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Services

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DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	2.0	September 1, 2014	Initial version Uniform Managed Care Manual, Chapter 8.7, "Medicaid Managed Care Electronic Visit Verification." Version 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, 529-12-0002, and 529-13-0042.
Revision	2.1	October 15, 2014	Version 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, 529-12-0002, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. Section I "Applicability of Chapter 8.7" is modified to add the Medicare-Medicaid Dual Demonstration.
Revision	2.2	February 8, 2019	Version 2.2 applies to contracts issued as a result of HHSC RFP numbers 529-12-0002, 529-10-0020, 529-13-0042, 529-15-0001, 529-13-0071, and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. Chapter number changed from 8.7 to 8.7.1. Section I. "Applicability of Chapter 8.7.1" is modified to revise chapter number from 8.7 to 8.7.1, add STAR Kids to the applicability, clarify attendant care services, and clarify how the chapter applies. Section II. "Purpose" is modified to clarify what this chapter includes and add reference



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			<p>to EVV UMCM chapters to be used in conjunction with this chapter.</p> <p>Section III. "Statutory and Regulatory Authority" is modified to update the list of references.</p> <p>Previous Section IV. "Informational Resources" is removed and the language, which is based on the Texas Government Code, has been updated to be consistent with the terms used in this document.</p> <p>Section IV. "Background" is modified to indicate the verification information relating to the delivery of Medicaid services to be implemented within the Electronic Visit Verification system.</p> <p>Section V. "Definitions" is modified to add/revise the following definitions and to place the definitions in alphabetical order: Authorization Data, Eligibility Data, Electronic Visit Verification (EVV), EVV Provider Compliance Plan, EVV Contractor, EVV Rejection Codes, EVV System, Global Positioning System (GPS) Mobile Application, Non-preferred Reason Code, Preferred Reason Code, Prospective Claim Review, Provider, Reason Code, Small Alternative Device, Visit Maintenance, Visits, Verified, Visits Auto-Verified, Visits Verified Preferred, and Visits Verified Non-Preferred.</p>



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STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
			<p>Section VI. "MCO Contracting for Electronic Visit Verification" is modified to remove language that HHSC will select, approve, and negotiate implementation and transaction costs with EVV approved contractors.</p> <p>Section VII. "EVV Programs and Services Required to Use EVV" is added.</p> <p>Section VIII. A. "General Requirements" is reformatted, language clarifications are made and "or at a defined frequency" is removed from the end of the sentence in A.6.</p> <p>Section VIII. B. "Visit Verification Requirements" is reformatted and modified move the language related to HHSC approval required for post-implementation alternatives for visit verification via use of telephone and when other forms of EVV technology are limited or non-existent prior to Provider use to the beginning of the applicable sentences. Language was added to clarify that the MCO must provide the alternatives references in B. 4 and 5.</p> <p>Section VIII. C. "Data Input Requirements" is reformatted and modified to add "authorization data" to C. 1 and to add C. 3, which requires EVV contractor submission of daily Member lists with MCO response file follow up.</p>



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STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
			<p>Section VIII. D. "Training and Support Requirements" is reformatted.</p> <p>Section VIII. E. "Data/Record Access Requirements" is reformatted.</p> <p>Section VIII. F. "Reporting Requirements" is reformatted and removes reference to the EVV vendor monthly report.</p> <p>Section VIII. G. "EVV Appeal Requirements" is added.</p> <p>Section IX. "MCO Education Requirements" is added.</p> <p>Previous Section IX. "Provider Compliance Requirements" is removed.</p> <p>Previous Section X. "MCO Member Education Requirements" is removed. This requirement is now addressed in Section IX. "MCO Education Requirements."</p> <p>Section X. "EVV Required Data Elements" is added.</p> <p>Section XI. "MCO EVV Reporting Requirements" is modified to provide new reporting requirement language.</p> <p>Section XII. "MCO EVV Meeting Requirements" is added.</p>



