COMMUNITY FIRST
HEALTH PLANS

Electronic Visit Verification (EVV) Provider Training

Medicaid | STAR Kids

Electronic Visit Verification (EVV) Policy Training

for Program Providers and Financial Management Service Agencies (FMSAs)

CFHP_1614GOV_0822

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

COMMUNITY FIRST HEALTH PLANS

EVV Policy Training

Community First Health Plans (Community First) values our Provider Network.

We've created Provider educational opportunities to help you stay informed on a variety of important topics.

The purpose of this training is to offer program providers and Financial Management Service Agencies (FMSAs) in-depth information about 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.

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What is EVV?

EVV stands for Electronic Visit Verification.

EVV is a computer-based system that:

1. Electronically verifies that service visits occur.
2. Documents the date and time that service delivery begins and ends.

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

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EVV Training Topics

- EVV Required Services
- Health & Human Services Commission (HHSC) EVV Policy Handbook*
- EVV Compliance Review
- EVV Claim Denial & Informational Codes
- EVV Retrospective Claim Review
- EVV Overpayment Projects
- EVV Visit Maintenance (VM) Unlock Request Process
- EVV Recap of Requirements**
- EVV Tips & Recommendations
- Other EVV Resources & References

** 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.*

*** This section provides a recap of a few select requirements within the EVV policies and procedures that Community First 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.*

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EVV Required Services

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EVV Required Services

STAR Kids	
Service Name	**Service Model Option**
Community First Choice (CFC) Personal Care Service (PCS)	Agency Model
Community First Choice (CFC) Habilitation (HAB)	Agency Model
Personal Care Service (PCS)	Agency Model
In-home Respite Care	Agency Model
Flexible Family Support Services	Agency Model
Community First Choice (CFC) Personal Care Service (PCS)	Consumer Directed Services (CDS)
Community First Choice (CFC) Habilitation (HAB)	Consumer Directed Services (CDS)
Personal Care Service (PCS)	Consumer Directed Services (CDS)
In-home Respite Care	Consumer Directed Services (CDS)
Flexible Family Support Services	Consumer Directed Services (CDS)
Community First Choice (CFC) Personal Care Service (PCS)	Service Responsibility Option (SRO)
Community First Choice (CFC) Habilitation (HAB)	Service Responsibility Option (SRO)
Personal Care Service (PCS)	Service Responsibility Option (SRO)
In-home Respite Care	Service Responsibility Option (SRO)
Flexible Family Support Services	Service Responsibility Option (SRO)

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EVV Service Codes – Agency Model

STAR Kids							
HCPCS	**MOD 1**	**MOD 2**	**MOD 3**	**MOD 4**	**Service Description**	**Service**	**Units**
T1019	UD				CFC PCS Attendant care only - Agency Model	CFC Attendant Care Only (CFC-PCS)	15 mins = 1 unit
T1019	U9				CFC Attendant care and habilitation, HAB - Agency Model	Attendant Care and Habilitation (CFC-HAB)	15 mins = 1 unit
T1019	U6				PCS - Agency Model	Personal Care Services (PCS)	15 mins = 1 unit
T1019	UA	U6			PCS, BH Condition - Agency Model		15 mins = 1 unit
H1015	U1				Attendant - Agency Model	In-Home Respite	15 mins = 1 unit
H1015	U1	UA			Attendant with RN delegation - Agency Model		15 mins = 1 unit
H1015	99	U1			Attendant - Agency Model	Flexible Family Support Services	15 mins = 1 unit
H1015	99	U1	UA		Attendant with RN delegation - Agency Model		15 mins = 1 unit

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EVV Service Codes – CDS and SRO

STAR Kids							
HCPCS	**MOD 1**	**MOD 2**	**MOD 3**	**MOD 4**	**Service Description**	**Service**	**Units**
T1019	U3				CFC PCS Attendant Care Only - Consumer Directed Services Model	CFC Attendant Care Only (CFC-PCS)	15 mins = 1 unit
T1019	U1				CFC PCS Attendant Care Only - Service Responsibility Option Model		15 mins = 1 unit
T1019	U4				CFC Attendant Care and Habilitation, HAB - Consumer Directed Services Model	Attendant Care and Habilitation (CFC-HAB)	15 mins = 1 unit
T1019	U2	U6			CFC Attendant Care and Habilitation, HAB - Service Responsibility Option Model		15 mins = 1 unit
T1019	UC				PCS - Consumer Directed Services Model	Personal Care Services (PCS)	15 mins = 1 unit
T1019	US				PCS - Service Responsibility Option Model		15 mins = 1 unit
T1019	UA	UC			PCS, BH Condition - Consumer Directed Services Model		15 mins = 1 unit
T1019	UA	US			PCS, BH Condition - Service Responsibility Option Model		15 mins = 1 unit
H2015	U1	UC			Attendant - Consumer Directed Services Model	In Home Respite	15 mins = 1 unit
H2015	U1	US			Attendant - Service Responsibility Option Model		15 mins = 1 unit
H2015	U1	UA	US		Attendant with RN delegation - Service Responsibility Option Model		15 mins = 1 unit
H2015	U1	UA	UC		Attendant with RN delegation - Consumer Directed Services Model		15 mins = 1 unit
H2015	99	U1	UC		Attendant - Consumer Directed Services Model	Flexible Family Support Services	15 mins = 1 unit
H2015	99	U1	US		Attendant - Service Responsibility Option Model		15 mins = 1 unit
H2015	99	U1	UA	US	Attendant with RN delegation - Service Responsibility Option Model		15 mins = 1 unit
H2015	99	U1	UA	UC	Attendant with RN delegation - Consumer Directed Services Model		15 mins = 1 unit

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EVV Service Codes

For more information regarding EVV services and service codes, please visit:

- Texas Health and Human Services Commission EVV website (refer to the *Service Bill Codes Table).* URL: ***https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification***

Service Bill Codes Table

The EVV Services Table below provides current billing codes and details for EVV-relevant services in Long-Term Care, Acute Care, and Managed Care Programs.

Program providers must use the appropriate Healthcare Common Procedure Coding System and modifier combinations to prevent EVV claim match denials.

Personal Care Services:

- EVV PCS Service Bill Codes Table
- EVV PCS Service Bill Codes Table

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HHSC EVV Policy Handbook

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

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Section 1000, EVV Policy Handbook Introduction

The HHSC EVV Policy Handbook provides EVV standards and policy requirements that program providers and Financial Management Services Agencies (FMSAs) contracted with Texas Health and Human Services Commission (HHSC) and managed care organizations (MCOs) must follow. The EVV Policy Handbook also includes requirements for Consumer Directed Services (CDS) employers.

