Texas | Medicaid • Medicare-Medicaid Plan

Electronic visit verification policy training for program providers and financial management service agencies

Wellpoint℠

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Electronic visit verification policy training

The purpose of this training is to offer program providers and financial management service agencies (FMSAs) in-depth information regarding electronic visit verification (EVV). The information in this training is designed to assist you with establishing your own internal processes with how EVV is managed within your organization for you to be successful when it comes to EVV compliance, policies, and procedures.

What is EVV?

EVV is a computer-based system that electronically verifies that service visits occur. It also documents the date and time that service delivery begins and ends.

EVV training topics

EVV required services and procedure codes

Health and Human Service Commission (HHSC) EVV Policy Handbook:

- **Note:** The information in this training document provides a high-level overview of all EVV policies and procedures. Program providers and FMSAs are required to read and adhere to the full EVV policies and procedures and all requirements within each policy.

EVV compliance reviews

EVV training requirements

EVV claim matching process

EVV claim denial and informational codes

EVV retrospective claim reviews

EVV overpayment projects

EVV visit maintenance (VM) unlock request process

EVV recap of requirements:

- **Note:** This section provides a recap of a select few requirements within the EVV policies and procedures that Wellpoint feels are most important. Program providers and FMSAs are required to read and adhere to the full EVV policies and procedures and all requirements within each policy.

EVV tips and recommendations

Other EVV resources and references

EVV required services and procedure codes

EVV required services and procedure codes

Personal care services (PCS)
The *EVV PCS Service Bill Codes Table* provides current billing codes and details for EVV relevant services. Program providers must use the appropriate Healthcare Common Procedure Coding System (HCPCS) and modifier combinations to prevent EVV visit transaction rejections and EVV claim match denials. The information can be viewed in Excel or PDF.

On the Excel version, the tab titled *MCO EVV Services* shows all the procedure codes and services required to use EVV under Wellpoint.

EVV PCS Service Bill Codes Table — version 12.0 (Excel)

On the PDF version, when the *payer* is listed as MCO, these are the procedure codes and services required to use EVV under Wellpoint.

EVV PCS Service Bill Codes Table — version 12.0 (PDF)

EVV required services and procedure codes

Home health care services (HHCS)
The *EVV HHCS Service Bill Codes Table* provides current billing codes and details for EVV relevant services. Program providers must use the appropriate Healthcare Common Procedure Coding System (HCPCS) and modifier combinations to prevent EVV visit transaction rejections and EVV claim match denials. The information can be viewed in Excel or PDF.

On the Excel version, the tab titled *MCO EVV Services* shows all the procedure codes and services required to use EVV under Wellpoint.

EVV HHCS Service Bill Codes Table — version 2 (Excel)

On the PDF version, when the *payer* is listed as MCO, these are the procedure codes and services required to use EVV under Wellpoint.

EVV HHCS Service Bill Codes Table — version 2 (PDF)

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

HHSC EVV Policy Handbook

Handbook: https://www.hhs.texas.gov/handbooks/electronic-visit-verification-policy-handbook

Section 1000, EVV policy handbook introduction

The *Electronic Visit Verification (EVV) Policy Handbook* provides EVV standards and policy requirements with which the following entities must comply:

- Program providers contracted with Texas Health and Human Services Commission (HHSC) and managed care organizations (MCOs)
- Financial management services agencies (FMSAs) contracted with HHSC and MCOs
- Consumer directed services (CDS) employers

EVV standards and policy requirements do not replace or supersede program or licensure requirements. Program providers, FMSAs, and CDS employers must follow all applicable program and licensure rules and policies in addition to EVV policies.

The handbook has EVV requirements for HHSC and MCOs (the payers). Program providers and FMSAs must adhere to their individual contracts with HHSC or an MCO and contact the payer for questions on EVV and non-EVV requirements.

The requirements in this handbook apply to the programs and services identified in Texas Administrative Code Title 1 (1 TAC) Part 15, Chapter 354, Subchapter O, Sections 354.4005 Personal Care Services that Require the Use of EVV and 354.4006 Home Health Care Services that Require the Use of EVV.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 1000, EVV policy handbook introduction (cont.)

Section 1000 also provides EVV policy information regarding:

- 1100 EVV Overview
- 1200 State Laws and Texas Administrative Code
- 1300 Federal Law
- 1400 Failure to use an EVV System
- 1500 Resources and Communications
- 1600 Key Terms

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation

Section 2000, EVV stakeholders

The following EVV stakeholders must meet all state and federal EVV requirements:

- Payers (HHSC and MCOs)
- Texas Medicaid and Healthcare Partnership (TMHP)
- EVV vendors
- Program providers delivering services under the agency option
- FMSAs
- Medicaid members and SRO participants
- CDS employers

Section 2000 also provides EVV policy information regarding:

- 2100 Payers
- 2200 Texas Medicaid and Healthcare Partnership (TMHP)
- 2300 State Provided EVV System Vendor
- 2400 EVV Proprietary System Operator (PSO)
- 2500 Program Provider
- 2600 Financial Management Service Agency (FMSA)
- 2700 Member
- 2800 CDS Employer

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation

Section 3000, program and service required to use EVV

Programs and services required to use EVV are defined in Title 1 of the Texas Administrative Code, Subchapter O, Sections 354.4005, Personal Care Services that Require the Use of EVV, and 354.4006, Home Health Care Services that Require the Use of EVV.

A summary of the personal care services and home health care services required to use EVV is on the HHSC EVV webpage.

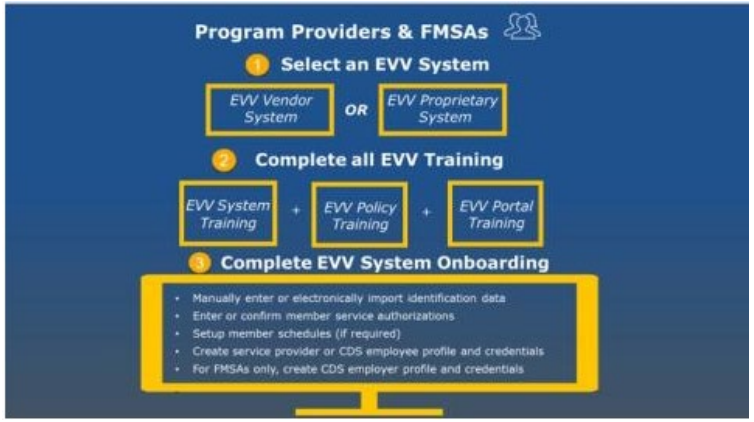
Section 3000 also provides EVV policy information regarding 3100 EVV Service Bill Codes:

- The EVV Service Bill Codes Table provides current billing codes for EVV-relevant services in long-term care, acute care, and managed care programs.
- Program providers and FMSAs must use the appropriate Healthcare Common Procedure Coding System (HCPCS) and modifier combinations in the EVV Services Bill Codes table to prevent EVV visit transaction rejections and EVV claim match denials.

Note: You may also refer to pages 5 and 6 of this training document for the list of EVV required services and service codes.

Section 4000, EVV system, and setup

Program providers and FMSAs must implement and begin using an EVV system before submitting an EVV claim for reimbursement. Program providers and FMSAs must complete the following steps before using an EVV system.



- **Step 1: Select an EVV system (see 4100 EVV System Selection):**
  - EVV vendor system
  - EVV proprietary system
- **Step 2: Complete all EVV trainings (see 4200 EVV Training):**
  - EVV System
  - EVV Policy
  - EVV Portal
- **Step 3: Complete EVV system Onboarding:**
  - Manually enter or electronically import identification data (see 4400 Data Collection).
  - Enter or confirm member service authorizations (see 4500 Service Authorizations).
  - Set up member schedules (if required) (see 4600 Schedules).
  - Create service provider or CDS employee profiles and credentials. (see 4300 Credentialing and 17020 CDS Employer Steps Prior to Using an EVV System).
  - For FMSAs only, create CDS employer profiles and credentials depending on the option selected on *Form 1722, Employer's Selection for EVV Responsibilities* (see 17020 CDS Employer Steps Prior to Using an EVV System).

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 4000, EVV system, and setup (cont.)

Section 4000 also provides EVV policy information regarding:

- 4100 EVV System Selection
- 4110 State Provided EVV System
- 4120 EVV Proprietary Systems
- 4130 Select an EVV System
- 4200 EVV Training
- 4210 EVV Training Requirements for Program Providers
- 4220 EVV Training Requirements for FMSAs
- 4230 EVV Training Requirements for CDS Employers
- 4240 Training Requirements for Service providers and CDS Employees
- 4250 EVV Training Registration
- 4300 Credentialing
- 4400 Data Collection
- 4410 Data Collection Overview Diagram
- 4500 Service Authorizations
- 4600 Schedules
- 4610 Schedule Types
- 4700 EVV System Transfer
- 4710 How to Transfer to the State Provided EVV System
- 4720 How to Transfer to an EVV Proprietary System

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 5000, EVV proprietary system

Section 531.024172 of the Texas Government Code provides the authority for HHSC to recognize an EVV proprietary system as complying with EVV standards and policy requirements. Program providers or FMSAs approved by HHSC to operate an EVV proprietary system must comply fully with the *EVV Policy Handbook*. Program providers or FMSAs must submit an *EVV Proprietary System Request Form* directly to TMHP to enter the PSO onboarding process.

