Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.
The purpose of this training is to offer providers in-depth information regarding EVV. The information in this training is designed to help providers establish their own internal processes with how EVV is managed within their agency. In order for provider agencies to be successful when it comes to EVV compliance, policies and procedures must be in place.
EVV covered topics

- **EVV Overview**
  - EVV requirements
    - Provider agency
    - Financial management service agency (FMSA)
  - EVV required services and codes
  - EVV methods to call-in and call-out

- **EVV policies and procedures**
  - EVV compliance oversight policy
  - EVV reason code and required free text reviews
  - EVV allowable phone identification reviews
  - Texas Health and Human Service Commission (HHSC) Form 1718 – EVV Rights and Responsibilities (Managed Care Organization)

- **EVV standard reports**
  - EVV system reports
  - EVV portal reports

- **EVV portal search tools**

- **EVV claim submission**
  - New claims
  - Corrected claims

- **EVV prepayment claim matching**
  - Amerigroup process
  - Texas Medicaid Healthcare and Partnership (TMHP) Process

- **EVV postpayment claim matching**
  - EVV claim overpayment process
    - Dispute process

- **EVV claim tips for provider agencies**

- **EVV data correction request**

- **Other EVV resources and references**

- **Amerigroup EVV contact information**
EVV overview
EVV overview

• 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 replaces paper timesheets for EVV required services.
• EVV visits are required for EVV claim payment.
• EVV electronically documents the following visit data:
  o Member receiving services.
  o Attendant providing services.
  o Location of service delivery.
  o Date of service delivery.
  o Time the attendant begins and ends service delivery.

Note: EVV does not replace any contract, program or licensure requirements regarding service delivery or service delivery documentation.
There are five participants in EVV:

1. Contract provider
   - Provider agency
   - Financial Management Service Agency (FMSA)

2. Member
   - Medicaid recipient
   - CDS employer

3. EVV vendor
   - An HHSC approved EVV vendor provides an EVV system that must be used for EVV

4. Payers
   - HHSC
   - Managed Care Organizations (MCOs)

5. EVV data aggregator
   - Operated by the Texas Medicaid Claims Administrator — Texas Medicaid Healthcare and Partnership (TMHP)
   - EVV online portal and reports
Provider agencies that provide EVV required services are required to adhere to the following:

- Must use an HHSC-approved EVV system to document the provided service.
- Training is mandatory for all attendants and other assigned staff prior to beginning services with members. The provider agency is responsible for keeping track of details of training for staff. This documentation may be reviewed by Amerigroup upon reasonable request.
- Providers must complete all required EVV training.
- Providers should use EVV reports to review visit verification and adherence to compliance standards.
- All visits must be electronically documented in the EVV system and the EVV visit must be verified to confirm the service was provided to an Amerigroup member.
- Visit maintenance must be completed within 60 days from date of service.
- Must use the most appropriate HHSC reason code to verify a visit that requires visit maintenance.
- Must follow EVV policies outlined in the HHSC EVV Policy Handbook.
- Must contact Amerigroup and HHSC within 48 hours of an unresolved EVV system issue that has been reported to the EVV Vendor.
EVV requirements

• For EVV-required services, Amerigroup will not accept paper timesheets from a provider agency to confirm service was provided to an Amerigroup member.

• Effective September 1, 2019, all claims for EVV required services with a date of service starting September 1, 2019, through ongoing must be submitted to Texas Medicaid and Healthcare Partnership (TMHP).

• Financial Management Services Agency (FMSA) will be required to use EVV for Consumer Directed Services (CDS) starting January 1, 2020.
  - Additional FMSA requirements for EVV are still being established by HHSC. Amerigroup will update our training material once HHSC has established the final FMSA requirements.
EVV required services

EVV is required for the following services:

- **STAR+PLUS and Medicare-Medicaid (MMP):**
  - In-home respite care (agency model)
  - Personal assistance service (PAS) (agency model)
  - Personal assistance service protective supervision (PAS-PS) (agency model)
  - Community first choice (CFC) Personal Assistance Service (agency model)
  - CFC habilitation (HAB) (agency model)

- **STAR Kids:**
  - CFC personal care service (PCS) (agency model)
  - CFC habilitation (agency model)
  - PCS (agency model)
  - PCS behavioral health (BH) condition (agency model)
  - In-home respite care (agency model)
  - Flexible family support services (agency model)
Effective January 1, 2020, EVV will be required for the following consumer- directed services (CDS) and service responsibility option (SRO) services:

• STAR+PLUS and MMP:
  o In-home respite care (CDS and SRO)
  o Personal assistance service (PAS) (CDS and SRO)
  o Personal assistance service protective supervision (PAS-PS) (CDS and SRO)
  o Community first choice (CFC) Personal Assistance Service (CDS and SRO)
  o CFC habilitation (HAB) (CDS and SRO)

• STAR Kids
  o CFC personal care service (PCS) (CDS and SRO)
  o CFC habilitation (CDS and SRO)
  o PCS (CDS and SRO)
  o PCS, behavioral health (BH) condition (CDS and SRO)
  o In-home respite care (CDS and SRO)
  o Flexible family support services (CDS and SRO)
## EVV service codes

### STAR+PLUS and MMP

#### EVV service codes and units through August 31, 2019

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<thead>
<tr>
<th>HCPC</th>
<th>Mod 1</th>
<th>Mod 2</th>
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<th>Mod 4</th>
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#### EVV service codes and units beginning September 1, 2019

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### EVV Service codes and units

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Effective January 1, 2020, the following service codes will be required for EVV:

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## STAR Kids - EVV service codes and units

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</tbody>
</table>
When an attendant provides services to a member in the home or community, the attendant will use one of three approved EVV time recording methods to call in when service delivery begins and call out when service delivery ends:

1. Mobile application
2. Alternative device
3. Member’s home phone landline
The EVV vendors may have a mobile application for calling in and calling out of the EVV system that:

- Uses a free, downloadable application on a smart device.
- Only captures the location when the attendant clocks in and clocks out.
- Does not track the attendant or member at any time.
- Does not store protected health information (PHI).

To read the EVV Mobile Application Policy that went into effect on April 1, 2019, please visit: https://hhs.texas.gov/sites/default/files/documents/govdelivery/evv-mobile-application-policy.pdf.
An alternative device is an HHSC-approved device provided by the EVV vendor at no cost to the contract provider or CDS employer. The alternative device:

• Must remain in the member’s home at all times.
• Generates codes that indicate the call in and out time of the EVV system.

