Electronic Visit Verification (EVV)

Provider Training
Last Update August 2020
Introductions and Agenda

• Presenter Introductions
• What is EVV?
• Reason Codes
• EVV Compliance
• EVV Claims
• EVV Changes
• Questions and Answers
What is EVV?

- The 21st Century Cures Act Section 12006, is a federal law requiring all states to use Electronic Visit Verification (EVV) for all Medicaid personal care services.

- Service attendants providing EVV related services to an individual or health plan member must use one of the three HHSC approved EVV clock in and clock out methods.

- The EVV system records the time the attendant begins providing services and the time the attendant stops providing services.

- Once a program provider has ensured an EVV visit passes all validation edits they may reference the time recorded in the EVV system to determine billable units/hours.
The EVV system:

- Electronically verifies the occurrence of authorized personal attendant service visits.
- Electronically documents the precise time a service delivery visit begins and ends.
- Replaced paper attendant timesheets and is a requirement for claim payment.
- EVV state and federal statutes and rules include:
  - Texas Government Code 531.024172
  - Human Resources Code 161.086
  - Section 12006 of the Cures Act
  - TAC Title 1, Part 15, Rule 354.1177(d)
  - TAC Title 40, Chapter 49, Subchapter C
  - TAC Title 40, Chapter 6
Programs and Services Requiring EVV

• STAR+PLUS:
  – Personal Attendant Services (PAS)
  – In-Home Respite Services
  – Community First Choice (CFC)-PAS and Habilitation (HAB)
  – Protective Supervision

• STAR Health:
  – PCS
  – CFC PAS
  – CFC HAB

• STAR Kids
  – PCS
  – CFC PAS
  – CFC HAB
In 2020, HHSC began implementation of the EVV requirement for all Medicaid personal care services in programs and service delivery options not currently required to use EVV by state law to do so by January 1, 2021.

FMSAs, CDS employers, and program providers effected by the Cures Act EVV Expansion should follow the milestones set in the HHSC timeline below:

- By May 1, 2020: Providers and FMSAs must select an EVV vendor system and begin the onboarding process.

- Between July 1, 2020 – Nov. 30, 2020: Providers and FMSAs can participate in the EVV practice period to learn more about using the EVV system, EVV Portal, and EVV claims matching. CDS employers can learn more about using the EVV system during this time.

- Beginning December 1, 2020: EVV Claims without a matching EVV visit transaction accepted into the EVV Portal will be denied for payment. Additionally, program providers, FMSAs, and CDS employers must complete all EVV training requirements by this date.

For more details related to the EVV Cures Act Expansion, refer to the HHSC EVV Website.
Cures Act EVV Expansion

- Effective January 1, 2021, the Cures Act EVV Expansion will require Financial Management Services Agency (FMSA) and the Consumer Directed Services (CDS) employer to use EVV.

- The CDS employer will use the EVV vendor selected by the FMSA to collect and transmit EVV visit data.

- The EVV vendor will be able to provide training to CDS employers and the FMSA.

- CDS employers are responsible for training their attendants on how to clock in/out using the EVV vendor’s system.
EVV Visit Maintenance

- Providers are responsible for making corrections to EVV visit transactions when performing visit maintenance in the EVV vendor system.

- When making corrections through visit maintenance select the most appropriate reason code number, reason code description, and free text.

- Each provider is responsible for ensuring their attendants are trained on using the EVV systems and that accurate data is being submitted to Superior.

- Per the HHSC Visit Maintenance Unlock Request Policy, any visit maintenance not completed in the EVV system within 60 days of the date of service will require a visit maintenance unlock.
  - Visit maintenance unlock requests are to be submitted to Superior and are reviewed on a case by case basis.
When attendants fail to clock in and out, providers must select the EVV non-preferred reason code and most appropriate reason code description.

Using the same EVV reason code number and reason code description for the same member more than 14 days within a calendar month constitutes misuse of reason codes.

Superior will analyze utilization of reason codes on a monthly basis. If patterns of misuse of reason codes are present, provider may be subject to:
- Additional training on EVV policy.
- A corrective action plan.
- Potential termination from the network (if continued non-compliance).
Reason Codes

- **Preferred Reason Code** – Preferred reason codes indicate situations that are acceptable variations in the proper use of the EVV system.

- **Non-preferred Reason Code** – Non-preferred reason codes indicate situations where there was a failure to use the EVV system properly.

  - For an up to date list of all HHSC EVV reason codes, visit: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-reason-codes.pdf
Reason Codes

- Provider agencies are not required to provide services to members who do not have Medicaid eligibility or a current service authorization.

- If the provider agency *voluntarily* chooses to continue providing services which require EVV documentation in anticipation of the eligibility or authorization being retroactively reinstated, those services must be completely and accurately documented in the EVV system, including completing visit maintenance prior to billing.