An EVV proprietary system is an HHSC-approved EVV system that a program provider or FMSA may use instead of an EVV vendor system that:

- Is purchased or developed by a program provider or an FMSA.
- Is used to exchange EVV data with the EVV Aggregator.
- Complies with HHSC EVV policy as it relates to EVV proprietary systems.
- Complies with HHSC EVV business rules for proprietary systems.
- Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

There are two onboarding paths a program provider or FMSA can choose:

1. The standard path is for requesting approval to use an EVV system that has not been previously approved by HHSC.
2. The expedited path is for requesting approval to use an existing operational EVV system that HHSC has previously approved. The list of approved EVV proprietary systems is on the TMHP EVV Proprietary Systems webpage.

View the PSO onboarding process guide on the TMHP EVV Proprietary Systems webpage for more information about each path.

Section 5000, EVV proprietary system (cont.)

Program providers or FMSAs must meet applicable HHSC EVV Business Rules for Proprietary Systems posted on the TMHP Proprietary Systems webpage and follow all HHSC EVV standards and policy requirements. These include but are not limited to:

- State and federal laws governing EVV.
- *HHSC EVV Policy Handbook*.
- HHSC EVV business rules for proprietary systems.
- PSO onboarding process.

After the program provider or FMSA has received HHSC approval to use an EVV proprietary system, they are known as a PSO. Refer to 2400 EVV Proprietary System Operator for more information.

The PSO must:

- Follow all requirements specified through HHSC or MCO program provider or FMSA contracts:
  - The PSO will be subject to HHSC and MCO EVV compliance reviews and other compliance monitoring under the program provider or FMSA contract(s). Refer to 5080 Proprietary System Operator Compliance for more information.
- Inform HHSC if the EVV proprietary system is not compliant with EVV standards and requirements or when making significant changes to the EVV system.
- Notify the payers when transferring from an EVV proprietary system and when status changes occur.

The PSO may be subject to periodic verification, system testing, and auditing as specified by HHSC. PSOs, EVV proprietary system vendors, and outside entities may only use the HHS logo on materials and websites if approved by the HHSC Office of Communications.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 5000, EVV proprietary system (cont.)

Section 5000 also provides EVV policy information regarding:

5010 Reimbursement for Use of an EVV Proprietary System
5020 EVV Proprietary System Operator Responsibilities
5030 EVV Proprietary System Onboarding Process
5040 EVV Proprietary System Operational Readiness Review
5050 Success or Failure of the Operational Readiness Review
5060 EVV Proprietary System General Operations
5070 Access to the EVV Proprietary System
5080 Proprietary System Operator Compliance

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 6000, EVV visit transaction

An EVV visit transaction is a record generated by an EVV system that contains data elements for an EVV visit. The EVV visit transaction includes:

- Service authorization data.
- Member data.
- Service provider data.
- Program provider or FMSA data.
- EVV service delivery data.

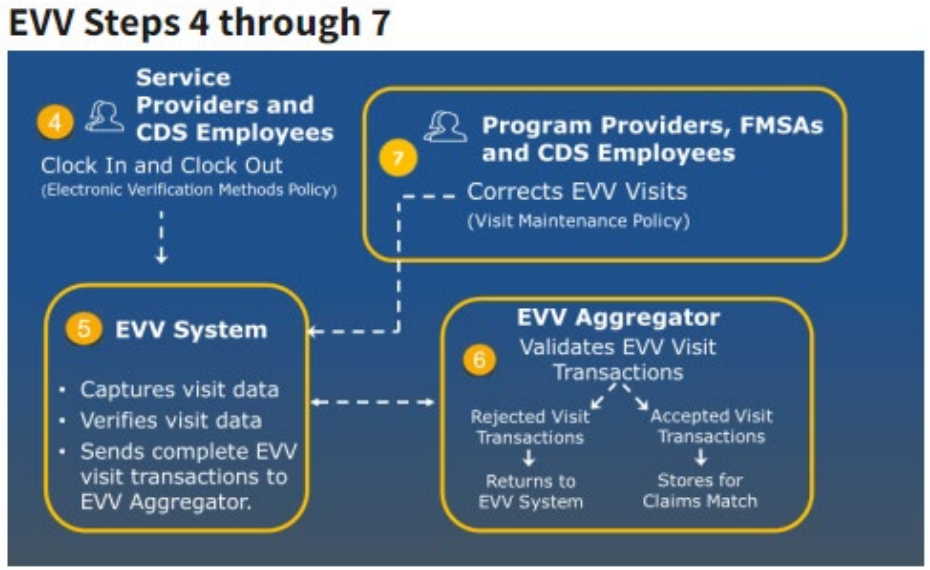
Once steps 1 to 3 are complete as described in 4000 EVV System and Setup, program providers, FMSAs, or CDS employers are ready to begin using the EVV system. The following steps explain how to use the EVV system and how the EVV system processes EVV visit transactions:

- Step 4: Service providers and CDS employees must:
  - clock-in at the beginning of service delivery using an approved clock-in and clock-out method.
  - clock-out at the end of service delivery using an approved clock-in and clock-out method.
- Step 5: The EVV system:
  - Captures and verifies visit data (see 4400 Data Collection)
  - Validates the identification and visit data against Texas Medicaid data.
  - Notifies program providers, FMSAs, or CDS employers of exceptions in the EVV visit transaction.
  - Submits the EVV visit transaction to the EVV aggregator.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 6000, EVV visit transaction (cont.)

- Step 6: The EVV aggregator:
  - Conducts data validation.
  - Determines if the EVV visit transaction is an accepted or rejected EVV visit transaction.
  - Stores accepted EVV visit transactions for the claims matching process.
  - Stores rejected EVV visit transactions and returns results to the EVV system.
- Step 7: Program providers, FMSAs, and CDS employers complete visit maintenance, if necessary, to:
  - Correct exceptions and rejected visit transactions sent back by the EVV aggregator.
  - Adjust bill hours.
  - Add reason codes and free text as required.

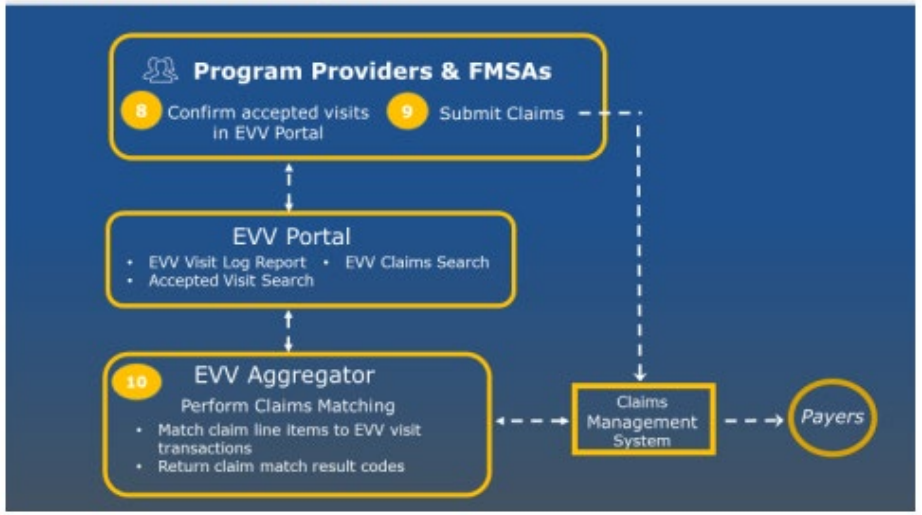


Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 6000, EVV visit transaction (cont.)

- Step 8: Program providers and FMSAs use the EVV portal to:
  - Search and review visit data.
  - Verify accepted EVV visits for billing.
  - Access the claims matching results.
- Step 9: Program providers and FMSAs:
  - Submit EVV claims to the appropriate claims management system.
  - Step 10: EVV aggregator:
  - Matches EVV claim line items to accepted EVV visit transactions.
  - Returns EVV claims match result codes to the claims management system.

EVV Steps 8 through 10



Section 6000, also provides EVV policy information regarding:

- 6100 EVV System
- 6200 EVV Aggregator
- 6300 EVV Portal

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 7000, clock-in and clock-out methods

A service provider or CDS employee must use an HHSC-approved clock-in and clock-out method to begin and end service delivery when providing EVV services to a member in the home or the community.

The state provided EVV system vendor offers three HHSC-approved clock-in and clock-out methods:

- Mobile method
- Home phone landline
- Alternative device

A PSO must offer one or more of the three HHSC-approved clock-in and clock-out methods listed above.

The state provided EVV system vendor must provide access to clock-in and clock-out methods at no cost to the member, program provider, FMSA, CDS employer, service provider, HHSC, MCO, or TMHP. An EVV proprietary system vendor may charge for access to a specific clock-in and clock-out method. The program provider or FMSA may not pass those costs on to the member, program provider, FMSA, CDS employer, service provider, HHSC, MCO, or TMHP.