The attendant is required to record alternative device codes. The attendant or the contracted provider must call the alternative device codes into the EVV system within seven days of the visit.
A member can decide to allow an attendant to use their home phone landline to clock in and clock out of the EVV system. The phone landline is located in the member’s primary residence. The attendant dials a toll-free number, issued by the EVV vendor, to clock in and out.
EVV policies and procedures
Beginning September 1, 2019, the EVV compliance oversight team will review program providers’ use of EVV vendors to electronically document authorized service delivery visits. Program providers will be reviewed on a regular basis to ensure they are following EVV policies in the following areas:

- **EVV usage:**
  - Program providers will be reviewed for manually entered visits and rejected visit transactions.

- **EVV reason codes and required free text:**
  - Program providers will be reviewed for use of appropriate reason codes and required free text.

- **EVV allowable phone identification:**
  - Program providers will be reviewed for landline numbers used to clock in and out.
• EVV usage reviews — Effective for visits on or after September 1, 2019, the EVV usage review will monitor:
  o Graphical user interface (GUI).
  o EVV visit transactions.
  o Rejected EVV visit transactions.
• A GUI visit transaction — is a manually entered visit into the EVV system.
• A rejected EVV visit transaction — is an EVV visit transaction submitted to the EVV Aggregator from an HHSC approved EVV Vendor that is not accepted because it does not pass the EVV Aggregator validation edits.
• Compliance standard — All program providers must achieve and maintain a minimum EVV Usage score of 80 percent per quarter, unless otherwise notified by HHSC. This score applies for both HHSC fee-for-service and MCO programs.
• Grace period — Program providers currently required to use EVV will receive a grace period for visits between September 1, 2019, through August 31, 2020.
  o The grace period is a time for program providers to:
    ▪ Train or re-train their staff on how to use the EVV system.
    ▪ Pull the *EVV Usage Report*, become familiar with data.
EVV compliance oversight policy (cont.)

- Grace period (continued) — During the grace period program providers will:
  - Be required to use the EVV system.
  - Complete visit maintenance before billing.
  - Not be required to meet the minimum EVV compliance score of 80 percent until further notice.

- Quarterly review period — The EVV Usage Review period consists of all accepted visits within the following state’s fiscal quarters:
  - First quarter = September, October, November
  - Second quarter = December, January, February
  - Third quarter = March, April, May
  - Fourth quarter = June, July, August

- Review schedule — Payers will begin EVV usage reviews 60 calendar days from the last day of the quarter beginning on or after the fifth day of the following month. This allows visit maintenance to be completed for all visits in the quarterly review period.

<table>
<thead>
<tr>
<th>Quarter #</th>
<th>EVV provider compliance review begin date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>February 5</td>
</tr>
<tr>
<td>2</td>
<td>May 5</td>
</tr>
<tr>
<td>3</td>
<td>August 5</td>
</tr>
<tr>
<td>4</td>
<td>November 5</td>
</tr>
</tbody>
</table>
EVV compliance oversight policy (cont.)

- Report — Effective for visits on or after September 1, 2019, the *EVV Usage Report* (located in the EVV Portal) is used to determine the EVV usage score for each program provider’s contract with HHSC and the MCOs. This report will show the EVV compliance score for the preceding quarter and is available for up-to-date monitoring of compliance scores.

- **Score calculations** — The EVV usage score consists of two metrics:
  - **GUI transactions** — weighs 60 percent of the total exported transactions
    - Non-GUI transactions divided by total exported visits multiplied by 60 percent, equals non-GUI transaction percent
  - **Rejected EVV visit transactions** — weighs 40 percent of the total exported transactions
    - Non-rejected transactions divided by total exported visits multiplied by 40 percent equals non-rejected transactions

- The EVV usage score is calculated by adding the number of non-GUI EVV visit transactions percentage to the number of non-rejected EVV visit transaction percentage for the quarter.

- **EVV usage score criteria:**
  - Any accepted visit transaction marked with one or more GUI methods is considered a GUI transaction and will be counted towards the usage score.
  - GUI transactions are counted once.
  - GUI transaction with zero pay hours will be excluded from usage score calculations.
  - Rejected transactions, caused by the program provider, are counted as many times as they are resubmitted to EVV Aggregator.
• Review start date — The EVV Usage reviews start date will be posted on the HHSC and MCOs websites prior to the start of the review.
• Failure to meet the compliance standard — Enforcement actions for failure to meet the minimum EVV Usage score will be posted on the HHSC and MCO websites prior to action being taken.
• Policy — Please see the HHSC EVV Policy Handbook for the EVV Usage Policy.
• Effective for visits on or after September 1, 2019, EVV Reason Code and Required Free Text Reviews will monitor misuse of EVV reason codes and failure to enter required free text.

• Compliance standards
  o Misuse of reason codes:
    ▪ Using the same reason code more than 14 calendar days within a calendar month for the same member.
    ▪ Inappropriate use of preferred reason codes.
  o Required free text:
    ▪ Program provider must enter any required free text, including the correct free text information into the EVV system.
    ▪ Free Text is required for any missing (applies to all reason codes):
      • Actual clock in time (only) when EVV services begin
      • Actual clock out time (only) when EVV services end
      • Actual clock in and clock out time when EVV services begin and when services end

• Grace period for misuse of reason codes — Program providers currently required to use EVV will receive a grace period for visits with dates of service September 1, 2019-August 31, 2020.

• During the grace period program providers will:
  o Be required to use the EVV system.
  o Train/re-train their staff on using the most appropriate reason codes.
  o Pull the *EVV Reason Code Usage and Free Text Report* and become familiar with the data.
• Grace period for required Free Text — There is no grace period for entering correct required Free Text. Program providers must always document required Free Text.

• Review period:
  o Misuse of reason codes will not be reviewed until further notice.
  o The review period for required Free Text is determined by the reviewer’s date range sample.

• Review schedule:
  o Misuse of reason codes will not be reviewed until further notice.
  o The review schedule for required Free Text may occur at any time.

• Report — Effective for visits on or after September 1, 2019, the EVV Reason Usage and Free Text Report (located in the EVV Portal) is used to determine the reason codes used for each member and if any required Free Text was entered correctly. This report is available for up-to-date monitoring of EVV reason codes.

