Electronic Visit Verification
Frequently Asked Questions

Electronic Visit Verification (EVV) Implementation	
What is Electronic Visit Verification (EVV)?	Electronic Visit Verification (EVV) is a computer-based system that electronically verifies the occurrence of authorized personal attendant service visits, by electronically documenting the precise time a service delivery visit begins and ends.
What services are required to be verified by EVV?	Services that require EVV include Primary Home Care/PAS-type services, In Home Respite Services, Personal Care Services (PCS), and PAS/Habilitation provided through both CFC and non-CFC model. In alignment with current implementation timeline Consumer Directed Services (CDS) is optional, however required effective January 2020.
When does EVV compliancy begin?	All providers providing the mandated services must use the EVV system and must maintain compliance. Providers, who contract with Superior from the compliancy date forward, and provide services required to use EVV, must select and enroll with an HHSC-approved EVV vendor prior to furnishing services to Superior members.
How does EVV work?	Provider claims that are subject to EVV requirements must use an EVV system to verify times of service using the vendor's specified process. Provider claims will be transacted against EVV data prior to adjudication. Superior will only pay for verified units of service as authorized and transacted in accordance with EVV data entry.
Will I have to pay to use this service?	HHSC-contracted EVV services are at no cost to the provider, as the vendor will not bill providers or members for any equipment associated with EVV. Providers will need to contact the vendor to inquire about other EVV related additional services for purchase.
Who will train me on using the EVV system?	DataLogic is responsible for training and technically supporting the visit verification systems they offer. Please contact the vendor directly for training, system problems or questions. The contact information for the current vendor is provided below.
What if my claim does not match EVV data?	Only verified units of service will be paid. If claim information does not match the visit transactional data received from an EVV vendor, then the unverified portions of the claim are subject to denial or retrospective review. If the billed units exceed the EVV validated transactional units, the claim is subject to denial or partial payment for units that were validated. Effective September 1, 2019, an exact match of the visit data to the claim through the Texas Medicaid and Healthcare Partnership (TMHP) aggregator model will be required for claims to pay. Partial payments will no longer process and will deny.
Who do I call for denials based on EVV data?	A denial resulting from the inability to verify units based on EVV data requires Providers to call the EVV vendor to confirm their data is in the vendor system.

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Once my data has been updated, do I resubmit the claim to Superior?	**Fully Denied Claims**: Once providers have reviewed their data submission with their vendor and Superior has received updated data, providers will need to submit a new claim. If services are more than 95 days from the date of service but within 120 days from the date of denial, providers may submit a corrected claim for the fully denied claims. Effective September 1, 2019, the implementation of the Aggregator model will require providers to resubmit any denials to TMHP. **Partially Denied Claims**: Once providers have reviewed their data submission with their vendor and Superior has received updated data, providers will need to submit a corrected claim for the full amount of EVV units verified for the appropriate dates of service line by line. Following the September 1, 2019 implementation, partial approvals will no longer process. All EVV claims must be billed with accurate data entry. **Visit Maintenance**: Providers who perform visit maintenance on visit transactional data must submit claim corrections for each claim already paid, based on the visit data that was updated. Claims that are not corrected based on visit data maintenance could be subject to recoupment if a corrected claim is not submitted and the visit data maintenance impacted the claim match or paid amount.
How do I avoid claim denials?	Effective September 1, 2019, EVV claims should be submitted to TMHP, and will be subject to the EVV claims matching process, with an additional annotation of having the EVV claims submitted with a single date of service. Claims not submitted accordingly will be denied. Personal Assistance Services and In-Home Respite increments will also change from 1 hour to 15 minute units. Please refer to the Long-Term Services and Supports (LTSS) billing matrix, for further clarification. In alignment with the Aggregator functionality HCPCS, modifiers and units must be an exact match for the Aggregator to advise Superior in processing EVV claims. Please note: Providers must bill appropriately based on current billing guidelines. On and after September 1, 2019, providers must follow the billing requirements and changes that will go into effect on this date. EVV claims are processed on the date of service.
Does EVV affect claims adjudication timelines?	No. All EVV claims follow normal submission and adjudication timelines (95 days to bill for providers and 30 days for Superior to pay).

EVV Vendors	
DataLogic (Vesta) Software, Inc.	Phone: 1-844-880-2400 Fax:1-956-412-1464 Website: www.vestaevv.com

General Information	
Provider Services	1-877-391-5921

https://www.SuperiorHealthPlan.com/providers/resources