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

The HHSC EVV Policy Handbook has EVV requirements for both 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.

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Section 1000, EVV Policy Handbook Introduction (continued)

The requirements in this handbook apply to the programs and services identified in the HHSC Texas Administrative Code (TAC) Title 1, Part 15, Chapter 354, Subchapter O, RULE Section 354.4005, Applicability Code, Section Applicability.

Section 1000, also provides EVV policy information regarding:

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

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 Health Care Partnership (TMHP)
- 2300 EVV Vendors
- 2400 EVV Proprietary System Operator (PSO)
- 2500 Program Provider
- 2600 Financial Management Service Agency
- 2700 Member
- 2800 CDS Employer

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Section 3000, Programs & Services Required To Use EVV

The programs and services required to use EVV are defined in the HHSC Texas Administrative Code Rule Section 354.4005, Applicability. A summary of the Personal Care Services Required To Use EVV (.pdf) is also available on the HHSC EVV webpage.

Section 3000, also provides EVV policy information regarding:

- 3100 EVV Service Bill Codes

NOTE: Refer to slides 4-11 of this training presentation for a list of EVV required services and service codes.

Section 4000, EVV System & Setup

All program providers and FMSAs must implement and begin using EVV prior to submitting a claim for reimbursement and complete the following steps prior to using an EVV system.

- **Step 1: Select an EVV system (refer to 4100 EVV System Selection)**
  - EVV vendor system or EVV proprietary system
- **Step 2: Complete all EVV training (refer to 4200 EVV Training)**
  - EVV System, EVV Policy, and EVV Portal
- **Step 3: Complete EVV System Onboarding**
  - Manually enter or electronically import identification data (refer to 4400 Data Collection)
  - Enter or verify Member service authorizations (refer to 4500 Service Authorizations)
  - Setup Member schedules, if required (refer to 4600 Schedules)
  - Create the CDS employer profile for CDS employer credentials to the EVV system

Section 4000, EVV System & Setup (continued)

Section 4000 also provides EVV policy information regarding:

4100 EVV System Selection	**4250** EVV Training Registration
4110 EVV Vendor Systems	**4300** Credentialing
4120 EVV Proprietary Systems	**4400** Data Collection
4130 Select an EVV System	**4410** Data Collection Overview Diagram
4200 EVV Training	**4500** Service Authorizations
4210 EVV Training Requirements for Program Providers	**4600** Schedules
4220 EVV Training Requirements for FMSAs	**4700** EVV System Transfer
4230 EVV Training Requirements for CDS Employers	**4710** Transferring EVV Systems
4240 Training Requirements for Service Providers & CDS Employees	**4720** How to Transfer to an EVV Vendor within the State Vendor Pool
	4730 How to Transfer to an EVV Proprietary System

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Section 5000, EVV Proprietary System

HHSC EVV Proprietary Systems Policy explains the selection and use of an EVV proprietary system by a program provider or FMSA.

Section 531.024172 of the Texas Government Code provides the authority for HHSC to recognize an EVV proprietary system to comply with EVV requirements. Program providers or FMSAs authorized by HHSC to operate an EVV proprietary system must comply fully with the EVV Policy Handbook, including all specific EVV proprietary system policies, except where noted.

Section 5000, EVV Proprietary System (continued)

An EVV proprietary system is an HHSC-approved EVV system that a program provider or FMSA may use, instead of an EVV vendor system from the state vendor pool 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.

A PSO is a program provider or FMSA that uses an EVV proprietary system. The PSO must submit a PSO Request Packet to enter the PSO Onboarding Process which includes:

- An *EVV Proprietary System Request Form*
- PSO DQ
- TMHP Interface Access Request

Section 5000, EVV Proprietary System (continued)

There are two paths a program provider or FMSA can choose to become a PSO:

- **Path 1:** For a program provider or FMSA requesting approval to use an EVV system that **has not been** previously approved by HHSC.
- **Path 2:** For a program provider or FMSA requesting approval to use an existing operational EVV system that **has been** previously approved by HHSC. (The list of EVV Proprietary Systems can be found on the TMHP EVV Proprietary Systems website.)

For more information about each path, review the PSO Onboarding Process guide on the TMHP EVV Proprietary Systems website.

The PSO must meet applicable HHSC EVV Business Rules for Proprietary Systems and follow all HHSC EVV standards and requirements. These include, but are not limited to:

- State and federal laws governing EVV
- Health Insurance Portability and Accountability Act (HIPAA) and the Americans with Disabilities Act (ADA)
- HHSC EVV Policy Handbook
- HHSC EVV Business Rules for Proprietary Systems
- PSO Onboarding Process

Section 5000, EVV Proprietary System (continued)

The PSO must:

- Continue to 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).
- Inform HHSC EVV 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 switching EVV proprietary systems and when status changes occur.

The PSO may be subject to periodic verification, system testing, and auditing as specified by HHSC.

PSOs, EVV system vendors, and outside groups may only use the HHS logo on materials and websites reviewed by HHSC staff and approved by the HHSC Office of Communications.

Section 5000, EVV Proprietary System (continued)

Section 5000, also provides EVV policy information regarding:

5010 Eligibility to Use an EVV Proprietary System	**5080** Access to the EVV Proprietary System
5020 Reimbursement for Use of an EVV Proprietary System	**5090** Required EVV Proprietary System Standard Reports
5030 EVV Proprietary System Operator Responsibilities	**5100** Proprietary System Operator Compliance Reviews
5040 EVV Proprietary System Onboarding Process	**5200** HHSC Cancellation of EVV Proprietary System Approval
5050 EVV Proprietary System Readiness Review	**5300** Transferring EVV Systems
5060 Success or Failure of the Readiness Review	**5400** Proprietary System Fraud, Waste and Abuse
5070 EVV Proprietary System General Operations	

Section 6000, EVV Visit Transaction

An EVV visit transaction is a complete, verified, and confirmed visit generated by an EVV system that contains the program provider or FMSA identification data and the Member's visit data.