• Review start date — (For revised Reason Codes and Free Text requirements, effective September 1, 2019)
  o Misuse of Reason Codes - Review start date will be posted on the HHSC and MCOs websites prior to the start of reviews.
  o Required Free Text - Reviews for the revised required Free Text will start on September 1, 2019.
Failure to meet the compliance standard:

- Misuse of reason codes — Enforcement actions for misuse of reason codes will be posted on the HHSC and MCO websites prior to action being taken.
- Required free text — Failure to document any required Free Text may result in visits being recouped.
- Policy — Please see the *HHSC EVV Policy Handbook* for the *EVV Reason Code and Free Text Policy*.
Amerigroup will follow HHSC-established reason codes effective September 1, 2019. Program providers will need to select the correct EVV reason code description from the drop-down menu. **For EVV Visits with a date of service before September 1, 2019, Amerigroup follows the HHSC established reason codes that became effective July 1, 2017.**

<table>
<thead>
<tr>
<th>Reason code</th>
<th>Number</th>
<th>Reason code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overnight visit (If applicable)</td>
<td>000</td>
<td>This reason code is a system generated reason code used by the EVV vendor when the EVV system auto-generates a clock-out at 11:59pm and a clock-in at 12:00am for overnight visits. This reason code is not available for provider agency use. A. Overnight</td>
</tr>
<tr>
<td>Service variation</td>
<td>100</td>
<td>The provider will select from these reason codes when acceptable service variations occur. <strong>Free Text is required: Provider must document any missing actual clock in or clock out time.</strong> A. Staff hours worked differ from schedule B. Downward adjustment of pay hours C. Authorized services provided outside of home D. Fill-in for regular attendant E. Member agreed or requested staff not work F. Attendant failed to show up for work G. Confirm Visits with No Schedule H. Overlap Visits I. Split schedules In-home respite – Used when an in-home respite visit occurs and there is no scheduled in the EVV system</td>
</tr>
</tbody>
</table>
## HHSC EVV reason codes (cont.)

<table>
<thead>
<tr>
<th>Reason code</th>
<th>Number</th>
<th>Reason code description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disaster</strong></td>
<td>130</td>
<td>The provider will select from these reason codes when staff is unable to provide all or part of the scheduled services due to a natural disaster. Select natural disaster from drop down menu: A. Flood B. Hurricane C. Ice/Snow storm D. Tornado E. Wildfire</td>
</tr>
<tr>
<td><strong>Emergency</strong></td>
<td>131</td>
<td>The provider will select this reason code when staff is unable to provide all or part of the scheduled services due to an emergency with the member. Free Text Required: Must document the nature of the emergency and document any missing actual clock in or clock out time.</td>
</tr>
<tr>
<td><strong>Alternative device</strong></td>
<td>200</td>
<td>The provider will select from these reason codes when Alternative Device was not used. Free Text is required: Provider must document any missing actual clock in or clock out time. A. Alt Device Ordered B. Alt Device Pending placement C. Alt Device Missing</td>
</tr>
</tbody>
</table>

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An Anthem Company
<table>
<thead>
<tr>
<th>Reason code</th>
<th>Number</th>
<th>Reason code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile device</td>
<td>201</td>
<td>The provider will select from these reason codes when Mobile Device was not used. <strong>Free Text is required:</strong> Provider must document any missing actual clock in or clock out time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A. Mobile Device Ordered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. Mobile Device Pending placement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C. Mobile Device Missing</td>
</tr>
<tr>
<td>Technical issues</td>
<td>300</td>
<td>The provider will select from these reason codes when technical problems prevented the staff from clocking in and/or clocking out of the EVV system. <strong>Free Text is required:</strong> Provider must document any missing actual clock in or clock out time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A. Phone lines not working</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B. Malfunctioning Alternative Device</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C. Incorrect Alternative Device value</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D. Incorrect employee ID entered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E. Incorrect member EVV ID entered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F. Malfunctioning Mobile Device/Application</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G. Multiple calls for one visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>H. Reversal of Call in/out time</td>
</tr>
</tbody>
</table>
## HHSC EVV reason codes (cont.)

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landline not accessible</td>
<td>400</td>
<td>The provider will select this reason code when the member home telephone is not accessible, which prevented staff from using the EVV system. <strong>Free Text is required:</strong> Provider must document any missing actual clock in or clock out time. A. Member Does Not Have Home Phone B. Member Phone Unavailable C. Member Refused Staff Use of Phone</td>
</tr>
<tr>
<td>Service suspension</td>
<td>500</td>
<td>The provider will select this reason code when the individual/member services are suspended.</td>
</tr>
<tr>
<td>Other</td>
<td>600</td>
<td>The provider will select this reason code when a provider agency must address an EVV system exception that cannot be addressed using any other reason codes. <strong>Free Text is required:</strong> Must document why use of this reason code was required and document any missing actual clock in or clock out time.</td>
</tr>
<tr>
<td>Non-preferred</td>
<td>900</td>
<td>The provider will select from these reason codes when the staff failed to use the EVV system per EVV policy. <strong>Free Text is required:</strong> Provider must document any missing actual clock in or clock out time. A. Failure to call in B. Failure to call out C. Failure to call in and out D. Wrong Phone Number</td>
</tr>
</tbody>
</table>
The EVV-allowable phone identification review will monitor the use of a mobile- or cellular-enabled device or tablet when a program provider has selected the landline method to clock in and out of the EVV system.

Compliance standard — Program providers must ensure mobile- or cellular-enabled devices are not used to clock in and out of the EVV system when the landline method has been selected for the member.

Grace period — none

Review period — The Allowable Phone Identification Review period is determined by the reviewer’s date range sample.

Review schedule — Review may occur at any time.

Report — The EVV Phone Sampling Report (located in the EVV Vendor system) is used to identify wireless phone numbers used to clock in and out of the EVV system, when the method in and out is identified as landline for a member. This report is available for up-to-date monitoring of unallowable phone identification.

Review start date — August 1, 2018
• Failure to meet the compliance standard — If HHSC or an MCO identifies an unallowable phone type, the program provider will be notified in writing via email and mail. The written notification to the program provider must include, at a minimum, the following information:
  o Phone number identified
  o Phone type
  o Dates the phone number was used to clock in or clock out
  o Attendant associated with the EVV visit
  o Member’s first and last name
  o Member’s Medicaid ID number
  o Date HHSC or MCO identified the phone number associated with the device
  o List of supporting documentation the provider can submit to validate the identified unallowable phone number(s) is not a mobile phone or a cellular-enabled device or tablet
  o HHSC or MCO contact information

• HHSC or the MCO must provide the program provider a copy of the EVV Vendor Phone Sampling Report or other phone sampling reports used to identify the unallowable phone type.
• Failure to meet the compliance standard — The program provider must select one of the actions listed below within 20 business days from the date of receipt of the written notice:
  o Use the mobile method option
  o Request an alternative device
  o Submit supporting documentation showing the identified unallowable phone number(s) is not a mobile phone or cellular-enabled device or tablet
• HHSC or the MCO will review all supporting documentation submitted within the required 20 business day timeframe and provide written notice of a decision. If the supporting documentation submitted by the program provider cannot verify the unallowable phone number as an allowable phone type, the visit(s) identified in the written notice are subject to recoupment.
• Supporting documentation may include, but is not limited to:
  o Internet search sites such as White Pages, Free Carrier Look-up Service, Reverse Phone Check
  o Documentation from the phone company
• If the program provider fails to use the available mobile method, request an alternate device or submit supporting documentation to HHSC or the MCO within twenty business days from the date of the written notice, HHSC or the MCO may take enforcement actions against the program provider including recoupment of the visit(s) identified in the written notice.
• Please see the *HHSC EVV Policy Handbook* for the *EVV Allowable Phone Identification and Recoupment Policy*. 
EvV member right and responsibilities