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STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
			<p>Section XIII. "MCO EVV Rejected Transactions" is added.</p> <p>Section XIV. "EVV Prospective Reviews" is added.</p> <p>Section XVI. "MCO EVV Standardization" is added.</p>
Revision	2.3	February 21, 2020	<p>Chapter 8.7.1 is replaced in its entirety with a new chapter 8.7.1. Many of the changes were made due to restructuring of the EVV Systems within the Medicaid Managed Information System and in preparation for compliance with the Cures Act, including implementation of the following:</p> <ul style="list-style-type: none"> • Updates to MCO Provider compliance oversight • Adjust Pre-payment Claim Review to deny any EVV related claims without an EVV visit • Add claims matching performed by the EVV Aggregator • Add MCO providers sending all EVV-relevant claims to TMHP for matching • Add matched claims with match results will be forwarded by TMHP to the MCO • MCOs no longer having contracts with the EVV vendor(s)



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STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
			<ul style="list-style-type: none"> Updated list of services subject to EVV requirements under the federal Cures Act
Revision	2.3.1	June 17, 2020	Accessibility approved version.

¹ Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

² Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

³ Brief description of the changes to the document made in the revision.

I. APPLICABILITY OF CHAPTER

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR+PLUS, Medicare-Medicaid Dual Demonstration (MMP), STAR Kids, and STAR Health Programs. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR+PLUS, MMP, STAR Kids, and STAR Health Programs. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans, and any other entities licensed or approved by the Texas Department of Insurance.

The requirements in this chapter apply to the services identified in section VII of this chapter. Application of the chapter to the Consumer-Directed Services (CDS) option and Service Responsibility Option (SRO) is optional until mandated as part of HHSC’s implementation of the 21st Century Cures Act.

II. PURPOSE

The purpose of this chapter is to implement the requirements for the Texas Electronic Visit Verification (EVV) System to electronically verify that the services identified in this



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chapter, or other services identified by the HHSC, are provided to a Member in accordance with a prior authorization or plan of care as applicable to the appropriate program.

Nothing in this chapter is intended to relieve the MCO of its duties to comply with the provisions of its Managed Care Contract with HHSC (Contract). In the event of any conflict between or among the Contract documents, please refer to the order of documents in the General Terms and Conditions of the Contract.

III. STATUTORY AND REGULATORY AUTHORITY

- A. Section 1903(I) of the Social Security Act [42 U.S.C. § 1396b];
- B. Texas Government Code § 531.024172;
- C. Texas Human Resource Code § 161.086;
- D. 1 Texas Administrative Code § 354.1177, “Electronic Visit Verification (EVV) System”; and
- E. 40 Texas Administrative Code §§ 68.101-68.103, “Electronic Visit Verification (EVV) System”.

IV. INFORMATIONAL RESOURCES

Additional resources, including but not limited to, the following:

- A. The Centers for Medicare and Medicaid Services EVV website;
- B. The HHSC EVV Website;
- C. The HHSC EVV Policy Handbook;
- D. The HHSC Managed Care Contracts and Manuals;
- E. The Texas Medicaid Provider Procedures Manual;
- F. The Texas Medicaid Healthcare Partnership (TMHP) EVV website;
- G. The TMHP Learning Management System (LMS);
- H. The HHSC Learning Portal; and,



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- I. The TMHP MCO EVV Requirements and Technical Guide (accessible through the MCO portal in TxMedCentral).

V. BACKGROUND

MCOs that contract with HHSC must use EVV in accordance with federal and state requirements, including the requirements contained within this chapter. This chapter establishes minimum requirements for MCOs as it relates to EVV. This chapter also establishes minimum requirements with which MCOs must ensure Network Providers comply.

MCOs must adhere to all HHSC EVV requirements, including applicable federal and state laws, rules, and regulations; the HHSC EVV Policy Handbook; the MCO's applicable Contract with HHSC; and the Uniform Managed Care Manual.

VI. DEFINITIONS

Alternative Device means an HHSC-approved device used during a visit for attendant clock in and clock out provided by the EVV vendor at no cost to the Provider or Member.

