TEXAS Health and Human Services

UNIFORM MANAGED CARE MANUAL 8.7.1
Electronic Visit Verification Requirements Version 2.5

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

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			reference to EVV UMCM chapters to be used in conjunction with this chapter. Section III. “Statutory and Regulatory Authority” is modified to update the list of references. 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. 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. 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. Section VI. “MCO Contracting for Electronic Visit Verification” is modified to remove language that HHSC will select, approve, and negotiate implementation

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			and transaction costs with EVV approved contractors. Section VII. “EVV Programs and Services Required to Use EVV” is added. 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. 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. 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. Section VIII. D. “Training and Support Requirements” is reformatted. Section VIII. E. “Data/Record Access Requirements” is reformatted.

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
			Section VIII. F. “Reporting Requirements” is reformatted and removes reference to the EVV vendor monthly report. Section VIII. G. “EVV Appeal Requirements” is added. Section IX. “MCO Education Requirements” is added. Previous Section IX. “Provider Compliance Requirements” is removed. Previous Section X. “MCO Member Education Requirements” is removed. This requirement is now addressed in Section IX. “MCO Education Requirements.” Section X. “EVV Required Data Elements” is added. Section XI. “MCO EVV Reporting Requirements” is modified to provide new reporting requirement language. Section XII. “MCO EVV Meeting Requirements” is added. Section XIII. “MCO EVV Rejected Transactions” is added. Section XIV. “EVV Prospective Reviews” is added. Section XVI. “MCO EVV Standardization” is added.

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	2.3	February 21, 2020	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: • 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) • Updated list of services subject to EVV requirements under the federal Cures Act
Revision	2.3.1	June 17, 2020	Accessibility approved version.
Revision	2.4	November 10, 2022	Chapter 8.7.1 is revised to be consistent with the EVV Policy Handbook, the following changes/revisions have been made:

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			• Added the following to make consistent with the EVV Policy Handbook:
			  ○ requirements to address services provided through CDS option for which EVV must be used;
			  ○ requirements regarding an EVV Proprietary System;
			  ○ requirements regarding compliance reviews; and
			  ○ requirements regarding compliance standards and enforcement actions.
			• Revised current requirements to make consistent with the EVV Policy Handbook.
			• Removed the list of services for which EVV must be used and instead referenced a Bill Codes Table and HHSC Programs and Services Required to Use EVV Table.
			• Added requirements regarding the MCO requiring Providers and FMSAs to provide additional information to support a claim.

Revision	2.5	May 1, 2023	Administrative change- renumber section VII (Compliance) to number VIII and section number VIII (MCO Programs and Services Required to Use EVV) to number VII.

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Revision	2.6	June 1, 2023	Administrative change request: This is a request to remove the reference to TxMedCentral.

[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, 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, 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 including services that are provided through the Consumer-Directed Services (CDS) option and Service Responsibility Option (SRO).

II. PURPOSE

The purpose of this chapter is to ensure the MCO implements EVV in accordance with federal and state requirements.

Nothing in this chapter is intended to relieve the MCO of its duties to comply with the provisions of its Managed Care Contract (referred to as the "Contract") with Health and Human Services Commission (HHSC). 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, Part 15, Chapter 354, Subchapter O, Electronic Visit Verification (EVV); and

E. Texas Government Code §531.1135 .

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 Webpage;

C. The HHSC EVV Policy Handbook;

D. The HHSC Managed Care Contracts and Manuals;

E. The Texas Medicaid Provider Procedures Manual (TMPPM);

F. The Texas Medicaid Healthcare Partnership (TMHP) EVV website;

G. The TMHP Learning Management System (LMS);

H. The HHSC Learning Portal;

I. The MCO EVV Requirements and Technical Guide;

J. HHSC EVV Service Bill Codes Table; and

K. HHSC Programs and Services Required to Use EVV Table.

V. BACKGROUND

Section 1903(l) of the Social Security Act, requires states to use EVV for Medicaid-funded personal care services (PCS) and home health care services (HHCS) provided in the residence of a member.

VI. DEFINITIONS

Alternative Device means an HHSC-approved electronic device provided at no cost by an EVV Vendor or Proprietary System Operator (PSO) that allows the Service Provider or CDS Employee to clock in and clock out of the EVV System from the Member's home.