**HHSC Form 1718 – EVV Rights and Responsibilities (MCOs)**

- Amerigroup uses this HHSC form to communicate to our members their rights and responsibilities for EVV.
- Amerigroup service coordinators review this document in detail with the member and/or their legal representative during a member’s initial annual assessment for EVV-required services.
- The form requires the member’s and/or their legal authorized representative’s signature and the Amerigroup service coordinator’s signature at the time of the initial and annual assessment for EVV required services.
- This form is provided in English and Spanish.
- The first section of the form explains the member’s rights.
- The second section of the form explains the member’s responsibilities.
- The third section of the form has FAQs.
- The fourth section contains the acknowledgement statement and signature lines.
EVV standard reports
EVV standard reports

- The following reports are the most common reports from the EVV vendor’s system that Amerigroup uses to review EVV for all provider agencies.
- Provider agencies have the same access as Amerigroup to pull these reports and obtain the same information.
- The following reports are used for EVV visits that have a visit date before September 1, 2019.
- DataLogic/VESTA EVV reports:
  - **EVV Visit Log**: This report shows all of the EVV visits that have been sent to Amerigroup. Amerigroup advises for provider agencies to use this report to compare to the claim(s) that are submitted in order to confirm if the billing data elements match to the claim(s).
  - **EVV Compliance Plan Summary**: This report shows the compliance score as a whole, not per agency location, if all locations use the same NPI and TIN. All information is reported according to the provider agency’s NPI and TIN.
  - **Reason Code Use**: This report identifies the frequency use of each reason code per provider agency.
  - **Failed to Export Report**: This report shows all of the EVV visits that were not sent to Amerigroup due to data errors and visits that were rejected by Amerigroup due to data errors. Amerigroup advises provider agencies to check this report frequently in order to identify the visits that need to be corrected within the 60-day visit maintenance window. If these visits are not corrected, they will not be sent to Amerigroup.
MEDsys Historical Visit Reports

• For providers who used MEDsys EVV System in the past, the EVV visit data has been transferred into a web portal established by DataLogic/VESTA.

• Providers who used MEDsys in the past will need to contact DataLogic directly to get access to this web portal to pull the needed EVV reports for MEDsys EVV visits.

• Amerigroup uses the following reports for EVV Visits that have a visit date before September 1, 2019, or that have a visit date before the provider agency stopped using MEDsys.
  
  o *EVV Visit Log*: This report shows all of the EVV visits that have been sent to Amerigroup. Amerigroup advises for provider agencies to use this report to compare to the claim(s) that are submitted in order to confirm if the billing data elements match to the claim(s).
  
  o *EVV Compliance Plan Summary Snapshot*: This report shows the compliance score as a whole, not per agency location, if all locations use the same NPI and TIN. All information is reported according to the provider agency’s NPI and TIN.

  o *Reason Code Use*: This report identifies the frequency use of each reason code per provider agency.
Program providers, FMSAs, MCOs and HHSC will have access to standard EVV reports in the EVV Portal for dates of service on or after September 1, 2019.

EVV standard reports only include EVV visit transactions accepted by the EVV Aggregator.

EVV standard reports in the EVV Portal will be considered the source of truth and used for contract monitoring, recoupments and enforcement purposes.

Current program providers using the DataLogic vendor system will continue to pull EVV standard reports for dates of service prior to September 1, 2019, from DataLogic/Vesta EVV system.

The EVV Portal will only display visits with dates of service on or after September 1, 2019.

CDS employers will pull CDS-specific reports from the EVV vendor system (not the EVV Portal).

Using EVV Portal Standard Reports

- EVV standard reports will be used by program providers, FMSAs, HHSC, and MCOs. The EVV standard reports can be used at a minimum for:
  - Conducting contracting and billing audits.
  - Fee-for-service (FFS) EVV compliance monitoring.
  - MCOs EVV compliance monitoring.
  - Medicaid fraud investigations.
  - Medicaid data analysis.
EVV portal standard reports list

• The EVV Portal will include the following standard reports:
  o *EVV Visit Log*
  o Units of service summary (fee-for-service only)
  o *EVV Usage Report*
  o *EVV Reason Code Usage and Free Text*

• The final list of EVV standard reports will be included in training materials by September 1, 2019.
EVV portal standard reports (cont.)

- **EVV Visit Log** — Examples of the EVV visit data included in the *EVV Visit Log* will include:
  - All EVV visit transactions that have been accepted into the EVV Aggregator.
  - Planned visit schedule date and time, if applicable.
  - Actual visit date.
  - Actual clock in and clock out times.
  - Billed hours.
  - Reason codes and free text.
  - Last visit maintenance date.

- **EVV Usage Report:**
  - The *EVV Usage Report* will show the EVV provider compliance score for the preceding quarter and will be available for up-to-date monitoring of compliance scores.
  - This report shows how well program providers and CDS employers are using the EVV system to electronically document service delivery.
  - The EVV compliance score is a weighted score of manually entered visits and rejected EVV visit transactions.
  - The final *EVV Compliance Plan* will be posted in the summer of 2019.

- **Reason Code Usage and Free Text:**
  - The reason code used on accepted EVV visit transactions.
  - The percentage of overall reason code usage.
  - Any free text saved to an accepted EVV visit transaction.
EVV portal search tools
In addition to EVV standard reports:

- Program providers, FMSAs, MCOs, and HHSC staff can search for EVV visit transactions and claims matching data in the EVV Portal.
- EVV Portal users can use the *Accepted Visit Search*, *History/Rejected Visit Search*, and *EVV Claim to Visit Search* tabs to select specific criteria to run searches for:
  - Accepted EVV visit transactions.
  - Rejected EVV visit transactions.
  - History of updates made to EVV visit transactions.
  - EVV claims to EVV visit transaction match results.
- EVV Portal users can export search results to Microsoft Excel.

**Accepted Visit Search** tab

- The *Accepted Visit Search* tab allows viewing of the most current accepted EVV visit transactions within a specific date range.
- Before submitting an EVV claim, program providers and FMSAs use this tab to confirm an EVV visit transaction has been accepted by the EVV Aggregator.
EVV portal search tools (cont.)

• History/Rejected Visit Search tab displays:
  o All changes made to visits performed through visit maintenance.
  o Rejected EVV visit transactions with rejection codes.

