Maryland Department of Health
Division of Nursing Services (DONS)
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Electronic Visit Verification (EVV)
Private Duty Nursing (PDN) Program
Frequently Asked Questions

RN SUPERVISORY VISIT	
Does the RN Supervisory visit or Assessment require EVV?	No, you must bill through eMedicaid because RN Supervisory visits and Assessments do not require preauthorization.
PREAUTHORIZATION/THIRD PARTY LIABILITY	
Are private duty nursing (PDN) providers still required to submit preauthorizations (PA) forms to the MDH-DONS?	Yes. PDN providers are still required to follow the MDH-DONS preauthorization request process which considers all other potential and available resources including, but not limited to, third party liability (Medicare and other commercial insurance) when determining authorized PDN services. In LTSS*Maryland* Provider Portal, an approved request is also known as a "Service Authorization".
Some participants must exhaust their primary insurance PDN benefit each day prior to Medicaid paying for care. For example, a participant receives 10 hours/day through their primary insurer and Medicaid authorizes any hours over 10, up to 20 hours a day. Often, this is staffed with one nurse working 8 hours and another working 12 hours. In this case, the 2nd nurse would need to clock in 2 hours into the shift. What happens if the nurse is performing a vital task at the time clock-in is required?	There may be exceptions allowed in these types of instances. It is not our intent to penalize direct service workers, however, it is federally required that all home health and PDN providers use the EVV solution. Staff should always ensure participant safety before clocking in or clocking out.
Our agency has a device that our caregivers use to clock in and out. Please advise which device should be used first to clock in and out?	For staff clock in and clock out, if the agency elects to use both its and Maryland Medicaid's EVV methods for Medicaid fee-for-service PDN

	participants, it is up to the agency to decide and instruct staff on which to use first in accordance with authorized services, physician orders, and plans of care. For Medicaid, the participant's service authorization dictates the number of hours and plan of care the staff must follow for clock in and clock out. (If a participant has a primary insurer, this information was considered in the DONS' authorization of services.)
If a patient is hospitalized for 72 hours, the agency must send the " end auth notification" to the DONS and DONS will update the EVV system.	Yes, that's correct.
If the service authorization is not entered before the start of care, are staff able to clock in and out?	Yes, in this instance, when staff clock in and out, an exception is created. The exception is automatically resolved when the service authorization is entered.
Are past authorizations available for review in LTSS Provider Portal?	All currently active authorizations with end dates through and after November 3, 2023 will be available for review.
LIMITATION OF STAFF WORK HOURS	
Will the DONS allow a nurse to work over 16 hours per day/60 hours per week?	If an agency or agencies require a nurse/staff to work over the standard 60 hours per week, then they must submit a request to the DONS for review and approval. Pursuant to COMAR 10.09.53.03K, Conditions for Participation states that an agency must "ensure a nurse, CNA, or HHA is not scheduled to work for more than a total of 60 hours per week or 16 consecutive hours and that the individual is off 8 or more hours before starting another shift unless otherwise authorized by the Department." In some cases, requests may be denied to ensure nurse and participant safety.

	Submit your request to mdh.pdnpreauthorization@maryland.gov.
How will the DONS monitor if a nurse/staff works over the 60-hour per week limit?	With the implementation of the new EVV system, DONS will periodically audit for program compliance. One of the compliance components that will be audited is the 16 consecutive hours/day and/or 60-hour/week work limitation. When DONS finds an agency staff person who is exceeding the 16-hour or 60-hour limit, either for one agency or across multiple agencies, DONS will contact the agency(cies) to review the circumstances. Several options may be available including, but not limited to, authorization for the staff to continue working the hours or developing a transition plan to reduce the staff's hours.
SHARED SERVICES	
In a shared situation where participants are sharing nursing services, will the nurse have to clock in for each participant?	No, the nurse will need to clock-in for only one participant. The shared participants are linked by the service authorization.
How will EVV work with a nurse that serves up to four individuals at the same location such as a group home?	As noted above in the previous response, the nurse will clock-in for only one participant. The shared participants are linked, so the clock-in/out is only required for one of the shared participants.
BACK-UP AGENCY	
If our agency backs up another agency for service, do we need to use that agency's provider number to clock-in?	Yes, that's one option if agreed upon by both agencies. You may also submit a request for a separate authorization for hours provided by your agency.
If a participant with global hours uses multiple agencies, how will the agencies know if the participant has exceeded their authorized hours if the authorization is not shared between agencies?	Each agency will request and receive a separate authorization. The agency will be limited to the hours approved via their authorization. The agency will continue to coordinate services as is the process now, and any changes to the authorizations must be requested, approved by the DONS, and then will be reflected in the system.

