ELECTRONIC VISIT VERIFICATION (EVV)

Provider Training Presentation

Agenda

- Overview
- Services Required to Use EVV, including 21st Century Cures Act
- Vendors
- Upfront Claims Processing
  - Critical Data Elements
  - Common Denial Reasons
- Claim review: tips for provider agencies
- Visit Maintenance Request process
- Data Aggregator (TMHP Portal)
- Provider Resources
- Contact information
- Questions and answers

OVERVIEW

Electronic Visit Verification (EVV) Overview

- EVV is a computer-based system that electronically verifies the occurrence of personal attendant service visits by electronically documenting the times a visit starts and ends

- This is a major tool in the state of Texas' Medicaid Fraud, Waste and Abuse program. The state of Texas requires EVV for most Medicaid funded health plans.

- Prior to implementing the EVV Compliances, Cigna paid all EVV claims upfront without matching specific data elements of the transactions to the claims submitted for payment, that process has changed.

EVV Services Required to Use EVV

- Personal assistance services
- Personal care services
- PAS Protective Supervision
- In-home respite services
- Community First Choice - Personal assistance services and habilitation

The **21st Century Cures Act** is a federal law requiring all states to use Electronic Visit Verification for Medicaid Personal Care Services and Home Health Services

- Consumer Directed Service (CDS) and Service Related Option (SRO) Providers are required to use EVV starting *January 1, 2020*
- Home Health Services are required to use EVV *starting January 1, 2023*
- Website: 21st Century Cures Act

The 21st Century Cures Act

- FMSAs impacted by the Cures Act
- Program providers impacted by the Cures Act in the following programs:
  - Deaf-Blind with Multiple Disabilities (DBMD)
  - Home and Community-Based Services-Adult Mental Health (HCBS-AMH)
  - Home and Community-based Services (HCS)
  - Texas Home Living (TxHmL)
  - Youth Empowerment Services (YES) Waiver

More details and registration for the EVV Training – New Program Providers and FMSAs is available in the HHS Learning Portal.

Vendor Information

- DataLogic (Vesta)
- First Data Government Solutions

- All HHSC approved EVV vendors are directly contracted with Cigna STAR+PLUS

  – EVV vendors and CHS should be notified of any system issues that last longer than 48 hours
  – EVV vendors and CHS should be contacted immediately (within 48 hours) of any EVV system issues that affect the ability of your attendant's or office staff to use the system as expected

For more information on the steps you need to take to select an EVV vendor and the EVV vendor transfer process, refer to the following modules in the HHSC EVV Tool Kit:

- Module 16: Cures Act EVV Expansion: EVV Vendor Selection and Onboarding (PDF)
- Module 17: EVV Vendor Transfer Policy and Process (PDF)

Transaction Reports

- EVV reporting is done primarily through your selected vendor
- Vendors are required to provide reports of transaction activity
- The EVV vendor is required to provide access to the standard EVV reports created by HHSC. Raw transaction data that is submitted to Cigna STAR+PLUS can be made available upon request to the vendor
- Providers are responsible for ensuring that their vendor is submitting accurate data to Cigna STAR+PLUS on their behalf prior to submitting claims

Provider Role and Responsibility

- The provider agency must ensure all required data elements, as determined by HHSC, are uploaded or entered into the EVV system completely and accurately
- Provider agencies must complete all required visit maintenance in the EVV system within 60 days of the date which the service was delivered (date of service). Provider agencies cannot perform visit maintenance more than 60 days after the date of service
- Provider agencies must achieve and maintain an EVV provider compliance score of at least 90 percent per review period
- Reason codes must be used each time a change is made to an EVV visit record in the EVV System
- Provider agencies must use the reason code that most accurately explains why a change was made to a visit record
- Provider agencies must use the reason code that most accurately explains why a change was made to a visit record. The MCOs and HHSC will review reason code use by their contracted provider agencies to ensure preferred reason codes are not misused

Provider Role and Responsibility (cont.)

