Electronic Visit Verification (EVV)

Provider Compliance Requirements

September 2022

EVV Provider Compliance Requirements

Education and Outreach Efforts:

- The EVV Usage Score is a measure of a Provider's or Financial Management Services Agency's (FMSAs) manually entered and rejected EVV visit transactions. Providers and FMSAs must maintain a minimum EVV Usage score of 80%, rounded to the nearest whole percentage, each state fiscal year quarter, unless noted by HHSC.
- Superior will monitor compliance usage scores on a quarterly basis, and provide outreach and education to providers and FMSAs who fall below the required minimum 80% compliance score.
- The EVV mobile method, home phone landline and alternative device are the three approved methods to clock in and out.

EVV Provider Compliance Requirements

EVV Compliance Alignment:

- On a quarterly basis, Superior will analyze provider agencies' and FMSAs' utilization of visit maintenance codes. When performing visit maintenance an EVV Reason Code Number, EVV Reason Code Description, and any required free text, must be selected.

- On a quarterly basis, Superior will analyze provider agencies' and FMSAs phone numbers used for clocking in and clocking out in the EVV system to ensure compliance with an allowable phone type being used.

- Example of unallowable landline phone types include:
  - Cellular phones
  - Cellular enabled devices such as tablets and smart watches

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EVV Compliance Alignment:

- Providers and FMSAs are responsible for entering EVV transactions (arrival time and departure time) and/or updating EVV data through visit maintenance within 95 days of the date of service. Providers and FMSAs cannot submit claims before the EVV information is verified and entered into the system.
- If a provider demonstrates sustained non-compliance, Superior may take enforcement actions, as outlined by HHSC policy, up to terminating the provider’s participation in the network.

EVV Provider Compliance Requirements

The following changes took effect on September 1, 2019:

- All EVV claims must be billed to Texas Medicaid and Healthcare Partnership (TMHP) and will be subject to the EVV claims matching process, to confirm that a service visit occurred prior to the payment of a claim.
- Providers billing Personal Assistance Services (PAS) are required to bill separate service lines, per date of service.
  - Personal Assistance Services (PAS) billed with service line date spans will be denied.
- A claim is required to be an exact match to the Medicaid ID, NPI, date of service, HCPCS/modifier combinations and units in the EVV visit data.

EVV Provider Compliance Requirements

The following changes took effect on September 1, 2019:

- The visit data match results are forwarded to MCOs for claims processing. EVV claims that do not have an exact visit match in TMHP's system based on the above criteria will be denied.
- Providers and FMSAs are encouraged to verify the EVV visit data is present in TMHP's system prior to submitting a claim.
- Personal Assistance Services (PAS) and In-Home respite unit increments will change from 1 hours to 15 minutes.
  - Please refer to the Long-Term Services and Supports (LTSS) billing matrix for further clarification.

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Other Notes:

- There is no longer a grace period for PAS and PCS. All PAS and PCS must be compliant with EVV requirements upon contracting and entering into the network, and prior to submitting claims.

Contacts:

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