMA
103	BHSVC	HCBS Behavioral Services	Behavioral Services
104	HMKR	Homemaker	Homemaker
105	IHSS	In-Home Support Services	In-Home Support Services (IHSS)
106	PRSNL	HCBS Personal Care	Personal Care
107	RSPT	Respite	Respite
108	LST	Skills Training ILST/LST	Independent Living Skills Training (ILST) and Life Skills Training (LST)
109	HHNUR	Home Health - Nursing	Home Health - Nursing
110	HHBAS	Home Health - Basic	Home Health - Basic
111	HHPT	Home Health - PT	Home Health - Physical Therapy
112	HHOT	Home Health - OT	Home Health - Occupational Therapy
113	HHSLT	Home Health - S/LT	Home Health - Speech/Language Therapy
114	PDRN	Private Duty Nursing	Private Duty Nursing
115	HSPH	Hospice in Home	Hospice in Home
116	HSPIP	Hospice Inpatient	Hospice Inpatient
117	PEDPC	Pediatric Personal Care	Pediatric Personal Care Services
118	PEDBT	Ped Behavioral Therapies	Pediatric Behavioral Therapies
119	PT	Physical Therapy	Physical Therapy
120	OT	Occupational Therapy	Occupational Therapy
121	SLT	Speech Therapy	Speech Therapy
122	DME	Durable Medical Equipment	Durable Medical Equipment

B. Colorado EVV Types of Service Billing Conditions and Code Inclusions.

This section lists all billing conditions and codes included in each corresponding Colorado EVV Types of Service. All service descriptions are for reference only; if there is a difference in descriptions between this manual and reference coding books or Health First Colorado Billing Manuals located on the Billing Manual web page, providers must adhere to that advice.

All billing codes listed in this document will require the corresponding EVV Type of Service on file as part of a verified EVV to correctly bill Health First Colorado. If a service code or condition of service delivery is not mentioned in this section, it does not require an EVV record at the time of publication. All billing codes and conditions are subject to change.

The EVV Types of Service in Colorado are found on the following pages of this manual:

1. **Behavioral Therapies ... 21**
2. **Consumer Directed Attendant Support Services (CDASS) ... 22**
3. **Consumer Directed Attendant Support Services (CDASS) SLS Health Maintenance 22**
4. **Home Health - Basic (Certified Nurse Aid) ... 23**
5. **Home Health - Nursing ... 23**
6. **Home Health - Occupational Therapy ... 24**
7. **Home Health - Physical Therapy ... 24**
8. **Home Health - Speech/Language Therapy ... 24**
9. **Homemaker ... 25**
10. **Hospice - In Home ... 26**
11. **Independent Living Skills Training (ILST) and Life Skills Training (LST) ... 27**
12. **In-Home Support Services (IHSS) ... 28**
13. **Occupational Therapy ... 29**
14. **Pediatric Behavioral Therapy ... 32**
15. **Pediatric Personal Care ... 33**
16. **Personal Care ... 34**
17. **Physical Therapy ... 35**
18. **Private Duty Nursing ... 39**
19. **Respite and Youth Day ... 40**
20. **Speech Therapy ... 41**

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1. **Behavioral Therapies**
   - Used by HCBS Providers (Billing Provider Type 36).
   - Applicable in all locations except Place of Service 11 (Office).
   - Behavioral Consultations and Behavioral Plan Assessments billed with Place of Service 11 (Office) do not require EVV.
   - All billing codes associated with EVV Type of Service "Behavioral Therapies" are:

Procedure	Modifiers			Service Description
H2019	U3			Behavioral Line Staff (Developmental Disabilities Waiver)
H2019	U8			Behavioral Line Staff (Supported Living Services Waiver)
H2019	U3	22	TG	Behavioral Consultation (Developmental Disabilities Waiver)
H2019	U8	22	TG	Behavioral Consultation (Supported Living Services Waiver)
H2019	U3	TF	TG	Behavioral Counseling (Developmental Disabilities Waiver)
H2019	U8	TF	TG	Behavioral Counseling (Supported Living Services Waiver)
H2019	U3	TF	HQ	Behavioral Counseling, Group (Developmental Disabilities Waiver)
H2019	U8	TF	HQ	Behavioral Counseling, Group (Supported Living Services Waiver)
T2024	U3	22		Behavioral Plan Assessment (Developmental Disabilities Waiver)
T2024	U8	22		Behavioral Plan Assessment (Supported Living Services Waiver)

