Electronic Visit Verification (EVV)

Provider Training

Last Update September 2023

Introductions and Agenda

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What is EVV?

- The 21st Century Cures Act Section 12006, is a federal law requiring all states to use Electronic Visit Verification (EVV) for all Medicaid personal care services and home health care services.
- Service providers or Consumer Directed Services (CDS) employees providing EVV related services to an individual or health plan member must use one of the three HHSC approved methods to clock in and out.
- The EVV system records the time the service provider or CDS employee begins providing services and the time the service provider or CDS employee stops providing services.
- Once a provider or Financial Management Services Agency (FMSA) has ensured an EVV visit passes all validation edits they may reference the time recorded in the EVV system to determine billable units/hours.

What is EVV?

The EVV system:

- Electronically verifies the occurrence of authorized personal care and home health care service visits.
- Electronically documents the precise time a service delivery visit begins and ends.
- Replaced paper attendant timesheets and is a requirement for claim payment.
- 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)
  - In-Home Respite Services
  - Community First Choice (CFC)-PAS and Habilitation (HAB)
  - Protective Supervision
- STAR Health:
  - PCS
  - CFC PAS
  - CFC HAB
- STAR Kids
  - PCS
  - CFC PAS
  - CFC HAB

For a list of all current services requiring EVV refer to:
Personal Care Services required to use EVV (PDF)

Cures Act EVV Expansion

- As of January 1, 2021, the Cures Act expanded to require EVV for all Medicaid personal care services, which included those for Consumer Directed Services (CDS) model.

- Effective January 1, 2024, the Cures Act Expansion will require EVV for Medicaid home health care services (HHCS).
  - State of Texas Access Reform (STAR) services are included within this expansion

- For an up to date list of the home health care services requiring EVV, refer to: Home health care services required to use EVV (PDF)

EVV Visit Maintenance

- A process that allows edits to data elements on an EVV visit transaction in the EVV system.
  - Similar to how corrections would be made on a paper timesheet.

- Providers, FMSAs and CDS employers are responsible to complete visit maintenance by making corrections to EVV visit data elements in the EVV system.
  - CDS employers who selected option 2 or 3 on the Form 1722, Employer's Selection for Electronic Visit Verification Responsibilities are not responsible for competing visit maintenance.

- Each provider, FMSA or CDS employer is responsible for ensuring their attendants or employees are trained to use the EVV system and that accurate data is being submitted to Superior

EVV Visit Maintenance

- Program providers, FMSAs and CDS employers have 95 calendar Days from the date of service to complete visit maintenance.
  - After the 95 calendar Days the EVV system locks the EVV visit transaction.
- Visit maintenance needed after the 95 Day time frame requires a visit maintenance unlock request to be submitted to Superior.
  - HHS request forms can be found here: Request for Program Provider and FMSA or Request for Consumer Directed Services Employers
- Superior reviews all visit maintenance unlock requests on a case by case basis.
- Superior is unable to approve visit maintenance unlock requests to create manual visits after the 95 Day time frame.
  - The only exception is when reason for manual visit creation is due to Superior or EVV system error.

Reason Codes

- When service providers or CDS employees fail to clock in/ out, providers, FMSAs or CDS employers must select:
  - The most appropriate non-preferred reason code
  - The most appropriate reason code description
  - Any required free text

- **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 code indicates when situations when staff have failed to clock in/out of the EVV system.

- **Free Text** – Any additional information attached to an EVV Reason Code Description.

For an up to date list of all HHSC EVV reason codes, visit: EVV Reason Codes Jan. 1, 2021 - Sep 30, 2023 and EVV Reason Codes Effective Oct. 1, 2023

Reason Codes

- Program providers, FMSAs and CDS employers are no longer required to document free text describing:
  - The reason for using the same EVV Reason Code Number.
  - EVV Reason Code Description for the same member more than 14 Days in a calendar month.
- Superior continues to conduct utilization reviews of EVV Required Free Text for personal care services required to use EVV in 2016 or earlier.
  - Once notified by HHS, Superior will begin conducting EVV-Required Free Text reviews for Cures Act personal care services. Superior will update providers once the notification from HHS is received.
- The following actions may be issued by Superior based on determinations from required free text reviews:
  - Additional training issued on EVV policy.
  - A corrective action plan.
  - Recoupment of associated claim(s).
  - Potential termination from the network (if continued non-compliance).