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.

CDS Employer means a member or the member's LAR who participates in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

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 Reviews means a set of standards established by Texas HHSC and MCOs that are reviewed on a regular basis to ensure Providers, FMSAs and CDS Employers adhere to EVV requirements.

EVV Portal means an online system that allows users to perform searches and view reports associated with EVV visit data in the EVV Aggregator.

EVV Proprietary System means an HHSC-approved EVV System that a Provider or FMSA may choose to use instead of an EVV Vendor System that:

a. Is purchased or developed by a Provider or an FMSA.

b. Is used to exchange EVV data with HHSC or an MCO.

c. Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

EVV Proprietary System Operator (PSO) means a Provider or FMSA that selects to use an EVV System to meet HHSC EVV requirements, instead of an EVV Vendor System from the state vendor pool.

EVV Reason Code means a standardized HHSC-approved code entered in 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 identify errors in an EVV Visit Transaction that the EVV Aggregator sends to an EVV System.

EVV System means an EVV Vendor System or an EVV Proprietary System used to electronically document and verify critical data elements related to the delivery of EVV-required services.

EVV Vendor System means an EVV System developed and operated by a vendor that contracts with HHSC or HHSC's designated contractor that a program provider or FMSA uses instead of an EVV Proprietary System.

EVV Visit Maintenance means a process used by the Provider, FMSA, or CDS Employer to correct the identification and visit data in the EVV System to accurately reflect the delivery of service.

EVV Visit Transaction means a data record generated by an EVV System that contains data elements for a visit conducted to provide an EVV service.

Financial Management Services Agency (FMSA) means an entity that contracts with HHSC or an MCO to provide financial management services to a CDS Employer as described in 40 Texas Administrative Code, Part 15, Chapter 41, Subchapter A, Consumer Directed Services Option.

In Writing means communicated in written form by United States mail, email, or fax.

Legally Authorized Representative (LAR) means a person authorized by law to act on behalf of a Member which may include a parent, guardian or managing conservator of a minor, or the guardian of an adult.

Member means a person eligible to receive Medicaid services requiring the use of EVV under 1 Texas Administrative Code, Part 15, Chapter 354, Subchapter O, Electronic Visit Verification.

Program Provider, also referred to as "Provider" means an entity that contracts with HHSC or an MCO to provide an EVV service.

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

Service Provider , also referred to as "CDS Employee" means a person who provides an EVV service and who is employed or contracted by a:

a. Program Provider; or

b. CDS Employer.

Service Responsibility Option (SRO) means a service delivery option where a member or LAR selects, trains, and provides daily management of a Service Provider, while the fiscal, personnel and service back-up plan responsibilities remain with the Program Provider.

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, FMSA, EVV vendor, or EVV PSO that is given access to TMHP systems to exchange electronic transactions utilizing established secure interfaces.

VII. MCO PROGRAMS AND SERVICES REQUIRED TO USE EVV

The MCO must ensure that EVV is used to document:

- a service identified on the HHSC Program and Services Required to Use EVV table and the HHSC EVV Service Bill Codes table; and
- any other service required by federal or state mandate, as directed by HHSC.

The MCO must ensure that Providers and FMSAs use the appropriate Healthcare Common Procedure Coding System (HCPCS) and modifier combinations in the EVV Service Bill Codes table to prevent EVV Visit Transaction rejections and EVV claim match denials.

The MCO must also include the appropriate HCPCS codes and modifier combinations on service authorizations.

VIII. COMPLIANCE

The MCO must comply with the Uniform Managed Care Manual (UMCM), including the requirements in this chapter; 1 Texas Administrative Code, Part 15, Chapter 354, Subchapter O, Electronic Visit Verification; and the HHSC EVV Policy Handbook.