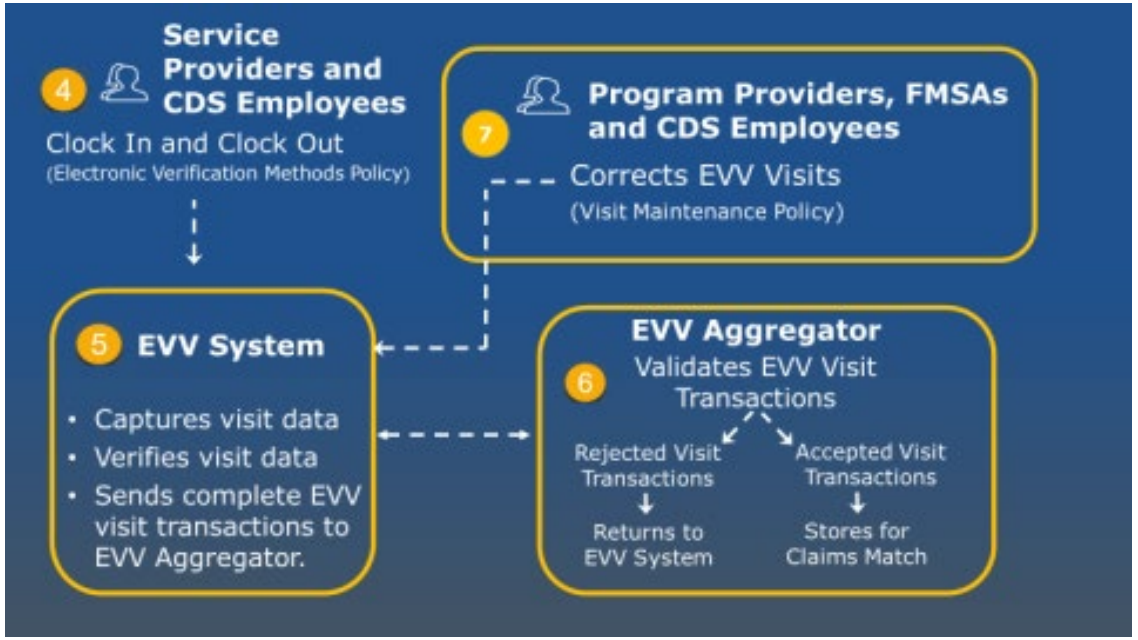
The EVV visit transaction includes the following data:

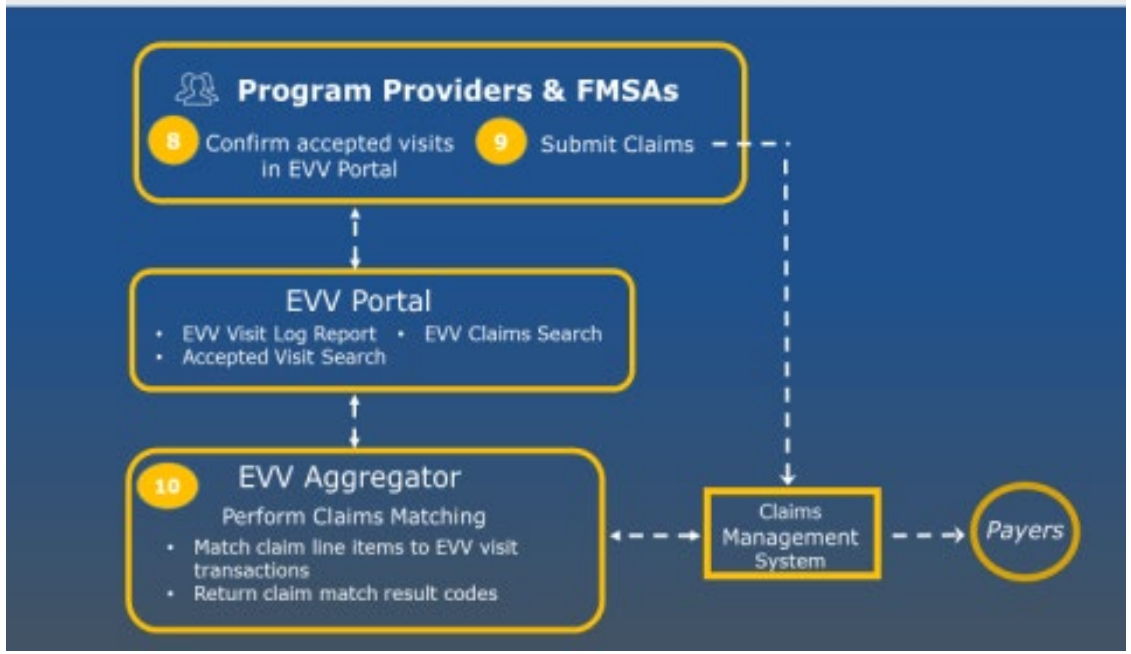
- Service Authorization Data, Member Data, Service Provider Data, Program Provider or FMSA Information, Data and Time of the Services, and Location of the Service

Once steps 1-3 as described in Section 4000 are complete, the program provider or FMSA is ready to begin using the EVV system.

Section 6000, EVV Visit Transaction (continued)

The diagram below explains how to use the EVV system and how the EVV system processes EVV visit transactions.





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Section 6000, EVV Visit Transaction (continued)

Section 6000 also provides EVV policy information regarding:

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

NOTE: CDS employers will not use the EVV Portal but will have access to EVV visit logs and related reports in the EVV system.

Section 7000, Clock In & Clock Out Methods

The Clock In and Clock Out Methods Policy was previously known as the Electronic Verification Methods Policy. It requires the service provider or CDS employee to use an HHSC approved clock in and clock out method to begin and end service delivery when providing services to a Member in the home or the community.

EVV vendors offer three approved clock in and clock out methods:

1. Mobile method (a downloadable application for use on a smart phone or tablet)
2. Home phone landline
3. Alternative device

A program provider or FMSA operating their own EVV proprietary system, known as the EVV PSO, must offer one or more of the three approved clock in and clock out methods listed above.

The EVV PSO or the EVV vendor will not charge the Member for a clock in or clock out method.

Section 7000, Clock In & Clock Out Methods
(continued)

If the clock in and clock out method malfunctions, the EVV system must allow manual entry by the program provider, FMSA, or CDS employer.

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

- The type of service provided (Service Authorization Data)
- The name of the recipient to whom the service is provided (Member Data)
- 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)

Section 7000, Clock In & Clock Out Methods (continued)

Failure to Clock In or Clock Out of the EVV System

If the service provider or CDS employee fails to or is unable to clock in or clock out using one of the approved methods, the program provider, CDS employer, or FMSA (if the CDS employer has designated the FMSA) must manually enter visit data in the EVV system. Failure to complete all required visit maintenance prior to the program provider or FMSA submitting an EVV claim will result in the denial or recoupment of the EVV claim.

