Electronic Visit Verification (EVV)

Provider Training

Last update June 10, 2015

Electronic Visit Verification

- Anyone providing covered services to an individual or health plan Member must use the selected Electronic Visit Verification (EVV) system to record visit arrival and departure times. The Provider agency will use the time recorded in the EVV system to determine billable units/hours before requesting payment.
- Services in the STAR+PLUS and STAR Health Programs that will require EVV include:
  - Primary Home Care/Personal Attendant Services (PAS)
  - Personal Care Services (PCS)
  - In-home Respite Services
  - Community First Choice (CFC) (basic attendant and habilitation)

Provider Responsibilities

- Providers are responsible for choosing a vendor and for ensuring that their vendor submits accurate data to Superior.
- All Providers must have selected an EVV vendor by February 10, 2015. For those that did not select, HHSC will default assign a vendor to the Provider.
- Providers are not allowed to request a vendor change before the first date of full compliance. Providers are required to submit the Medicaid EVV Provider System Selection Form 120 days before they begin receiving services from a different EVV vendor.
- To select a vendor, fill out a Vendor Selection Form. Using the contact information on the form, submit the completed form to:
  - Your selected vendor
  - Superior HealthPlan
  - TMHP

Provider Responsibilities

- Starting on April 16, 2015, PAS, PCS, in-home respite services and CFC services should begin using EVV, if they are operationally ready.
- There are three rolling implementation dates:
  - April 16, 2015
  - May 1, 2015
  - May 16, 2015
- Provider agencies must notify their EVV Vendor 14 days before one of the implementation dates.
- The final EVV implementation start date is June 1, 2015.

Provider Responsibilities

- The Grace Period is from April 16 – August 31, 2015.
- Provider Compliance Plan effective date is September 1, 2015.
- Providers should learn new and revised reason codes. There will not be a grace period after the first day of full compliance.
- Each Provider is responsible for ensuring their attendants are trained on the use of EVV and that accurate data is being submitted to Superior.

Provider Responsibilities

- EVV related claims are subject to denials when grace period ends.
- For partially or full claim denials, due to inaccurate\incomplete\invalid EVV transaction data, contact your vendor directly to review data submission.
  - Reason for denial will be listed on the Explanation of Payment (EOP)
- Providers must inform the Member about the use of their telephonic landline in order to use EVV.
- If a Member refuses the use of the landline, then the Provider must educate on the use of a small alternative device (SAD) and how that device must remain affixed to a designated location within the Member's home.
- Providers must inform the Member's Superior Service Coordinator in any instances where a Member refuses to allow the use of their landline and the installation of an alternative device.
  - STAR+PLUS: 1-877-277-9772
  - STAR Health: 1-800-213-7508

EVV Vendors

Care Monitoring 2000, LLC (CM2000)

Temporarily Not Accepting New Providers

www.cm2000.com/texas.aspx

DataLogic (Vesta) Software, Inc.

Phone: 1-844-880-2400

Fax: 1-956-412-1464

www.vestaevv.com

MEDsys Software Solutions, LLC

Phone: 1-877-698-9392

Fax: 1-866-437-9066

www.medsyshcs.com

Vendor Responsibilities

- Each Vendor is responsible for training Providers on the use of their system.
- Each vendor is responsible for providing technical support for their system. Contact your vendor directly for training or support.
- Vendors must submit a monthly training list of Superior contracted Providers to Superior.
- Vendors cannot pass on transaction fees to Providers nor Members.
- Vendors will provide EVV data reports to Providers for review.

Vendor Fees

- Providers nor Members pay EVV transaction fees. Superior HealthPlan will pay approved transaction fees for Superior Members directly to the vendor.
- EVV vendors will not bill Providers for the use of equipment that is needed.
- The transaction fee includes but is not limited to:
  - Vendor provision of Provider training
  - Visit verification
  - Customer assistance and support,
  - Interfacing
  - Reporting
  - Hardware
  - Software
  - Any other additional costs the Vendor will incur to perform all of the required services and deliverables
- For Superior HealthPlan, the transaction fee does not include upfront costs for Alternative Devices. Superior HealthPlan will not be paying for any costs associated with alternative devices.

Vendor Reports

- EVV Reporting is done primarily through your selected vendor.
- Any requests for EVV reports should be directed to your vendor.
- Each vendor is required to provide you reports of transaction activity.
- Each Provider is responsible for ensuring that their vendor is submitting accurate data to Superior on their behalf prior to submitting claims.

EVV Process and Claims

Process

- Providers will verify times of service using the vendor's specified process.
- Each vendor will submit daily reports directly to Superior for all completed EVV transactions.
- Provider claims are compared to EVV data prior to adjudication.
- Superior will only pay for verified units of service based on EVV data.