CLAIMS	
Is October 19th a soft date or will claims be rejected as of that date?	There is no soft date. November 30th is the new launch date.
When will claims begin to be denied?	Claims may be rejected once the system launches on November 30, 2023.
What is the billing week period?	Thursday 12am to Wednesday 11:59pm Providers will be paid on a weekly basis (services registered each Thursday through Wednesday). Claims will be processed and go to the Medicaid Management Information System (MMIS) the following Saturday. Providers should receive payment the following week (date depending on your bank) based on that week's claims. Reimbursement (i.e. direct deposit, etc.) will remain the same and the 835 is from MMIS so that should continue.
Are there rounding rules for EVV services?	The minimum service time is 7.5 minutes rounding to the next 15-minute increment.
How will we know when the missing time is paid?	First, you will see the MTR enter a closed status that will let you know that the MTR was approved. Then it will become a claim and if the claim is approved for payment it will have a paid status.
With LTSS, we are currently not dealing with billing, MDH does. What would be the difference?	LTSS Maryland is designed so that the clock-in and clock-out entries link to the participant's service authorization to ensure that those services are appropriately rendered by your agency in accordance with the participant's approved PDN hours. The LTSS Maryland data system transfers this information to the MMIS claims system where the claim will be adjudicated.
How do we bill for services provided to newborns without a Medicaid number assigned?	Any participant requiring urgent needs should be provided services per DONS policy. If and when the participant receives their Medicaid ID, LTSSMaryland will create a claim and submit for payment. This is the same process as today, except that LTSSMaryland will complete the claim submission instead of the agency.

	For billing purposes, the LTSSMaryland Provider Billing Support Office will approve all manual entries after service delivery (within 30 days of delivery) in these instances.
How do providers bill for services prior to the November 30 launch date compared to services after the launch date?	This is determined by the **date of service** the agency is billing for. For dates of service prior to November 30, agencies should continue billing via MMIS, as they currently do. For dates of service after November 30, providers should bill using the LTSSMaryland Provider Portal and EVV system.
EXCEPTIONS/MISSING TIME REQUESTS	
Will there be a maximum amount of exceptions for any agency penalized or the claim is denied?	Yes, up to six (6) missing time requests (MTRs) (each clock-in and clock-out will be considered as one (1)). When staff miss a full shift, that will count as two (2) MTRs. Each agency is allowed six (6) MTRs per month, per staff, NOT for each participant. Any MTRs over the 6 allowed may result in denied claims.
How do we determine who can perform manual entry; or is that enabled for everyone?	One provider administrator is enabled by MDH. Additional agency administrators and billing staff must be enabled by that provider administrator.
If the nurse misses either clock-in or clock-out, how is this resolved?	Agency administrators/billing staff may enter the clock-in and clock-out times manually. ● **Missing Time Submission Deadline:** Missing Time Requests (MTRs) must be submitted within 30 calendar days from the original Date of Service. ● **Six (6) Missing Time Limit:** Unless a valid and verifiable excuse is given, MDH will only approve up to 6 MTRs per month per clinical staff.

If a staff member goes over the limit, what is the penalty? Will the claim be rejected if there is no recourse?	As noted above, unless a valid and verifiable excuse is given, MDH will only approve up to 6 MTRs per month per clinical staff. Any MTRs over the 6 allowed may result in denied claims. This policy only impacts future manual entries during that month. Once the 6 limit is reached, future unexcused manual entries will not be reimbursed. However, any future entries via the EVV solution will pay as normal.
Will there be a grace period for the manual entry limit after the EVV launch?	There is a 6 month grace period in which the 6 manual entry limitation and the 30 day submission deadline are waived. It is, however, the expectation of MDH that the provider communicates with their staff to adhere to clock-in policies required for the Medicaid program.
What about rural locations with no Wi-Fi service? Is the agency penalized for having manual entries in this scenario?	There may be exceptions allowed in these types of instances. It is not our intent to penalize direct service workers, however, it is federally required that all home health and PDN providers use the EVV solution.

LTSS PROVIDER PORTAL/EVV MOBILE APP	
Is MDH using a specific aggregator that will allow agencies to submit EVV data via a 3rd party vendor? We have an EMR vendor that is actively meeting EVV requirements for various states. Is the EVV overview presented as an alternative for agencies not using an EMR vendor?	It is not an alternative. MDH's EVV system is the only system in which Maryland Medicaid may currently reimburse providers.
Will my agency have a different login for each service program?	Yes, that's correct. If your agency is already a Community First Choice (CFC) provider, your agency will need a new account login. PDN (PT53) or HH (PT41) location will be added to your profile. The accounts are linked to the agency locations by FEIN.

