DELAWARE HEALTH AND SOCIAL SERVICES

State of Delaware, Division of Medicaid and Medical Assistance (DMMA) Electronic Visit Verification

Claims Frequently Asked Questions

Q:	1. Will claims be submitted through the system or be handled outside the system?
A:	All claims for services subject to EVV will be submitted via the methods used today. There is no change to the claim's submission process. The EVV system does not submit claims.

Q:	2. Should providers wait to upload data until after the claim is paid or denied?
A:	Visit data must be submitted prior to claims submission. Once the hard claims edit is implemented on November 1, 2025, visit data must be present to match against claims.

Q: 3. Are there changes to current claims processes?

A:

In preparation for the matching of claims to visit data providers should:

a. Claims for EVV covered services must have each date of service on a separate claim detail line. For example, if a provider conducted two EVV covered visits daily from Monday to Friday, both Monday visits can be on the same detail line, but Tuesday's visits must be on a separate claim detail line. The 10 visits can be on the same claim, but each day must be on a separate claim detail line. Providers may no longer bundle visits onto the same claims line.

b. Example of span/bundled billing versus daily billing of visits on a claim

Individual received 2 hours of service a day (8 units) from 1/4/2025 to 1/8/2025.

SPAN BILLING			
DATE	**CODE**	**Units**	**COST**
1/4/2025 – 1/8/2025	T1019	40	$150.00

DAILY BILLING			
DATE	**CODE**	**Units**	**COST**
1/4/2025	T1019	8	$30.00
1/5/2025	T1019	8	$30.00
1/6/2025	T1019	8	$30.00
1/7/2025	T1019	8	$30.00
1/8/2025	T1019	8	$30.00

c. Multiple visits on the same day can be included on the same claim line. For example, the individual receives 1 hour (4 units) of service 3 x a day.

DAILY BILLING (Multiple Visits on Same Day)			
DATE	**CODE**	**Units**	**COST**
1/4/2025	T1019	12	$45.00
1/5/2025	T1019	12	$45.00
1/6/2025	T1019	12	$45.00
1/7/2025	T1019	12	$45.00
1/8/2025	T1019	12	$45.00

d. Overtime (denoted with the TU modifier) should be broken out on its own claim line. For example, the individual receives 10 hours (40 units) (2 five-hour visits) of service a day Monday-Friday.

DAILY BILLING (Multiple Visits on Same Day with OT)			
DATE	**CODE**	**Units**	
1/4/2025	T1019	40	
1/5/2025	T1019	40	
1/6/2025	T1019	40	
1/7/2025	T1019	40	
1/8/2025	T1019 TU	40	

If a DSP goes into overtime during a shift, the daily claim line should be broken into two claim lines. For example, an individual receives 9 hours (36 units) of service (1 4-hour visit and 1 5-hour visit) every day. Due to a staff calling off the same DSP covers all the shifts.

DAILY BILLING (Multiple Visits on Same Day with OT)			
DATE	**CODE**	**Units**	
1/4/2025	T1019	36	
1/5/2025	T1019	36	
1/6/2025	T1019	36	
1/7/2025	T1019	36	
1/8/2025	T1019	16	
1/8/2025	T1019 TU	20	
1/9/2025	T1019 TU	36	
1/10/2025	T1019 TU	36	

Q:	4. Can you please explain the rounding rules and how they will be used?

A:	For services where the unit of service is 15 minutes, the rounding rules are as follows:
	• 0s–479s (<8 min) = 0 Units
	• 480s–1379s (≥8 min <23 min) = 1 Unit
	• 1380s–2279s (≥23 min <38 min) = 2 Units
	• 2280s - 3179 (≥38min <53min) = 3 Units
	• 3180s – 4079(≥53min < 68min) = 4 Units, etc.
	
	For services that have a one-hour unit of service the rounding rules will vary by payer
	• FFS rounding rules for the following procedure codes: T2013, S9123, S9124
	  • 0s - 479s (<8 min) = 0 Units
	  • 480s - 1379s (≥8min <23min) = .25 Unit
	  • 1380s - 2279 (≥23min <38min) = .50 Unit
	  • 2280s - 3179 (≥38min <53min) = .75 Unit
	  • 3180s – 4079(≥53min < 68min) = 1 Unit
	  • (Calculated in partial hours)
	
	• Managed care rules for the following procedure codes: T2013, S9123, S9124, H0045
	  • >53 minutes and < 113 minutes= 1 unit
	  • >113 minutes and < 173 minutes = 2 units
	  • > 173 minutes and < 233 minutes = 3 units

Q:	5. Do the rounding rules in HHAeXchange impact rounding for claims submission?
A:	Yes, the rounding rules used for claims must match those used by HHAeXchange (see Q4).