EVV Service Claims

- Ensure that authorization for services is in place prior to providing services to the Member.
- To avoid denials and/or delay in payment, claims for multiple DOS 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.
- Only authorized and verified units of service will be paid. Any unauthorized and/or unverified units will be denied.
- Superior will adjudicate claim data starting with the first date of service billed.

EVV Service Claims

- If a claim fully denies:
  - Review submitted data with your EVV Vendor.
  - Any changes to your data will need to be made by the Provider agency into your vendor system.
  - Per HHSC, Providers must complete any and all required visit maintenance in EVV within 21 days of the date of service. No visit maintenance will be allowed more than 21 days after the date of service.

EVV Service Claims

- If a claim fully denies (continued):
  - Any data updates made outside the defined visit maintenance window will continue to deny regardless if EVV Vendor system allows such changes.
  - Once corrected data has been received by Superior, your claim will be automatically reprocessed.
  - DO NOT resubmit your claim. Resubmissions will result in a rejection or denial for duplicate claim.

EVV Service Claims

- If a claim partially denies:
  - Review data with your EVV Vendor.
  - Any changes to your data will need to be made by the provider agency into your vendor system.
  - Per HHSC, Providers must complete any and all required visit maintenance in EVV within 21 days of the date of service. No visit maintenance will be allowed more than 21 days after the date of service.

EVV Service Claims

- If a claim partially denies (continued):
  - Any data updates made outside the defined visit maintenance window will continue to deny regardless if Vendor system allows such changes.
  - Once corrected data has been received by Superior, resubmit a NEW claim for the portion of your claim that was previously denied.

Reason Codes

- Standardized HHSC approved numbers of up to three digits used during visit maintenance to explain the specific reason a change was made to an EVV visit record.
- Providers must use the most appropriate reason code(s) with each change made in the visit maintenance and enter any required free text in the required field.
- Superior will analyze utilization of reason codes on a monthly basis. If patterns of regular Visit Maintenance activity (usage of both/either preferred and non-preferred reason codes) are present, Provider may be subject to:
  - Additional education and Vendor training
  - A corrective action plan
  - Potential termination from the network (if continued non-compliance occurs)

Reason Codes: Definitions

- **Preferred Reason Code** – A reason code which documents a change to an EVV visit record that is caused by a situation in which the provider staff IS documenting services in accordance with program and policy requirements.
- **Non-preferred Reason Code** – A reason code which documents a change to an EVV visit record that is caused by a situation in which the provider staff is NOT documenting services in accordance with program and policy requirements.

Reason Codes: Preferred

- There are 20 preferred reason codes.
- Used when standard EVV visit documentation was not possible due to:
  - Permissible actions by the attendant (e.g., reason code 110)
  - Factors beyond the attendant's control (e.g., reason code 405)
  - Circumstances that don't prevent electronically verifying that the individual or member received services (e.g., reason code 120)

Reason Codes: Non-Preferred

- There are five non-preferred reason codes.
- Four of these document situations where the EVV data does not accurately document when service began and/or ended.
  - Reason Code 900 – Not calling in
    - Free text comments required to document actual time in
  - Reason Code 905 – Not calling out
    - Free text comments required to document actual time out
  - Reason Code 910 – Not calling in and not calling out
    - Free text comments required to document actual time in and time out
  - Reason Code 915 – Calling from an unrecognized phone number

Reason Codes: Non-Preferred

- One non-preferred reason code is used for situations that cannot be described by any other reason code.
  - Reason Code 999 – Other
    - Is used for situations that cannot be described by any other reason code.
    - It is non-preferred because the code prevents accurate data tracking in the EVV system.
    - Use of reason code 999 - “Other” should be very rare, as there are reason codes to explain most situations.
    - Providers must enter free text in the comments field to explain the use of this reason code.

Reason Codes: Not in use

- Companion Cases
  - When two or more members receive services from the same attendant in the same home, the attendant must use the EVV system to call in and out for **each** member
- Suspended Eligibility or Authorization
  - When Medicaid eligibility or service authorization has been suspended for an individual or member:
    - IF the provider agency *voluntarily* chooses to continue providing services which require EVV documentation in anticipation of the eligibility or authorization being retroactively reinstated,
    - THEN those services must be completely and accurately documented in EVV, including completing visit maintenance within 21 calendar days of the date of service, prior to billing.

Reason Codes: Not in use

- Suspended Eligibility or Authorization
  - IMPORTANT: If the Medicaid eligibility or service authorization is not reinstated retroactively, the provider agency will not be reimbursed for those visits.
  - Provider agencies are not required to provide services to members who do not have Medicaid eligibility or a current service authorization.

Reason Codes

- Providers must use a HHSC approved reason code on visit maintenance EVV Transactions.

- For an up-to-date list and definitions, visit: https://www.dads.state.tx.us/evv/reasoncodes.html

Questions