For more information, refer to 1400 Failure to Use an EVV System.

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

Section 8000, Visit Maintenance

Visit maintenance is the process used by the program provider, FMSA, or CDS employer to correct the identification and visit data in the EVV system to accurately reflect the delivery of service.

- EVV visit maintenance is like correcting a paper timesheet. Instead of making the correction on the paper timesheet, the program provider, FMSA, or CDS employer will make the correction in the EVV system. *See 4400, Data Collection for more information about identification and visit data.*

- The program provider, FMSA, or CDS employer must complete all required visit maintenance and ensure the visit transaction is accepted by the EVV Aggregator before a program provider or FMSA submits an EVV claim. If additional visit maintenance is completed after a claim is submitted, the program provider or FMSA must submit an adjusted claim to match the updated visit transaction.

Section 8000, Visit Maintenance (continued)

- If a program provider or FMSA submits an EVV claim before required visit maintenance is complete, the payer may deny or recoup the EVV claim as part of contract oversight.
- If a 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.
- If the program provider or FMSA delegates visit maintenance responsibilities to a third party, the program provider or FMSA ensures that the third party follows all privacy and security protocols, including when the subcontractor or third-party accesses EVV data.
- If the CDS employer delegates visit maintenance responsibilities to their Designated Representative (DR), the CDS employer is responsible for any actions taken by their DR. They must ensure that the DR follows all privacy and security protocols, including when the DR accesses EVV data.

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Section 8000, Visit Maintenance (continued)

Section 8000, also provides EVV policy information regarding:

- 8010 Required Visit Maintenance
- 8020 Auto Verification, Exceptions and Schedules
- 8030 EVV System Validation
- 8040 EVV Aggregator Validation
- 8050 Visit Maintenance Timeframes
- 8060 Visit Maintenance Unlock Request
- 8070 Visit Maintenance and Billing EVV Claims
- 8080 Last Visit Maintenance Date
- 8090 Rounding Rules
- 8100 Visit Maintenance Reduction Features

Section 9000, EVV Reason Code

The EVV Reason Code Policy describes the requirements for using reason codes when completing visit maintenance in the EVV system. *Refer to 8000, Visit Maintenance for more information about visit maintenance.*

Reason Code Number(s) describe the purpose for completing visit maintenance on an EVV visit transaction. Reason Code Description(s) describe the specific reason visit maintenance is necessary.

Program providers, FMSAs, or CDS employers must select the most appropriate Reason Code Number(s) and Reason Code Description(s) and must enter any required free text when completing visit maintenance in the EVV system.

If the EVV visit is missing a clock in or clock out, the program provider, FMSA, or CDS employer must use Reason Code Number 900 Non-Preferred, the appropriate Reason Code Description(s), and any other applicable EVV reason code.

Section 9000, EVV Reason Code (continued)

Program providers, FMSAs, and CDS employers can use multiple Reason Code Numbers and Reason Code Descriptions to clarify more than one exception when completing visit maintenance on a single visit.

Exceptions that could cause visit maintenance include but are not limited to:

- Service provider or CDS employee forgot to clock in or clock out
- Visit did not begin or end as scheduled due to an emergency
- The clock in and clock out method was not accessible when services began
- EVV system unavailable

Section 9000, EVV Reason Code (continued)

If the system is unavailable, the service provider or CDS employee must document service delivery information and submit to the program provider, FMSA, or CDS employer.

Program providers, FMSAs, and CDS employers must keep all service delivery documentation and enter EVV visits into the EVV system once operational.

Refer to 1400, Failure to Use an EVV System for more information regarding service delivery documentation.

Section 9000 also provides EVV policy information regarding:

- 9010 EVV Reason Code Free Text Requirements

For the Reason Code Number(s), Reason Code Description(s), and required free text that must be documented for each reason code, see the current HHSC EVV Reason Codes table.

Section 10000, EVV Compliance Reviews

The Health and Human Services Commission (HHSC) revised the Electronic Visit Verification (EVV) Compliance Oversight Reviews policy to:

- Include new program providers, financial management service agencies (FMSAs), and Consumer Directed Services (CDS) employers required to use EVV beginning January 1, 2021.
- Rename the EVV Compliance Oversight Reviews policy to EVV Compliance Reviews policy.
- Rename the EVV Allowable Phone Identification Review to the EVV Landline Phone Verification Reviews.
- Rename the EVV Reason Code and Required Free Text Review to EVV Required Free Text Review.
- Remove the compliance standard, Misuse of Reason Codes.

Section 10000, EVV Compliance Reviews (continued)

HHSC and managed care organizations (MCO), the payers, conduct EVV compliance reviews to ensure program providers, FMSAs, and CDS employers are in compliance with EVV requirements and policies. Payers will not start reviews until the EVV 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 of 80%, unless otherwise noted by HHSC
- EVV Landline Phone Verification
  - Ensure valid phone type is used
- EVV Required Free Text
  - Document required free text

For more information, see the Clock In or Clock Out Methods policy, EVV Reason Code policy, and Usage policy. HHSC may change compliance requirements due to a natural disaster or at their discretion.

Section 10000, EVV Compliance Reviews (continued)

Compliance Grace Periods

If program providers, FMSAs, and CDS employers do not meet any of the 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 prior to 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 re-train service providers on clock in and clock out methods
- Ask questions

Section 10000, EVV Compliance Reviews (continued)

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

Section 10000, EVV Compliance Reviews (continued)

State-Required Personal Care Services Grace Period

State-Required Personal Care Services are personal care services provided by program providers required to use EVV in 2016 or earlier per Texas Government Code, Section 531.024172.

The grace period dates of service for program providers started September 1, 2019, and ended August 31, 2020, and included:

- EVV Usage Reviews

Section 10000, EVV Compliance Reviews (continued)

Cures Act Personal Care Services Grace Period

Cures Act Personal Care Services are personal care services provided by program providers, FMSAs, and CDS employers required to use EVV by January 1, 2021, per the 21st Century Cures Act.

The grace period dates of service program providers, FMSAs, and CDS employers started January 1, 2021, and ended December 31, 2021, and include:

- EVV Usage Reviews (Program provider and FMSA only)
- EVV Landline Phone Verification Reviews
- EVV Required Free Text Reviews

Due to availability of the EVV CDS Employer Usage report, the grace period dates of service for CDS employers EVV Usage Reviews started January 1, 2021, and ended August 31, 2022, unless noted by HHSC.