2. **Consumer Directed Attendant Support Services (CDASS)**
   - Used by HCBS Providers (Billing Provider Type 36).
   - Applicable in all locations.
   - All billing codes associated with EVV Type of Service "Consumer Directed Attendant Support Services (CDASS)" are:

Procedure	Modifiers		Service Description
T2025	U8		Consumer Directed Attendant Support Service - Enhanced Homemaker, Homemaker, Personal Care (Supported Living Services Waiver)
T2025	U1		Consumer Directed Attendant Support Service - Health Maintenance, Homemaker, Personal Care (Elderly, Blind, and Disabled Waiver)
T2025	UA		Consumer Directed Attendant Support Services - Health Maintenance, Homemaker, Personal Care (Community Mental Health Supports Waiver)
T2025	U6		Consumer Directed Attendant Support Service - Health Maintenance, Homemaker, Personal Care (Brain Injury Waiver)
T2025	U1	SC	Consumer Directed Attendant Support Service - Health Maintenance, Homemaker, Personal Care (Spinal Cord Injury Waiver)

3. **Consumer Directed Attendant Support Services (CDASS) SLS Health Maintenance**
   - Used by HCBS Providers (Billing Provider Type 36).
   - Applicable in all locations.
   - All billing codes associated with EVV Type of Service "CDASS SLS Health Maintenance service" is:

Procedure	Modifiers		Service Description
T2025	U8	SE	Consumer Directed Attendant Support Services – Health Maintenance (Supported Living Services Waiver)

4. **Home Health - Basic (Certified Nurse Aid)**
   - Used by Home Health Agencies (Billing Provider Type 10).
   - Applicable in all locations.
   - All billing codes associated with "Home Health – CNA" services are:

Revenue	Service Description
570	Home Health Aide Basic (Acute)
571	Home Health Aide Basic (Long-Term)
572	Home Health Aide Extended (Acute)
579	Home Health Aide Extended (Long-Term)

5. **Home Health - Nursing**
   - Used by Home Health Agencies (Billing Provider Type 10).
   - Applicable in all locations.
   - All billing codes associated with "Home Health – RN" services are:

Revenue	Service Description
550	RN/LPN Standard Visit (Acute)
551	RN/LPN Standard Visit (Long-Term)
590	Uncomplicated Nursing (Brief Visit 1st of Day)
599	Uncomplicated Nursing Visit (Visit 2+ of Day)

6. **Home Health - Occupational Therapy**

- Used by Home Health Agencies (Billing Provider Type 10).
- Applicable in all locations.
- Occupational Therapists providing services that are billed with procedure codes instead of revenue codes through a Home Health Agency are advised to refer to the Occupational Therapy Service Type
- All billing codes associated with "Home Health – Occupational Therapy" services are:

Revenue	Service Description
430	Occupational Therapy (Acute)
431	Occupational Therapy (Long-Term)
434	Occupational Therapy for HCBS Home Mod Evaluation

7. **Home Health - Physical Therapy**

- Used by Home Health Agencies (Billing Provider Type 10).
- Applicable in all locations.
- Physical Therapists providing services that are billed with procedure codes instead of revenue codes through a Home Health Agency are advised to refer to the Physical Therapy Service Type
- All billing codes associated with "Home Health – Physical Therapy" services are:

Revenue	Service Description
420	Physical Therapy (Acute)
421	Physical Therapy (Long-Term)
424	Physical Therapy for HCBS Home Mod Evaluation

8. **Home Health - Speech/Language Therapy**

- Used by Home Health Agencies (Billing Provider Type 10).
- Applicable in all locations.
- Speech/Language Therapists providing services that are billed with procedure codes instead of revenue codes through a Home Health Agency are advised to refer to the Speech/Language Therapy Service Type
- All billing codes associated with "Home Health – Speech/Language Therapy" services are:

Revenue	Service Description
440	Speech/ Language Therapy (Acute)
441	Speech/ Language Therapy (Long-Term)

9. Homemaker

- Used by HCBS Providers (Billing Provider Type 36).
- Applicable in all locations.
- All billing codes associated with “Homemaker” services are:

Procedure	Modifiers				Service Description
S5130	U1				Homemaker (Elderly, Blind, and Disabled Waiver)
S5130	UA				Homemaker (Community Mental Health Supports Waiver)
S5130	U1	SC			Homemaker (Spinal Cord Injury Waiver)
S5130	U8				Homemaker - Basic (Supported Living Services Waiver)
S5130	U7				Homemaker - Basic (Children's Extensive Supports Waiver)
S5130	U8	22			Homemaker - Enhanced (Supported Living Services Waiver)
S5130	U7	22			Homemaker - Enhanced (Children's Extensive Supports Waiver)

