



# Electronic Visit Verification (EVV)

*Provider Training*

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Last Update February 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 Medicaid personal care services and home health services.
- Attendants providing covered services to an individual or health plan member must use the selected Health and Human Services (HHS)-approved Electronic Visit
- The EVV system records 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.

# What is EVV?



The computer-based system:

- Electronically verifies the occurrence of authorized personal attendant service visits.
- Electronically documents the precise time a service delivery visit begins and ends.
- Implemented to replace paper-based attendant timesheets.
- 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)
  - Personal Care Services (PCS)
  - In-Home Respite Services
  - Community First Choice (CFC)-PAS and Habilitation (HAB)
  - Protective Supervision
- STAR Health:
  - PCS
  - CFC (PAS/HAB)
- STAR Kids:
  - PCS
  - In-home respite services
  - Flexible family support services
  - CFC (PCS/HAB)

# EVV Visit Maintenance



- Providers are responsible for clearing visit exceptions through the visit maintenance process.
- Enter any required free text in the comment field for more explanation, as applicable.
- Each provider is responsible for ensuring their attendants are trained on the use of EVV and that accurate data is being submitted to Superior.
- Providers must complete any and all required visit maintenance in the EVV system within 60 days of the date of service; visit maintenance beyond 60 days is at the discretion of the Managed Care Organization (MCO) on a case by case basis.
- For an up-to-date list and definitions, visit:  
<https://hhs.texas.gov/sites/default/files/documents/doingbusiness-with-hhs/providers/long-term-care/evv/hhscreason-code.pdf>.

# Reason Codes



- Standardized Health and Human Services Commission (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).

# 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.
- Used when standard EVV visit documentation was not possible due to (for example):
  - Fill-in for Regular Attendant or Assigned Staff
  - Phone Unavailable Verified Services Were Delivered Invalid Attendant or Assigned Staff or Individual/Member ID Entered
  - Verified Services Were Delivered



# Reason Codes: Non-Preferred



- There are 5 non-preferred reason codes.
- 4 of these document situations where the EVV data does not accurately document when service began and/or ended.
  1. Attendant or Assigned Staff Failed to Call In - Reason Code 900-A
  2. Attendant or Assigned Staff Failed to Call Out - Reason Code 900-B
  3. Attendant or Assigned Staff Failed to Call In and Out - Reason Code 900-C
  4. Wrong Phone Number - Reason Code 900-D

# Reason Codes: Non-Preferred



- 1 non-preferred reason code is used for situations that cannot be described by any other reason code.
  - Reason Code 600 – 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 600 – “Other” should be very rare, as there are reason codes to explain most situations.

# Reason Codes



- For retro-eligibility or other exceptions, please contact your Account Manager.
- Providers must enter free text in the comments field to explain the use of this reason code.
- 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 EVV, including completing visit maintenance within 60 calendar days of the date of service, prior to billing.

# 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://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/hhsc-reason-code.pdf>.

# EVV System



- DataLogic 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  
Website: [www.vestaevv.com](http://www.vestaevv.com)
- **Superior HealthPlan**  
Phone: 1-877-391-5921  
Email: [SHP\\_EVV@SuperiorHealthPlan.com](mailto:SHP_EVV@SuperiorHealthPlan.com)

# Non-Compliance



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- Providers must inform the member's Superior Service Coordinator in any instances where a member refuses to allow the use of his or her landline and the installation of an alternative device.
- STAR+PLUS: 1-877-277-9772
- STAR Health: 1-866-912-6283
- STAR Kids: 1-844-433-2074

# EVV Vendor Responsibilities



- DataLogic is responsible for training providers on the use of their system.
- DataLogic is 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 adhere to the requirements of Texas HHS.
- Provider EVV Compliance reporting measures will become standard reports associated with EVV continued implementation.
- Three main components of Compliance Plan reports:
  - Summary Snapshot
  - Daily Snapshot
  - Ad hoc MCO monthly



# EVV Compliance



- EVV Provider Compliance Plan Score is a percentage that indicates how often billable visits are:
  - Auto-verified (no exceptions)
  - Verified Preferred – according to reason codes for exceptions
  - Verified Non-Preferred – according to reason codes for exceptions
- EVV Initiative Provider Compliance Plan Score =  $(\text{visits auto-verified} + \text{visits verified preferred}) \div (\text{total visits verified})$  rounded to the nearest whole percent.