• EVV Claim to Visit Search tab: allows users to match results for a claim that was submitted to Texas Medicaid & Healthcare Partnership (TMHP), and all of its associated EVV visit transactions. This tab provides the following information:
  o Match dates
  o Match results using matching codes:
    ▪ EVV01 — EVV match
    ▪ EVV02 — Medicaid ID mismatch
    ▪ EVV03 — Visit date mismatch
    ▪ EVV04 — Provider mismatch (NPI or Atypical Provider Identifier [API] mismatch)
    ▪ EVV05 — Service mismatch (HCPCS code/modifier mismatch)
    ▪ EVV06 — Units mismatch

• EVV claim match result code:
  o An EVV claim match result code is used to indicate if an EVV claim line item matched an accepted EVV visit transaction.
New and corrected claims:

• You must submit all claims for EVV-required services with a date of Service \textit{before} September 1, 2019, directly to Amerigroup.
• Effective September 1, 2019, all claims for EVV required services with a date of service on or after September 1, 2019, must be submitted to TMHP.
• EVV claims must be submitted to TMHP through TexMed Connect or through EDI using a C21 Submitter ID.
• MCO EVV claims will be forwarded to the appropriate payer after the EVV claims matching process is performed for further claims processing.
• EVV claims with dates of service on or after September 1, 2019 submitted directly to Amerigroup will be rejected.
  o Program providers will receive a response from Amerigroup informing them to submit EVV claims to TMHP.
  o If Amerigroup receives a claim directly from a provider for EVV-required services with a date of service that overlaps before and after September 1, 2019, Amerigroup will reject the claim and the provider will be notified to submit the claim to Amerigroup for only the dates of service before September 1, 2019; and to submit a claim to TMHP for \textit{only} the dates of service on or after September 1, 2019.
  o For CDS and SRO services that are required to use EVV starting January 1, 2020:
    ▪ If Amerigroup receives a claim directly from a provider, for CDS and SRO EVV-required services with a date of service that overlaps before and after January 1, 2020, Amerigroup will reject the claim and the provider will be notified to submit the claim back to Amerigroup for only the dates of service before January 1, 2020; and to submit a claim to TMHP for only the dates of service on or after January 1, 2020.
• For claims \textit{rejected} by Amerigroup, these claims should be re-submitted as \textit{new} claims to Amerigroup or TMHP accordingly.
Program providers and FMSAs can access TMHP’s EDI homepage at (http://www.tmhp.com/Pages/EDI/EDI_Home.aspx) for basic information needed to file claims electronically as well as user guides, forms and technical information intended for billing agents that file claims for program providers.

Program providers and FMSAs that need assistance in setting up C21 or CMS submitter IDs should contact the EDI Help Desk at 1-888-863-3638, option 4.

TMHP and Amerigroup will allow providers to submit claim dates of service with a range of service dates (span dates) or by a single date of service.

If the provider submits an EVV claim with a span date, the program provider must ensure that:

- Each date has one or more matching EVV visit transactions.
- The total units on the EVV claim must match the combined total units of the matched EVV visit transactions.

EVV claims with date spans starting prior to September 1, 2019, will be rejected by TMHP.
EVV claim submission (cont.)

- Program providers and FMSAs can view accepted EVV visit transactions in the EVV Portal before submitting EVV claims.
- If a program provider submits a claim with a span date that includes dates of service before September 1, 2019, and on/after September 1, 2019, the claim will be rejected by TMHP.
- Program providers and FMSAs should always check the EVV Portal to ensure the EVV visit transaction has been accepted by the EVV Aggregator before submitting the associated claim.
EVV prepayment claims matching
Effective January 1, 2019, Amerigroup began the process of prepayment reviews for claims submitted for EVV-required services with a date of service on or after January 1, 2019.

Amerigroup prepayment claim review will end with date of service August 31, 2019.

The system matches EVV transactions to the claim prior to claims adjudication:

- Complete match — Claim pays according to the provider’s contract.
- Partial match — Dates/units with an EVV transaction match will pay according to the provider’s contract, and the dates/units that do not have a matching EVV transaction will deny.
- No match — Claim will deny.
EVV claims matching (cont.)

• The provider will receive an EOP and the denial code will be GV2 — *Invalid/Missing EVV Transaction*.
• This will inform the provider that the claim was denied due to the missing EVV transaction to match to their claim.
• Provider should keep in mind that there is a 24-hour delay from when the EVV visit is verified or corrected in the EVV System to when Amerigroup will receive the EVV transaction from the EVV vendor. Amerigroup recommends providers wait at least 24-48 hours and check the *EVV Visit Log Report* to ensure the EVV transactions have been sent and accepted by Amerigroup.
  - Example: A provider verifies or makes corrections to a verified EVV visit in the EVV system on Monday. The EVV transaction will be exported to Amerigroup on Tuesday.
  - If the claim is received before the EVV transaction(s) is received, the claim may result in a denial because at the time the claim was submitted the EVV transaction was not received.
The system will match claims with EVV daily transaction files received from EVV vendors using the following data elements:

- Member Medicaid ID (state issued)
- Provider NPI number
- Provider Tax ID number
- Date of Service (EVV Visit Date)
- HCPCS code
- Modifiers 1-4
- Billed units (EVV Pay Hours)
If the provider agency receives an EOP and the claim shows it was denied for GV2 – Invalid/Missing EVV Transaction, the provider will need to complete the following steps:

- Pull the Failed to Export Report from the EVV System to verify there are no EVV visits for the member and date of service on the claim.
- If there are EVV visits listed and they are within the 60-day visit maintenance window, the provider agency will need to make the needed corrections to the visit in order for the EVV vendor to export the visit to Amerigroup.
- If there are EVV visits listed and they are over the 60-day visit maintenance window, the provider agency will need to submit a request to Amerigroup for EVV data corrections. In order to get approval make the needed corrections to the visit, and for the EVV Vendor to export the EVV visits to Amerigroup.
EVV claims matching (cont.)

- Pull the *EVV Visit Log Report* from the EVV System and make sure all visits are verified and match the seven data elements used for matching (see slide 51).
  - If one or more of the seven data elements used for matching does not match the claim data that was submitted, the provider will need to determine if the EVV visit has the wrong data or if the claim was submitted with the wrong data.
  - If the EVV visit has the wrong data and the visit is within the 60-day visit maintenance window, the provider agency will need to make the needed corrections to the visit in order for the EVV vendor to re-export the updated visit to Amerigroup.
  - If the EVV visit has the wrong data and the visit is over the 60-day visit maintenance window, the provider agency will need to submit a request to Amerigroup for EVV data corrections in order to get approval make the needed corrections to the visit and for the EVV Vendor to export the EVV visits to Amerigroup.
If the claim has the wrong data and the EVV visit has the correct data, the provider agency will need to submit a corrected claim, and no corrections are needed to the EVV visit.