- Use of preferred reason codes: Preferred reason codes indicate situations that are acceptable variations in the proper use of the EVV system
- There is only one EVV compliance plan for HHSC and managed care providers to follow. Failure to achieve and maintain an EVV provider compliance score of at least 90 percent per review period may result in enforcement actions that include but are not limited to assessment of liquidated damages, corrective action plans or the imposition of contract actions, including contract termination
- Each EVV payer will determine enforcement actions for their contracted provider agencies

EVV POLICIES

HHSC Policies

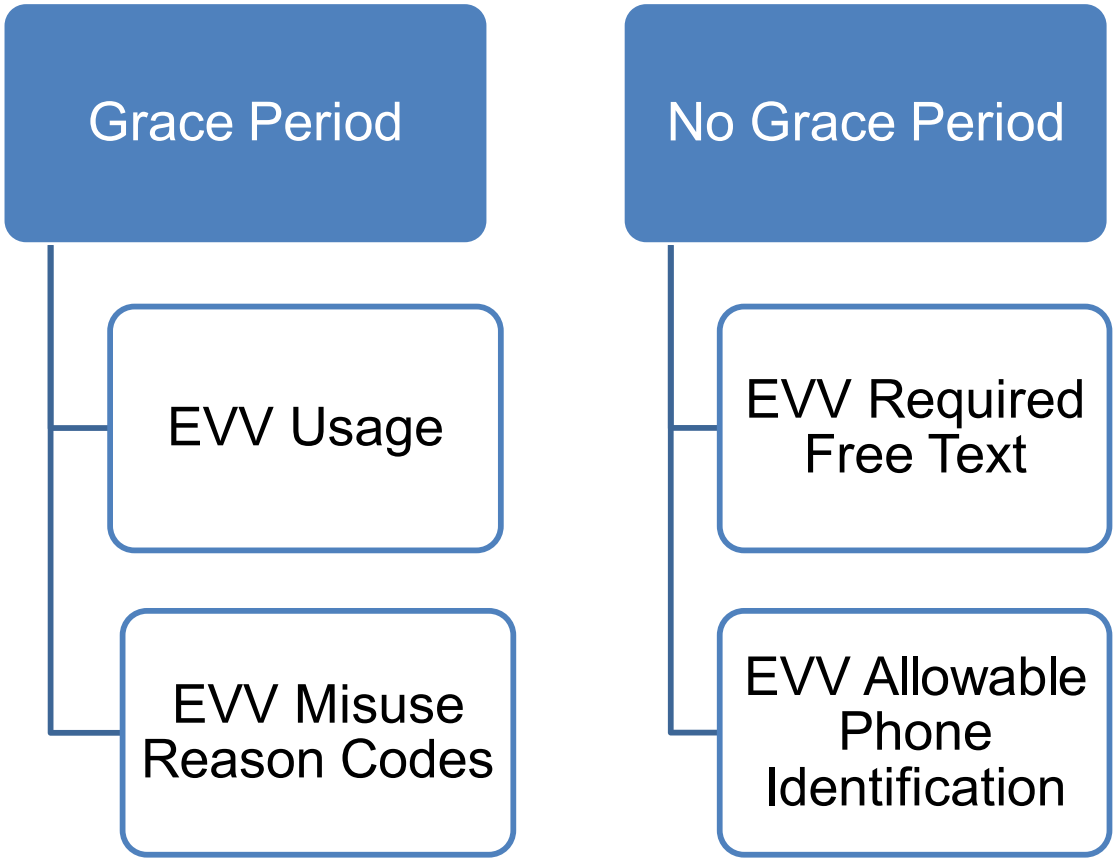
EVV Vendor Transfer

- Providers must select an HHSC-approved EVV vendor within 30 business days of receiving a contract
- EVV vendor access will not be granted until the EVV vendor training has been completed
  - Additional users who will be given access to the system
  - EVV vendor will also be required to complete the EVV vendor system trainings prior to gaining access
  - All required EVV system trainings must be completed prior to the appointment

- The HHSC EVV Vendor Transfer Policy requires program providers to request a transfer to another HHSC-approved EVV vendor 120 calendar days prior to the desired transfer date

HHSC Policy – Compliance Oversight

- Effective **September 1, 2019** with a grace period ending August 31, 2020



HHSC Policy – EVV Usage (new policy)

- Grace period for visits with dates of service between September 1, 2019 through Aug. 31, 2020.