10. Hospice – In Home

- Used by Hospice Agencies (Billing Provider Type 50).
- Applicable in all locations
- "Hospice – Inpatient" is currently not used in the Colorado EVV Program
- All Hospice services provided "in home" do require EVV and are subject to Post Payment review, but Hospice services do not require EVV records to pay initially.
- All billing codes associated with "Hospice - in Home" are:

Revenue	Service Description
650	Routine Home Care (1-60 days)
651	Routine Home Care (61+ days)
652	Continuous Home Care/Service Intensity Add-On

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11. Independent Living Skills Training (ILST) and Life Skills Training (LST)

- Used by HCBS Providers (Billing Provider Type 36).
- Applicable in all locations.
- All billing codes associated with "Independent Living Skills Training (ILST) and Life Skills Training (LST)" are:

Procedure	Modifiers		Service Description
T2013	U6		Independent Living Skills Training (Brain Injury Waiver)
H2014	UA		Life Skills Training (Community Mental Health Supports Waiver)
H2014	U3		Life Skills Training (Developmental Disabilities Waiver)
H2014	U1		Life Skills Training (Elderly, Blind, and Disabled Waiver)
H2014	U1	SC	Life Skills Training (Spinal Cord Injury Waiver)
H2014	U8		Life Skills Training (Supported Living Services Waiver)

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12. In-Home Support Services (IHSS)

- Used by HCBS Providers (Billing Provider Type 36).
- Applicable in all locations.
- All billing codes associated with "In-Home Support Services (IHSS)" are:

Procedure	Modifiers				Service Description (IHSS)
H0038	U5				In-Home Support Services (IHSS) - Health Maintenance (Children's Home and Community Based Services Waiver)
H0038	U1				In-Home Support Services (IHSS) - Health Maintenance (Elderly, Blind, and Disabled Waiver)
S5130	U1	KX			In-Home Support Services (IHSS) - Homemaker (Elderly, Blind, and Disabled Waiver)
T1019	U1	KX			In-Home Support Services (IHSS) - Personal Care (Elderly, Blind, and Disabled Waiver)
T1019	U1	HR	KX		In-Home Support Services (IHSS) - Relative Personal Care (Elderly, Blind, and Disabled Waiver)
H0038	U1	SC			In-Home Support Services (IHSS) - Health Maintenance (Spinal Cord Injury Waiver)
S5130	U1	SC	KX		In-Home Support Services (IHSS) - Homemaker (Spinal Cord Injury Waiver)
T1019	U1	SC	KX		In-Home Support Services (IHSS) - Personal Care (Spinal Cord Injury Waiver)
T1019	U1	SC	HR	KX	In-Home Support Services (IHSS) - Relative Personal Care (Spinal Cord Injury Waiver)

13. Occupational Therapy

- Used by Occupational Therapy providers (Billing Provider Types 16, 25, 27, and 48)
- Applicable in Places of Service 2, 4, 12, 15, 16, 18, or 99.
- Occupational Therapy providers are ineligible for Live-in Caregiver designation.
- All billing codes associated with “Occupational Therapy” are:

Procedure	Service Description (Occupational Therapy)
92526	Treatment of swallowing dysfunction and/or oral function for feeding
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
97010	Application of hot or cold packs to 1 or more areas
97012	Application of mechanical traction to 1 or more areas
97014	Application of electrical stimulation to 1 or more areas, unattended by physical therapist
97016	Application of blood vessel compression or decompression device to 1 or more areas
97018	Application of hot wax bath to 1 or more areas
97022	Application of whirlpool therapy to 1 or more areas
97024	Application of heat wave therapy to 1 or more areas
97026	Application of low energy heat (infrared) to 1 or more areas
97028	Application of ultraviolet light to 1 or more areas
97032	Application of electrical stimulation to 1 or more areas, each 15 minutes
97033	Application of medication through skin using electrical current, each 15 minutes
97034	Therapeutic hot and cold baths to 1 or more areas, each 15 minutes
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97036	Occupational therapy treatment to 1 or more areas, Hubbard tank, each 15 minutes
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes

Procedure	Service Description (Occupational Therapy)
97113	Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes
97124	Therapeutic massage to 1 or more areas, each 15 minutes
97129	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity; each additional 15 minutes
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97150	Therapeutic procedures in a group setting
97165	Evaluation of occupational therapy, low complexity typically 30 minutes
97166	Evaluation of occupational therapy, moderate complexity typically 45 minutes
97167	Evaluation of occupational therapy established plan of care, high complexity typically 60 minutes
97168	Re-evaluation of occupational therapy established plan of care, typically 30 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97533	Sensory technique to enhance processing and adaptation to environmental demands, each 15 minutes
97535	Self-care or home management training, each 15 minutes
97537	Community or work reintegration training, each 15 minutes
97542	Wheelchair management training, each 15 minutes
97545	Work hardening or conditioning, first 2 hours
97546	Work hardening or conditioning add-on
97597	Removal of tissue from wounds per session - rmvl devital tis 20 cm/<
97598	Removal of tissue from wounds per session - rmvl devital tis addl 20cm/<
97602	Wound(s) care non-selective - removal of tissue from wounds per session
97750	Physical performance test or measurement with report, each 15 minutes
97755	Assistive technology assessment to enhance functional performance, each 15 minutes
97760	Training in use of orthotics (supports, braces, or splints) for arms, legs and/or trunk, per 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure
L1902	Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated, off-the-shelf

Procedure	Service Description (Occupational Therapy)
L1960	Ankle foot orthosis, posterior solid ankle, plastic, custom fabricated
L3730	Elbow orthosis, double upright with forearm/arm cuffs, extension/ flexion assist, custom fabricated
L3763	Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3764	Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3808	Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment
L3900	Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, wrist or finger driven, custom fabricated
L3906	Wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3908	Wrist hand orthosis, wrist extension control cock-up, non-molded, prefabricated, off-the-shelf
L3912	Hand finger orthosis (hfo), flexion glove with elastic finger control, prefabricated, off-the-shelf
L3919	Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3923	Hand finger orthosis, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3925	Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), non-torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf
L3929	Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3933	Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment
L3982	Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment
Q4040	Cast supplies, short leg cast, pediatric (0-10 years), fiberglass
Q4048	Cast supplies, short leg splint, pediatric (0-10 years), fiberglass

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14. Pediatric Behavioral Therapy

- Used by Pediatric Behavioral Therapy providers (Billing Provider Types 16, 24, 25, 37, 38, 83, and 84)
- Applicable in Places of Service 2, and 12.
- Pediatric Behavioral Therapy providers are ineligible for Live-in Caregiver designation.
- All billing codes associated with “Pediatric Behavioral Therapy” are:

Procedure	Mod	Service Description
97153		Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient, each 15 minutes
97154		Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients, each 15 minutes
97155		Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient, each 15 minutes
97158		Group adaptive behavior treatment with protocol modification administered by qualified health care professional to multiple patients, each 15 minutes
97151		Behavior identification assessment, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report.
97151	TJ	Behavior identification re-assessment, limited to 2 units per six months, each 30 minutes

15. **Pediatric Personal Care**

- Used by Personal Care Agencies (Billing Provider Type 60)
- Applicable in Places of Service 2, 12, and 99.
- Personal Care provided by HCBS Providers (Billing Provider Type 36) also require EVV as well and are in the “Personal Care” section.
- The billing code associated with “Pediatric Personal Care” is:

Procedure	Modifiers				Service Description
T1019					Pediatric Personal Care Service

16. Personal Care

- Used by HCBS Providers (Billing Provider Type 36).
- Applicable in all locations.
- Pediatric Personal Care provided by Personal Care Agencies (Billing Provider Type 60) also require EVV as well and are in the “Pediatric Personal Care” section
- All billing codes associated with “Personal Care” are:

Procedure	Modifiers			Service Description
T1019	U1			Personal Care (Elderly, Blind, and Disabled Waiver)
T1019	UA			Personal Care (Community Mental Health Supports Waiver)
T1019	U6			Personal Care (Brain Injury Waiver)
T1019	U1	SC		Personal Care (Spinal Cord Injury Waiver)
T1019	U8			Personal Care (Supported Living Services Waiver)
T1019	U7			Personal Care (Children's Extensive Supports Waiver)
T1019	U1	HR		Personal Care - Relative (Elderly, Blind, and Disabled Waiver)
T1019	UA			Personal Care - Relative (Community Mental Health Supports Waiver)
T1019	U6	HR		Personal Care - Relative (Brain Injury Waiver)
T1019	U1	SC	HR	Personal Care - Relative (Spinal Cord Injury Waiver)

17. Physical Therapy

- Used by Physical Therapy providers (Billing Provider Types 16, 17, 25, and 48)
- Applicable in Places of Service 2, 4, 12, 15, 16, 18, or 99.
- Physical Therapy providers are ineligible for Live-in Caregiver designation.
- All billing codes associated with "Physical Therapy" are:

Procedure	Service Description (Physical Therapy)
90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
97010	Application of hot or cold packs to 1 or more areas
97012	Application of mechanical traction to 1 or more areas
97014	Application of electrical stimulation to 1 or more areas, unattended by physical therapist
97016	Application of blood vessel compression or decompression device to 1 or more areas
97018	Application of hot wax bath to 1 or more areas
97022	Application of whirlpool therapy to 1 or more areas
97024	Application of heat wave therapy to 1 or more areas
97026	Application of low energy heat (infrared) to 1 or more areas
97028	Application of ultraviolet light to 1 or more areas
97032	Application of electrical stimulation to 1 or more areas, each 15 minutes
97033	Application of medication through skin using electrical current, each 15 minutes
97034	Therapeutic hot and cold baths to 1 or more areas, each 15 minutes
97035	Application of ultrasound to 1 or more areas, each 15 minutes
97036	Occupational therapy treatment to 1 or more areas, Hubbard tank, each 15 minutes
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes

Procedure	Service Description (Physical Therapy)
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97113	Water pool therapy with therapeutic exercises to 1 or more areas, each 15 minutes
97116	Walking training to 1 or more areas, each 15 minutes
97124	Therapeutic massage to 1 or more areas, each 15 minutes
97129	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function and compensatory strategies to manage the performance of an activity; each additional 15 minutes
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97150	Therapeutic procedures in a group setting
97161	Evaluation of physical therapy, low complexity typically 20 minutes
97162	Evaluation of physical therapy, moderate complexity typically 30 minutes
97163	Evaluation of physical therapy, high complexity typically 45 minutes
97164	Re-evaluation of physical therapy, typically 20 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97533	Sensory technique to enhance processing and adaptation to environmental demands, each 15 minutes
97535	Self-care or home management training, each 15 minutes
97537	Community or work reintegration training, each 15 minutes
97542	Wheelchair management training, each 15 minutes
97545	Work hardening or conditioning, first 2 hours
97546	Work hardening or conditioning add-on
97597	Removal of tissue from wounds per session - rmvl devital tis 20 cm/<
97598	Removal of tissue from wounds per session - rmvl devital tis addl 20cm/<
97602	Wound(s) care non-selective - removal of tissue from wounds per session
97750	Physical performance test or measurement with report, each 15 minutes
97755	Assistive technology assessment to enhance functional performance, each 15 minutes
97760	Training in use of orthotics (supports, braces, or splints) for arms, legs and/or trunk, per 15 minutes
97761	Training in use of prosthesis for arms and/or legs, per 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure

Procedure	Service Description (Physical Therapy)
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles
L1902	Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated, off-the-shelf
L1960	Ankle foot orthosis, posterior solid ankle, plastic, custom fabricated
L3730	Elbow orthosis, double upright with forearm/arm cuffs, extension/ flexion assist, custom fabricated
L3763	Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3764	Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3808	Wrist hand finger orthosis, rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment
L3900	Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/ flexion, finger flexion/extension, wrist or finger driven, custom fabricated
L3906	Wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3908	Wrist hand orthosis, wrist extension control cock-up, non-molded, prefabricated, off-the-shelf
L3912	Hand finger orthosis (hfo), flexion glove with elastic finger control, prefabricated, off-the-shelf
L3919	Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3923	Hand finger orthosis, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3925	Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), non-torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf
L3929	Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3933	Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment

Procedure	Service Description (Physical Therapy)
L3982	Upper extremity fracture orthosis, radius/ulnar, prefabricated, includes fitting and adjustment
Q4040	Cast supplies, short leg cast, pediatric (0-10 years), fiberglass
Q4048	Cast supplies, short leg splint, pediatric (0-10 years), fiberglass

18. Private Duty Nursing

- Used by Home Health Agencies (Billing Provider Type 10).
- Applicable in all locations.
- All billing codes associated with “Private Duty Nursing” are:

Revenue	Service Description
552	Private Duty Nursing -RN
559	Private Duty Nursing -LPN
580	Private Duty Nursing -RN (group-per client)
581	Private Duty Nursing - LPN (group-per client)
582	Blended Group rate (RN/LPN)

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19. Respite and Youth Day

- Used by HCBS Providers (Billing Provider Type 36).
- Applicable in all locations.
- All billing codes associated with "Respite and Youth Day" are:

Procedure	Modifiers		Service Description
S5150	U6		Respite - In-Home (Brain Injury Waiver)
S5150	U7		Respite - Individual (Children's Extensive Supports Waiver)
S5151	U7		Respite - Individual, Per Diem (Children's Extensive Supports Waiver)
S5151	U7	HQ	Respite - Group (Children's Extensive Supports Waiver)
S5150	U9	HA	Individual – In Family Home (15 minutes) (Children's Habilitation Residential Program Waiver)
S5151	U9	HA	Individual – In Family Home (Day) (Children's Habilitation Residential Program Waiver)
T1005	UD		Respite - CNA (4 hours or less) (Children with Life Limiting Illness Waiver)
S9125	UD		Respite - CNA (4 hours or more) (Children with Life Limiting Illness Waiver)
T1005	UD	TD	Respite - Skilled RN/LPN (4 hours or less) (Children with Life Limiting Illness Waiver)
S9125	UD	TD	Respite - Skilled RN/LPN (4 hours or more) (Children with Life Limiting Illness Waiver)
S5150	UD		Respite - Unskilled (4 hours or less) (Children with Life Limiting Illness Waiver)
S5151	UD		Respite - Unskilled (4 hours or more) (Children with Life Limiting Illness Waiver)
S5150	U1		Respite - In-Home (Elderly, Blind, and Disabled Waiver)
S5151	U8	HQ	Respite - Group (Supported Living Services Waiver)
S5150	U1	SC	Respite - In-Home (Spinal Cord Injury Waiver)
S5150	U8		Respite - Individual (Supported Living Services Waiver)
S5151	U8		Respite - Individual - Day (Supported Living Services Waiver)
T2026	U7	HQ	Youth Day Services - Group (Children's Extensive Supports Waiver)
T2027	U7		Youth Day Services - Individual (Children's Extensive Supports Waiver)

20. Speech Therapy

- Used by Speech Therapy providers (Billing Provider Types 16, 25, 27, and 48)
- Applicable in Places of Service 2, 4, 12, 15, 16, 18, or 99.
- Speech Therapy providers are ineligible for Live-in Caregiver designation.
- All billing codes associated with Speech Therapy are:

Procedure	Service Description (Speech Therapy)
92521	Evaluation of speech fluency (e.g. stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92507	Treatment of speech, language, voice, communication and/or auditory disorder; individual.
92508	Speech/hearing treatment, group, 2 or more individuals
92520	Laryngeal function studies
92526	treatment of swallowing and/or oral feeding function
92597	#N/A
92605	Evaluate for device
92606	Non-speech device service
92607	Evaluation for speech generating device, first hour
92608	Additional 30 minutes of evaluation for 92607
92609	Use of speech device service
92610	Evaluation of oral and pharyngeal swallowing function
92611	Motion fluoroscopic evaluation of swallowing function
92612	Flexible fiber optic endoscopic evaluation by cine or video recording
92614	Flexible fiber optic endoscopic laryngeal sensory testing by cine or video recording
92626	Evaluation of auditory rehab status; first hour
92627	Each additional 15 minutes of 92626
96105	Assessment of aphasia, per hour
96111	Developmental testing; extended with interpretation and report, per hour
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

Procedure	Service Description (Speech Therapy)
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
97755	Assistive technology assessment to enhance functional performance, each 15 minutes
Q3014	Telehealth originating site facility fee

VI. Appendix A: Alternate Location Guidance for State EVV Solution

Correcting EVV locations after caregiver has completed visit

All EVV records may be updated to reflect actual locations of service delivered. Providers are responsible for reporting correct EVV and billing appropriately.

Caregiver notification (if needed)	Provider Agency creates and fixes EVV record Exception
• Report any relevant information of actual service delivery location and reasoning to Provider Agency	• Search for the visit in “Visit Maintenance” • Select “Exceptions” and select “Location Required” • Select reason code, “Manual Entry” • Enter the actual location in the prompted “Reason Note” field

Alternate Location using Mobile Visit Verification (MVV/mobile app)

Though the mobile application should capture a GPS location, if service is being delivered at a location other than what is recorded, Alternate Locations may be entered.

Caregiver notates Alternate Location from the mobile application	Provider Agency fixes MVV record Exception
• At the end of service delivery, log into MVV (the Home screen shows the visit is in progress) • Select “Resume Visit” (blue button) • Select “Add Tasks” (blue button) • Check “Alternate Location” (check box) • Select “Complete Visit” (blue button) • Select “Confirm” (blue button) • Report the actual location of service delivery and reasoning to Provider Agency.	• “Location Required” Exception must be acknowledged in the Sandata Portal. • Of the reason code options, select “Location captured by MVV/TVV incorrect” • Enter the actual location in the prompted “Reason Note” field.