- For retro-eligibility or other exceptions, please contact your Superior Account Manager.
• **Note**: If DataLogic is your elected EVV vendor, the Vesta system systematically clocks out at 11:59 p.m. with reason code 000, and it clocks in with a new visit ID at 12:00 a.m. with reason code 000. Any claim where this occurs will need to be submitted for 2 dates of service (2 claim line details).

• For example:

<table>
<thead>
<tr>
<th>EVV Visit ID</th>
<th>Actual Visit Date</th>
<th>Actual Call In Time</th>
<th>Actual Call Out Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>814286370225</td>
<td>01022019</td>
<td>01022019 07:59 PM</td>
<td>01022019 11:59 PM</td>
</tr>
<tr>
<td>814286411521</td>
<td>01032019</td>
<td>01032019 12:00 AM</td>
<td>01032019 04:01 AM</td>
</tr>
<tr>
<td>814286773432</td>
<td>01032019</td>
<td>01032019 07:59 PM</td>
<td>01032019 11:59 PM</td>
</tr>
<tr>
<td>814286812089</td>
<td>01042019</td>
<td>01042019 12:00 AM</td>
<td>01042019 04:00 AM</td>
</tr>
<tr>
<td>814287158590</td>
<td>01042019</td>
<td>01042019 07:59 PM</td>
<td>01042019 11:59 PM</td>
</tr>
<tr>
<td>814287192898</td>
<td>01052019</td>
<td>01052019 12:00 AM</td>
<td>01052019 04:01 AM</td>
</tr>
</tbody>
</table>
Providers should notify Superior or HHSC within 48 hours of an ongoing EVV system issue that has been unresolved after contacting the EVV vendor, and affects the attendant's ability to use the system.

- **DataLogic (Vesta) Software, Inc.**
  Phone: 1-844-880-2400
  Website: [www.vestaevv.com](http://www.vestaevv.com)

- **First Data (AuthentiCare) Government Solutions**
  Phone: 1-877-829-2002
  Website: [www.firstdata.com](http://www.firstdata.com)

- **Superior HealthPlan**
  Phone: 1-877-391-5921
  Email: [SHP_EVV@SuperiorHealthPlan.com](mailto:SHP_EVV@SuperiorHealthPlan.com)
Non-Compliance

• Providers must inform the member’s Superior Service Coordinator of any instances where the member refuses to allow the use of his or her landline and the placement of an alternative device in the home.

• STAR+PLUS: 1-877-277-9772
• STAR Health: 1-866-912-6283
• STAR Kids: 1-844-433-2074
EVV Vendor Responsibilities

- EVV vendors are responsible for training providers on use of their system.
- EVV vendors are responsible for providing technical support for their system. Please contact the vendor directly for training or support.
- EVV vendors cannot pass on transaction fees to providers nor members.
- EVV vendors will not bill providers for the use of equipment that is needed.
EVV Compliance

• Requirements that establish standards for EVV usage.

• Provider agencies must meet the standards for EVV outlined in the HHSC EVV Compliance Oversight Reviews Policy.

• Providers are reviewed on a regular basis to ensure they are in compliance and are measured along the following areas
  – EVV Usage
  – EVV Reason Codes and Required Free Text
  – EVV Allowable Phone Identification
EVV Compliance

• **Usage Review**
  – Manually entered/Graphical User Interface (GUI) EVV visit transactions;
  – Rejected EVV visit transactions caused by provider error
    • All program providers must maintain a minimum EVV Usage Score of 80%  

• **EVV Reason Codes and Required Free Text**
  – Misuse of EVV reason code numbers and reason code description options
    • Same EVV reason code number and reason code description option for the same member more than 14 days within a calendar month
  – Failure to enter required free text

• **EVV Allowable Phone Identification**
  – Use of unallowable phone type when a provider has selected the member’s home phone landline method to clock in and clock out
EVV Reports

- Providers and FMSAs may access the EVV Portal to view the following EVV reports:
  - EVV Provider Report
  - EVV Reason Code Usage and Free Text Report
  - EVV Usage Report
  - EVV Visit Log Report
  - EVV Clock In/Clock Out Usage Report
  - EVV Units of Service Summary Report
  - EVV Attendant History Report

- For additional reports, providers, CDS employers, and FMSAs should access the EVV vendor’s system.

- Each provider is responsible for verifying their EVV vendor is submitting accurate data to Superior prior to submitting claims.
EVV Claims
EVV Claims

- Providers will verify times of service using the vendor-specified EVV system.

- TMHP submits daily files directly to Superior for all approved EVV transactions.

- Provider claims are processed in accordance with EVV data prior to adjudication.