IX. EVV PROVIDER AND FMSA REQUIREMENTS

The MCO must ensure, through its Provider and FMSAs Contracts, Provider and FMSA Contract oversight, and that Providers and FMSAs comply with all EVV requirements. At a minimum, the MCO must ensure that Providers and FMSAs:

A. Select an EVV System.

B. Do not pass any EVV related costs to CDS Employers and Members.

C. Comply with the requirements in this chapter, including:

1. Use an EVV System to electronically document the delivery of an EVV required service;
2. Comply with all EVV requirements specified in the HHSC EVV Policy Handbook including the following;
    a. Comply with EVV Compliance Reviews as outlined in the following areas:
        i. EVV Usage;
        ii. EVV Landline Phone Verification; and
        iii. EVV Required Free Text.
    b. Follow compliance monitoring and other compliance guidelines during compliance grace periods;
3. The FMSA must provide a Member's completed and signed copy of HHSC Form 1722, Employer's Selection for Electronic Visit Verification, to the MCO within 10 Business Days of the MCO's written request;
4. Complete all required EVV training;
5. Complete all required EVV Visit Maintenance prior to submitting an EVV claim. If a Provider or FMSA submits an EVV claim prior to completing required EVV Visit Maintenance, the MCO may deny or recoup the EVV claim, unless otherwise directed by HHSC;
6. Use the appropriate HCPCS and modifier combinations in the most current EVV Services Bill Codes table to prevent EVV Visit Transaction rejections and EVV claim match denials;
7. Ensure all required data elements in a EVV Visit Transaction are correct and accepted in the EVV Aggregator prior to billing for services;
8. Notify the MCO in writing of any ongoing issues or unresolved issues with the EVV System;
9. Notify a Member's Service Coordinator if the Member does not allow the Service Provider to clock in and clock out of the EVV System using an approved electronic verification method; and
10. Ensure a service authorization is in the EVV System at or prior to the date and time of service delivery.

X. PRIOR AUTHORIZATIONS

A. For EVV Services, MCOs must include all required data elements necessary for a Provider or FMSA to enter an authorization in the EVV System. Required data elements include the following:

1. Payer;
2. Provider (NPI/API, TIN TPI if applicable);
3. Member Medicaid ID;
4. HCPCS code and Modifier(s);
5. Authorization start date; and
6. Authorization end date.

B. For prior authorization with insufficient or inadequate documentation, MCOs must follow the timeframes in UMCM Chapter 3.22.

C. If an authorization expires and the member receives a retroactive authorization, the MCO may not recoup from the Provider or FMSA for the period covered by the retroactive authorization.

XI. EVV VISIT MAINTENANCE UNLOCK REQUEST PROCESS

A. Overview

1. The EVV Visit Maintenance unlock request allows a Provider, FMSA or CDS Employer to request that an MCO allow the Provider, FMSA, or CDS Employer to correct data elements(s) on an EVV Visit Transaction(s) via manual entries into the EVV System after the standard 95-day or HHSC approved EVV Visit Maintenance timeframe has expired.
2. An MCO reviews EVV Visit Maintenance unlock requests on a case-by-case basis and has the discretion to approve or deny a request except as provided in this section.

B. MCO Responsibilities

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, FMSAs, or CDS Employers to request to edit EVV Visit Transactions after the EVV Visit Maintenance timeframe expires. The MCO's EVV Visit Maintenance unlock request process must include steps for the Providers, FMSAs, or CDS Employers to request that the MCO approve EVV Visit Maintenance and steps to take when the MCO denies the Provider's, FMSA's, or CDS Employer's EVV Visit Maintenance unlock request.

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. EVV Visit Maintenance Unlock Process

To request an unlock of an EVV Visit Transaction(s) after the EVV Visit Maintenance timeframe has expired, the Provider, FMSA or CDS Employer must complete a EVV Visit Maintenance unlock request spreadsheet found on the MCO's website. If the CDS Employer submits the request, the CDS Employer must notify their FMSA, in writing, that a request was submitted.

Approvals and denials of EVV Visit Maintenance unlock requests are at the MCO's discretion and are determined on a case-by-case basis. If the request is submitted by the CDS Employer and the MCO has approved or denied the request, the MCO must also notify the FMSA. The MCO will deny requests to create manual visits after the EVV Visit Maintenance timeframe unless the reason for creating a manual visit is due to MCO or EVV System error.

1. Processing the Request

   If an MCO receives an EVV Visit Maintenance unlock request, the MCO must notify the Provider, FMSA, or CDS Employer, in writing, of whether the request is approved or denied, within the following timeframes:

   a. Ten Business Days after receipt of a secure and complete request. An MCO may deny an email request not sent securely by the Provider, FMSA, or CDS Employer because of a violation of the Health Insurance Portability and Accountability Act (HIPAA).

   b. Thirty Business Days after receipt of a secure and complete request, if the request was submitted as supporting documentation with an appeal of a previous decision on the request.