Alternate Locations using Telephony Visit Verification (TVV)

Providers may enter all known phone numbers in the Client Module of the Sandata Portal. The primary address listed will link to all entered phone numbers in the Client file when TVV is used. If calling from a known phone number but service is delivered at a location other than the client’s primary address (for example using the client’s cell phone while in the community), an Alternate Location must be notated:

Caregiver notates Alternate Location from a known phone number	Provider Agency fixes TVV record Exception
• During the TVV call-out process, when prompted to “enter the number of tasks” - enter “1”. • When prompted to “enter task ID”, enter “1”. (This notates an Alternate Location Exception to the Provider Agency.) • When prompted for any additional tasks, enter “0”.	• The Exception “Location Required” must be acknowledged in the Sandata Portal. • Of the Reason Code options prompted, select “Location captured by MVV/TVV incorrect”.

• After completing the TVV call, report the actual location of service delivery and reasoning to Provider Agency.	• Enter the actual location of service delivery in the prompted "Reason Note" field.

Caregivers may call from a phone number that is not entered in the Client Module of the Provider Portal to record EVV, however a call from an unrecognized number will be recorded as an "unknown phone number" and will trigger an Exception that must be fixed.

Caregiver notates Alternate Location from an unknown phone number	**Provider Agency fixes TVV record Exception**
• Calling from a number not associated with the client automatically creates an Exception; further notation is not needed from the caregiver. • After completing the TVV call, report the actual location of service delivery and reasoning to Provider Agency.	• The Exception "Unmatched Client ID/ Phone" must be acknowledged in Sandata Portal • Of the Reason Code options prompted, select "Location captured by MVV/TVV incorrect" • Enter the actual location in the prompted "Reason Note" field.

Manual Visit EVV Records

If no EVV data is recorded at the Time of Service, a Manual Visit entry may be entered. The State EVV Solution requires the location component of Manual Entries be entered as a Reason Note:

Caregiver requests a Manual Visit EVV	**Provider Agency enters a Manual Visit EVV record**

• Report any relevant information of actual service delivery location and reasoning to Provider Agency	• In the Visit Maintenance screen, select "CREATE CALL" (top right)
	• Search for and select a client (select next)
	• Search for and select an employee (select next)
	• Enter the Date, Time, and Service (select finish)
	• Find the call created in Visit Maintenance then:
	  • In the Tasks tab, select the Alternate Location task
	  • In the Exceptions tab, fix the "Location Required" Exception and select the "Manual Entry" reason code
	  • Enter the actual location in the prompted "Reason Note" field

If using the optional Scheduling Module within the State EVV Solution, a scheduled visit that has not been recorded by a caregiver at the Time of Service may be entered as a Manual Visit by adding the times of service and location:

Caregiver requests a Manual Visit EVV for scheduled visit after completion of services	**Provider Agency enters a Manual Visit EVV record for a scheduled visit** after caregiver has completed the service
• Report any relevant information of actual service delivery location	• Find the scheduled visit in Visit Maintenance • Select "CALL LOG"

and reasoning to Provider Agency	• Manually enter call times and select “Manual Entry” reason code when prompted • Enter the actual physical location in the prompted “Reason Note” field

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VII. Appendix B: EVV Live-in Caregiver Attestation

The EVV Live-in Caregiver Attestation form is available as a fillable pdf on the Electronic Visit Verification Resources web page under the Live-in Caregiver Resources section. The Live-in Caregiver Attestation form also may be printed from the following pages and filled out manually.

Electronic Visit Verification (EVV) Live-in Caregiver Attestation Form

****Send completed form to provider agency or FMS vendor unless you are requesting PART C: Extenuating Circumstances Determination ****

Instructions

Validity of information on this form must be reviewed and updated by the provider agency or Financial Management Service (FMS) vendor with the member and caregiver annually. Changes must be documented immediately. The provider agency or FMS vendor is responsible for maintaining this form and any relevant evidence for Department verification and auditing. If live-in caregiver status is not valid at any time, the attendant and provider agency or FMS vendor shall collect EVV per state rule. Service dates prior to the completion of this form and required approvals must have a corresponding EVV record. The Department reserves the right to deny or revoke live-in caregiver status for an EVV exemption when information on completed form does not meet Department specification or if information is found to be misrepresented or falsified.

On the attached form, complete all informational fields with the most current and accurate information available. Part A, Part B, or Part C attest to the determination of live-in caregiver status by meeting the criteria of a Federal entity definition or Department approval of extenuating circumstances. Select only one and provide the most relevant evidence for that definition. If attesting to an extenuating circumstance, contact the Department for pre-approval*. "Reside" for Part B means the place of residence or the place used most often for domestic activities outside of work such as sleeping, living, eating, etc. "Premise" for Part B means any property, dwelling, apartment, or structure that the member resides in.