If the clock-in and clock-out method malfunctions, the EVV system must allow the program provider, FMSA, or CDS employer to manually enter EVV visits.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 7000, clock-in and clock-out methods (cont.)

When the service provider or CDS employee clocks in and clocks out using an HHSC-approved method, the EVV system captures the following visit data:

- Service authorization, including the type of service provided
- The name of the member who received the services
- The date and times the provider began and ended the service delivery visit
- The location, including the address where the service is provided
- The name of the person who provided the service, Service Provider Data

A PSO does not have to require a service authorization for a service provider to clock in and clock out. This does not eliminate the requirement to provide the required data described in 4400, Data Collection. The PSO must make sure that all required data is included in the visit transaction, or the claim may reject.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 7000, clock-in and clock-out methods (cont.)

Section 7000 also provides EVV policy information regarding:

- 7010 Manually Entered EVV Visits
- 7020 Mobile Method
- 7030 Home Phone Landline
- 7040 Alternative Device
- 7050 Using Multiple clock-in and clock-out Methods
- 7060 EVV Services Delivered Outside the Member's Home
- 7070 Multiple EVV Visit Transactions

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 8000, calculation of bill hours

Bill hours is the number of hours provided that is transmitted to the EVV Aggregator. Bill hours are used for claims matching when program providers and FMSAs submit billing through the applicable billing system. If bill hours do not match the units of service billed by the program provider or FMSA, the claim may be denied. Refer to Section 13020 Claims Matching for more information.

Section 8000 also provides EVV policy information regarding:

- 8010 Bill Time In and Bill Time Out
- 8020 Rounding
- 8030 Bill Hours

Section 9000, visit maintenance

Visit maintenance is the process used by the program provider, FMSA or CDS employer to:

- Correct inaccurate data elements;
- Add missing data elements;
- Indicate the visit transaction is valid; or
- Manually enter a visit transaction.

Program providers, FMSAs, or CDS employers must complete all required visit maintenance. They must also make sure the EVV Aggregator accepts the EVV visit transaction before the program provider or FMSA submits an EVV claim. If more visit maintenance is completed after an EVV claim is submitted, program providers or FMSAs must submit an adjusted claim to match the updated EVV visit transaction.

If the program provider or FMSA submits an EVV claim before required visit maintenance is complete, a payer may deny or recoup the EVV claim as part of contract oversight.

If the program provider or FMSA delegates visit maintenance responsibilities to a third party, such as a subcontractor, the program provider or FMSA:

- Is always responsible for actions taken by the third party.
- Makes sure the third party follows all privacy and security protocols, including when the subcontractor or third-party accesses EVV data.

If CDS employers delegate visit maintenance responsibilities to their designated representative (DR), the CDS employer is responsible for any actions taken by their DR. They must make sure the DR follows all privacy and security protocols, including when the DR accesses EVV data.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 9000, visit maintenance (cont.)

Section 9000 also provides EVV policy information regarding:

- 9010 Required Visit Maintenance
- 9020 Auto-Verification
- 9030 EVV System Validation
- 9040 EVV Aggregator Validation
- 9050 Visit Maintenance timeframe
- 9060 Visit Maintenance Unlock Request
- 9070 Visit Maintenance and Billing EVV Claims
- 9080 Last Visit Maintenance Date
- 9090 Visit Maintenance Reduction Features

Section 10000, EVV reason code

Reason codes are used to indicate why the program provider, FMSA, or CDS employer is completing visit maintenance. A reason code consists of a **reason code number** and a **reason code description**. The reason code number represents the overall issue for the need to complete visit maintenance on an EVV visit transaction. The reason code description provides more detail about why the program provider, FMSA or CDS employer completed visit maintenance.

Program providers, FMSAs, and CDS employers must select the most appropriate reason code number and description and must enter any required free text when completing visit maintenance in the EVV system.

See the current HHSC EVV reason codes on the EVV webpage for reason code numbers, reason code descriptions, and free text requirements for each reason code.

EVV Reason Codes Effective Oct. 1, 2023, and after (PDF)

EVV Reason Codes Effective Jan. 1, 2021, through Sept. 30, 2023 (PDF)

EVV Reason Codes Effective Sept. 1, 2019 — Dec. 31, 2020 (PDF)

EVV Reason Codes Effective July 1, 2017 — Aug. 31, 2019 (PDF)

Section 10000, EVV reason code (cont.)

This table shows examples of when to use certain reason code numbers and descriptions.

Reason code	Reason code number and description	When to use reason code
110 A	Service Delivery Exception — Service delivery differs from schedule	Only used when the program provider, FMSA, or CDS employer has entered a schedule in the EVV system.
110 B	Service Delivery Exception — Downward adjustment of Bill Hours	Used when the program provider, FMSA, or CDS employer will be billing for less time than the actual time worked. Refer to Section 8000, Calculation of Bill Hours.
110 D	Service Delivery Exception — Allowable overlapping visits	Used when one service provider is delivering services to two members at the same time or when two service providers are delivering services to one member

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 10000, EVV reason code (cont.)

Multiple reason codes

Program providers, FMSAs, and CDS employers may use multiple reason code numbers and descriptions to provide details when completing visit maintenance on a single visit if they choose or if it is required by program policy.

Free text requirements

Free text is additional information the program provider, FMSA, and CDS employer must enter to further describe the need for visit maintenance.

Program providers, FMSAs, and CDS employers completing visit maintenance in the EVV system must enter additional information in the free text field when using the following reason code number and description:

- 210 I (Emergency)
- 600 (Other)

EVV staff may review the free text entered in these reason codes during EVV compliance reviews. HHSC does not require free text when other reason code numbers and descriptions are used.

Program providers, FMSAs, and CDS employers may enter free text for the other reason code numbers and descriptions if they choose.

Section 11000, EVV compliance reviews

Payers conduct EVV compliance reviews to ensure program providers, FMSAs, and CDS employers comply with EVV requirements and policies. Payers will not start reviews until the visit maintenance timeframe has expired.

Payers will conduct reviews and initiate contract or enforcement action if the program providers, FMSAs, or CDS employers do not meet any of the following EVV compliance requirements:

- EVV usage: Meet the minimum EVV Usage Score
- EVV landline phone verification: Ensure valid phone type is used

Refer to 7000 clock-in and clock-out Methods, 10000 EVV Reason Code, and 12000 Usage for more information.

HHSC may change compliance requirements due to a natural disaster or at the discretion of HHSC.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 11000, EVV compliance reviews (cont.)

Compliance grace periods
Under certain circumstances, HHSC may choose to suspend certain compliance requirements. If program providers, FMSAs and CDS employers do not meet the suspended EVV compliance requirements during the compliance grace period, payers will not initiate enforcement action unless noted by HHSC.

Payers will post a notice on their websites 90 days before the start of reviews.

During the compliance grace periods
Program providers and FMSAs must monitor compliance reports monthly, at a minimum, in the EVV portal and perform the following:

- Use the EVV system as required
- Establish a process to monitor compliance reports with their CDS employer (if Option 3 on *Form 1722, Employers Selection for Electronic Visit Verification Responsibilities*) unless the CDS employer has read only access in the EVV system
- Complete all required visit maintenance before billing
- Train or retrain service providers on clock-in and clock-out methods
- Ask questions

The CDS employer must monitor compliance reports monthly, at a minimum, in the EVV system and perform the following:

- Use the EVV system as required
- Complete all required visit maintenance (if Option 1 on *Form 1722, Employers Selection for Electronic Visit Verification Responsibilities*)
- Establish a process to monitor compliance reports with their FMSA (if Option 3 on *Form 1722, Employers Selection for Electronic Visit Verification Responsibilities*) unless they have read only access in the EVV system
- Train or re-train CDS employees on clock-in and clock-out methods
- Ask questions

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 11000, EVV compliance reviews (cont.)

Section 11000 also provides EVV policy information regarding:

- 11010 EVV Usage Reviews
- 11020 EVV Landline Phone Verification Reviews
- 11030 HHSC EVV Informal Reviews and MCO Disputes
- 11040 Formal Appeal of HHSC Enforcement Actions

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 12000, usage

Program providers, FMSAs, and CDS employers are required to use an EVV system and meet the minimum EVV Usage Score.

Payers will monitor the number of manually entered EVV visit transactions and the number of rejected EVV visit transactions to ensure the minimum EVV Usage Score is met for the state fiscal year quarter.

Refer to 11000 EVV Compliance Reviews for more information.

A **manually entered EVV visit transaction** is an EVV visit that is manually entered into the EVV system when a service provider or CDS employee fails to use the EVV system to clock-in when service delivery begins, clock-out when service delivery ends, or both. Refer to 7000 clock-in and clock-out Methods for more information.

A **rejected EVV visit transaction** is an EVV visit transaction that is exported from an EVV system to the EVV Aggregator but is not accepted by the EVV Aggregator.

Section 12000, usage (cont.)