Consumer Directed Services (CDS) option means a service delivery option in which a Member or legally authorized representative (LAR) employs and retains service providers and directs the delivery of eligible managed care program services. A Member participating in the CDS option is required to use a Financial Management Services Agency (FMSA) chosen by the Member or LAR to provide financial management services.

Electronic Visit Verification (EVV) means the documentation and verification of service delivery through an EVV System.

EVV Aggregator means a centralized database that collects, validates, and stores statewide EVV visit data transmitted by an EVV System.

EVV Compliance Oversight Review means the standards created by HHSC which HHSC and MCOs use to monitor Provider compliance with EVV requirements for EVV Usage, EVV Reason Codes, and EVV allowable phone types.

EVV Portal means an online system operated by TMHP that allows users to perform searches and view reports associated with EVV visits in the EVV Aggregator.



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EVV Proprietary System means an HHSC-approved EVV System that a program provider or Financial Management Services Agency (FMSA) may opt to use instead of an EVV Vendor System that:

- a) is purchased or developed by a program provider or an FMSA;
- b) is used to exchange EVV information with HHSC or an MCO; and
- c) complies with the requirements of Texas Government Code §531.024172.

EVV Reason Code means a standardized HHSC-approved code entered into an EVV System to explain the specific reason a change was made to an EVV Visit Transaction.

EVV Rejection Codes means a set of rejection codes that the EVV Aggregator returns to indicate errors found in an EVV Visit Transaction transmitted from the EVV vendor.

EVV System means an EVV Vendor System or an EVV Proprietary System used to electronically document and verify the following data elements for a visit conducted to provide a service required to use EVV:

- a) the type of service provided;
- b) the name of the Member who received the service;
- c) the name of the service provider who provided the service;
- d) the date of the service;
- e) the time the service began and ended;
- f) the location, including the address, at which the service was provided; and
- g) other information HHSC determines necessary to ensure the accurate payment of a claim for services as described in the EVV Policy Handbook.

EVV Usage means the standards created by HHSC to ensure Provider use of an EVV System as documented in the EVV Policy Handbook.

EVV Vendor System means an EVV System provided by an EVV vendor that a program provider or FMSA may select to provide EVV services.



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EVV Visit Maintenance means a process that allows edits to certain data elements in an EVV Visit Transaction within an EVV System.

EVV Visit Transaction means a data record generated by an EVV System that contains the data elements described in the definition of EVV System for a visit conducted to provide the services required to use EVV.

Financial Management Services Agency (FMSA) has the meaning assigned under Attachment A, Article 2 of the Contract.

MCO Electronic Visit Verification Member Rights and Responsibilities Form means an HHSC-approved form that details a Member’s EVV rights and responsibilities.

Pre-payment Claim Review means the process of matching a claim for service which requires the use of EVV against the EVV Visit Transaction before the MCO adjudicates the claim.

Recoupment means the recovery of an “overpayment”, as defined under 42 C.F.R. §438.6.

Texas Medicaid Healthcare Partnership (TMHP) means the HHSC Medicaid claims administrator performing contract services under an agreement with HHSC. TMHP operates the state’s Medicaid Management Information System (MMIS), which houses the EVV Aggregator and EVV Portal.

Trading Partner means an entity such as an MCO, Provider, or EVV vendor given access to TMHP systems to exchange electronic transactions utilizing established secure interfaces.

Written Notification or **in writing** means by letter, email, or fax; unless specifically noted otherwise.

VII. MCO PROGRAMS AND SERVICES REQUIRED TO USE EVV

The MCO must ensure the use of EVV for the following managed care programs and service delivery options and any other service required by federal or state mandates. The MCO must use the most current HHSC EVV Service Bill Codes table found on the HHSC EVV website.