Section 10000, EVV Compliance Reviews (continued)

Section 10000, also provides EVV policy information regarding:

- 10010 EVV Usage Reviews
- 10020 EVV Landline Phone Verification Reviews
- 10030 EVV Required Free Text Reviews
- 10040 HHSC EVV Informal Reviews and MCO Disputes
- 10050 EVV Formal Appeal of the Review

Section 11000, Usage

The Health and Human Services Commission (HHSC) Electronic Visit Verification (EVV) Usage Policy requires HHSC and Managed Care Organizations (MCOs), the payers, to monitor the number of manually entered EVV visit transactions and the number of rejected EVV visit transactions to meet the minimum state fiscal year quarter EVV Usage Score. *See the EVV Compliance Reviews policy for more information.*

Manually entered EVV visit transactions are EVV visits that were manually entered into the EVV system when the service provider or CDS employee did not use the EVV system to clock in and clock out when service delivery started and ended. *See the Clock In and Clock Out Methods policy for more information.*

Rejected EVV visit transactions are EVV visit transactions that were not accepted by the EVV Aggregator and may require visit maintenance. *See the TMHP EVV website for additional information on the EVV Visit Transaction Rejection Guide.*

Section 11000, Usage (continued)

Section 11000 also provides EVV policy information regarding:

- 11010 EVV Usage Score
- 11020 Manually Entered EVV Visit Transactions
- 11030 Rejected EVV Visit Transactions
- 11040 EVV Usage Reviews
- 11050 Compliance

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Section 12000, 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 12000 also provides EVV policy information regarding:

- 12100 Claims Submission
- 12200 Claims Matching
- 12210 Claims Matching Process
- 12220 Exceptions to the Claims Matching Process
- 12230 Claims Match Result Codes

Section 13000, 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 13000, also provides EVV policy information regarding:

- 13010 EVV Portal Standard Reports
- 13020 EVV System Standard Reports
- 13030 EVV Vendor Ad Hoc Reporting
- 13040 EVV Portal Search Tools

Section 14000, Non-EVV Services

A non-EVV service is an authorized service that is not required to use EVV. Program providers and CDS employers must continue to follow program documentation requirements for non-EVV services. Using the EVV system does not replace paper documentation for non-EVV services.

The program provider, FMSA, or CDS employer will determine how the service provider or the CDS employee will clock in and clock out of the EVV system when delivering non-EVV services and EVV services throughout the day.

The program provider or the CDS employer may select one of the following options for their service provider or CDS employee to document a non-EVV service that occurs during an EVV visit:

- **Option 1:** Clock in to the EVV system and clock out of the EVV system before the non-EVV service begins and clock back in to the EVV system after the non-EVV service has ended.
- **Option 2:** Remain clocked in to the EVV system while delivering the non-EVV service and document the amount of time spent on the non-EVV service.

NOTE: Follow the EVV vendor or EVV PSO instructions on how to subtract the non-EVV service time at the end of the visit and use an appropriate EVV Reason Code Number and EVV Reason Code Description, as necessary.

Section 14000, Non-EVV Services (continued)

Example for Recording Non-EVV time

The service provider or CDS employee is working from 8 a.m. to 2 p.m. The service provider or CDS employee spends **five hours on EVV required services** from 8 a.m. to noon and 1 to 2 p.m., and **one hour on non-EVV services** from noon to 1 p.m.

- **Option 1:** Clock out of the EVV system before the non-EVV service begins and clock back in to the EVV system after the non-EVV service has ended.
    - The service provider or CDS employee will:
        - Clock in to the EVV system at 8 a.m. and clock out at noon
        - Begin the non-EVV service
        - Clock back in to the EVV system at 1 p.m. and clock out at 2 p.m.
        - Document the non-EVV services in accordance with program policy

Section 14000, Non-EVV Services (continued)

- **Option 2:** Remain clocked in to the EVV system while delivering the non-EVV service and document the amount of time spent on the non-EVV service.
    - The service provider or CDS employee will:
        - Clock in to the EVV system at 8 a.m. and clock out at 2 p.m.
        - Record the non-EVV service time in accordance with program policy and report the time to the program provider.
        - The program provider, CDS employer, or FMSA will use the EVV system to indicate one hour of time spent.
        - Contact the EVV vendor or EVV PSO for instruction to adjust the bill hours for a claim that is delivering a non-EVV service.

The program provider, CDS employer, and FMSA can review the reported non-EVV service time by accessing the **Non-EVV Relevant Time Report** in the EVV system. The report will show the total hours worked for non-EVV services.

NOTE: The program provider or CDS employer must contact their EVV vendor or EVV PSO to determine how to document non-EVV services for Members with pre-scheduled visits.

Section 15000, 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 at:

https://oig.hhsc.state.tx.us/wafrep/

SIURequests@cfhp.com

*or call the toll-free fraud hotline at **800-436-6184***

EVV Compliance Reviews

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

COMMUNITY FIRST HEALTH PLANS

EVV Compliance Reviews

Community First follows all EVV policies and requirements outlined in the HHSC EVV Policy Handbook. EVV compliance reviews will be completed on a quarterly basis according to the state fiscal year (SFY) quarters to ensure Program Providers and FMSAs are following EVV policies in the following areas:

- EVV usage
  - Meet the minimum EVV usage score
- EVV required free text
  - Document required free text
- EVV landline phone verification
  - Ensure valid phone type is used

SFY QUARTERS	DATES OF SERVICE	EVV USAGE REVIEW START DATES (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.

COMMUNITY FIRST HEALTH PLANS

EVV Compliance Reviews

The *HHSC 90-Day Notice of EVV Compliance for State-Required Personal Care Services Providers* was posted to the Community First EVV website in September 2021.

- The notice confirms that effective December 1, 2021, the payers, HHSC, and MCOs will begin EVV Usage Reviews to ensure State-required Personal Care Services providers are following EVV requirements and policies. State-required Personal Care Services are those that implemented EVV in 2016 prior to the federal EVV requirements.
    - For example, all service codes under the Agency Model service option listed on slide 8 in this training presentation.

The *HHSC 90-Day Notice of EVV Compliance for Cures Act Personal Care Services Providers* was posted to the Community First EVV website in October 2021.