Reason Codes

- 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 the EVV system, including completing visit maintenance prior to billing.
- For retro-eligibility or other exceptions, please contact your Superior Account Manager.

Reason Codes

- **Note**: If DataLogic is your elected EVV vendor, the Vesta system systematically clocks out at 11:59 p.m. with reason code 000, and it clocks in with a new visit ID at 12:00 a.m. with reason code 000. Any claim where this occurs 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 Systems

- Providers and FMSAs must implement and begin using an EVV system prior to submitting an EVV claim.

- The two types of EVV systems available
  1. EVV vendor system
  2. EVV proprietary system

- Providers, FMSAs and CDS employers are required to complete all EVV training prior to using an EVV system and annually thereafter.

- For more information on EVV training requirements, please reference the HHS Electronic Visit Verification Training Requirements Checklists.

EVV Systems

- Providers and FMSAs must follow their program requirements for schedules to determine if they are required to enter a schedule in their EVV system.
- EVV systems allow program providers and FMSAs to use no schedule or select from the following three schedule types:

1. Daily Fixed Schedules track if service delivery occurs on a specific date, for a specific duration, at a specific time.
    - If service delivery deviates from the schedule, the visit will not auto-verify.
2. Daily Variable Schedules track if service delivery occurs on a specific date, for a specific duration.
    - If service delivery deviates from the schedule, the visit will not auto-verify.
3. Weekly Variable Schedules track if service delivery occurs within a specific week and within a total number of scheduled hours for the week.
    - Visits can occur on any day of the week, at any time, for any duration.
    - Any visits that exceed the total scheduled hours for the week will not auto-verify.

EVV Systems

- Providers and FMSAs may transfer from one EVV system to another:
  - EVV vendor system to another EVV vendor system.
  - EVV vendor system to an EVV proprietary system.
  - EVV proprietary system to an EVV vendor system.
  - EVV proprietary system to another EVV proprietary system.
- FMSAs must notify CDS employers 60 Days in advance of a planned Go-Live date for a system transfer to allow time for retraining CDS employers and their CDS employees on the new EVV system.
- During a system transfer, the program provider and FMSA must:
  - Use their current EVV system until they have successfully transferred to the new EVV system.
  - Document the EVV visits before and after their Go-Live date in the new system.

EVV Vendor Systems

- An EVV vendor is contracted with the state's claims administrator to provide a cost free EVV system for program providers and FMSAs.
  - Adheres to all HHSC EVV vendor business rules for system operation and functionality.
  - Provide EVV system and equipment, including mobile application and alternative device.
  - Provide technical support for their system. Please contact the vendor directly for training or support.
  - EVV vendors cannot pass on transaction fees to providers, FMSAs, nor members.
  - EVV vendors will not bill providers or FMSAs for the use of equipment that is needed.
- To select an EVV vendor system, providers or FMSAs must submit the EVV Provider Onboarding Form directly to the selected EVV vendor.

EVV Vendor Systems

- HHSC is in the process of transitioning from the current EVV vendor systems, DataLogic/Vesta and First Data/AuthentiCare, to a new single state-funded EVV vendor system provided by HHAeXchange.

- By Oct. 1, 2023, program providers, FMSAs, CDS employers, and service providers using the current EVV vendor systems (DataLogic/Vesta or First Data/AuthentiCare) **must transition to HHAeXchange** if they are not approved to use a proprietary system.
  - The transition process includes completing EVV training requirements and EVV system onboarding by Oct. 1, 2023.