The provider will need to submit a corrected claim once the EVV Visit(s) have been corrected and the updated EVV visit(s) have been sent to Amerigroup.

If the provider submits an dispute before submitting a corrected claim, the dispute will be upheld if denial was correct. Only when the claim was denied in error will the denial be overturned. It is best for the provider agency to submit a corrected claim after the provider verifies all EVV visits match the claim that was denied with a GV2 denial code.

Timely filing limits remain the same for corrected claim submissions. EVV does not extend or change the timely filing limits.

Provider agencies need to ensure all corrected claims are labeled as a corrected claim and submitted using resubmission code 7.
• HHSC will implement a new claims matching process for new and corrected claims effective September 1, 2019, for current program providers of EVV-required services.
  o This is for claims and EVV visits with dates of service on or after September 1, 2019.
• Effective January 1, 2020, the claims matching process will begin for new and corrected claims for CDS and SRO services that will require EVV, and FMSAs required to use EVV.
  o This is for claims and EVV visits with dates of service on or after January 1, 2020.
• TMHP will forward the claim to Amerigroup with the matching results and Amerigroup will continue with claim processing.
• The TMHP EVV aggregator will match the EVV claim line item with the accepted EVV visit transactions using the following critical data elements:
  o NPI or API
  o Date of service
  o Medicaid ID
  o HCPCS code
  o Modifiers, if applicable
  o Units
• EVV claim line items that are not successfully matched with EVV visit transactions will be denied by Amerigroup.
If a provider submits a claim to TMHP with the date of service in a span date, there must be an EVV visit for each day within the date range in order for the claim to fully match to the date of service critical data element.

- For example, if the claim date of service is listed as September 1-15, 2019, but the member did not receive any services on September 6, 9 or 12. There will not be an EVV transaction for these three dates. Therefore, TMHP will consider this claim to not match the EVV transactions because there will be missing EVV transactions for dates September 6, 9 and 12.

- In this example, the provider may submit the claim with four claim line items using dates of service:
  - Claim line #1: 09/01/2019 – 09/05/2019
  - Claim line #2: 09/07/2019 – 09/08/2019
  - Claim line #3: 09/10/2019 – 09/11/2019
  - Claim line #4: 09/13/2019 – 09/15/2019

- Or the provider may submit four individual claims with one claim line using the dates of services listed above.
• EVV claim line items will be denied if:
  o Critical data elements do not match the EVV claim.
  o The claim was not submitted according to the payer’s guidelines regarding span dates.
  o A date within the span of dates does not have a matching EVV visit.
  o The total units of the matched EVV visit for a date span do not match the units billed on the EVV claim.
• EVV claims can be denied for other reasons identified by Amerigroup.
TMHP will send Amerigroup the matching results using the following match result codes:

<table>
<thead>
<tr>
<th>Match result code</th>
<th>Match result description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVV01</td>
<td>EVV Match</td>
<td>EVV MATCH - Amerigroup will continue claim processing</td>
</tr>
<tr>
<td>EVV02</td>
<td>Medicaid ID Mismatch</td>
<td>NO EVV MATCH - Amerigroup will deny the claim</td>
</tr>
<tr>
<td>EVV03</td>
<td>Visit Date Mismatch</td>
<td>NO EVV MATCH - Amerigroup will deny the claim</td>
</tr>
<tr>
<td>EVV04</td>
<td>Provider Mismatch (National Provider Identifier (NPI) or Atypical Provider Identifier (API) Mismatch)</td>
<td>NO EVV MATCH - Amerigroup will deny the claim</td>
</tr>
<tr>
<td>EVV05</td>
<td>Service Mismatch (Healthcare Common Procedure Coding System (HCPCS)/Modifier Mismatch)</td>
<td>NO EVV MATCH - Amerigroup will deny the claim</td>
</tr>
<tr>
<td>EVV06</td>
<td>Units Mismatch</td>
<td>NO EVV MATCH - Amerigroup will deny the claim</td>
</tr>
</tbody>
</table>
For Medicaid claims that come from TMHP with a match result code that results in a “NO EVV MATCH”, Amerigroup will deny the claim. The provider will receive an *Explanation of Payment (EOP)* and will see one of the following denial codes based on the TMHP match result code that is received.

<table>
<thead>
<tr>
<th>TMHP match result code</th>
<th>Amerigroup denial code</th>
<th>Denial Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVV02 (Medicaid ID Mismatch)</td>
<td>ZV2</td>
<td>No EVV visits with the Medicaid ID. Verify all data elements used for EVV match the claim data being billed.</td>
</tr>
<tr>
<td>EVV03 (Date(s) of Service Mismatch)</td>
<td>ZV3</td>
<td>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.</td>
</tr>
<tr>
<td>EVV04 (Provider Mismatch)</td>
<td>ZV4</td>
<td>No EVV visits with the Medicaid ID &amp; NPI/API on the Date of Service. Verify all data elements used for EVV match the claim data being billed.</td>
</tr>
<tr>
<td>EVV05 (Service Mismatch)</td>
<td>ZV5</td>
<td>No EVV visits with the Medicaid ID &amp; HCPCS/Mods on the DOS. Verify all data elements used for EVV match the claim data being billed.</td>
</tr>
<tr>
<td>EVV06 (Units Mismatch)</td>
<td>ZV6</td>
<td>EVV claim billed units do not equal units total of matched visit(s).</td>
</tr>
</tbody>
</table>
For MMP claims that come from TMHP with a match result code that results in a “NO EVV MATCH”, Amerigroup will deny the claim. The provider will receive an *Explanation of Payment (EOP)* and will see one of the following denial codes based on the TMHP match result code that is received:

<table>
<thead>
<tr>
<th>TMHP match result code</th>
<th>Amerigroup denial code</th>
<th>Denial Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVV02 (Medicaid ID Mismatch)</td>
<td>ZE2</td>
<td>No EVV visits with the Medicaid ID. Verify all data elements used for EVV match the claim data being billed</td>
</tr>
<tr>
<td>EVV03 (Date(s) of Service Mismatch)</td>
<td>ZE3</td>
<td>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</td>
</tr>
<tr>
<td>EVV04 (Provider Mismatch)</td>
<td>ZE4</td>
<td>No EVV visits with the Medicaid ID &amp; NPI/API on the Date of Service. Verify all data elements used for EVV match the claim data being billed</td>
</tr>
<tr>
<td>EVV05 (Service Mismatch)</td>
<td>ZE5</td>
<td>No EVV visits with the Medicaid ID &amp; HCPCS/Mods on the DOS. Verify all data elements used for EVV match the claim data being billed</td>
</tr>
<tr>
<td>EVV06 (Units Mismatch)</td>
<td>ZE6</td>
<td>EVV claim billed units do not equal units total of matched visit(s)</td>
</tr>
</tbody>
</table>
For claims that result in a denial due to a NO EVV MATCH result, providers should take the following steps:

• Check the EVV Portal to ensure the EVV visit has been accepted by the EVV Aggregator.