Section 12000, also provides EVV policy information regarding:

- 12010 EVV Usage Score
- 12020 Manual EVV Visit Transaction Score
- 12030 Rejected EVV Visit Transaction Score
- 12040 How EVV Usage Reviews are Conducted

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 13000, EVV claims

The program provider or FMSA must only submit claims for reimbursement once all the visits for the claim line items have been completed and accepted in the EVV aggregator. The EVV aggregator will perform a claims match against the accepted EVV visit transactions stored in the EVV Portal.

The payer must not pay a claim without a matching accepted EVV visit transaction stored in the EVV portal.

Section 13000, also provides EVV policy information regarding:

- 13010 Claims Submission
- 13020 Claims Matching
- 13030 Claims Matching Process
- 13040 Exceptions to the Claims Matching Process
- 13050 Claims Match Result Codes

Section 14000, reports

The EVV Reports Policy covers EVV standard reports that HHSC and MCOs use for oversight and data analysis, such as but not limited to:

- Contract monitoring.
- Recoupment.
- EVV compliance reviews.
- Fraud, waste, and abuse reviews.

Program providers and FMSAs must access the HHSC EVV standard reports located in the EVV portal and EVV systems.

CDS employers must access HHSC EVV standard reports in the EVV system.

Section 14000 also provides EVV policy information regarding:

- 14010 EVV Portal Standard Reports
- 14020 EVV System Standard Reports
- 14030 EVV Vendor Ad Hoc Reporting
- 14040 EVV Portal Search Tools

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 15000, EVV optional services and non-EVV services

Only EVV required services must be documented in an EVV system. A program provider, FMSA, or CDS employer may choose to document EVV optional services in the EVV system. They must not document non-EVV services in the EVV system.

Failure to document EVV required services in an EVV system will result in denied or recouped EVV claims. See 1400, Failure to use an EVV System, for more information.

Section 15000 also provides EVV policy information regarding:

- 15010 EVV Optional Services
- 15020 Non-EVV Services

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 16000, fraud, waste and abuse

If the payers determine that a program provider, FMSA, or CDS employer is not compliant with EVV policy and procedures, it could result in a referral for a fraud, waste, and abuse investigation.

If you are made aware of, or suspect situations that may be considered Medicaid fraud, waste, or abuse, report it to the HHSC Inspector General online or by calling their toll-free fraud hotline at **800-436-6184**.

Section 17000, EVV CDS Employer Policies

This section provides important EVV policies and identifies sections in the *EVV Policy Handbook* applicable to CDS employers. CDS employers must read this section, and any other *EVV Policy Handbook* sections referred to throughout this section to review all EVV policies relevant to CDS employers.

This section provides EVV standards and policy requirements CDS employers and Medicaid members who selected the CDS option must follow if they receive an EVV-required service.

EVV requirements apply to programs and services identified in Title 1 of the Texas Administrative Code (1 TAC), Part 15, Chapter 354, Subchapter O, Sections 354.4005, Personal Care Services that Require the Use of EVV and 354.4006, Home Health Care Services that Require the Use of EVV. The EVV required programs and services are also on the EVV website.

CDS employers must make sure CDS employees' clock-in and clock-out of the EVV system. Refer to 7000 clock-in and clock-out Methods for more information.

CDS employers must use the EVV system selected by their FMSA. Contact your FMSA to find out which EVV system your FMSA uses.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 17000, EVV CDS Employer Policies (cont.)

If CDS employees do not use the EVV system, or if CDS employers do not comply with EVV requirements:

- CDS employees may experience a delay in payment or inaccurate payments.
- CDS employers must take more training.
- An FMSA may require CDS employers to complete a *Corrective Action Plan* per 26 TAC, Part 1, Chapter 264, Subchapter B, Section 41.221, *Corrective Action Plans*.
- CDS employers may be subject to removal from the CDS option.
- EVV claims payments without an accepted EVV visit transaction may be denied or recouped.

Refer to 11000 EVV Compliance Reviews and 16000 Fraud, Waste and Abuse for more information.

To avoid these consequences, contact your FMSA immediately. Begin using the EVV system as soon as possible.

CDS employers must complete *Form 1722, Employer's Selection for Electronic Visit Verification Responsibilities,* to select how they will participate in EVV. All CDS employers, regardless of what option they select on the form, must:

- Make sure CDS employees use the EVV system to clock in when EVV services begin and clock out when EVV services end.
- Approve CDS employee time worked in a timely manner.

CDS employers must continue to follow program rules on documentation requirements. EVV does not change applicable federal and state laws related to documentation requirements. FMSAs, CDS employers and CDS employees must comply with applicable federal and state laws related to confidentiality of a member's information.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Section 17000, EVV CDS Employer Policies (cont.)

Section 17000, also provides EVV policy information regarding:

- 17010, CDS Option Stakeholders
- 17020, CDS Employer Steps Prior to Using an EVV System
- 17030, CDS Employer(s) Using an EVV System
- 17040, Failure to Use an EVV System in the CDS Option
- 17050, CDS EVV Compliance
- 17060, CDS Bonuses and Overtime
- 17070, CDS Complaints

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV compliance reviews

EVV compliance reviews

Wellpoint follows all EVV policies and requirements outlined in the *HHSC EVV Policy Handbook*. EVV compliance reviews are completed to ensure program providers and FMSAs are following EVV policies in the following areas:

- EVV usage: Meet the minimum EVV usage score.
- EVV landline phone verification: Ensure valid phone type is used.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV compliance reviews (cont.)

The following EVV compliance review will be conducted **quarterly** according to the state fiscal year (SFY) quarters:

- Meet the minimum EVV usage score.

Quarter	Months	Review start date (on or after)
1	September, October, November	March 15
2	December, January, February	June 15
3	March, April, May	September 15
4	June, July, August	December 15

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV compliance reviews (cont.)

The following EVV compliance review will be conducted **monthly** according to the months within the calendar year:

- EVV landline phone verification reviews — Ensure that a valid phone type is used.

Month	Review start date (on or after)
January	February 1
February	March 1
March	April 1
April	May 1
May	June 1
June	July 1
July	August 1
August	September 1
September	October 1
October	November 1
November	December 1
December	January 1 (the next year)

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV compliance reviews (cont.)

Failure to meet the compliance standards

EVV usage reviews

Program providers and FMSAs enforcement actions: When a program provider or FMSA fails to meet and maintain the minimum EVV Usage Score (80%) in a state fiscal year quarter, Wellpoint may send a noncompliance notice to enforce one or more of the following progressive enforcement actions based on the number of occurrences within a 24-month period:

- First occurrence within a 24-month period — Require additional EVV policy, system, and portal trainings within a specific timeframe:
  - Wellpoint will review the EVV Usage Score for the following quarter from the date of the noncompliance notice requiring additional EVV training:
  - If the minimum EVV Usage Score is met, no further action will be taken by the payer for the compliant quarter
  - If the minimum EVV Usage Score is not met, Wellpoint will document and apply a *Corrective Action Plan (CAP)*
- Two or more occurrences within a 24-month period — Require completion of a *CAP* within 10 business days of the notice of noncompliance:
  - Wellpoint will review the EVV Usage Score for the following quarter from the date of implementation of a *CAP*.
  - If the minimum EVV Usage Score is met, no further action will be taken by the payer for the compliant quarter
  - If the minimum EVV Usage Score is not met, Wellpoint may initiate contract termination.
- Three or more occurrences within a 24-month period — Initiate contract termination:
  - Wellpoint cannot terminate a contract unless:
  - The payers have followed the above progressive enforcement actions.
  - The program provider or FMSA has not met the minimum EVV Usage Score for a total of three quarters (nine months) within a 24-month period

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV compliance reviews (cont.)

Failure to meet the compliance standards

EVV usage reviews (cont.)

CDS employers enforcement actions: When a CDS employer fails to meet and maintain the minimum EVV Usage score in a state fiscal year quarter the payer may send a noncompliance notice to enforce one or more of the following progressive enforcement actions based on the number of occurrences within a 24-month period:

- First occurrence within a 24-month period — Require additional EVV policy, system and portal trainings within a specific timeframe:
  - Wellpoint must review the EVV Usage Score for the following quarter from the date of the noncompliance notice requiring additional EVV training:
    - If the minimum EVV Usage Score is met, no further action will be taken by the payer for the compliant quarter
    - If the minimum EVV Usage Score is not met, the payer may document and apply a *Corrective Action Plan (CAP)*
- Two or more occurrences within a 24-month period — Require completion of a *CAP* within 10 business days of the notice of noncompliance:
  - Wellpoint must review the EVV Usage Score for the following quarter from the date of implementation of an accepted *CAP*.:
    - If the minimum EVV Usage Score is met, no further action will be taken by the payer for the compliant quarter
    - If the minimum EVV Usage Score is not met, the payer may recommend removal from the CDS option.
- Three or more occurrences within a 24-month period — Recommend removal from the CDS option

EVV compliance reviews (cont.)