A. STAR Health Program services



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1. Community First Choice (CFC) Personal Assistance Services (PAS);
 2. CFC Habilitation (HAB);
 3. Personal Care Services (PCS); and
 4. Medically Dependent Children’s Program (MDCP) STAR Health covered service:
 - a. in-home respite; and
 - b. flexible family support;
- B. STAR Kids Program services
1. CFC PAS;
 2. CFC HAB;
 3. PCS; and
 4. MDCP STAR Kids covered service:
 - a) in-home respite care; and
 - b) flexible family support;
- C. STAR+PLUS services:
1. personal assistance services;
 2. CFC PAS; and
 3. CFC HAB;
- D. STAR+PLUS HCBS Program services:
1. in-home respite care;
 2. protective supervision; and
 3. personal assistance services.



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VIII. EVV PROVIDER REQUIREMENTS

The MCO must ensure, through its Provider Contract, Provider Contract oversight, including review of standard EVV system reports, and Provider education, that Providers comply with all EVV requirements. At a minimum, the MCO must ensure the following:

- A. Providers select an EVV Vendor System unless the Provider has received written approval from HHSC to use an EVV Proprietary System.
- B. The MCO does not pass any EVV related costs to Providers and Members.
- C. The Provider follows the requirements in this chapter, including those stated below:
 1. Uses an EVV System to electronically document the delivery of a service for which the use of EVV is required;
 2. Complies with all EVV requirements specified in the HHSC EVV Policy Handbook;
 3. Gives the MCO access to EVV documentation related to the MCO's Member or provides a copy of that documentation at no charge to the MCO;
 4. Completes all required EVV training;
 5. Meets and maintains the minimum HHSC EVV Usage score, as specified in the HHSC EVV Policy Handbook, on a quarterly basis;
 6. Uses the most appropriate EVV Reason Codes to resolve visit exceptions, including documenting required free text;
 7. Ensures all required data elements in a EVV Visit Transaction are correct and accepted in the EVV Aggregator prior to billing for services;
 8. Notifies the MCO in writing of any ongoing issues with an EVV vendor or unresolved issues with the EVV System;
 9. Notifies a Member's Service Coordinator if the Member does not allow the attendant to clock in and clock out of the EVV System using an approved EVV data capture method for example: home landline phone, mobile application, or Alternative Device).



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IX. EVV VISIT MAINTENANCE UNLOCK REQUEST PROCESS

- A. Written process. The MCO must have a written EVV Visit Maintenance unlock request process that aligns with the HHSC EVV Visit Maintenance Unlock Request Policy to allow Providers to request to edit EVV Visit Transactions after the standard 60 Day EVV Visit Maintenance period has passed. The EVV Visit Maintenance unlock request process must include steps for the Providers to request that the MCO approve reopening EVV Visit Maintenance and steps to take when the MCO denies the Provider’s EVV Visit Maintenance unlock request.
- B. Posting process. The MCO must post the EVV Visit Maintenance unlock request process on the MCO’s Provider Portal or EVV webpage, as applicable.
- C. Timeframes. The MCO must process EVV Visit Maintenance unlock requests, including providing a written notification to the Provider of the outcome of the request, within the following timeframes:
 - 1. Ten Business Days after receipt of a secure and complete request by the Provider, or
 - 2. Thirty Business Days after receipt of a secure and complete request from the Provider, if the Provider submitted the request as supporting documentation with an Appeal, including a reconsideration.
- D. Request for additional information. The MCO must allow the Provider at least five Business Days to respond to any MCO requests for additional information_or fifteen Business Days if the MCO requests the supporting documentation as part of an Appeal, including a reconsideration.
- E. Notification process. The MCO must notify the EVV Vendor within three Business Days of the approved EVV Visit Maintenance unlock requests and which data elements to unlock for editing.
- F. Approval process. The MCO must approve EVV Visit Maintenance unlock requests under the following circumstances:
 - 1. When the MCO previously provided incorrect or incomplete information on the prior authorization for a Member_and the updated authorization will require



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updates to EVV Visit Transactions outside the EVV Visit Maintenance window of 60 Days prior to the current date;

2. When the MCO submits a retroactive authorization for a Member that will require the Provider to resubmit EVV Visit Transactions or claims; and,
 3. Upon request by HHSC and within the timeframe specified in the HHSC request.
- G. Retroactive authorization process. When the MCO issues a retroactive authorization for a Member with an effective or start date greater than 60 Days prior to the date the MCO issues the retroactive authorization, the result of which requires the Provider to make changes to EVV Visit Transactions which have already occurred, the MCO must approve a EVV Visit Maintenance unlock request, for example, when an authorization retroactively changes the bill code and modifier combination.