2. Request for Additional Information

The MCO may request additional information from the Provider, FMSA, or CDS Employer to make a determination about an EVV Visit Maintenance unlock request. The MCO must allow the Provider, FMSA, or CDS Employer to submit additional information to the MCO within:

a. Ten Business Days after the request for additional information is received. If the MCO does not receive the information within ten Business Days after the request is received, the Provider, FMSA, or CDS Employer must submit a new EVV Visit Maintenance unlock request for the request to be considered.

b. Fifteen Business Days of the request for additional information if the request for additional information is part of an appeal a previous decision on the request.

3. Denial of Requests

If the MCO denies an EVV Visit Maintenance unlock request, the MCO must notify the Provider, FMSA, or CDS Employer of the denial by email within 10 Business Days after the receipt of the request and include the reason for the denial in the email.

a. The MCO must inform the Provider, CDS Employer, or FMSA in the email notification on how to:

i. Submit a new EVV Visit Maintenance unlock request.

ii. Request a claims appeal, as applicable.

iii. Submit a formal complaint against the MCO.

b. The MCO may automatically deny an EVV Visit Maintenance unlock request for the following reasons:

i. The request was not sent through a secure method.

ii. The request is incomplete or missing required information.

4. Approval of Requests

If an MCO approves an EVV Visit Maintenance unlock request, the MCO will send the approved EVV Visit Maintenance unlock request to the EVV Vendor or EVV PSO within three Business Days after the MCO approves the request.

a. Only approved data elements listed on the EVV Visit Maintenance unlock request will be unlocked for editing.

b. The EVV Vendor or EVV PSO must only allow changes to the fields approved by the MCO.

c. The MCO must approve the EVV Visit Maintenance unlock request meeting the requirements in Section XI.C5, MCO Retroactive Authorization Process.

d. The EVV Vendor or EVV PSO has 10 Business Days after receipt of the approved EVV Visit Maintenance unlock request to complete EVV Visit Maintenance or schedule a meeting with the Provider, FMSA, or CDS Employer to complete EVV Visit Maintenance.

5. MCO Retroactive Authorization Process

   When the MCO issues a retroactive authorization for a Member with an effective or start date that is before the end of the EVV Visit Maintenance timeframe and it requires the Provider, FMSA, or CDS Employer to make changes to EVV Visit Transactions which have already occurred, the MCO must approve the EVV Visit Maintenance unlock request. In addition, the MCO must approve an EVV Visit Maintenance unlock request for one of the following reasons:

   a. The MCO previously provided incorrect or incomplete information on the prior authorization for a Member and the updated authorization will require updates to EVV Visit Transactions outside of the EVV Visit Maintenance timeframe.

   b. The MCO submits a retroactive authorization for a Member that will require the Provider, FMSA, or CDS Employer to resubmit an EVV Visit Transaction or EVV claim outside of the EVV Visit Maintenance timeframe.

   c. HHSC requests and within the timeframe specified in the EVV Policy Handbook.

6. The EVV Visit Maintenance unlock request process for a retroactive authorization:

   a. The MCO must identify the affected EVV Visit Transactions that are outside of the visit maintenance timeframe in an EVV Visit Maintenance unlock request form developed by the MCO. The MCO must send the completed form in a secure email to the Provider, FMSA, or CDS Employer within 10 Business Days after issuing the retroactive authorization.

b. The Provider, FMSA, or CDS Employer must within 10 Business Days after receiving the secure email from the MCO:

   i. Review the pre-approved EVV Visit Maintenance unlock request form to determine whether the form accurately identifies the affected EVV Visit Transactions; and

   ii. Reply to the secure email notifying the MCO of the determination.

c. If the Provider, FMSA, or CDS Employer determines that the completed EVV Visit Maintenance unlock request form accurately identifies the affected EVV Visit Transactions, the MCO must send the approved form in a secure email to the EVV vendor or EVV PSO and copy the Provider, FMSA, or CDS Employer.