Failure to meet the compliance standards

EVV landline phone verification reviews

Failure to meet required actions outlined in the *HHSC EVV Policy Handbook*, section 7030 Home Phone Landline and in the notification sent by Wellpoint may result in temporarily withholding Medicaid claims payments from the program provider or FMSA until compliance is met.

If the FMSA is unable to meet required actions due to the CDS employer not meeting required actions outlined in the *HHSC EVV Policy Handbook*, section 7030 Home Phone Landline, the FMSA must notify Wellpoint immediately in writing by email to txevvsupport@wellpoint.com.

Program providers and FMSAs enforcement actions: When a program provider or FMSA fails to meet required actions within 20 business days of the notification sent by Wellpoint, the payer may temporarily withhold Medicaid claims payments from the program provider or FMSA.

Wellpoint will remove the temporary withholding of Medicaid claims payments within two business days of receiving acceptable documentation as outlined in the notification sent by Wellpoint and described in the *HHSC EVV Policy Handbook*, section 7030 Home Phone Landline.

CDS employer enforcement actions: When the CDS employer fails to meet required actions within 10 business day of notification by the FMSA:

- The FMSA can remove the unallowable landline phone type from the EVV system as the member's home phone landline.
- The FMSA can follow TAC 40, Part 1, Chapter 41, Subchapter B, Rule Section 41.221 relating to failure to submit complete service delivery documentation or meeting CDS employer responsibilities and place the CDS employer on a *CAP*.

EVV compliance reviews (cont.)

EVV compliance review reports

EVV usage reviews

Wellpoint will use the *EVV Usage Report* (located in the EVV Portal) to conduct the EVV Usage Reviews for visits with a date of service within the review period:

- Program providers and FMSAs have access to the *EVV Usage Report* in the EVV Portal.
- FMSAs have access to the *EVV FMSA Usage Report* in the EVV Portal.
- The *EVV CDS Employer Usage Report* is available in the EVV Portal and EVV systems.

EVV landline phone verification reviews

Wellpoint will use the *EVV Landline Phone Verification Report* (located in the EVV system) to conduct EVV Landline Phone Verification Reviews:

- Program providers, FMSAs, and CDS employers who have selected Option 1 or 2 on *Form 1722, Employer Selection for Electronic Visit Verification Responsibilities,* have access to the *EVV Landline Phone Verification Report* in the EVV system.
- CDS employers who selected Option 3 on *Form 1722, Employer Selection for Electronic Visit Verification Responsibilities,* must establish a process to obtain the *EVV Landline Phone Verification Report* with their FMSA unless the CDS employer has read only access to the EVV system. Contact your FMSA for more information.

Refer to the EVV Reports Policy in the *EVV Policy Handbook,* section 13000, for more information.

EVV training requirements

EVV training requirements

The HHSC EVV Training Policy requires program providers, FMSAs, and CDS employers or any staff who performs EVV system operations to complete all required EVV training:

- Prior to using either an EVV vendor system or an EVV proprietary system
- Yearly thereafter

If the program provider or FMSA does not take the following EVV training, it may result in the payer taking contract and enforcement action:

- EVV System
- EVV Policy
- EVV Portal

If the CDS employer does not take EVV system and EVV policy trainings, the following may result:

- CDS employee(s) may experience a delay in payment or inaccurate payments if the EVV system is not used correctly.
- An FMSA may require the CDS employer to complete a *Corrective Action Plan (CAP)*.

The payers may request proof of completed trainings. Do not submit proof of training completion to HHSC, an MCO, or TMHP unless requested. Proof of completed trainings must include the:

- Name of the training.
- Name of the person completing the training.
- Date of the training.

Program providers, FMSAs, and CDS employers can review the EVV Training Requirements Checklists found on the EVV webpage for more information.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV training requirements (cont.)

EVV training requirements for program providers and FMSAs

Program providers and FMSAs must complete the required EVV training shown in the table below:

- **EVV system users** are staff who have access to the EVV system, perform EVV system operations and visit maintenance in the EVV vendor system or EVV proprietary system.
- **EVV portal users** are staff who have access to the EVV portal, conduct visit or claim searches and generate reports.
- **Billing staff** are staff who submit Medicaid claims for an EVV-required service.

EVV training requirement	Taken by	Provided by
EVV system training	EVV system users	EVV vendor or EVV PSO
EVV portal training	EVV portal users Billing staff	TMHP
EVV policy training	EVV system users EVV portal users Billing staff	Payer (HHSC or MCO)

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV training requirements (cont.)

EVV training requirements for CDS employers

CDS employers complete applicable required EVV training. If the CDS employer has a designated representative (DR), the DR completes the required EVV training based on the option selected by the CDS employer. This information is shown in the table below. CDS employers must train their CDS employees on the clock-in and clock-out methods with assistance from the EVV vendor or the EVV PSO.

See details in the table for CDS employer training based on delegation of visit maintenance on *Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities*.

Note: If a CDS employer switches their option by completing a new *Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities,* they must take the proper training for that option before being granted greater access to the EVV system by an EVV vendor, their FMSA, or an EVV PSO.

Form 1722 Options	EVV Training Requirement	Provided By
Option 1: The CDS employer agrees to complete all visit maintenance and approve their employee's time worked in the EVV system.	• Full EVV system training • Includes clock in and clock out methods	EVV vendor or EVV PSO (FMSA)
	• EVV policy training	Payer (HHSC or MCO) or FMSA
Option 2: The CDS employer elects to have their FMSA complete all visit maintenance on their behalf. However, the CDS employer will approve their employee's time worked in the EVV system.	• Full EVV system training • Includes clock in and clock out methods	EVV vendor or EVV PSO (FMSA)
	• EVV policy training	Payer (HHSC or MCO) or FMSA
Option 3: The CDS employer elects to have their FMSA complete all visit maintenance on their behalf. The FMSA will confirm the employee's time worked in the EVV system based on approval documentation from the CDS employer.	• Overview of EVV system training. Covers key elements of the EVV system training. • Includes clock in and clock out methods	EVV vendor or EVV PSO (FMSA)
	• EVV policy training	Payer (HHSC or MCO) or FMSA

EVV training requirements (cont.)

Training requirements for service providers and CDS employees (attendants)

Service providers and CDS employees (attendants) must complete the required EVV training shown in the table below. The EVV vendor or EVV PSO will provide materials and resources.

EVV training requirement	Provided by
Clock-in and clock-out methods	Program provider or CDS employer

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV training requirements (cont.)

EVV training registration

EVV policy training — This training topic is provided by the payers (HHSC and MCOs):

- You can find Wellpoint's EVV policy training schedule located on our EVV website under *EVV Training & Materials*.
- To take the EVV policy training with HHSC access the HHSC Learning Portal then create an account. You may review the information HHSC has posted about their EVV policy training sessions that is located on the HHSC EVV training resources website: hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification/evv-training-resources.
- To take the EVV policy training for another MCO that is not Wellpoint. You will need to contact the MCO directly to obtain their EVV policy training schedule and registration information.

EVV portal training — This training topic is provided by TMHP. It is not provided by HHSC and MCOs:

- Access the TMHP Learning Management System (LMS) and create an account.
- You can find the information on how to register and take the EVV portal training with TMHP by going to the TMHP EVV training website: tmhp.com/topics/evv/evv-training

EVV system training — This training topic is provided by the EVV vendors. It is not provided by HHSC, TMHP, or MCOs:

- You will need to contact your EVV vendor or EVV PSO directly to obtain information on how to register and take the EVV system training with them. You can contact your EVV vendor or EVV PSO by phone call or emailing them.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV claim matching process

EVV claim matching process

Wellpoint uses the EVV claims matching process to identify one or more EVV visits that support a claim submitted for an EVV required service. Once a program provider or FMSA submits an EVV claim to TMHP, the claims management system forwards any claim for EVV services to the EVV aggregator for the claim matching process. The claim matching process is completed for each individual claim line.

The automated claims matching process includes:

- Receiving an EVV claim line.
- Matching data elements from each EVV claim line to data elements from one or more accepted EVV visit transactions in the EVV aggregator.
- Forwarding the EVV claim with an EVV claim match result code for each individual claim line to Wellpoint once the claims match process is complete.

Program providers and FMSAs must use the EVV Portal to review and confirm the EVV aggregator has accepted the EVV visit transactions before submitting the EVV claim(s) for those services.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV claim matching process (cont.)

These **data elements** from the claim line and the EVV visit transaction must match.

EVV Claim Line (information billed on the claim)	Accepted EVV Visit Transaction (information verified on the EVV visit)
Medicaid ID	Medicaid ID
Date of service	EVV visit date
National Provider Identifier (NPI) or Atypical Provider Identifier (API)	NPI or API
Healthcare Common Procedure Coding System (HCPCS) Code	HCPCS Code
Modifiers	Modifiers
Billed units	Billable units (if applicable)

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV claim matching process (cont.)

Unit matching for multiple visits on the same date of service

If there are multiple visits for the same member for the same service (HCPCS and modifier combination) from the same provider on the same date of service, the claims matching process combines the total number of units on all accepted EVV visits for that date and compares the unit total to the billed units on the claim line item.