• Compare the critical data elements from the claim to the EVV transaction to validate each critical data element matches.
  - If there is a discrepancy between any of the critical data elements used for matching the provider will need to make the needed corrections to the EVV Visit or the claim (if the claim was submitted with the wrong data).

• Once any corrections have been made the provider will need to re-submit the claim as a corrected claim.

• Make sure the corrected claim is marked correctly as a “corrected” claim and for Amerigroup use resubmission code number seven (7).

• If a provider submits an dispute to Amerigroup for a denied claim that was denied with one of the denial codes listed on slide 59. The dispute will be dismissed, and the provider will be instructed to re-submit the claim to TMHP as a corrected claim.

• There are no changes to the timely filing limits. Providers must submit corrected claims within the current timely filing requirements.
EVV postpayment claim matching
EVV postpayment claim matching

- Amerigroup claims with dates of service from January 1, 2017, to present are reviewed to verify matching EVV transactions.
- Amerigroup matching process:
  - Pull ongoing claims reports for paid claims that require EVV, then match claims with EVV daily transaction files from EVV vendors using the following data elements:
    - Medicaid ID
    - Provider NPI number
    - Provider Tax ID number
    - Date of service (EVV visit date)
    - HCPCS code
    - Modifiers 1-4
    - Billed units (EVV pay hours)
  - Starting with date of service September 1, 2019, thru ongoing, if a claim had a valid match result from TMHP, but then after the claim was paid the provider made changes to one or more of the claim matching data elements on the EVV transaction, and did not submit a corrected claim. The claim that was paid no longer has a valid match to an EVV transaction. This claim could be subjected for possible recoupment due to no match to EVV Transaction.
EVV postpayment claim matching

Complete match

• All claim data and EVV transaction data fully match.
• No action is taken on the paid claim.

Partial match

• Some dates and/or units of the claim match to an EVV transaction, but some do not have a matching EVV transaction.
• Only the nonmatching dates and/or units are sent for recovery.

No match

• There are no EVV transaction(s) that match to the claim.
• All dates and units on the claim are sent for recovery.
EVV postpayment claim matching (cont.)

First notice:
• The Amerigroup EVV team will mail the first notice. This notice will include claim details and identify the data element that does not match the claim and EVV transaction.
• Providers have 60 days from the date of the first notice to:
  o Contact Amerigroup via secure email at TXEVVSupport@Amerigroup.com to file a dispute.
  o Submit a request for any EVV data corrections, if an EVV Visit needs data corrections.
  o If the issue is with the claim and the claim was submitted with the wrong data. Only if the claim is within the timely filing limit can it be re-submitted as a corrected claim.
  o If the provider does not make contact with Amerigroup within 60 days of the date of the first notice, then the claim(s) will be sent to the Cost Containment Unit (CCU) for recovery.

Cost Containment Unit (CCU) first overpayment notice:
• The CCU will mail out a first overpayment notice. This notice will include claim details.
• Providers have 60 days from the date of the CCU first overpayment notice to:
  o Contact Amerigroup via secure email at TXEVVSupport@Amerigroup.com to file a dispute.
  o Submit a request for any EVV data corrections, if an EVV Visit needs data corrections.
  o If the issue is with the claim and the claim was submitted with the wrong data. Only if the claim is within the timely filing limit can it be re-submitted as a corrected claim.
EVV postpayment claim matching (cont.)

- CCU final overpayment notice
  - The Amerigroup CCU team will mail out the final notice 45 days after the CCU first overpayment notice if the provider has not refunded the amount or disputed the recovery.

- CCU recovery
  - If the provider has not refunded the amount or disputed the recovery within 60 days from the date of the CCU First Overpayment Notice, the Amerigroup CCU team will adjust the claim to automatically offset the provider’s account.

- Dispute process
  - Providers need to submit all request for disputes to an EVV overpayment project via secure email to TXEVVSupport@Amerigroup.com.
  - Providers need to provide any supporting documentation and information to support their dispute. Examples of supporting documentation:
    - Request for EVV Data Corrections
    - EVV Visit Log Report (CSV Version)
    - Screen shots of the EVV system
    - Documentation from the EVV Vendor
    - Any documentation or information on situations outside of the agency’s control to correct the data within the 60-day visit maintenance window
  - Amerigroup will send a secure email to the provider once the review has been completed.
  - Once the dispute is finalized, Amerigroup will mail a letter to the provider that identifies any claim(s) that are being overturned or upheld.
EVV claim tips for provider agencies
EVV claim tips for provider agencies

• Tip 1: Be ready to submit electronic claims to TMHP starting with date of service on or after September 1, 2019.
  - 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 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.
  - For assistance, contact the TMHP EDI Help Desk at: 1-888-863-3638, Option 4.

• Tip 2: For EVV visits with a date of service before September 1, 2019:
  - Before submitting an EVV claim, always check the EVV visit has been received by Amerigroup and check the EVV visit data matches the claim data.
    - Providers may do this by pulling the EVV Visit Log Report and Failed to Export Report from the EVV System for EVV visits dated before September 1, 2019.
  - Refer to slide 51 for the list of data elements Amerigroup uses for claim matching.
Tip 3: For EVV visits with a date of service on or after September 1, 2019:
- Before submitting an EVV claim, always check the EVV visit has been received by TMHP and that the EVV visit data matches the claim data.
- Providers may do this by checking the EVV Portal for EVV visit dates on or after September 1, 2019.
- Refer to page 55 for the list of data elements TMHP uses for claim matching.

Tip 4: For EVV visits with a date of service on or after September 1, 2019:
- Check EVV visit transaction status before submitting claims.
- Always check the “Accepted Visit Search” tab to ensure the EVV visit transaction was accepted by the EVV Aggregator before submitting the claim.

Tip 5: Provider agencies should wait at least 24 hours prior to billing claims to ensure EVV transaction(s) have been exported to Amerigroup and TMHP. There is a 24-hour delay from when the EVV visit is verified or when corrections are made to a verified visit, to when the EVV transaction is exported to Amerigroup and TMHP.
- For example, a provider verifies or makes corrections to a verified EVV visit in the EVV system on Monday. If the visit date is before 9/1/2019 the EVV transaction will be exported to Amerigroup on Tuesday.
- For example, a provider verifies or makes corrections to a verified EVV visit in the EVV system on Thursday. If the visit date is on or after 9/1/2019 the EVV transaction will be exported to TMHP on Friday.
- If the claim is received before the EVV transactions is received, the claim will result a denial because at the time the claim was submitted the EVV transaction was not received.
Tip 6: Provider agencies should always make sure they are entering the correct data into the EVV system at all times. This includes all data for:
  - Member/Client information
  - Provider agency information
  - Attendant information
  - Schedule and Visit information
  - Service information
    - Service information is based on the Amerigroup authorization that is sent to the provider agency from Amerigroup.