Q:	6. Will DMMA establish a threshold for an acceptable level of manual changes to EVV visits?
A:	No, not currently. This may be revisited by DMMA later.

	7. How should overnight visits be treated?
	Visits that span overnight do not need to be broken up into two separate visits. For example, the workers shift is from 9:00 pm to 6:00 am. The shift should be reflected as one visit. In terms of how we would expect to see this on a claim. For visits that occur overnight and span two days, the visit should be submitted on one claim line with all units claimed on the date of service when the visit began. For example, DSW arrives to provide T1019 Waiver Personal care at 9:00 pm and departs at 6:00 am. The claim should look as follows: 1/4/2025 | T1019 | 36 units

	8. For self-directed services, does overtime impact EVV?
	Self-directed respite and self-directed attendant care DSPs are paid overtime as appropriate. Overtime is not prior authorized. The payment of overtime is indicated with the inclusion of the TU modifier on the claim line. For purposes of EVV, the payment of overtime does not impact how visit data is collected. Providers will need to break out dates of service and indicate the payment of overtime with the TU modifier on separate claim lines. Be sure the TU modifier is in the last modifier position. All other modifiers should be listed prior to TU.

Q:	9. What will happen with our claims once this goes live? Will they still process timely with or without EVV? Will they pend for a set period looking for EVV and then process?
A:	There are no changes to claims submission processes because of EVV implementation. Beginning in the spring of 2024 the State and the MCOs will use visit data as part of a soft edit review process. If the outcome of this process shows a claim for a service subject to EVV cannot be matched to a visit the State and the MCOs will provide education and technical assistance to the provider. Beginning November 1, 2025, the State and all MCOs will institute a hard edit in the claims systems. This means that when a claim for a service subject to EVV is submitted, before it is paid, there will be a check for a corresponding visit, if no visit is present the claim will be denied.

Q:	10. Will there be an error message on the explanation of benefit/remittance advice (EOB/RA) that providers can look for to indicate future claims impact?
A:	Yes. CARC and RARC codes will be included on remittance advice.

Q:	11. Is there a portal for agencies using an alternate EVV system to view what is, is not accepted, or has exceptions?
A:	Yes, they can use the HHAeXchange aggregator portal (https://evv.sandata.com/VM/Login) to view visits. If a visit requires correction, the provider will need to make changes in their EVV system and then resubmit it to HHAeXchange.

Q:	12. Are alternate EVV systems required to use the same rounding rules for visits as those being used in HHAeXchange?
A:	We suggest sending HHAeXchange raw visit data with no rounding rules applied. HHAeXchange will apply rounding rules listed in Q4 of this FAQ.

Q:	13. If a provider provides multiple shifts to the same members on the same date of service, can the visits be rolled up into a single claim detail line?
A:	Yes, in this scenario, multiple visits subject to EVV can be rolled up into the same claim line for the same date of service.

Q:	14. If you are using alternate EVV vendor, what happens if you submit a visit after seven days?
A:	At this time, there is no negative consequence for providers if the alternate EVV vendor does not submit visits within seven days; however, it will be advantageous to the provider for the vendor to develop a cadence of submission that meets this timeframe. Visit data must be present in the aggregator prior to claim submission.

Q:	15. How will the State distinguish claims for visits that are typically subject to EVV, but are performed by live-in caregivers?
A:	The caregiver (CG) modifier will be used on claims that would normally be subject to EVV, but meet the conditions prescribed by the State to not be subject to EVV. This informational modifier is assigned to claims with procedure codes that are typically subject to EVV to indicate that the service is not subject to EVV per DMMA policy. Reasons include: services provided by a paid caregiver who lives with the individual, services provided in a location outside of the home (e.g., school, hospital when an individual is enrolled in the Lifespan waiver), services provided in a residential setting, services provided as part of the hospice benefit when the individual is enrolled in hospice, services provided to a newborn who does not yet have their own Medicaid ID number, and service provided out of State.

Q:	16. Some members receive services from both a DSW who lives with them and a DSW who comes in from outside of the home. In this case, how is the CG modifier used?
A:	The CG modifier is only used for claims for visits that are not subject to EVV. In this case, the CG modifier would be used for claims for those DSWs who live with the member. Claims for services provided by DSWs who come in from outside of the home would not include the CG modifier. The CG modifier must be put in the first modifier position.

Q:	17. What if a member receives services from a DSW who lives with them and a DSW who comes into the home on the same date of service? Will there be an issue with the claim being denied as a duplicate?
A:	No, the provider needs to put the visits on two separate claim detail lines and include the CG modifier on the claim line for the visit performed by the DSW who lives with the member.