Unit matching requirement for EVV claims with span dates (more than one consecutive date)

Program providers and FMSAs submitting an EVV claim with a span of dates for a line item must ensure that:

- Each date of service within the span of dates has one or more matching EVV visit transactions accepted in the EVV aggregator.
- The total units on the EVV claim line item must match the combined total units on the accepted EVV visit transactions for the span of dates, if applicable.

The payer will deny or recoup an EVV claim line item with span dates that does not meet the above criteria.

Units matching bypass

The EVV claims matching process does not match units on the EVV visit transaction against the billed units on the EVV claim line item for any of the services associated with the CDS option.

In addition, the claim matching process does not match units on the EVV visit transactions against the billed units on the claim line item for other specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

EVV claim matching process (cont.)

EVV claims match result codes

After the EVV claims matching process, the EVV aggregator returns an EVV claims match result code for each individual claim line that is forwarded with the claim to Wellpoint. Program providers and FMSAs can see the EVV claim match result code for the individual claim line in the EVV Portal by preforming an EVV claim search. EVV claim match result codes are:

- EVV01 — EVV Successful Match
- EVV02 — Medicaid ID Mismatch
- EVV03 — Visit Date Mismatch
- EVV04 — Provider (NPI/API)
- EVV05 — Service Mismatch (HCPCS and Modifiers if applicable)
- EVV06 — Units Mismatch
- EVV07 — Match Not Required
- EVV08 — Natural Disaster

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV claim matching process (cont.)

EVV claim match result code EVV01
If the EVV aggregator identifies one or more accepted EVV visit transactions match the EVV claim line, the EVV claims matching process will return an EVV01 — EVV Successful Match result code. The claim line will not be denied for an EVV mismatch. However, Wellpoint may still deny or recoup an EVV claim with a match code result of EVV01 if other claim requirements fail the claims adjudication process.

EVV claim match result codes EVV02 to EVV06
If the EVV aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line, the EVV claims matching process will return one of the EVV claim match result codes: EVV02, EVV03, EVV04, EVV05, or EVV06. Wellpoint will deny the EVV claim line if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06. Refer to page 62 and 63 for EVV claim denial codes.

EVV claim match result codes EVV07 and EVV08
When HHSC implements a bypass of the claims matching process for a disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- Payers will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- A payer may still deny an EVV claim if other claim requirements fail the claims adjudication process.

When HHSC sets the EVV claims match bypass, the EVV aggregator will still perform a match between the EVV claim line item and the EVV visit transactions and record the actual match outcome. Program providers and FMSAs can view the actual match results using the Informational Match Result column in the EVV Claim Search results in the EVV Portal to determine whether the claim would have matched without the bypass.

Even though the payer will not deny the claim for an EVV07 or EVV08 upfront, payers may recoup the EVV claim if the program provider or FMSA does not follow instructions from HHSC or their MCO for an EVV claim match result code of EVV07 or EVV08. Refer to page 65 for the EVV informational codes.

EVV claim denial and informational codes

EVV claim denial codes

Wellpoint will deny a claim or claim line(s) due to an EVV mismatch if the match result code is an EVV02 thru EVV06. For Medicaid claims, the program provider and FMSA will receive an *Explanation of Payment (EOP)* and will see one of the following denial codes based on the EVV claims match result code that is received from TMHP.

Medicaid denial code information

TMHP match result code	Wellpoint denial code	Denial code description
EVV02 (Medicaid ID Mismatch)	ZV2	No EVV visits with the Medicaid ID. Verify that all data elements used for EVV match the claim data being billed.
EVV03 (Date(s) of Service Mismatch)	ZV3	No EVV visits with the Medicaid ID on the Date of Service. Verify that all data elements used for EVV match the claim data being billed.
EVV04 (Provider Mismatch)	ZV4	No EVV visits with the Medicaid ID and NPI/API on the Date of Service. Verify that all data elements used for EVV match the claim data being billed.
EVV05 (Service Mismatch)	ZV5	No EVV visits with the Medicaid ID and HCPCS/Mods on the DOS. Verify that all data elements used for EVV match the claim data being billed.
EVV06 (Units Mismatch)	ZV6	EVV claim billed units do not equal units total of matched visit(s).

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV claim denial codes (cont.)

Wellpoint will deny a claim or claim line(s) due to an EVV mismatch if the match result code is an EVV02 thru EVV06 for Medicare-Medicaid Plan (MMP) claims. The program provider and FMSA will receive an *Explanation of Payment (EOP)* and will see one of the following denial codes based on the EVV claims match result code that is received from TMHP.

MMP denial code information

TMHP match result code	Wellpoint denial code	Denial code description
EVV02 (Medicaid ID Mismatch)	ZE2	No EVV visits with the Medicaid ID. Verify that all data elements used for EVV match the claim data being billed.
EVV03 (Date(s) of Service Mismatch)	ZE3	No EVV visits with the Medicaid ID on the Date of Service. Verify that all data elements used for EVV match the claim data being billed.
EVV04 (Provider Mismatch)	ZE4	No EVV visits with the Medicaid ID & NPI/API on the Date of Service. Verify that all data elements used for EVV match the claim data being billed.
EVV05 (Service Mismatch)	ZE5	No EVV visits with the Medicaid ID & HCPCS/Mods on the DOS. Verify that all data elements used for EVV match the claim data being billed.
EVV06 (Units Mismatch)	ZE6	EVV claim billed units do not equal units total of matched visit(s).

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV claim denial codes (cont.)

For EVV claim(s) that result in a denial with the Wellpoint denial codes listed on pages 62 and 63, program providers and FMSAs should take the following steps:

- Check the EVV portal to ensure the EVV visit transaction(s) has been accepted by the EVV aggregator.
- Compare the critical data elements from the claim to the EVV visit transaction(s) to validate each critical data element matches:
  - If there is a discrepancy between any of the critical data elements used for EVV claim matching the provider will need to make the needed corrections to the EVV visit transaction(s), or the claim (only if the claim was submitted with the wrong data).

Once any corrections have been made, the provider will need to resubmit the claim as a corrected claim and:

- Make sure the corrected claim has the frequency code number 7.
- Make sure the corrected claim has the original claim number on the claim form.

If a program provider or FMSA submits a dispute to Wellpoint for a denied claim that was denied with one of the denial codes listed on pages 62 and 63, the dispute will be **dismissed or upheld** and the provider will be instructed to resubmit the claim to TMHP as a corrected claim:

- Disputes will be dismissed or upheld because, per HHSC requirements, Wellpoint cannot internally reprocess claims with an EVV claim match result code of EVV02 thru EVV06.

There are no changes to the timely filing limits. Providers must submit corrected claims within the current timely filing requirements. EVV does not change or override the timely filing requirements for new and corrected claims.

EVV claim informational codes

As applicable, HHSC may implement a bypass of the claims matching process for a disaster or other temporary circumstances. TMHP will apply the EVV07 and EVV08 match result code, and in turn Wellpoint will apply an informational code to the claim or claim line(s).

For Medicaid claims, the provider will receive an *Explanation of Payment (EOP)* and will see one of the following informational codes based on the EVV07 and EVV08 match result code that is received from TMHP.

	Medicaid informational code information	
TMHP match result code	Wellpoint informational code	Informational code description
EVV07 (Match Not Required)	ZV1	EVV Claims match not performed per State direction.
EVV08 (Natural Disaster)	ZV8	EVV Claims match not performed per State direction, due to a Natural Disaster.

For MMP claims, the provider will receive an *Explanation of Payment (EOP)* and will see one of the following informational codes based on the EVV07 and EVV08 match result code that is received from TMHP.

	MMP informational code information	
TMHP match result code	Wellpoint informational code	Informational code description
EVV07 (Match Not Required)	ZE7	EVV Claims match not performed per State direction.
EVV08 (Natural Disaster)	ZE8	EVV Claims match not performed per State direction, due to a Natural Disaster.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV retrospective claim reviews

EVV retrospective claim reviews

Pertaining to EVV paid claims with a date of service on or after September 1, 2019, Wellpoint will complete a retrospective claim review of all paid claim line(s) that resulted an EVV07 and EVV08 (EVV Claim Match Result Code). Wellpoint follows all direction and guidance from HHSC regarding EVV retrospective claim reviews.

The EVV retrospective claim reviews:

- Are only for paid claim line(s) with EVV required services.
- The reviews will be based on dates of services:
  - The date of service is determined by HHSC's direction to Wellpoint.
- Wellpoint will use the *EVV Claim Match Reconciliation Report* from the EVV portal to identify the paid claim line(s) that resulted an EVV07 and EVV08 match result code.
- In order to ensure the paid claim line(s) have a matching EVV visit transaction(s), Wellpoint will look at the following columns on the *EVV Claim Match Reconciliation Report:*
  - Claim_Informational_Match_Result
  - Match_Result_on_Report_Run_Date:
    - If the *Match_Result_on_Report_Run_Date* shows an EVV01 as the EVV Claim Match Result Code, Wellpoint will acknowledge the paid claim line(s) to have a matching EVV visit transaction(s).
    - If the *Match_Result_on_Report_Run_Date* shows an EVV02 thru EVV06 as the EVV Claim Match Result Code, Wellpoint will start an EVV overpayment project for the paid claim line(s).
- The review will begin after full guidance is received from HHSC.