d. If the Provider, FMSA, or CDS Employer determines that the completed EVV Visit Maintenance unlock request form does not accurately identify the affected EVV Visit Transactions, the Provider, FMSA, or CDS Employer must update the form with the correct EVV Visit Transactions and send the updated form to the MCO in a secure email. The MCO must review the updated form within 10 Business Days after receipt of the secure email to determine whether the updated form has the correct EVV Visit Transactions. If the form does not accurately identify the correct EVV Visit Transactions, the MCO must work with the Provider, FMSA, or CDS Employer to accurately identify the EVV Visit Transactions on the form. Once the form accurately identifies the correct EVV Visit Transactions, the MCO must send the form to the EVV vendor or EVV PSO in a secure email and copy the Provider, FMSA, or CDS Employer.

e. Once the EVV Vendor or EVV PSO receives the approved EVV Visit Maintenance unlock request spreadsheet from the MCO, the EVV Vendor or EVV PSO must determine whether the information in the spreadsheet is accurate.

f. If the EVV vendor or EVV PSO determines that the information in the approved EVV Visit Maintenance unlock request spreadsheet is accurate, the EVV vendor or EVV PSO have 10 Business Days from receipt of the spreadsheet to complete EVV Visit Maintenance or schedule a meeting with the Provider, FMSA, or CDS Employer to complete EVV Visit Maintenance.

g. If the EVV vendor or EVV PSO determines that the information in the approved EVV Visit Maintenance unlock request spreadsheet is incorrect, invalid, or missing data elements, the EVV vendor or EVV PSO will:

    i. Not unlock EVV Visit Transaction(s) for EVV Visit Maintenance;

    ii. Return the EVV Visit Maintenance unlock request to the Provider, FMSA, or CDS Employer;

    iii. Notify the MCO, Provider, FMSA, or CDS Employer why the EVV Visit Transaction(s) cannot be unlocked for EVV Visit Maintenance; and

    iv. Once the information is corrected, the Provider, FMSA, or CDS Employer must submit a new EVV Visit Maintenance unlock request to the MCO.

7. EVV Visit Maintenance and Billing EVV Claims

    a. The Provider, FMSA, and CDS Employer must ensure that all required data elements on the EVV Visit Transaction are correct, and that EVV Visit Maintenance is complete prior to the Provider or FMSA submitting an EVV claim to the appropriate claims management system.

    b. If the Provider, FMSA, or CDS Employer needs to complete EVV Visit Maintenance on an accepted EVV Visit Transaction that has already been billed, the Provider or FMSA must:

        i. Complete EVV Visit Maintenance on the EVV Visit Transaction;

        ii. Ensure the EVV Aggregator accepts the corrected EVV Visit Transaction; and

        iii. Resubmit the EVV claim in accordance with the MCO's corrected claim process.

    c. The EVV Visit Maintenance unlock request does not override the timely filing deadline for submission of a new and corrected claim.

XII. MCO EDUCATION REQUIREMENTS

A. MCO Education Requirements for Members

1. The MCO must educate all Members and CDS Employers required to use EVV, using, at a minimum, the MCO Electronic Visit Verification Responsibilities and Additional Information Form (Form 1718) and obtaining the signature of a Member or CDS Employer on the form:

    a. during the initial assessment; and

    b. if an annual assessment is conducted, during the annual assessment.

2. The MCO must make all EVV educational materials for Members and CDS Employers available for review by HHSC upon request within a timeframe specified by HHSC.

3. The MCO must ensure all EVV educational materials for Members and CDS Employers, including information on the MCO's websites are current.

4. The MCO must ensure that EVV training information for Members and CDS Employers is located on the Member's website and not the program website.

5. The MCO, the Member, and CDS Employer must sign Form 1718 during the initial assessment and during an annual reassessment if one is conducted. If the Member or CDS Employer refuses to sign the form, the MCO must:

    a. Document the Member's or CDS Employer's refusal to sign Form 1718;

    b. Leave a copy of Form 1718 with the Member or CDS Employer or deliver a copy through the mail; and

    c. Follow the MCO's established process for Member and CDS Employer noncompliance.

6. If a Provider or FMSA notifies the MCO of the Member's or CDS Employer's noncompliance with EVV requirements, the MCO Service Coordinator must meet with the Member or CDS Employer and the Provider or FMSA, as applicable, to discuss the EVV requirements. At a minimum, the MCO must ensure the following steps are taken:

    a. Within five

    b. 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 or CDS Employer to become compliant with EVV requirements; and

c. Within seven

d. after the meeting, the Service Coordinator must provide a copy of the documentation to the Member or CDS Employer, and Provider or FMSA.