# Vendor Reports



- EVV reporting is done primarily through DataLogic.
- Vendors are required to provide reports of transaction activity.
- The EVV vendor is required to provide access to the standard EVV reports created by HHSC. Raw transaction 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



- DataLogic will provide EVV data reports to providers 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 Claims

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# EVV Claims



- Providers will verify times of service using the vendor-specified submission procedure.
- DataLogic submits daily reports directly to Superior for all completed 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



- For claim denials (due to inaccurate\incomplete\invalid EVV transaction data), contact DataLogic directly to review data submission.
- Providers need to ensure all data fields entered are an accurate representation of data fields with the associated claim.
- Ensure the appropriate authorization is in place prior to rendering any services to the member.
- Reason for claim denial will be listed on the Explanation of Payment (EOP).

# EVV Claims



- 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 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 the EVV transactional units match the billed units, the claims will pay appropriately.

# EVV Claims



## If a Claim Denies:

- Review submitted visit transactions with DataLogic to confirm the transactions.
- 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. After 60 days, visit maintenance will only be allowed via Superior's approval and on a case-by-case basis.
- Any data updates made outside the defined visit maintenance window will continue to deny, regardless if EVV vendor system allows such changes. Only Superior-approved changes will be allowed and re-exported by the vendor.
- After visit maintenance has been completed and the updated EVV transaction is received by Superior, you will need to submit a new claim
  - For retro-eligibility claims or other exceptions, please contact your Provider Account Manager.

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



# EVV Claims



- Reminder: The DataLogic Vendor system systematically clocks out at 11:59 p.m. with reason code 0. It clocks in with a new visit ID at 12:00 a.m. with reason code 0. The claim will need to be submitted for 2 dates of service (2 claim line details).
- For example:

EVV Visit ID	Actual Visit Date	Actual Call In Time	Actual Call Out Time
814286370225	01022019	01022019 07:59 PM	01022019 11:59 PM
814286411521	01032019	01032019 12:00 AM	01032019 04:01 AM
814286773432	01032019	01032019 07:59 PM	01032019 11:59 PM
814286812089	01042019	01042019 12:00 AM	01042019 04:00 AM
814287158590	01042019	01042019 07:59 PM	01042019 11:59 PM
814287192898	01052019	01052019 12:00 AM	01052019 04:01 AM

# EVV Changes Effective September 1, 2019



- Effective September 1, 2019, EVV-relevant claims must be billed to Texas Medicaid and Healthcare Partnership (TMHP) and will be subject to the EVV claims matching process.
- Additionally, effective September 1, 2019, PAS and In-Home Respite increments will change from 1 hour to 15 minute units. Please refer to the Long-Term Services and Supports (LTSS) billing matrix for further clarification.
- Please ensure to note, effective September 1, 2019, Healthcare Common Procedure Coding System (HCPCS), modifiers and units must be an exact match for the aggregator to advise Superior in processing EVV-related claims.
- If modifiers billed and units billed do not match, the claim will be denied. Additionally, providers should note claims submitted using date spans will be denied.

# EVV Changes Effective September 1, 2019



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

*Please note: Billing changes are processed based on date of services delivered, as opposed to date of service claim submission or received.*

# EVV Changes Effective September 1, 2019



- The EVV claims matching process supports claims submitted with a single date of service. Claims should not be billed utilizing date spans.
- EVV data will be required to have a match status code of 01 for Superior to pay the claim.
- Claims not submitted according to the guidelines will be denied.
- TMHP will compare EVV data prior to Superior's claim adjudication process.
- Additionally, providers will need to ensure accurate data is being submitted to TMHP to prevent claim denials.
- Providers will be required to resubmit any denials to TMHP.

# CDS EVV – Effective January 1, 2021



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- Effective January 1, 2021, Financial Management Services Agency (FMSA) will be required to use EVV for Consumer Directed Services (CDS).
- It is the responsibility of the FMSA to select an EVV vendor to collect and transmit EVV visit data.
- The EVV vendors will be able to provide training to CDS employers and FMSAs.
- CDS employers are responsible for training their attendants on how to clock in/out of the EVV system.

# CDS EVV – Billing After January 1, 2021



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- 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.
- CDS employers will use the EVV Vendor System to view EVV data and reports.
  - CDS employers will not use the EVV portal.



# Questions and Answers

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