To complete the EVV Visit Maintenance unlock request process for a retroactive authorization, the MCO must:

1. Identify and document all existing EVV Visit Transactions and data elements affected by the change.
2. Record the affected EVV Visit Transactions in a pre-approved EVV Visit Maintenance unlock request spreadsheet and submit it to the Provider within 10 Business Days of issuing the retroactive authorization for the Provider's review and confirmation.
3. Upon the Provider's confirmation, submit the approved EVV Visit Maintenance unlock spreadsheet and notification to the Provider and EVV vendor for processing.
4. Notify the Provider of the process and timeframes to correct the identified EVV Visit Transactions and resubmit claims to avoid Recoupment of prior reimbursements. MCO must include adequate time for the Provider to correct and re-export EVV Visit Transactions to the EVV Aggregator and submit corrected claims.



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X. MCO EDUCATION REQUIREMENTS

A. MCO Education Requirements for Members

1. The MCO must educate all Members required to use EVV during the initial assessment and thereafter during the annual reassessments, using, at a minimum, the MCO Electronic Visit Verification Member Rights and Responsibilities Form (Form 1718).
2. The MCO must make all EVV Member education materials available for review by HHSC upon request within a timeframe specified by HHSC.
3. The MCO and the Member must sign the Form 1718 during the initial assessment and annual reassessments. Should the Member refuse to sign the form, the MCO must:
 - a) Document the Member's refusal to sign the Form 1718;
 - b) Leave a copy of Form 1718 with the Member or deliver a copy through the mail; and,
 - c) Follow the MCO's established process for Member noncompliance.
4. If a Provider notifies the MCO of the Member's noncompliance with EVV requirements, the MCO Service Coordinator must meet with the Member and the Provider, as applicable, to discuss the EVV requirements. At a minimum, the MCO must ensure the following steps are taken:
 - a) Within five Business Days after the meeting, the MCO Service Coordinator must document the results of the discussion and any actions agreed upon to be taken by the Member to become compliant with EVV requirements;
 - b) Within seven Business Days of the meeting, the Service Coordinator must provide a copy of the documentation to the Member and Provider; and,
 - c) the MCO established process for Member noncompliance must be followed.
5. The MCO must include a specific EVV informational section, including Member EVV requirements, within its Member Handbook and within its online Member Portal or EVV webpage, as applicable. The specific EVV informational section(s) must be updated at least annually.



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6. The MCO must perform educational outreach to Members upon HHSC's request.

B. MCO Education Requirements for Providers

1. The MCO must make all EVV Provider educational materials available to HHSC for review, upon request, within the HHSC timeframe noted in the request.
2. The MCO must make all EVV Provider educational materials available on the MCO's Provider Portal or EVV webpage, as applicable.
3. The MCO must educate all Providers, at a minimum, about the following:
 - a) All programs and services required to use EVV;
 - b) All HHSC EVV policies as specified in the HHSC EVV Policy Handbook;
 - c) MCO EVV Visit Maintenance unlock request process; and
 - d) All new or revised MCO EVV procedures and policies.
4. The MCO must perform educational outreach to Providers upon request by a Provider or HHSC.
5. The MCO must have a specific EVV section within the MCO's Provider Portal or EVV webpage that the MCO updates at least once a year and that includes the following information:
 - a) All HHSC notifications and policy updates;
 - b) All available MCO and HHSC EVV training opportunities, schedules, and training materials;
 - c) All EVV support resources, including MCO Service Coordinator contact information;
 - d) EVV contact information for entities involved in the EVV System, including HHSC, TMHP and EVV vendors;
 - e) The MCO's EVV Visit Maintenance unlock request process;
 - f) How to file an EVV related Provider Complaint in accordance with the Contract;
 - g) How to file an EVV related Provider Appeal in accordance with the Contract; and