7. The MCO must include a specific EVV informational section, including Member EVV requirements, in its Member Handbook and in its online Member Portal or EVV website, as applicable. The MCO must ensure the EVV informational section is current and notify Members and CDS Employers, at least annually, of any changes made to the section.
8. The MCO must perform educational outreach to Members and CDS Employers upon HHSC's request.
9. If CDS is a service option, the MCO must create and maintain a distinct training about EVV for CDS Employers.

B. MCO Education Requirements for Providers and FMSAs

1. The MCO must make all EVV educational materials for Providers and FMSAs available to HHSC for review, upon request, within the HHSC timeframe noted in the request.
2. The MCO must make all EVV educational materials for Providers and FMSAs available on the MCO's Provider Portal or EVV webpage, as applicable.
3. The MCO must educate all Providers and FMSAs, 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. The 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 or FMSAs upon request by a Provider, FMSA, or HHSC.
5. If CDS is a service option, the MCO must develop and maintain a distinct policy training for Providers and FMSAs.
6. The MCO must have a specific EVV section in the MCO's Provider Portal or EVV webpage that is current. The MCO must update the EVV section as changes occur. The EVV section must include the following:

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, PSOs, and EVV vendors;

e. The MCO's EVV Visit Maintenance unlock request process;

f. How to file an EVV related Provider or FMSA Complaint in accordance with the Contract;

g. How to file an EVV related Provider or FMSA Appeal in accordance with the Contract; and

h. Notice of any new or revised MCO EVV procedures and policies.

7. The MCO must post on the EVV section of the Provider Portal or EVV webpage a quarterly summary of the EVV Compliance Reviews by the last Business Day of the fifth month that follows the end of the fiscal year report quarter. Provider and FMSA data must be posted separately. The summary must include:

   a. The total number of Provider, FMSA, and CDS Employer compliance reviews completed by type including EVV Usage, EVV Required Free Text, and EVV Landline Phone Verification;

   b. The total number of Providers, FMSAs, and CDS Employers not in compliance with HHSC EVV policy requirements by type of review;

   c. The total number of Providers, FMSAs, and CDS Employers not in compliance with HHSC EVV policy requirements by type of review;

   d. The top five reasons (from one to five) for the MCO Recoupment of Provider and FMSA EVV-relevant claims.

8. The MCO must notify Providers and FMSAs, in writing, of a new or revised EVV policy within 10 Business Days that the policy takes effect, unless otherwise directed by HHSC.

9. The MCO must notify Providers and FMSAs of billing requirements that the Provider and FMSA must follow when submitting claims for services requiring the use of EVV.

XIII. EVV CLAIMS

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

B. The MCO must not pay any claims without an accepted matching EVV Visit Transaction stored in the EVV Aggregator unless directed by HHSC.

C. The MCO must ensure that Providers and FMSAs submit claims for services required to use EVV to the TMHP's 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 and FMSA directly to the MCO. The Provider and FMSA 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 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) or the MCO denial code that means the same as the claims matching result code to the Provider or FMSA 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 and FMSAs in the written notice of claim denials.

XIV. EVV AGGREGATOR

The MCO must use data collected by the EVV Aggregator and displayed in the EVV Portal to conduct EVV Compliance Reviews for Providers and FMSAs. The MCO may also access standard reports within the EVV System(s) according to applicable system access and data use agreements or business associate agreement with the EVV endors or EVV PSOs.

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:

1. Transmit validated Provider and FMSA 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 or FMSA; and
4. Store all accepted and rejected EVV Visit Transactions.

B. EVV Claims Submission and Claims Matching

1. The MCO must require Providers and FMSAs 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 or FMSA 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 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 and FMSAs 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 and FMSAs to follow the criteria listed below:

    a. Each date of service within the span of dates has one or more matching EVV Visit(s) Transactions in the EVV Aggregator; and

    b. The total units on the EVV claim line item must match the combined total units on the accepted EVV Visit Transaction for the span of dates, if applicable. This requirement may not apply in all instances, such as when a service is provided through the CDS option.