Permissible Supporting Documentation (Minimum of 1):

Copy of both state ID's showing shared residency; address listed on tax returns; automobile registration; voter registration card, utility or other household bill showing individuals address; bank account statement; or Medicaid records. All documentation must be current or have a date within the last three months. Other documentation may be used upon Department approval.

****Extenuating circumstance exceptions may be approved for time less than one year. Approval of extenuating circumstance may take 2 - 4 weeks.***

EVV Live-In Caregiver Attestation Form
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Live-In Caregiver Attestation Form

Electronic Visit Verification (EVV) is a technology solution which electronically verifies visit information to ensure that home or community-based services are delivered to members needing those services by documenting the precise time service begins and ends. Section 12006 of the 21st Century Cures Act requires all state Medicaid agencies implement an EVV solution. Federal guidance permits states to exempt live-in caregivers from EVV. This exemption may or may not apply to the parent or family of a member, depending on **living** arrangement.

Caregiver/Member Information
Caregiver Name:
Last 5 digits of Caregiver SSN:
Member Name:
Member Medicaid ID#:
Shared Address:
Provider or FMS Vendor Information
Provider Agency or FMS Vendor Name:
Medicaid Provider ID:
Provider Agency or FMS Vendor Representative Name:

A **live-in caregiver** is a caregiver who permanently or for an extended period of time resides in the same residence as the Medicaid member receiving services. Live-in caregiver status is determined by meeting requirements established by either the U.S. Department of Labor, Internal Revenue Service, or Department-approved extenuating circumstances. Documentation of live-in caregiver status must be collected and maintained by the provider agency. Live-in caregiver status is established by the member/caregiver relationship and only pertains to relationships where documentation has been provided and approved.

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Part A: IRS Determination[1]

☐ I declare that I am an individual care provider receiving payments under a qualifying state Medicaid program as defined in IRS notice 2014-7 for care I provide to an individual (whether or not related) living in the individual care provider's home.

Part B: DOL Determination[2]

☐ "Permanently" - I reside on the same premises as the individual I provide services to permanently by living, working, and sleeping on premises seven days per week and have no home of my own.

☐ "Extended Periods of Time" - I reside on the same premises as the individual I provide services to for an extended period of time by living, working, and sleeping on premises for five days a week (120hrs or more) OR I spend less than 120 hours per week working and sleeping on premises, but I spend five consecutive days or nights residing on premises.

Part C: Extenuating Circumstances Determination

The Department, at its discretion, permits live-in caregiver establishment beyond the above definitions. Pre-approval of the extenuating circumstances is required by emailing the completed form first to EVV@state.co.us

☐ Joint Custody	☐ Members transitioning out of residential service
☐ Child in Foster Care	
☐ Other:	
Part C Department Approver:	
Part C Date of Approval:	

Signing this document is an attestation that, to the best of my knowledge, the information on this form is true and accurate. I understand that falsifying information may result in a Program Integrity investigation or recoupment of paid claims.

Caregiver Signature:
Member or Authorized Representative Signature[3]:
Provider Agency:
Effective Date:

Send completed form to provider agency or FMS vendor **unless requesting PART C**: Extenuating Circumstances Determination - **See Part C for details**

[1] IRS Notice 14-07 effective January 03, 2014 regarding §131 of the Internal Revenue Code

[2] Department of Labor Application of the Fair Labor Standards Act to Domestic Service, Final Rule; Fact Sheet #79B: Live-in Domestic Service Workers Under the Fair Labor Standards Act (FLSA)

[3] For CDASS, this signature line is intended for the Employer of Record.

For FMS Vendor Processing Only
Date of form and supporting documentation receipt:
Effective date of EVV exemption:
By dating this form, the FMS vendor confirms the receipt and review of documentation. Review includes verification that all necessary information is included, not a validation of validity. Section required to be completed by FMS at processing. If section is not completed, EVV must be submitted per state rule. Electronic stamp acceptable.

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VIII. Version History

This program manual will be updated on the Electronic Visit Verification web page to reflect the current state of the Colorado EVV program. As items are added or modified a short note will indicate the version and date.

Version	Released	Comments
1.1	August, 2020	First release of EVV Program Manual.
1.2	October, 2020	Updates, feedback incorporation, consolidation of Colorado EVV Types of Service information, compliance timeline information incorporated