EVV Vendor Systems

- **HHAeXchange**
  Website: https://www.hhaexchange.com/info-hub/texas
- **DataLogic (Vesta) Software, Inc.**
  Website: www.vestaevv.com
- **First Data (AuthentiCare) Government Solutions**
  Website: www.firstdata.com
- **Superior HealthPlan**
  Email: SHP_EVV@SuperiorHealthPlan.com

***Please Note**: Providers, FMSAs, and CDS employers must notify Superior or HHSC within 48 hours of an ongoing EVV system issue that remains unresolved after contacting the EVV vendor, and affects the service provider's or CDS employer's ability to use the system.*

EVV Proprietary Systems

- An EVV proprietary system is an HHSC-approved EVV system that a program provider or FMSA may opt to use instead of an EVV vendor system from the state vendor pool that:
  - Is purchased or developed by the program provider or FMSA.
  - Is used to exchange EVV information with the EVV Aggregator.
  - Complies with the requirements of Texas Government Code §531.024172 and HHSC EVV Business Rules for Proprietary Systems governing the use of EVV proprietary systems.
  - Complies with all HHSC EVV standards, rules and reporting requirements.

EVV Proprietary Systems

- An EVV PSO is a program provider or FMSA that selects to use a proprietary system.

- PSO responsibilities include:
  - Adhering to all HHSC EVV Business Rules for Proprietary Systems.
  - Following all EVV requirements described in:
    - The EVV Policy Handbook .
    - Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter O , and Texas Government Code Section 531.024172 or its successors.
  - Providing EVV system training and technical support.
  - Ensuring the accuracy of EVV data collected, stored and reported by the EVV system .
  - Accountability for costs required to develop, implement, operate and maintain the EVV proprietary system.

- For more information, please reference the HHS EVV Policy Handbook.

Non-Compliance

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

EVV Compliance

- Ensure program providers, FMSAs and CDS employers are in compliance with EVV requirements and policies.
- Superior conducts EVV compliance reviews on a regular basis and may initiate contract or enforcement action for dates of service on or after January 1, 2022 for program providers, FMSAs who do not meet any of the following EVV compliance requirements:
  - EVV Landline Phone Verification: ensures valid phone type is used.
  - EVV-Required Free Text: ensures required free text is documented.
  - EVV Usage: ensures the minimum EVV Usage Score has been met.
- Superior conducts EVV Landline Phone Verification reviews for CDS employers and will begin EVV Usage reviews for CDS employers since the Usage Review grace period has ended effective 9/1/2022.

EVV Compliance

- Usage Review
  - Manually entered/Graphical User Interface(GUI) EVV visit transactions.
  - Rejected EVV visit transactions caused by provider or FMSA error.
    - All program providers, FMSAs, and CDS employers must maintain the minimum EVV Usage Score as established by HHS.
- EVV-Required Free Text
  - Failure to enter required free text.
- EVV Allowable Phone Identification
  - Use of unallowable phone type selected as the method to clock in and clock out.

EVV Reports

- Providers and FMSAs may access the EVV Portal to view the following EVV reports:
  - EVV Provider Report
  - EVV Reason Code Usage and Free Text Report
  - EVV Usage Report
  - EVV Visit Log Report
  - EVV Clock In/Clock Out Usage Report
  - EVV Units of Service Summary Report
  - EVV Attendant History Report
  - EVV Claim Match Reconciliation Report
- For additional reports, providers, CDS employers, and FMSAs should access their EVV system.
- Each provider or FMSA is responsible for verifying their EVV system is submitting accurate data to Superior prior to submitting claims.

EVV Claims

EVV Claims

- Effective September 1, 2019, EVV-relevant claims for programs required to use EVV, must be billed to Texas Medicaid and Healthcare Partnership (TMHP) and are subject to the EVV claims matching process performed by the EVV Aggregator.
  - PAS and In-Home Respite increments changed from 1 hour to 15 minute units.
  - Please refer to the Long-Term Services and Supports (LTSS) billing matrix for further clarification.
- Claims for Personal Attendant Services (PAS) submitted using date spans will be denied.

EVV Claims

Former Code	Code eff. 9/1/2019	Service	Current Unit Increment	New Unit Increment
S5125	S5125	(PAS)	1 Hour=1 Unit	15 minutes = 1 Unit
T2021	T2017 (NEW)	Habilitation	1 Hour=1 Unit	15 minutes = 1 Unit
S5151	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 Claims

- Providers and FSMAs must verify all data elements on EVV claims, including times entered in the EVV system, prior to submitting to EVV Aggregator.
- Providers and FMSAs must ensure the appropriate authorization has been received prior to services being rendered and billed on the claim.
- TMHP submits daily files directly to Superior for all accepted EVV transactions and claims.
- EVV Claims are analyzed by the EVV Aggregator in accordance with EVV data matching requirements before claim adjudication.