- The notice confirms that effective January 1, 2022, the payers, HHSC, and MCOs will begin EVV compliance reviews to ensure Cures Act Personal Care Services providers are following EVV requirements and policies. Cures Act Personal Care Services are those that implemented EVV on January 1, 2021.
    - For example, all service codes under the CDS Option and SRO Option service model listed on slide 9 of this training presentation.

EVV Compliance Reviews

EVV Usage Reviews
Program Provider and FMSA Failure To Meet Compliance Standards

- **Program Provider and FMSA 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, Community First may send a non-compliance notice to enforce one or more of the following progressive enforcement actions based on the number of occurrences within a 24-month period:

EVV Compliance Reviews

EVV Usage Reviews, Program Provider and FMSA Enforcement Actions (continued)

First occurrence within a 24-month period	Two or more occurrences within a 24-month period	Three or more occurrences within a 24-month period
Require more EVV policy, system and portal trainings within 20 business days of receipt of the notice of non-compliance	Require completion of a CAP within ten business days of receipt of the notice of non-compliance	Propose to terminate contract
Follow Up Actions		
Community First reviews the EVV Usage Score for the following quarter from the date of the notice of non-compliance requiring EVV training.	Community First reviews the EVV Usage Score for the following quarter from the date of implementation of an accepted CAP	Community First cannot terminate a contract unless:
• 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 met, no further action will be taken by the payer for the compliant quarter.	• Progressive enforcement actions have been taken.
• If the minimum EVV Usage Score is not met, Community First may document and apply a corrective action plan (CAP).	• If the minimum EVV Usage Score is not met, Community First may initiate contract termination.	• The program provider or FMSA has not met the minimum EVV Usage Score for a total of three quarters (nine months) within in a 24-month period.

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

COMMUNITY FIRST HEALTH PLANS

EVV Compliance Reviews

EVV Usage Reviews

CDS Employers must achieve and maintain a minimum EVV Usage Score as noted below by service delivery dates beginning SFY 2023

SFY	Dates of Service	Compliance Usage Score
Q1	September, October, November	40%
Q2	December, January, February	60%
Q3	March - ongoing	80%

- **CDS Employer 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 non-compliance notice to enforce one or more of the following progressive enforcement actions based on the number of occurrences within a 24-month period:

EVV Compliance Reviews

EVV Usage Reviews, CDS Employer Enforcement Actions (continued)

First occurrence within a 24-month period	Two or more occurrences within a 24-month period	Three or more occurrences within a 24-month period
Require additional EVV policy and system trainings within a specific time frame	Require completion of a CAP with assistance from the FMSA within ten business days of the notice of non-compliance	Recommend removal from the CDS option
Follow Up Actions		
Community First reviews the EVV Usage Score for the following quarter from the date of the notice of non-compliance requiring additional EVV training.	Community First reviews the EVV Usage Score for the following quarter from the date of implementation of an accepted CAP	Prior to removal from CDS option:
• If the minimum EVV Usage Score is met, Community First takes no further action for the compliant quarter.	• If the minimum EVV Usage Score is met, no further action will be taken by Community First for the compliant quarter.	• Ensure progressive enforcement actions were met.
• If the minimum EVV Usage Score is not met, Community First may document and apply a corrective action plan (CAP).	• If the minimum EVV Usage Score is not met, Community First may recommend removal from the CDS option.	

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

COMMUNITY FIRST HEALTH PLANS

EVV Compliance Reviews

EVV Required Free Text Reviews
Program Provider and FMSA Failure to Meet Compliance Standards

- Program providers who fail to ensure required free text is entered into the EVV system prior to submitting an EVV claim may have associated claims recouped.
- FMSAs who fail to ensure required free text is entered into the EVV system prior to confirming an EVV visit transaction and submitting an EVV claim may have associated claims recouped.

- 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 Community First may result in temporarily withholding Medicaid claims payments from the program provider or FMSA until compliance is met.

EVV Compliance Reviews

EVV Landline Phone Verification Reviews
Program Provider and FMSA Failure to Meet Compliance Standards

- Failure to meet required actions outlined in the *HHSC EVV Policy Handbook, section 7030 Home Phone Landline* and in the notification sent by Community First 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 Community First immediately in writing by email to cfvmurevv@cfhp.com.
        - When a program provider or FMSA fails to meet required actions within 20 business days of the notification sent by Community First, the payer may temporarily withhold Medicaid claims payments from the program provider or FMSA.
        - Community First will remove the temporary withholding of Medicaid claims payments within two (2) business days of receiving acceptable documentation as outlined in the notification sent by Community First and described in the *HHSC EVV Policy Handbook, section 7030 Home Phone Landline*.

EVV Compliance Reviews

EVV Landline Phone Verification Reviews
CDS Employer Failure to Meet Compliance Standards

- When the CDS employer fails to meet required actions within ten (10) business days 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, and
    - 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

EVV Compliance Review Reports

- **EVV Usage Reviews** – Community First 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* will be available in 2022 in the EVV Portal and EVV systems.
- **EVV Required Free Text Reviews** – Community First will use the EVV Reason Code Usage and Free Text Report or the EVV Visit Log Report (located in the EVV Portal) to conduct EVV Required Free Text Reviews.
  - Program providers and FMSAs must use the EVV Reason Code Usage and Free Text Report or the EVV Visit Log Report (located in the EVV Portal) to monitor compliance of required free text.

EVV Compliance Reviews

- **EVV Landline Phone Verification Reviews** – Community First 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 Compliance Reviews

EVV Compliance Review Start Dates & Schedule

- Community First will start the quarterly EVV Compliance Reviews for the SFY 2022 quarters.
- The reviews will only include EVV visit transactions for the Agency Model service model option.
- Community First will publish a Provider notice and post it to our EVV webpage with the start date and EVV Compliance Review schedule for EVV Visit Transactions under the CDS and SRO service model option.

EVV Compliance Review Schedule For SFY 2022		
Quarter	**Months**	**Review Start Day (on or after)**
1	September 2021, October 2021, and November 2021	March 15, 2022
2	December 2021, January 2022, and February 2022	June 15, 2022
3	March 2022, April 2022, and May 2022	September 15, 2022
4	June 2022, July 2022, and August 2022	December 15, 2022

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

COMMUNITY FIRST HEALTH PLANS

EVV Claim Denial and Informational Codes

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

COMMUNITY FIRST HEALTH PLANS

EVV Denial Codes

Community First 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 received from TMHP.