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- h) Notice of any new or revised MCO EVV procedures and policies.
6. The MCO must post on the EVV section of the Provider Portal or EVV webpage a quarterly summary of the EVV Compliance Oversight Reviews by the last Business Day of the third month that follows the end of the fiscal year report quarter. The first quarterly summary will be for quarter one of fiscal year 2020. The summary must include:
 - a) The total number of Provider compliance oversight reviews completed by type including EVV Usage Reviews, EVV Reason Code Reviews, Required Free Text Reviews, and EVV Allowable Phone Identification Reviews;
 - b) The total number of Providers not compliant with HHSC EVV policy requirements by type;
 - c) The total number of Providers compliant with HHSC EVV policy requirements by type;
 - d) The top five reasons (from zero to five) that the MCO denied EVV-relevant claims including, but not limited to, EVV claims that match result codes returned from the EVV Aggregator; and
 - e) The top five reasons (from zero to five) for the MCO Recoupment of EVV-relevant claims.
 7. The MCO must give Providers written notice at least 60 Days before a new or revised EVV policy may take effect, unless otherwise directed by HHSC.
 8. The MCO must notify Providers of billing requirements the Provider must follow when submitting claims for services which require the use of EVV.

XI. EVV CLAIMS

- A. The EVV Aggregator will perform all pre-payment claims matching for EVV-relevant claims by claim line item. The MCO must comply with the HHSC EVV Claims Matching Policy and must use the claims match result code provided to the MCO by TMHP as the only valid method for identifying an EVV claims match.



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- B. The MCO must not pay any claims without a matching EVV Visit Transaction reported by the EVV Aggregator.
- C. The MCO must ensure that Providers submit claims for services required to use EVV to the TMHP claims management system to facilitate claims matching by the EVV Aggregator.
- D. The MCO must not accept and must reject or deny any claims for EVV services submitted by the Provider to the MCO. The Provider must submit claims directly to TMHP.
- E. Once the EVV Aggregator has performed the EVV claims match, TMHP will transmit all EVV claims and claims match result codes to the appropriate MCO for further claim adjudication, as specified in the TMHP MCO EVV Requirements and Technical Guide.
- F. The MCO must use the EVV Aggregator claims matching process result codes provided with the managed care EVV relevant claim in its communications with the Provider to indicate a 'Match' or a 'No Match'. If the EVV Aggregator returns a 'No Match', the MCO must return the claims matching result code(s) to the Provider to indicate the reason for the 'No Match' and the subsequent denial of the claim.
- G. The MCO must communicate the EVV standard Claim Adjustment Reason Code (CARC) and associated Remittance Advise Remark Code (RARC) as indicated by the EVV match result code to Providers in the written notice of claim denials.

XII. EVV AGGREGATOR

The MCO must use data collected by the EVV Aggregator to conduct EVV Compliance Oversight Reviews for Providers. The MCO must use the data stored in the EVV Aggregator as the EVV System of record for compliance oversight reviews. The MCO may also access standard reports within the EVV System(s) according to applicable system access and data use agreements with the EVV vendors or EVV proprietary system operators.

A. EVV Visit Transaction Validation

The EVV Aggregator will collect, validate and store all EVV Visit Transactions transmitted by EVV Systems. The EVV Aggregator will:



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1. Transmit validated Provider contract or enrollment data to EVV Systems;
2. Accept or reject EVV Visit Transactions using standardized validation edits;
3. Return results of EVV Visit Transaction edits to the appropriate EVV System to indicate an accepted or rejected transaction, which may require remediation by the Provider; and
4. Store all accepted and rejected EVV Visit Transactions.

B. EVV Claims Submission and Claims Matching

The EVV Aggregator will perform pre-payment claims matching for services required to use EVV and forward all submitted claims and the matching results to the MCO. The MCO is responsible for final adjudication of forwarded claims.