EVV Claims

- The EVV Aggregator performs matching edits verifying the data on the billed claim matches the visit data in the EVV portal before forwarding the claim to Superior for adjudication.
- To prevent claim denials, providers and FMSAs should verify the EVV visit transaction is accepted before billing.
- When billing claims, providers and FMSAs must verify the data elements billed match the data listed in the EVV portal.
- EVV claims must display a match status code of EVV01, listed in the EVV Portal, in order for EVV claims to be paid by Superior.
- Providers and FMSAs are required to resubmit claim denials to TMHP.
  - Note: TMHP refers to the process of resubmitting claims as the appeal process.

EVV Claims

- Helpful Claims Terminology:
  - Adjusted Claim – The re-adjudication of a previously finalized claim, as result of a claims reconsideration or claims appeal.
  - Claim Appeal – A claim that has been previously adjudicated as a clean claim and the and the claim is being appealed through written notification with supporting documentation.
  - Corrected Claim – A corrected claim is a resubmission of an original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claim submission required corrections.

EVV Claims

- EVV claims billed for program providers must match an accepted EVV transaction between the following data elements:

1. National Provider Number (NPI) or (Atypical Provider Identifier)
2. Date of Service
3. Medicaid ID
4. HCPCS Codes
5. Modifier(s), if applicable
6. Units

EVV Claims

- 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 an accepted EVV transaction along the following data elements:
  1. National Provider Number (NPI) or (Atypical Provider Identifier)
  2. Date of Service
  3. Medicaid ID
  4. HCPCS Codes
  5. Modifier(s), if applicable
- All CDS claim line items billed without matching EVV visit transactions will result in denials.
  - Claims must be billed with units; however, the units data element will not be used for matching.
- For reviewing EVV data and reporting, the FMSA may access the EVV Portal and EVV system.
  - CDS employers have access to the EVV system only.

EVV Claims

- Any EVV claim line with a matching EVV visit transaction will receive the following match status code:
  - EVV01 – EVV Successful Match result code
- Any EVV claim line item billed without an accepted EVV claim match in the EVV Portal will result in match status code EVV02 – EVV06.
  - EVV02 – Medicaid ID Mismatch
  - EVV03 – Visit Date Mismatch
  - EVV04 – Provider (NPI/API) or Attendant Mismatch
  - EVV05 – Service Mismatch (HCPCS and Modifiers if applicable)
  - EVV06 – Units Mismatch
    - Note: When HHSC implements a bypass of the claims matching process for a disaster or other temporary circumstance a match status code of **EVV07** or **EVV08** will be indicated.
- Info on the claim match status code will be found in the EVV Portal as well as your Explanation of Benefits.

EVV Claims

If a Claim Denies:

- Begin by searching the EVV Portal or reviewing the Explanation of Payment to determine the reason associated with the claim denial.
- Review submitted visit transactions in your EVV system to confirm the transactions were accepted.
- If corrections are required through visit maintenance, once completed, review the EVV Portal to ensure the updated EVV visit transaction has been accepted by the EVV Aggregator and then resubmit the EVV claim.
- Per the HHS EVV Policy Handbook, providers must complete all required EVV visit maintenance within 95 Days of the date of service. After 95 Days, visit maintenance will only be allowed based on Superior's approval and on a case-by-case basis.
- For retro-eligibility claims or other exceptions, please contact your Superior Account Manager.

EVV Claims

- Superior may periodically perform audits of EVV claims for a rolling 24-month lookback period.
- In the event Superior identifies EVV claim overpayments Superior will provide written notice of the intent to recoup to the provider or FMSA within 30 Days from the completion of the audit.
- If the provider or FMSA intends to dispute Superior's findings, a response to the written notice must be received by Superior within 30 Business Days.
- Providers and FMSAs have 60 Calendar Days from the notice date to correct and explain the deficiencies related to EVV claims identified in the audit before Superior may begin recovery effort for the identified overpayments.
- Superior may only recover for claims where deficiencies have not been corrected within 60 Calendar Days.

Questions and Answers