Medical Denial Code Information		
TMHP Match Result Code	**Community First Denial Code**	**Denial Code Description**
EVV02 (Medicaid ID Mismatch)	ZV2	No EVV visits with the Medicaid ID. Verify 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 all data elements used for EVV match the claim data being billed.
EVV04 Provider Mismatch	ZV4	No EVV visits with the Medicaid ID & NPI/API on the Date of Service. Verify all data elements used for EVV match the claim data being billed.
EVV05 (Service Mismatch)	ZV5	No EVV visits with the Medicaid ID & HCPCS/Mods on the DOS. Verify all data elements used for EVV match the claim 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.

COMMUNITY FIRST HEALTH PLANS

EVV Denial Codes

For EVV claim(s) that result in a denial with the Community First denial codes listed on the previous slide (slide 64) program providers and FMSAs should take the following steps:

1. Check the EVV portal to ensure the EVV visit transaction(s) have been accepted by the EVV aggregator.
2. Compare the critical data elements from the claim to the EVV visit transaction(s) to validate that 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 necessary corrections to the EVV visit transaction(s) or the claim (only if the claim was submitted with the incorrect data).
3. Once any corrections have been made, the Provider will need to re-submit the claim as a corrected claim.
4. Make sure the corrected claim has the frequency code number **seven**.

EVV Denial Codes

5. If a program provider or FMSA submits a dispute to Community First for a denied claim that was denied using one of the denial codes listed on slide 64, 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, Community First cannot internally reprocess claims with an EVV claim match result code of EVV02 thru EVV06.

6. 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, Community First 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 received from TMHP.

Medicaid Informational Code Information		
TMHP Match Result Code	**Community First Informational Code**	**Informational Code Description**
EVV07	ZV1	EVV Claims match not performed per State direction.
EVV08	ZV8	EVV Claims match not performed per State direction, due to Natural Disaster.

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

COMMUNITY FIRST HEALTH PLANS

EVV Retrospective Claim Reviews

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

COMMUNITY FIRST HEALTH PLANS

EVV Retrospective Claim Reviews

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

EVV Retrospective Claim Reviews

- EVV retrospective claim reviews are only for paid claim line(s) with EVV required services.
- The reviews will be based on date of service.
    - Date of service is determined by HHSC's direction to Community First.
- Community First will use the *EVV Claim Match Reconciliation Report* from the EVV portal to identify the paid claim line(s) that resulted in an EVV07 and EVV08 match result code.

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

COMMUNITY FIRST HEALTH PLANS

EVV Retrospective Claim Reviews

EVV Retrospective Claim Reviews (continued)

- In order to ensure the paid claim line(s) have a matching EVV visit transaction(s), Community First will review the following columns on the *EVV Claim Match Reconciliation Report:*
  - *Claim_Informational_Match_Result,* and
  - *Match_Result_on_Report_Run_Date*

- If the *Match_Result_on_Report_Run_Date* shows an EVV01 as the EVV Claim Match Result Code, Community First 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, Community First 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

Exceptions to EVV Retrospective Claim Reviews

- If HHSC provides direction to not complete an EVV retrospective claim review on paid claim line(s) that result in an EVV07 and EVV08, Community First will not complete the review.
    - For example, paid claim line(s) for EVV required services that were part of the *21st Century Cures Act EVV Expansion* that received an EVV07 match result code during the dates of service within EVV practice period (July 1, 2020, thru December 31, 2020), will not be reviewed by Community First as the directive provided by HHSC.
- For additional information regarding the EVV match result codes EVV07 and EVV08, and the EVV Claim Match Reconciliation Report, please refer to the *EVV Training for EVV07 and EVV08 Match Result Code* document posted on Community First's EVV webpage under Community First Training Information: https://medicaid.communityfirsthealthplans.com/providers/evv/
- To request additional training regarding EVV retrospective claim reviews, please submit your request via email to cfhpevv@cfhp.com.

EVV Overpayment Projects

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

COMMUNITY FIRST HEALTH PLANS

EVV Overpayment Projects

An EVV Overpayment Project will be started if:

- Community First 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.
    - Community First 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 Community First'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

Cost Containment Unit (CCU) first overpayment notice:

- The CCU team will mail out the first overpayment notice.
- Program providers or FMSAs have **60 days** from the date of the first overpayment notice to:
  - Contact Community First via secure email at cfhpevv@cfhp.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, the Community First CCU team will adjust the claim to automatically offset the program provider's account.

EVV Overpayment Projects

If the program provider or FMSA intends to dispute the EVV overpayment project, Community First 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.

Both 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 the program provider and FMSAs can quickly recognize that 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.

EVV Overpayment Projects

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

NOTE: If the program provider or FMSA wants a detailed claims report for the claims associated with the EVV overpayment project, the program provider or FMSA must send an email to cfhpevv@cfhp.com and request a detailed claims report.

EVV Overpayment Projects

Dispute Process

- Program providers or FMSAs must submit all requests for disputes to an EVV overpayment project via secure email to cfhpevv@cfhp.com.
- Providers need to provide supporting documentation and information to support their dispute.
- The dispute must include the following information:
    - Provider agency name and NPI number
    - Project number
    - Supporting documentation attached to the email
- Community First 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, Community First will mail a letter to the Provider that identifies any claim(s) that are being overturned or upheld.

EVV Overpayment Projects (continued)

Dispute Process (continued):

- Examples of supporting documentation include but are not limited to:
  - The *VM Unlock Request Form* to request corrections to EVV visit transactions.
  - Copy of 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 Community First.
  - 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.

For questions regarding the dispute process for EVV overpayment projects, email cfhpevv@cfhp.com.

EVV Visit Maintenance (VM) Unlock Request Process

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

COMMUNITY FIRST HEALTH PLANS

EVV VM Unlock Request

Providers have 95 days from the date of the visit to perform any visit maintenance in the Electronic Visit Verification (EVV) vendor system before the visit transaction is locked. A Visit Maintenance Unlock (VMU) Request form can be completed and submitted to Community First Health Plans to unlock a visit under certain circumstances, as noted in this reference guide.

- Download the **Community First EVV Visit Maintenance Unlock Request Form** from the Community First EVV webpage at https://medicaid.communityfirsthealthplans.com/providers/evv/ or request a copy by emailing cfvmurevv@cfhp.com.
  - Refer to the instructions tab on the form for directions on how to complete it.
  - The request must be submitted using the form. Do not modify the form in any way.
  - When complete, email the form to cfvmurevv@cfhp.com.