1. The MCO must require Providers to submit EVV relevant claims to TMHP using either TexMedConnect or Electronic Data Interchange (EDI) for claims matching to be performed.
2. The MCO must either reject or deny an EVV relevant claim that is submitted directly to the MCO and redirect the Provider to resubmit the claim directly to TMHP.
3. The EVV Aggregator claims matching process will only return a 'Match' result when the claim data and the corresponding EVV Visit Transaction in the EVV Aggregator match on all applicable data elements. The EVV Aggregator will use the following critical data elements in the claims match process:
 - a) National Provider Identifier (NPI) or Atypical Provider Identifier (API)
 - b) Date of service
 - c) Medicaid Identifier (ID)
 - d) Healthcare Common Procedure Coding System (HCPCS)
 - e) Modifier(s) (if applicable)
 - f) Billed Units (may not apply for all services, for example CDS services)
4. If any of the critical data elements on the claim do not match the same data elements in a corresponding EVV Visit Transaction, the claims matching process will return a 'No Match' result. The MCO must deny a claim when the claims



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match returns a 'No Match' result on the forwarded claim from TMHP, unless otherwise directed by HHSC.

5. The EVV Aggregator claims matching process will support claims submitted with a single date of service per line item and claims submitted with a span of services dates on a claim line item ("span date billing"). The MCO may allow for span date billing or require single line billing from their Providers for EVV services.
6. The EVV Aggregator will process span date billing where a claim line item specifies a date range instead of a single date of service. If the MCO allows span date billing on EVV related claims, the MCO must require Providers to follow the criteria listed below:
 - a) Each date within the span date range must have at least one or more associated EVV visit(s) in the EVV Aggregator; and
 - b) The total units on the line item of the claim must match the combined total units of the matched EVV visits for the period covered by the span date. This requirement may not apply for all services, for example, CDS services.
7. The MCOs must participate in Trading Partner testing with TMHP to confirm their ability to receive a forwarded claim with the results of the claims matching process.
8. The MCO may opt to retrieve EVV Visit Transaction data sets from the EVV Aggregator using one of the two methods below as described in the TMHP MCO guidance located on the TMHP website:
 - a) The MCO EVV Retrieval Service, which is a web service used to request EVV Visit Transactions based on the claim identifier found in the forwarded claim; or
 - b) The MCO Batch Visits Request, which is a process to request EVV Visit Transactions by date range based on a combination of input parameters.
9. Once the MCO receives a claims match result from TMHP for a claim, the Provider may submit any attachments or supporting documentation necessary to adjudicate the claim directly to the MCO.
10. The MCO may opt to reprocess denied claims without subsequent EVV matching by the EVV Aggregator when the MCO does not require the Provider to submit a new or corrected claim.



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XIII. SYSTEM ACCESS REQUIREMENTS

- A. The MCO must be an approved TMHP Trading Partner to exchange data with the EVV Aggregator.
- B. The MCO must successfully complete any Trading Partner testing required by HHSC, or its designee, to become an approved Trading Partner and maintain approved Trading Partner status.
- C. The MCO may be required to sign a data use agreement with an EVV vendor from the state vendor pool or with an EVV proprietary system operator to gain direct access to Provider and Member data within the EVV Systems.

XIV. EVV PORTAL

- A. The MCO must use the EVV Portal to search, view, print, and export the following information:
 - 1. Accepted EVV Visit Transactions;
 - 2. Rejected EVV Visit Transactions;
 - 3. History of changes to EVV Visit Transactions;
 - 4. Claim to EVV Visit Transaction data match results;
 - 5. Provider lists;
 - 6. Standard EVV reports; and,
 - 7. Other information as needed.
- B. The MCO must check the EVV Portal as needed for the most current EVV Visit Transaction data and claims matching results before issuing EVV-related Provider enforcement actions.



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XV. EVV COMPLIANCE OVERSIGHT REVIEWS

- A. The MCO must conduct the following EVV Compliance Oversight Reviews in accordance with the HHSC EVV Policy Handbook. At a minimum, the MCO must conduct EVV Usage reviews and EVV Reason Code reviews on a quarterly basis and may elect to conduct EVV allowable phone identification reviews as needed.