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 or FMSA 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 or FMSA to submit a new or corrected claim.

XV. REQUIREMENT FOR ADDITIONAL INFORMATION TO SUPPORT A CLAIM

A. If an MCO chooses to require Providers and FMSAs to submit information to support a claim for a service on the HHSC Programs and Services Required to Use EVV Table, other than the information in the EVV Portal, the MCO must, before enforcing the requirement:

1. Include the requirement in its contracts with Providers and FMSAs and in its Provider Manual; and

2. Inform Providers and FMSAs of the requirement by publishing a written notice.

B. In the requirement to submit additional information to support a claim, the MCO must specify the type of information that is required.

C. The MCO must provide a copy of the written notice required in A.2 of this section to Providers and FMSAs as part of any required EVV policy training for Providers or FMSAs.

XVI. 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 or a business associate agreement with an EVV vendor from the state vendor pool or with an EVV PSO to gain direct access to Provider, FMSA, CDS Employer, and Member data within the EVV Systems.

XVII. EVV SYSTEM AND EVV PORTAL SEARCH TOOLS AND REPORTS

A. The MCO must:

1. Use the EVV Portal to use the following EVV Portal Search Tools:

    a. Accepted Visit Search;

    b. Visit History Search; and

    c. EVV Claim Search.

2. Use the EVV Portal to view, print, and export the following EVV Portal Standard Reports:

    a. EVV Attendant History Report;

b. EVV Claim Match Reconciliation Report;

c. EVV CDS Employer Usage Report;

d. EVV Clock In/Clock Out Usage Report;

e. EVV Provider Report;

f. EVV Reason Code Usage and Free Text Report;

g. EVV Units of Service Summary Report;

h. EVV Usage Report;

i. EVV Visit Log; and

j. EVV System History Report.

3. Use the EVV System to view, print, and export the following EVV System Standard Reports:

   a. EVV Alternative Device Order Status Report;

   b. EVV Attendant History Report;*

   c. EVV CDS Service Delivery Log;

   d. EVV CDS Employer Usage Report;

   e. EVV Clock In/Clock Out Usage Report;*

   f. EVV Landline Phone Verification Report;

   g. EVV Reason Code Usage and Free Text Report;*

   h. EVV Service Delivery Exception Report;

   i. EVV Units of Service Summary;* and,

   j. Non-EVV Relevant Time Logged Report.

   *This report is exported from the EVV Portal.

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 or FMSA enforcement actions.

XVIII. EVV COMPLIANCE REVIEWS

A. The MCO must conduct EVV Compliance Reviews to ensure that Providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies. The three types of EVV Compliance Reviews are EVV Usage Reviews, EVV Required Free Text Reviews, and EVV Landline Phone Verification Reviews.

B. The MCO must use the EVV Portal to access the data in the EVV Aggregator for the EVV Usage Reviews and EVV Required Free Text Reviews. In addition, the MCO must not conduct an EVV Usage Review or EVV Required Free Text Review of the Provider, FMSA, or CDS Employer until the EVV Visit Maintenance timeframe has expired.

1. EVV Usage Reviews

a. For Providers and FMSAs, the MCO must use the EVV Usage Report available in the EVV Portal to determine the EVV Usage Score.

b. For CDS Employers, the MCO will use the EVV CDS Employer Usage Report available in the EVV Portal or the EVV System to determine the EVV Usage Score for each Member that selects the CDS option.

2. EVV Required Free Text Reviews:

a. The MCO must use the EVV Reason Code Usage and Free Text Report or the EVV Visit Log Report (located in the EVV Portal) to conduct EVV Required Free Text Reviews.

b. The purpose of an EVV Required Free Text Review is to determine if the Provider, FMSA, or CDS Employer entered the required free text on the visit based on a review of the EVV Visit Transactions.

3. EVV Landline Phone Verification Reviews:

a. The MCO may conduct EVV Landline Phone Reviews at their discretion. A review may be conducted only after the date of the EVV visit if the phone number used to clock in and clock out has been entered in the EVV System.

b. The MCO must use the EVV Landline Phone Verification Report located in the EVV System to conduct EVV Landline Phone Verification Reviews.

c. The purpose of an EVV Landline Phone Verification Review is to determine if the phone number that the Service Provider used for clocking in and clocking out of the EVV System to ensure the phone number is from an allowable phone type.