- The Provider is responsible for ensuring that visit transactions are successfully transmitted and accepted in the EVV aggregator prior to claim submission, and that visit maintenance is performed before the visit is locked. Visit transaction errors can be identified on the Failed to Export Report, including the reason codes for the rejection.

- Refer to the Best Practices to Avoid EVV Claim Mismatches guide for technical guidance and for help avoiding EVV claim mismatches.

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

COMMUNITY FIRST HEALTH PLANS

EVV VM Unlock Request

Community First will review the Visit Maintenance Unlock Request Form within:

a. Ten (10) business days from the date of receipt of the secure email with the completed Unlock Request Form attached.

b. b. 30 business days from the date of receipt of a secure email with the completed request for an appeal or reconsideration with supporting documentation.

If a Provider is asked to send additional supporting documentation, the Provider must respond within five (5) business days through a secure email or 15 business days if the additional request of information is related to an appeal or reconsideration

A Visit Maintenance Unlock Request Form missing information or that attempts to correct a data element field that is not allowed or not listed as an approved reason will be denied. The Following data elements cannot be corrected:

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

EVV VM Unlock Request

If the VM Unlock Request Form is not completed correctly, or the EVV Visit transaction is not in the verified status, the request will be denied.

- Information on what was incorrectly completed 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 denied.
- 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 have been made.
- To dispute a denial, the program provider or FMSA may resubmit their request and provide additional information needed to support their request for correction on the EVV visit transaction.
- Community First will complete another review for any request that is denied if the provider agency resubmits with additional information.

EVV Recap of Requirements

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

COMMUNITY FIRST HEALTH PLANS

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 Community First 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: https://public.govdelivery.com/accounts/TXHHSC/subscriber/new?topic_id=TXHHSC_247

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

COMMUNITY FIRST HEALTH PLANS

EVV Recap of Requirements)

- 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 Community First 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.

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

COMMUNITY FIRST HEALTH PLANS

EVV Recap of Requirements

- 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 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 Community First 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, Community First will not accept paper timesheets from a program provider, FMSA, or CDS employer to confirm EVV required services were provided to a Member.

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

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EVV Tips & Recommendations

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EVV Tips & Recommendations

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 at https://www.tmhp.com.
    - Visit TMHP's EDI homepage at http://www.tmhp.com/Pages/EDI/EDI_Home.aspx for information on filing claims electronically.
        - TMHP's EDI homepage also has user guides, forms, and technical information intended for billing agents that file claims for program providers.

2. Before submitting an EVV claim, always check if the EVV visit transaction has been accepted by the EVV Aggregator. Also, check to make sure the EVV visit transaction data matches the claim data.
    - Program providers and FMSAs can do this by doing a search in the TMHP EVV portal for EVV visit transactions under **Accepted Visit Search**. This will also help ensure that your agency is **not** submitting EVV claims **before** the EVV visit transactions are accepted by the EVV aggregator.
    - If program providers and FMSAs do not complete this step before submitting EVV claims, they run the risk of having high claim denials due to mismatching EVV visit transactions.

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EVV Tips & Recommendations

3. Program Providers and FMSAs should wait at least 24 hours before submitting claims to ensure 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 aggregator did not yet accept the EVV visit transaction.

4. Program providers and FMSAs should always ensure they are entering the correct data into the EVV system. This includes:
    - Member/client information
    - Provider agency information
    - Attendant information
    - Schedule and visit information
    - Service information (based on the Community First authorization sent to the provider agency from Community First)

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COMMUNITY FIRST HEALTH PLANS

EVV Tips & Recommendations

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

6. Any additional staff working in the EVV portal, EVV system, or billing EVV claims should complete EVV training.

7. EVV claims may be submitted with multiple claim lines for a single date of service. Community First recommends program providers and FMSAs submit EVV claims for a single date of service versus a date span. This will prevent a date of service from being billed that does not have an EVV visit transaction.
    - Community First 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** dates of service within the date span.

EVV Tips & Recommendations

8. Program providers and FMSAs must sign up for GovDelivery with HHSC in order to receive EVV alerts and notices from the state. Use this link to sign up: https://public.govdelivery.com/accounts/TXHHSC/subscriber/new?topic_id=TXHHSC_247

9. Program providers and FMSAs should check the Community First EVV page frequently for alerts, updates, and changes to EVV policies and requirements: https://medicaid.communityfirsthealthplans.com/providers/evv/

10. Program providers and FMSAs must sign up to receive Community First email notifications to review Provider notices posted to the EVV webpage. Use this link to sign up: https://medicaid.communityfirsthealthplans.com/providers/evv/

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Other EVV Resources & References

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Other EVV Resources & References

Ctrl+Click to follow link

- **Community First EVV Provider website:**
- **HHSC EVV website:**
- **HHSC EVV Policy Handbook:**
- **HHSC EVV Training website:**
- **HHSC Learning Portal:**

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Other EVV Resources & References

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- **HHSC EVV Existing Provider EVV Training Requirements Checklist:**
- **HHSC EVV Cures Act Training Requirements Checklist:**

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Other EVV Resources & References

Ctrl+Click to follow link

- **HHSC 90-Day Notice of EVV Compliance for State-Required Personal Care Services Providers:**
- **HHSC 90-Day Notice of EVV Compliance for Cures Act Personal Care Services Providers:**
- **HHSC GovDelivery website:**
- **HHSC EVV 21stCentury Cures Act website:**

Other EVV Resources & References (continued)

Ctrl+Click to follow link

- **HHSC Form 1718 – EVV Rights and Responsibilities (MCO):**
- **HHSC EVV Service Bill Codes Table**:
- **TMHP EVV Training website:**
- **TMHP Learning Management System (LMS):**
- **TMHP EDI homepage:**
- **EVV Historical Provider Compliance Plan** (effective April 1, 2016, through August 31, 2019):

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COMMUNITY FIRST HEALTH PLANS

Community First EVV Contact Information

EVV Vendor Contact Information:

- **DataLogic Software Inc. (VESTAEVV)**
  Website: ***https://vestaevv.com***
  Phone **1-844-880-2400**

- **First Data Government Solutions (AuthentiCare EVV)**
  Website: ***http://solutions.fiserv.com/authenticare-tx***
  Phone: **1-877-829-2002**

- **Community First Health Plans**
  Website: https://medicaid.communityfirsthealthplans.com/providers/evv/
  Phone: 1-855-607-7827

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COMMUNITY FIRST HEALTH PLANS

Thank You!

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