EVV retrospective claim reviews (cont.)

Exceptions for EVV retrospective claim reviews

If HHSC provides direction to not complete an EVV retrospective claim review on paid claim line(s) that result an EVV07 and EVV08, Wellpoint will not complete the review.

For additional information regarding the EVV match result codes EVV07 and EVV08 and the *EVV Claim Match Reconciliation Report.* Refer to the *EVV Training for EVV07 and EVV08 Match Result Code* document posted on Wellpoint's EVV webpage under the Wellpoint training information section: provider.wellpoint.com/docs/gpp/TX_CAID_EVV_ProviderTrainingDocument.pdf?v=202107072256

To request additional training regarding EVV retrospective claim reviews, please submit your request in an email to txevvsupport@wellpoint.com.

EVV overpayment projects

EVV overpayment projects

An EVV overpayment project will be started if:

- Wellpoint identifies paid claim lines do not have matching EVV visit transactions; or
- Paid claim lines resulted in an EVV claim match result code of EVV07 or EVV08 and the paid claim lines do not have matching EVV visit transactions based on the *Match_Result_on_Report_Run_Date* column on the *EVV Claim Match Reconciliation Report* in the EVV portal:
  - Wellpoint follows HHSC's directive regarding retrospective reviews on paid claim lines that contain these match result codes to ensure the paid claim lines have matching EVV visit transactions.

Any paid claim lines identified as not having matching EVV visit transactions will be submitted to Wellpoint's Cost Containment Unit (CCU) to start the EVV overpayment project. An EVV overpayment project is limited to claim lines with a date of service that occurred within 24 months prior to the start of the overpayment project.

EVV overpayment projects (cont.)

Cost Containment Unit (CCU) first overpayment notice:

- The CCU team will mail out a first overpayment notice.
- Program providers or FMSAs have 60 days from the date of the first overpayment notice to:
  - Contact Wellpoint via secure email at txevvsupport@wellpoint.com to file a dispute with supporting documentation.
  - Submit a *VM Unlock Request Form* if an EVV visit transaction needs data corrections.

CCU final overpayment notice:

- The CCU team will mail out a final notice if the program provider or FMSA has not refunded the dollar amount or disputed the recovery.

CCU recovery:

- If the program provider or FMSA has not refunded the dollar amount or disputed the recovery within 60 days from the date of the *first* overpayment notice, Wellpoint's CCU team will adjust the claim to automatically offset the program provider's account.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV overpayment projects (cont.)

If the program provider or FMSA intends to dispute the EVV overpayment project, Wellpoint must receive a response to the notice from the program provider or FMSA no later than the 30th day after the date the program provider or FMSA receives the first notice.

The first and final notice for an EVV overpayment project will include the following information:

- A description of the reason for the overpayment. The description will include the term *Electronic Visit Verification* as part of the reason for the overpayment so that the program provider and FMSAs can tell if the overpayment project is specific to an EVV overpayment project.
- The list of claims associated with the EVV overpayment project. The claim information will include high-level claim information.
- Where to submit a dispute for the EVV overpayment project and examples of supporting documentation that may be submitted.

If the program provider or FMSA want to seek an *informal resolution* with Wellpoint for the EVV overpayment project, the program provider or FMSA must email txevvsupport@wellpoint.com with a proposal of their request for an informal resolution.

Note: If the program provider or FMSA want a detailed claims report for the claims associated with the EVV overpayment project, the program provider or FMSA must send an email to txevvsupport@wellpoint.com to request a detailed claims report.

EVV overpayment projects (cont.)

Dispute process
Program providers or FMSAs need to submit all requests for disputes to an EVV overpayment project via secure email to txevvsupport@wellpoint.com.

Providers need to provide any supporting documentation and information to support their dispute. The dispute must include:

- Provider agency name and NPI number
- Project number
- Any supporting documentation attached

Wellpoint will send a secure email to the provider once the dispute review has been completed. When the dispute is in-process, all communication regarding the dispute is sent in a secure email to the provider.

Once the dispute is finalized, Wellpoint will mail a letter to the provider that identifies any claim(s) that are being overturned or upheld.

EVV overpayment projects (cont.)

Dispute process (cont.)

Examples of supporting documentation include but not limited to:

- The *VM Unlock Request Form* to request corrections to EVV visit transactions.
- Copy of the search results from the Accepted Visit Search tool in the EVV portal if the claim dates of service are on or after September 1, 2019:
  - All search results can be exported to Excel in the EVV portal in order to email the results to Wellpoint.
- Copy of the *EVV Claim Match Reconciliation Report* from the EVV portal.
- Any other documentation showing all EVV visit transaction(s) were accepted by the EVV aggregator and match the claim line(s) that were paid.

If you have questions regarding the dispute process for EVV overpayment projects, please contact the EVV email box at txevvsupport@wellpoint.com.

EVV visit maintenance (VM) unlock request process

EVV VM unlock request process

Wellpoint allows program providers and FMSAs to submit a request to unlock VM to request corrections for verified EVV visit transactions after the allowable VM timeframe has passed.

The VMUR process is not used to make corrections to claims. The VMUR process does not change or override the timely filing limit for submitting claims. All claims (new and corrected) must be submitted within the timely filing limits.

Program providers and FMSAs should use the Wellpoint's ***EVV Visit Maintenance Unlock Request (VMUR) Form*** to submit their request.

To request a copy of this form, write to txevvsupport@wellpoint.com, or you can obtain the form on Wellpoint's EVV webpage: https://www.wellpoint.com/tx/provider/state-federal/resources/electronic-visit-verification.

Program providers and FMSAs need to refer to the instructions tab on the spreadsheet for directions on how to complete the spreadsheet.

The request must be submitted in Microsoft Excel and do not make any modifications to the layout of the form.

Providers must email secure the completed spreadsheet to txevvsupport@wellpoint.com

Once Wellpoint receives the request, it will be reviewed and the decision will be emailed securely back to the program provider or FMSA and the EVV vendor listed, if applicable, within 10 business days after receiving a secure and complete request or 30 business days for request pertaining to an EVV overpayment project.

Requests not sent securely could result in a *HIPAA* violation and Wellpoint will deny the request.

All requests for VM unlocks are reviewed on a case-by-case basis.

EVV VM unlock request process (cont.)

Wellpoint reviews for situations that were outside of the program provider's and FMSA's control to correct the visits within the visit maintenance timeframe:

- Standard visit maintenance timeframe is 95 days from the date of the visit.
- HHSC may temporarily change the visit maintenance timeframe. Any temporary changes that HHSC makes to the visit maintenance timeframe will be posted on Wellpoint and HHSC's EVV websites.

A program provider and FMSA may request Wellpoint to unlock visit maintenance to correct data element(s) on a *verified* EVV visit transaction; however, the following data elements **cannot** be changed:

- Actual visit date
- Actual time in
- Actual time out
- Actual hours
- Reason codes (the provider can add a new reason code, but cannot remove or change the existing reason code)

EVV VM unlock request process (cont.)

Wellpoint **will not** approve a VMUR to manually enter EVV visit transactions or confirm/verify EVV visit transactions that were not entered or confirmed/verified within the visit maintenance timeframe. All EVV visit transactions must be entered and confirmed/verified in the EVV system within the visit maintenance timeframe.

The only possible exceptions are:

- The program provider was unable to manually enter and export an EVV visit during the visit maintenance timeframe because of a payer or EVV vendor system error, and the error was not resolved within the visit maintenance timeframe.
- The CDS employer, or the FMSA on behalf of the CDS employer, was unable to manually enter and export an EVV visit during the visit maintenance timeframe because of a payer, EVV vendor system or EVV proprietary system error, and the error was not resolved within the visit maintenance timeframe.
- HHSC determines an exception is required for circumstances, such as a natural disaster.

If a program provider, FMSA, or CDS employer needs to submit a *VMUR Form* to create a manual EVV visit transaction or confirm/verify the EVV visit transaction past the visit maintenance timeframe, due to payer or EVV system error, they must provide evidence that demonstrates:

- They informed the payer of the error within the visit maintenance timeframe.
- The error was not resolved during the visit maintenance timeframe.
- They made a good faith effort to comply with the visit maintenance timeframe.

EVV VM unlock request process (cont.)

The program provider or FMSA can only select these items from the *Incorrect Data Element* column of their *Visit Maintenance Unlock Request Form* to be unlocked for correction.

Data Element Name	
Bill Hours	Bill Time In
Bill Time Out	Contract Number
Employee ID	HCPCS Code/Modifier
Member Medicaid ID	Payer
NPI/API	Service Code
Reason Code	Units
Service Group	N/A — Export Only
Visit Location	

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV VM unlock request process (cont.)

The CDS employer can only select these items from the *Incorrect Data Element* column of their *Visit Maintenance Unlock Request Form* to be unlocked for correction.