Will the app be available before EVV gets implemented?	The app and Provider Portal are available now to give providers the opportunity to set up staff profiles. At a date closer to the launch date, providers will have access to participant information.
Are provider staff required to enable location access for the EVV mobile app?	Yes. The EVV mobile app will not work unless the location is enabled.
Does the app work on an iPad with Cellular data?	It may work on your iPad, but the app was not built for or tested on tablets, and it is not currently being supported for other devices.
What happens if the staff forget their password? Does the provider administrator have to reset it or can the staff reset it themselves?	Staff should use the "Forgot Password" function on the app to reset and get access to their account once created. Provider administrators are responsible for giving staff permission to access the mobile app.
Is the app capable of entering nursing notes or just clock-in and clock-out?	At this time, the app is used for clock-in and clock-out only.
How will a nurse clock-in/out if the parent's/family caregiver's device is not available?	The nurse may clock in and out of EVV using their own smartphone (with the EVV app), or the ISAS telephone EVV using the participant/family's phone, or any phone available alongside an OTP device.
Will the system show the actual clock-in/out times (i.e. 9am-6pm)? Our nurses arrive 10 minutes early to give reports related to the participant's care. Is the agency paid for the additional 10 minutes?	Yes, the system will show the actual clock-in/out times. The agency MAY be paid if the number of hours provided are included in the service authorization. Providers are paid in accordance with the services authorized by the DONS.
REFERRING PROVIDERS	
Is the referring provider automatically put into the authorization so that it is included in the billing?	No, the provider (PDN agency) is required to enter the referring provider's information.
Can the agency add the referring provider once for a participant and cover all services?	A referring provider must be added to each service authorization.
When searching for the referring provider, will the system show out of state locations? Inactive status?	Yes, the system will show active enrolled providers and those providers with an inactive status.
STAFF PROFILES	

For staff profiles for LPN staff, the system only allows a one-year span. LPN licenses are good for 2 years. How should my agency enter this information?	The DONS is aware of this system error. The correction is expected in November 2023. In the meantime, please enter a span for 1 year.
In the staff profiles, how are out-of-state licenses entered?	The DONS is aware of the character limitation in the licenses field. The correction is expected in November 2023. If possible, please enter the state's abbreviation in front of the license number.
Do staff names have to match what is in the LTSS system to their nursing license?	MDH recommends matching the staff name to the license. This ensures MDH and the provider can look up information as necessary. However, the system will not require the clinician's name to match their license.
If we have a clinician with an expired license, will it prevent them from clocking in and out?.	No, they can still clock in/out. An exception is generated and cannot be processed for payment until or unless the license is updated.
What if a staff member doesn't want to supply their social security number?	The LTSSMaryland system has required SSN entry for caregiver staff since 2013 for Residential Service Agencies serving participants in other Medicaid programs. This is necessary to confirm staff identity because we must track staff's employment and clock-in/out times across multiple agencies. This is required to prevent fraud due to unauthorized individuals clocking in for the staff and duplicative billing across multiple agencies.
What disciplines are covered by EVV?	PDN services covered include: RN, LPN, CNAs, CNA-CMT and also the corresponding shared services. These can be found under the service provider type.
OTP DEVICES	
Is there a cost for OTP devices?	No, OTP devices are provided at no cost to the participant. The participant should keep it with them, so it must remain in their possession. If

	services are frequently provided in the community, the participant should bring the OTP device with them so the staff can use it when that service starts. If participants need replacement OTP devices, please contact the participants' case managers or the DONS.
Who trains the staff and participants on the use of the OTP devices and app?	It is the responsibility of the provider to train its staff on the use of the OTP device and mobile app. Case managers distribute OTP devices to participants and have been provided guidance to assist them. Resources and Videos can be found online at MDH website. • **Click here to view a video on clocking in and out for staff**
When will the OTP devices be distributed to the clients?	Case managers will begin distributing OTP devices approximately 2 weeks prior to the launch date.
ATTACHMENTS	
What documents should providers add to the provider portal?	Providers may only add documents as requested by MDH on an as-needed basis.
Who at MDH has access to view provider portal attachments?	MDH-DONS staff
Who is responsible for changing the participant addresses in the Provider Portal?	Participant information in Provider Portal comes from the participant record in LTSS. This information can only be updated by MDH or other authorized users. Please contact the participant's case manager to relay address changes.

21st Century Cures Act

It is a federal requirement for ALL states mandated by the **21st Century Cures Act** to promote fiscal integrity in HCBS Waivers and Medicaid programs. The **21st Century Cures Act** mandates that states implement EVV for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider. Click here to view more information about the **21st Century Cures Act**.

EVV Training Videos

- **Creating a user account for LTSSMaryland EVV Mobile**
- **Clocking in and out with LTSSMaryland EVV Mobile**
- **Adding a Participant and other functions**
- **Staff Creation**

EVV questions should be directed to Shauna Thompson, Administrator IV of the MDH-DONS at 410-767-1448 or mdh.preauthorizations@maryland.gov.

Contacts and Resources

Billing and Policy Questions	**LTSSMaryland Provider Billing Support Office** **MDH.LTSSBilling@maryland.gov** **410-767-1719**
Technical Issues **How to Questions** **Account Registration**	**LTSSMaryland Help Desk** **ltsshelpdesk@ltssmaryland.org** **1-855-463-5877**
Register for Direct Deposit **Missing Checks**	**Maryland Controller** **1-800-638-2937** **410-260-7980**