The MCO must use the EVV Policy Handbook requirements when conducting any of the following EVV Compliance Oversight Reviews:

1. EVV Usage reviews
 2. EVV Reason Code reviews
 3. EVV Allowable Phone Identification reviews
- B. The requirement for the MCO to conduct EVV Compliance Oversight Reviews in accordance with the HHSC EVV Policy Handbook does not restrict the MCO from conducting other types of reviews related to Fraud, Waste and Abuse.

XVI. MCO EVV COMPLAINTS

- A. The MCO must follow the established policies and procedures under the Contract to handle Provider or Member Complaints related to EVV. These Complaint policies must be available to the Provider and Member on the appropriate MCO Provider Portal or EVV webpage and within the applicable Provider and Member Handbooks.
- B. For all EVV related Complaints resulting in a review by HHSC EVV Operations, the MCO must:
1. Follow HHSC’s directions to resolve the Complaint in accordance with the applicable compliance plan or EVV policy;
 2. Notify the Provider or Member in writing of the HHSC EVV Operations Complaint review results and action the MCO will take to resolve the Complaint;
 3. Implement HHSC’s directions no later than the due date specified by HHSC; and



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4. Notify HHSC through the HHSC MCO Communications mailbox at: MCO_EVV_Communication@hhsc.state.tx.us and the Provider or Member in writing within five Business Days of completion of specified actions.

XVII. MCO EVV REPORTING REQUIREMENTS

- A. The MCO must submit the EVV MCO Quarterly Performance Measures Report throughout the Contract term.
 1. The MCO must submit the EVV MCO Quarterly Performance Measures Report to HHSC using the HHSC-approved template and instructions. The report is to be based on the fiscal year quarter and is due by the last Business Day of the third month in the fiscal quarter following the period covered by the report.
 2. The first reporting period for the EVV MCO Quarterly Performance Measures Report is quarter one of fiscal year 2020 (September, October, November 2019), with the first report due on or before March 31, 2020.
- B. The MCO must also provide ad hoc reports for EVV information or data at the request of HHSC.
- C. The MCO must research and resolve all EVV issues identified by HHSC within the timeframe specified by HHSC.
- D. The MCO must submit all reports to the HHSC MCO EVV Communications mailbox at: MCO_EVV_Communication@hhsc.state.tx.us. The MCO must submit all HHSC requested information within the timeframe specified by HHSC.

XVIII. MCO EVV MEETING REQUIREMENTS

- A. The MCO must ensure at least one MCO representative attends all HHSC sponsored EVV Payer (MCO) workgroup meetings in person unless HHSC specifies that the MCO attend via conference call.
- B. The MCO must ensure at least one MCO representative attends, either in person or via conference call, as specified by HHSC, all HHSC sponsored EVV stakeholder work group meetings.



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- C. The MCO is not required to attend EVV Provider trainings conducted by HHSC if the location is not within the MCOs service area, unless HHSC specifically requests that the MCO attend.
- D. The MCO must respond to assigned action items from these meetings through the HHSC MCO EVV Communications mailbox within the timeframe specified by HHSC.

XIX. MCO EVV STANDARDIZATION

- A. HHSC will issue EVV standardized policies and procedures through regular updates to this chapter and through formal communications on an as needed basis.
- B. The MCO must implement EVV standardized policies and procedures within the HHSC specified timeframe, unless HHSC approves an exception.
- C. All MCO EVV policies and procedures that impact Members and Providers are subject to review by HHSC upon request.
- D. The MCO must send all documents that HHSC requests for review to the MCO EVV Communications mailbox.
- E. The MCO must use language consistent with HHSC EVV terminology where applicable.
- F. The MCO must meet all HHSC required deadlines, unless HHSC approves an extension requested by the MCO.
- G. The MCO must send EVV Vendor complaints to Texas Medicaid and Health Care Partnership at EVV@tmhp.com.