Data Element Name	
Bill Hours	Bill Time In
Bill Time Out	Employee ID
Member Medicaid ID	HCPCS Code/Modifier
Payer	Service Code
Reason Code	Units
Service Group	N/A — Export Only
Visit Location	

EVV VM unlock request process (cont.)

If the *VM Unlock Request Form* is not completed correctly the request will be denied:

- The information on what was incorrectly completed will be listed on the *Reason for Denial* column.
- The program provider, FMSA, or CDS employer will need to make the needed corrections to their request, and they may resubmit their request once the corrections to the request form have been made.

If the EVV visit transaction is not in the *verified* status the request will be denied.

If the request is denied the information as to why the request was denied will be detailed in the *Reason for Denial* column on the request form.

The program provider, FMSA, or CDS employer will need to review the reason for denial for each EVV visit transaction that was denied.

To dispute a denial, the program provider or FMSA may resubmit their request that was denied and provide the additional information need to support the situation for their request for correction on the EVV visit transaction.

Wellpoint will complete another review for any request that is denied if the provider agency resubmits with additional information.

EVV recap of requirements

EVV recap of requirements

All program providers and FMSAs must use an HHSC approved EVV system to document the provided services that require the use of EVV.

Training is mandatory for all attendants and other assigned staff prior to beginning services with members. The program provider, FMSA, and CDS employer is responsible for keeping track of details of training for staff. This documentation may be reviewed by Wellpoint upon reasonable request.

Program providers, FMSAs, and CDS employers must complete all required EVV training.

Sign up for HHSC GovDelivery email notices and receive EVV alerts at public.govdelivery.com/accounts/TXHHSC/subscriber/new?topic_id=TXHHSC_247.

All visits must be electronically documented in the EVV system and the EVV visit transaction must be verified to confirm the service was provided to a Wellpoint member.

Visit maintenance must be completed within 95 days from date of service.

If HHSC issues a temporary change to the visit maintenance time period, then visit maintenance must be completed within the time period identified in the temporary change.

Program providers, FMSAs, and CDS employers must use the most appropriate HHSC reason code, reason code option description, and any required free text to verify a visit that requires visit maintenance.

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EVV recap of requirements (cont.)

Program providers and FMSAs must follow EVV policies outlined in the HHSC *EVV Policy Handbook* and in the policy section of the HHSC EVV website.

CDS employers must follow EVV policies that are outlined in the HHSC *EVV Policy Handbook* that are specific to CDS employers. Example: EVV Training Policy and EVV Compliance Reviews

Program providers and FMSAs must contact Wellpoint and HHSC within 48 hours of an unresolved EVV system issue that has been reported to the EVV vendor or proprietary system operator (PSO).

For EVV required services, Wellpoint will not accept paper timesheets from a program provider, FMSA, or CDS employer to confirm EVV required services were provided to a Wellpoint member.

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

EVV tips and recommendations

EVV tips and recommendations

Tip 1: Program providers and FMSAs should make sure their agency can submit electronic claims to TMHP:

- Program providers and FMSAs required to submit electronic claims directly to TMHP can create a TexMed Connect account on tmhp.com.
- Visit TMHP's EDI homepage, (tmhp.com/Pages/EDI/EDI_Home.aspx , for information on filing claims electronically.

This page also has user guides, forms, and technical information intended for billing agents that file claims for program providers.

Tip 2: Before submitting an EVV claim, always check the EVV visit transactions has been accepted by the EVV aggregator and check to make sure the EVV visit transaction data matches the claim data:

If program providers and FMSAs do not complete this step before submitting EVV claims, you run the risk of having high claim denials due to mismatching EVV visit transactions.

Program providers and FMSAs may do this by doing a search in the TMHP EVV portal for EVV visit transactions under the *Accepted Visit Search.*

By doing this, it will also help to make sure your agency is *not* submitting EVV claims *before* the EVV visit transactions are accepted by the EVV aggregator.

EVV tips and recommendations

Tip 3: Program providers and FMSAs should wait at least 24 hours prior to submitting claims to ensure that EVV visit transaction(s) have been exported and accepted by the EVV aggregator.

There is a 24-hour delay from when EVV visit transaction(s) are verified or when corrections are made to a verified visit to when the EVV visit transaction is exported to the EVV aggregator. For example: A provider verifies, or makes corrections to a verified EVV visit transaction, in the EVV system on Thursday the EVV visit transaction will be exported to the EVV aggregator on Friday.

If the claim is received before the EVV visit transaction(s) is received, the claim will result in a denial because at the time the claim was submitted, the EVV visit transactions was not accepted by the EVV aggregator.

Tip 4: Program providers and FMSAs should make sure they are always entering the correct data into the EVV system. This includes all data for:

- Member/client information.
- Provider agency information.
- Attendant information.
- Schedule and visit information.
- Service information (which is based on the Wellpoint authorization that is sent to the provider agency from Wellpoint).

EVV tips and recommendations (cont.)

Tip 5: If a program provider and FMSA has some staff responsible for the EVV system and other staff responsible for claim submissions, the program provider and FMSA should make sure the staff responsible for the EVV system and the staff responsible for claims submissions are in communication in order to prevent discrepancies between the EVV visit transaction data and the claim data.

Tip 6: Wellpoint recommends that program providers and FMSAs submit EVV claims for a single DOS, not a date span. EVV claims may also be submitted with multiple claim lines for a single DOS. This will prevent a DOS from being billed that does not have an EVV visit transaction.

Wellpoint does allow date span billing; however, the EVV claim matching process will consider the claim a mismatch to EVV visit transactions if there is not an accepted EVV visit transaction for all the DOS within the date span.

Tip 7: Program providers and FMSAs must sign up for GovDelivery with HHSC in order to receive EVV alerts and notices from the state:

public.govdelivery.com/accounts/TXHHSC/subscriber/new?topic_id=TXHHSC_247

Tip 8: Program providers and FMSAs should frequently check Wellpoint's EVV page for alerts, updates, and changes to EVV policies and requirements:

Electronic visit verification

Tip 9: Program providers and FMSAs must sign up to receive emails in order to receive Wellpoint notifications when provider notices are posted to the EVV webpage::

Receive emails from Wellpoint

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

Other EVV resources and references

Other EVV resources and references

Wellpoint's EVV provider site
provider.wellpoint.com/texas-provider/resources/electronic-visit-verification

HHSC EVV website
hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification

HHSC EVV Policy Handbook
hhs.texas.gov/handbooks/electronic-visit-verification-policy-handbook

HHSC EVV training website
hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/training-materials-resources

HHSC learning website
learningportal.dfps.state.tx.us/login/index.php

HHSC EVV Existing Provider EVV Training Requirements Checklist
hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/existing-evv-training-requirement-list.pdf

HHSC EVV Cures Act Training Requirements Checklist
hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-required-training-checklist.pdf

Other EVV resources and references (cont.)

HHSC 90-Day Notice of EVV Compliance for State-Required Personal Care Services Providers provider.wellpoint.com/docs/gpp/TX_CAID_EVV_90-DayNtcofCFCActPrsnlCare.pdf?v=202110062245

HHSC 90-Day Notice of EVV Compliance for Cures Act Personal Care Services Providers provider.wellpoint.com/docs/gpp/TX_CAID_EVV_Provider-NoticeforEVVCompliance_9321.pdf?v=202109031505

HHSC GovDelivery website public.govdelivery.com/accounts/TXHHSC/subscriber/new?topic_id=TXHHSC_247

HHSC *EVV 21st Century Cures Act* website hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/21st-century-cures-act

HHSC *Form 1718 — EVV Rights and Responsibilities* (MCO) hhs.texas.gov/laws-regulations/forms/1000-1999/form-1718-electronic-visit-verification-evv-rights-responsibilities-managed-care-organization

HHSC EVV service bill codes table hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification

TMHP EVV training website tmhp.com/topics/evv/evv-training

TMHP Learning Management System (LMS) learn.tmhp.com/

TMHP EDI home tmhp.com/Pages/EDI/EDI_Home.aspx

EVV Historical Provider Compliance Plan effective April 1, 2016 through August 31, 2019 hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/hhsc-provider-compliance-plan.pdf

EVV contact information

Vendor's EVV contact information
HHAeXchange Website: hhaexchange.com/info-hub/Texas Email: txsupport@hhaexchange.com Phone: **833-430-1307**

Wellpoint's EVV email address
txevvsupport@wellpoint.com

Provider relationship management representatives

Name	Email	Phone number
Deidre Haynie	deidre.haynie@wellpoint.com	682-321-8207
Leslie Goffney	leslie.goffney@wellpoint.com	346-347-2063
Kristal Babino	kristal.babino@wellpoint.com	469-984-8671
Pearl Adkison	pearl.adkison@wellpoint.com	512-417-1592
Tim Matthews	tim.matthews@wellpoint.com	682-265-0829
Cheryl Green	cheryl.green@wellpoint.com	806-474-4157

Note: EVV does not replace any contract, program, or licensure requirements regarding service delivery or service delivery documentation.

provider.wellpoint.com/tx

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