C. The requirement for the MCO to conduct EVV Compliance 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.

XIX. COMPLIANCE STANDARDS AND ENFORCEMENT ACTIONS

A. EVV Usage Review

1. If a Provider, FMSA or CDS Employer fails to meet the minimum EVV Usage Score in a state fiscal year quarter, the MCO may send a non-compliance notice to enforce one or more of the following progressive enforcement actions based on the number of occurrences within a 24-month period:

a. First occurrence of a below minimum score within a 24-month period - Require EVV policy, EVV System and EVV Portal trainings within a specific timeframe.

b. Two or more occurrences of a below minimum score within a 24-monh period – Require completion of a Corrective Action Plan (CAP) within 10 Business Days of the notice of non-compliance.

c. Three or more occurrences of a below minimum score within a 24-month period – Initiate Contract termination for Providers or FMSAs and termination of the CDS option for CDS Employers.

2. An MCO must not take an enforcement action based on an EVV Usage Review if the failure of the Provider, FMSA, or CDS Employer to meet the minimum EVV Usage score was due to one of the following:

a. MCO errors such as: late authorizations; missing or incorrect HCPCS and Modifiers provided by the MCO (for Providers or FMSAs); or

b. FMSA errors such as not responding to the CDS Employer; or

c. A system outage, defect or issue related to the:

i. EVV Aggregator (for Providers, FMSAs and CDS Employers)

ii. EVV Portal (for Providers, FMSAs and CDS Employers)

iii. EVV Vendor System (for Providers, FMSAs and CDS Employers)

iv. EVV Proprietary System (for CDS Employers)

d. Natural disasters.

B. EVV Required Free Text Reviews:

The MCO may recoup associated EVV claims when Providers and FMSAs if required free text is not entered into the EVV System prior to submitting the claim.

C. EVV Landline Phone Verification Reviews

If the MCO identifies an unallowable phone type on the EVV Landline Phone Verification Report, the MCO may send a notice to the Provider or FMSA about the non-compliance informing the Provider or FMSA that the MCO may withhold Medicaid claims payments to the Provider or FMSA until the Provider or FMSA complies with the required actions in the notice.

XX. MCO EVV COMPLAINTS

A. The MCO must follow the established policies and procedures under the Contract to handle Provider, FMSA, or Member Complaints related to EVV. These Complaint policies must be available to the Provider, FMSA, and Member on the appropriate MCO Provider Portal or EVV webpage and within the applicable Provider, FMSA, 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, FMSA, 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
4. Notify HHSC through the HHSC EVV MCO email address (EVVMCO@hhs.texas.gov), and the Provider, FMSA, or Member, in writing, of the action that the MCO took to resolve the complaint within five Business Days after the action was completed.

XXI. 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 in UMCM Chapter 8.7.2. 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 MCO must use the following naming convention for quarterly report submissions: {MCO abbreviated name}Report Quarter_FYXX,PerformanceMeasuresRpt_{date submitted} for example:

      "MCO acronym_Q1_FY22_PerformanceMeasuresRpt_04.30.22"

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 EVV MCO email address at EVVMCO@hhs.texas.gov. The MCO must submit all HHSC requested information within the timeframe specified by HHSC.

XXII. 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 or Webinar.

B. The MCO must ensure at least one MCO representative attends, either in person or via conference call or Webinar, as specified by HHSC, all HHSC sponsored EVV stakeholder work group meetings.

C. The MCO is not required to attend EVV Provider or FMSA 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 email address, EVVMCO@hhs.texas.gov, within the timeframe specified by HHSC.

XXIII. 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 waives this requirement through an EVV temporary policy or other written communication.

C. All MCO EVV policies and procedures that impact Members, FMSAs, and Providers are subject to review by HHSC upon request.

D. The MCO must send all documents that HHSC requests for review to the following HHSC MCO EVV email address: EVVMCO@hhs.texas.gov.

E. The MCO must use language consistent with HHSC EVV terminology where applicable.

F. The MCO must meet all HHSC required deadlines, unless HHSC extends the deadline or approves an extension requested by the MCO.

G. The MCO must send EVV Vendor complaints to TMHP at EVV@tmhp.com.