superior healthplan™

Electronic Visit Verification (EVV)

Provider Training

Last update October 2016

SHP_2015868A

Electronic Visit Verification

- Attendants providing covered services to an individual or health plan member must use the selected HHSC-approved 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)
  - Flexible Family Support Services

Provider Responsibilities

- Providers are responsible for choosing a vendor and for ensuring that their vendor submits accurate data to Superior.
- Providers are allowed to request a vendor transfer, 120 days after the submission date of the Provider EVV Vendor System Selection form.
- To select a vendor, fill out a Provider EVV Vendor System Selection form. Using the contact information on the form, submit the completed form to Texas Medicaid and Healthcare Partnership (TMHP).

Provider Responsibilities

- Provider EVV selection and onboarding process must be complete prior to rendering EVV services.
- Providers are responsible for clearing visit exceptions through the visit maintenance process.
- Providers should learn new and revised reason codes.
- Each provider is responsible for ensuring their attendants are trained on the use of EVV and that accurate data is being submitted to Superior.
- Small Alternative Device (SAD) values must be entered into the EVV System within seven (7) days of the visit Date of Service.

Provider Responsibilities

- EVV related claims are subject to denials when compliance is enforced, effective April 1, 2016.
- For partially or full claim denials, due to inaccurate\incomplete\invalid EVV transaction data, contact your vendor directly to review data submission.
  - Reason for claim 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.
  - Attendants may not use their personal cell phone to clock in or out of the EVV system.

Provider Responsibilities

- 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. To order a SAD, visit:
  - https://www.dads.state.tx.us/evv/docs/SmallDeviceAgreementOrderForm.pdf
- 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: 1-866-912-6283
  - STAR Kids: 1-844-590-4883
  - STAR+PLUS MMP: 1-866-896-1844

EVV Vendors

EVV vendors and Superior should be contacted immediately (within 48 hours) of any EVV system issues that affect the ability of your attendant's or office staff to use the system as expected.

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

Superior HealthPlan

Phone: 1-877-391-5921

Email: SHP_EVV@centene.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.
  - Training list information includes:
    - Course Name
    - Actual Start Date/Time
    - Course Duration
    - Training ID Attended
    - Last Name
    - First Name
    - Email Address
    - Registration Date/Time
    - Time in Session
    - Organization
    - Tax ID
    - Job Title
    - DADS, TMHP, MCO and Provider Regions.
- Vendors cannot pass on transaction fees to providers nor members.

Vendor Fees

- Neither providers nor members pay EVV transaction fees. Superior 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 cost of the SAD is included in the vendor's contract rate.
- 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, the transaction fee does not include upfront costs for SADs. Superior will not be paying for any costs associated with SADs.

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 vendor is required to provide you access to the standard EVV reports created by the Texas Health and Human Services Commission (HHSC). Raw transition data that is submitted to Superior can be made available upon request to the vendor.
- Each provider is responsible for ensuring that their vendor is submitting accurate data to Superior on their behalf prior to submitting claims.

Vendor Reports

- Vendors will provide EVV data reports to providers for review upon request. Standard reports include:
  - Alternate Device Order Status
  - Attendant Providing Services by Individual
  - CDS Employee List
  - Contracts List
  - EVV Compliance Plan Summary Snapshot Report
  - EVV Compliance Plan Daily Snapshot Report
  - EVV Visit Log
  - Provider Agency/Financial Management Services Agency (FMSA) List
  - Reason Code Free Text Report
  - Reason Code Use Report
  - Units of Service Summary Report

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.

Process

Providers will need to ensure that all information is appropriately entered:

The provider agency:

- TIN (Taxpayer Identification Number)
- NPI (National Provider Identifier)
- API or TPI (if applicable)
- Provider Legal Name
- Provider Address
- Provider City
- Provider Zip

The individual/member receiving services:

- Medicaid Identification Number (all 9 digits)
- First and Last Name
- Date of Birth
- Home Telephone Landline Number, if applicable (no cell phones numbers)
- Individual/Member's Payor (MCO, HHSC, DADS)
- MCO HCPCS (if applicable)
- MCO Modifier(s) (if applicable)
- MCO System Unique Member ID (if applicable)
- MCO Service Delivery Area of Member's Residence (if applicable)

Process

Providers will need to ensure that all information is appropriately entered:

Employee providing services:

- Employee ID (Employer Assigned ID for HR/Payroll Purposes)
- Employee Last four Social Security Number or Passport Number
- Employee Discipline (attendant, CNA, other)
- Employee First and Last Name
- Employee Start Date (start date of employment with provider)
- Employee End Date (end date of employment with provider, if applicable)
- Employee EVV User ID (user ID used to conduct visit maintenance)
- Employee EVV User First Name (first name of person associated with EVV user ID)
- Employee EVV User Last Name (last name of person associated with EVV user ID)

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 dates of service (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.
- Effective April 1, 2016, only authorized and verified units of service will be paid. Any unauthorized and/or unverified units will be denied.
- Effective April 1, 2016, Superior will adjudicate claim data starting with the first date of service billed.

EVV Service Claims

- Bill units using the rounded “Pay Hours” calculated in the EVV vendor system.
  - Example: If a client was serviced for 48 minutes, .75 units (rounded down to 45 minutes) should be billed. If a client was serviced 52 minutes (rounded up to 1 hour), 1 full unit should be billed for the respective visit.
- All unit increments should be billed in the following format after rounding:

Service Time (in minutes)	Units
60	1
45	.75
30	.50
15	.25
0	0

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 60 days of the date of service. No visit maintenance will be allowed more than 60 days after the date of service.
- 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, you will need to submit a new claim (For retro-eligibility claims or other exceptions, please contact your Provider Account Manager). In the event a provider bills more units than are validated through EVV on one service line, billed charges will be divided by the units billed to determine the billed charges for validated and non-validated service units.

Note: To avoid claim denials, bill EVV services for each date of service line by line verses spanned dates.

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 60 days of the date of service. No visit maintenance in EVV within 60 days of the date of service. No visit maintenance will be allowed more than 60 days after the date of service.
- 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, you will need to submit a corrected claim for the full amount of EVV units verified for the appropriate dates of service line by line (For retro-eligibility claims or other exceptions, please contact your Account Manager).

Note: To avoid claim denials, bill EVV services for each date of service line by line verses spanned dates.

Reason Codes

- Standardized HHSC-approved three-digit numbers are 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.
- 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 60 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.
    - For retro-eligibility or other exceptions, please contact your Account Manager.
  - 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 an 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/docs/hhscReasonCode.pdf

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Questions