- Superior will only pay for verified units of service aligned with EVV data.
EVV Claims

• Providers need to verify all data elements entered in the EVV vendor system are accurate prior to billing.

• Ensure the appropriate authorization has been received prior to services being rendered and billed on the claim.

• Reason for claim denial will be listed on the Explanation of Payment (EOP).

• For claim denials (due to inaccurate/incomplete/invalid EVV transaction data), contact your Provider Account manager if assistance is needed when reviewing data submissions.
To avoid denials, claims for multiple Dates of Service should be billed on a separate line for each day with the number of units per day.

Superior will compare EVV data to claims prior to adjudication.

Superior may conduct claim matching for EVV transactional data either upfront for visits prior to 9/1/2019 (for a pre-payment review) or retrospectively (for a post-payment potential recoupment).

Following standard claim adjudication rules matching EVV Provider ID, Member ID, dates of service, procedure codes, modifier codes (where applicable) and billed units are then applied.

- If each of these billed data elements match the visit transaction, the claim will continue the adjudication process instead of a denial caused by EVV data element mismatch.
EVV Claims

If a Claim Denies:

- Begin by searching the EVV Portal or reviewing the explanation of benefits (EOP) to determine the reason associated with the claim denial.
- Review submitted visit transactions in your EVV vendor’s system to confirm the transactions were accepted.
- If corrections are required through visit maintenance, once completed, review the EVV Portal to ensure the updated EVV visit transaction has been accepted by the EVV Aggregator and then resubmit the EVV claim.
- Per HHSC’s [Visit Maintenance Unlock Request policy](#), providers must complete all required EVV visit maintenance within 60 days of the date of service. After 60 days, visit maintenance will only be allowed based on Superior’s approval and on a case-by-case basis.
- For retro-eligibility claims or other exceptions, please contact your Provider Account Manager.
Effective September 1, 2019, EVV-relevant claims for programs required to use EVV, must be billed to Texas Medicaid and Healthcare Partnership (TMHP) and are subject to the EVV claims matching process.

PAS and In-Home Respite increments changed from 1 hour to 15 minute units. Please refer to the Long-Term Services and Supports (LTSS) billing matrix for further clarification.

Healthcare Common Procedure Coding System (HCPCS), modifiers, and units must be exact matches for the EVV Aggregator to forward a full matching result to Superior.

If modifiers billed and units billed do not match, the claim will be denied.

  – Additionally, providers should note claims with Personal Attendant Services (PAS) submitted using date spans will be denied.
EVV Changes Effective September 1, 2019

<table>
<thead>
<tr>
<th>Former Code</th>
<th>Code eff. 9/1/2019</th>
<th>Service</th>
<th>Current Unit Increment</th>
<th>New Unit Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5125</td>
<td>S5125</td>
<td>(PAS)</td>
<td>1 Hour=1 Unit</td>
<td>15 minutes = 1 Unit</td>
</tr>
<tr>
<td>T2021</td>
<td>T2017 (NEW)</td>
<td>Habilitation</td>
<td>1 Hour=1 Unit</td>
<td>15 minutes = 1 Unit</td>
</tr>
<tr>
<td>S5151</td>
<td>T1005 (NEW)</td>
<td>Respite Care – In Home</td>
<td>1 Hour=1 Unit</td>
<td>15 minutes = 1 Unit</td>
</tr>
</tbody>
</table>

Please note: Billing changes are processed based on date of services delivered, as opposed to date of service claim submission or received.
• The EVV Aggregator performs matching edits verifying the data on the billed claim matches the visit data in the EVV portal before forwarding to Superior for adjudication.

• To prevent claim denials, providers should verify the EVV visit transaction is accepted before billing.

• When billing claims, providers must verify the data elements billed on match the data listed in the EVV portal

• EVV claims must display a match status code of EVV01, listed in the EVV Portal, in order for EVV claims to be paid by Superior.
  – Claims displaying a match status code EVV02 - EVV06 will result in claim denial

• Providers will be required to resubmit any denials to TMHP.
CDS EVV – Billing After January 1, 2021

- CDS claims billed with dates of service on or after January 1, 2021 must be submitted to TMHP and will be subject to the EVV claims matching process.

- CDS claims must match EVV transaction data, including:
  - National Provider Number (NPI) or (Atypical Provider Identifier)
  - Date of Service
  - Medicaid ID
  - HCPCS Codes
  - Modifier(s), if applicable

- All CDS claims line items billed without matching EVV visit transactions will result in denials.

- Claims must be billed with units; however, the units will not be used for matching.

- For reviewing EVV data and reporting, the FMSA may access the EVV Portal and EVV vendor system.
  - CDS employers have access to the EVV vendor system only.
Questions and Answers