Tip 7: If a provider agency has a staff who is responsible for the EVV system and another staff who is responsible for claim submissions, the provider agency should make sure the staff who is responsible for the EVV system and the staff who is responsible for claims submissions are in communication with each other in order to prevent discrepancies between the EVV data and the claim data.
EVV data corrections
Amerigroup allows providers to submit a request for EVV Data Corrections on EVV visits over 60 days old if a correction is needed to a specific data element.

Providers must use the Amerigroup EVV Visit Maintenance Unlock Request Spreadsheet in order to submit their request.

Providers 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®.

Providers must email secure the completed spreadsheet to: TXEVVSupport@Amerigroup.com

Once Amerigroup receives the request it will be reviewed and the decision will be emailed secure back to the provider agency and the EVV Vendor.

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

All requests for EVV Data Corrections/Unlock are reviewed on a case-by-case basis.
EVV data corrections (cont.)

- Amerigroup reviews for situations that were outside of the provider agency’s control to correct the visits within the 60-day visit maintenance window.
- Amerigroup will not approve a request to “verify” a visit after 60 days as all visits must be verified within 60 days.
- A provider may request Amerigroup to unlock visit maintenance to correct data element(s) on an 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)
• If the spreadsheet is not completed correctly, the request will be denied.
  o The information on what was incorrectly completed will be listed on the *Reason for Denial*.
  o The provider will need to make the needed corrections to their request and they may resubmit their request once the corrections to the spreadsheet have been made.
• If the EVV Visit is not in the verified status the request will be denied.
• If the request is denied the information as to why the provider’s request was denied will be detailed in the *Reason for Denial* column.
• The provider agency will need to review the “Reason for Denial” for each EVV Visit that was denied.
• To dispute a denial, the provider agency may re-submit their request that was denied and provide the additional information need to support the situation for their request for correction on the EVV Visit.
• Amerigroup will complete another review for any request that is denied, if the provider agency resubmits with additional information.
Other EVV resources and references
Other EVV resources and references

• Request EVV Data Correction Spreadsheet: Microsoft Excel Worksheet

• Amerigroup provider website:
  o [https://providers.amerigroup.com/tx](https://providers.amerigroup.com/tx)
  o EVV Section is located under Provider Resources & Documents
    o All Amerigroup EVV documents and alerts are posted in the EVV Section


Other EVV resources and references

  o Module One: An Introduction to EVV
  o Module Two: EVV Roles and Responsibilities Part 1 of 2
  o Module Three: EVV Roles and Responsibilities Part 2 of 2
  o Module Four: EVV Visit Transactions
  o Module Five: EVV Visit Maintenance
  o Module Six: EVV Process Flow: Beginning to End
  o Module Seven: EVV Aggregator and EVV Portal
  o Module Eight: Submitting an EVV Claim
  o Module Nine: EVV Portal Standard Reports and Search Tool
EVV terms, abbreviations and definitions

- **Electronic Visit Verification (EVV)** - is the electronic verification and documentation of visit data, such as the date and time services begin and end, the name of the attendant, the service recipient, and the services provided.
- **EVV Vendor** is the vendor that supplies the EVV system. Providers must use an approved HHSC EVV vendor for their EVV system.
- **EVV System** is the system that tracks the electronic visit of all members and their attendants. This is the system that paid attendants call in out when they begin and end the services.
- **EVV Schedule** is the schedule the provider agency enters into the EVV System. This documents when the services *should* begin and end.
- **EVV Visit** once the EVV schedule is verified, it turns into an EVV Visit. This documents the *actual* time the services began and ended.
- **Visit maintenance** is when the provider agency has to manually verify an EVV schedule because the call-in and call-out did not automatically link to the EVV schedule. Provider agencies have 60 days from the date of service to complete visit maintenance. Provider agencies must contact the member to confirm services actually occurred, prior to verifying the EVV schedule.
- **Auto-verify** is when an EVV schedule is automatically verified in the EVV System. The EVV schedule does not require visit maintenance.
- **Auto-link** is when a call-in and/or call-out automatically links to the EVV schedule.
- **Verification** is the process of the EVV schedule being verified in the EVV system. When the EVV schedule is verified this confirms the EVV visit actually occurred.
- **Date of Service (DOS)** is the date the EVV Visit occurred. This is also known as the *EVV visit date*. 
## Amerigroup EVV contact information

<table>
<thead>
<tr>
<th>EVV vendor contact information</th>
<th>Amerigroup EVV email address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vesta/DataLogic</strong>&lt;br&gt;Website: <a href="http://www.vestaevv.com">www.vestaevv.com</a>&lt;br&gt;Phone: 1-844-880-2400</td>
<td><strong><a href="mailto:TXEVVSupport@amerigroup.com">TXEVVSupport@amerigroup.com</a></strong></td>
</tr>
</tbody>
</table>

## Provider Relations Representative

<table>
<thead>
<tr>
<th>Service delivery area/Counties</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexar/Travis</td>
<td>Jennifer Pena</td>
<td><a href="mailto:jennifer.pena@anthem.com">jennifer.pena@anthem.com</a></td>
</tr>
<tr>
<td>El Paso</td>
<td>Maribel Martinez</td>
<td><a href="mailto:maribel.martinez@anthem.com">maribel.martinez@anthem.com</a></td>
</tr>
<tr>
<td>Harris</td>
<td>Eric Preston</td>
<td><a href="mailto:eric.preston@amerigroup.com">eric.preston@amerigroup.com</a></td>
</tr>
<tr>
<td>Jefferson</td>
<td>Kristal Babino</td>
<td><a href="mailto:kristal.babino@amerigroup.com">kristal.babino@amerigroup.com</a></td>
</tr>
<tr>
<td>Johnson, Dallas, Tarrant</td>
<td>I’Esha Hudson-Buggs</td>
<td>l’<a href="mailto:esha.hudsonbuggs@amerigroup.com">esha.hudsonbuggs@amerigroup.com</a></td>
</tr>
<tr>
<td>Denton, Wise, Hood, Parker</td>
<td>Deidre Haynie</td>
<td><a href="mailto:deidre.haynie@amerigroup.com">deidre.haynie@amerigroup.com</a></td>
</tr>
<tr>
<td>Western Region Rural Service Area, Lubbock/Amarillo</td>
<td>Nancy Belcher</td>
<td><a href="mailto:nancy.belcher@amerigroup.com">nancy.belcher@amerigroup.com</a></td>
</tr>
</tbody>
</table>
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An Anthem Company