During the grace period, providers will be required to:

- Use the EVV system
- Complete visit maintenance before billing
- Train/re-train their staff on how to use the EVV system
- Review the *EVV Usage Report* and become familiar with the data
- Providers *will not be required to* meet the minimum EVV compliance score of 80 percent until further notice

HHSC Policy - Misuse Reason Code (Revised)

- Grace period for visits with dates of service between Sept. 1, 2019 through Aug. 31, 2020
- Using the same EVV reason code number and reason code description option for the same member more than 14 days within a calendar month may constitute misuse of reason codes
- If a program provider uses the same EVV reason code number and same reason code description option for more than 14 days within a calendar month, the program provider must document the situation that caused the use of the same reason code number and description option

HHSC Policy - Reason Code Free Text Policy (Revised)

- Effective September 1, 2019; **NO GRACE PERIOD**

- Free text is required for all reason codes on **ANY** missing:
  - Actual clock in time when EVV services begin
  - Actual clock out time when EVV services end or
  - Actual clock in and clock out time when EVV services begin and end

- Free text is also required for the following reason codes:
  - **Reason Code 131 -Emergency:** The program provider must describe the nature of the emergency and document any missing actual clock in or clock out time.
  - **Reason Code 600 -Other:** The program provider must document the reason why "other" was selected and document any missing actual clock in or clock out time
  - Failure to document any required *free text* may result in recoupment of associated claims

HHSC Policy - Allowable Phone Identification and Recoupment (Revised)

- Effective September 1, 2019; **NO GRACE PERIOD**
- Program providers must ensure unallowable phone types are not used to clock in and clock out of the EVV system when the visit *Clock In Method* field or visit *Clock Out Method* field is identified as Landline for the member.
- The Allowable Phone Identification Review period will be reviewed at the payer's discretion and may occur at any time. Each payer will determine the date range of the review period for Allowable Phone Identification Reviews.
- HHSC or the MCO must provide the program provider a copy of the *EVV Landline Phone Verification Report* or other phone sampling reports used to identify the unallowable phone type.

HHSC EVV Visit Maintenance Unlock Request Policy

Purpose:

- Providers have 60 days from the date of the visit(s) to perform visit maintenance in the EVV vendor system
- If a provider did not make the correction to the visit(s) within the allotted 60 days, the *Visit Maintenance Unlock Request Form* is used to request approval to open visit maintenance from their payer for the visit(s) the provider wishes have opened

  - Retro or late authorizations
  - Retro eligibility of member
  - Providers requesting payer change (if provider submits EVV visit log with confirmed visits as proof)
  - Other reasons outside of provider control – will be reviewed on case-by-case basis

NOTE: approval is at MCO's Discretion, and on a case-by-case basis.

HHSC EVV Visit Maintenance Unlock Request Policy (continued)

The following data elements **cannot** be changed:

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

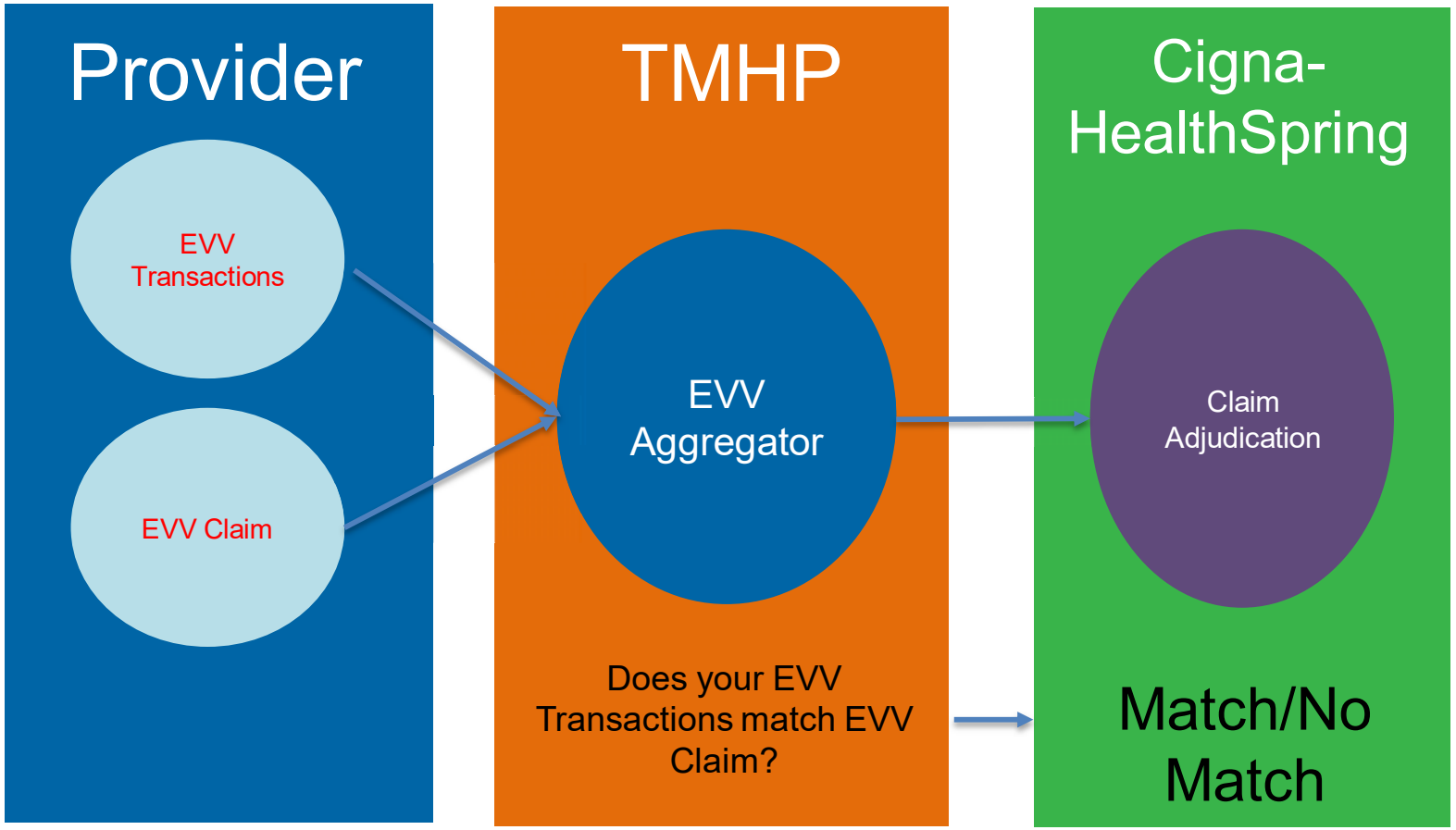
- HHS Website: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification

- Cigna STAR+PLUS Website: EVV Visit Maintenance Unlock Request Form

TMHP CLAIMS SUBMISSION AND MATCHING PROCESS

All EVV relevant claims must be sent to TMHP

High Level Process of New EVV Data Aggregator



For more information on EVV Aggregator and Portal can be found in **EVV Module 7**: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-module-7-aggregator.pdf

Critical EVV Data Elements

EVV Aggregator will be matching the following data elements per claim line item:

- Member Medicaid ID
- EVV visit date and claim date of service
- Provider NPI or API
- HCPCS code
- Modifier(s)
- EVV Pay hours and billed units (must be exact match between units on the claim per date of service and EVV transaction)

For more information on submitting an EVV claim can be found in **EVV Module 8**: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-module-8-claim.pdf

FAQ

Question: What happens if my EVV claim does not have an EVV visit transaction that matches?

- **Answer**: EVV claims that do not have matching EVV visit transactions are denied by the payer.

Question: Where can I view my EVV claims matching results?

- **Answer**: Program providers, FMSAs, MCOs, and HHSC will use the EVV Portal to view EVV visit transactions to EVV claim line item matching results.

CLAIMS

EVV Upfront Claims Processing

- Claims will be evaluated for EVV matching criteria upfront and denied prior to adjudication if no matches are found
- If EVV data elements do not match the line items billed, the claim is denied and providers will receive notification via Explanation of Payment
- Date span billing will be allowed **ONLY** if you have an EVV transaction for each day within the date span on the claim line item
- Pay hours on EVV transactions must match the unit billed on claim **exactly**

Critical EVV Data Elements

Cigna will be matching the following data elements:

- Member Medicaid ID
- Date of Service
- Provider NPI
- HCPCS code
- Modifier(s)
- Pay hours (must be exact match between units on the claim per date of service and EVV transaction)

Common Denial Reasons relevant to EVV

Definition:
There are no matching EVV visits with the Medicaid ID
There are no matching EVV visits with the Medicaid ID on the Date of Service
There are no matching EVV visits with the NPI/API
There are no matching EVV visits for the HCPCS/Modifier combination
There are no matching EVV visits for the HCPCS code
There are no matching EVV visits for the Modifier
Claim billed units do not match EVV units
There are no matching EVV visits for one or more of the dates in the claim date span range

Note: This is not an all inclusive list. The EOP provides the Denial Code and explanation

Tips and advice – prior to claims submission

- **Step 1** - validate the critical data elements and match between the EVV transaction(s) and the claim you submit
- **Step 2** - check the failed to export report before submitting claim to make sure the transaction(s) did not get rejected
- **Step 3** - wait at least 48 hours after confirmed visit has been successfully submitted to TMHP before billing the claim for payment

EVV Billing Matrix For S+P – Effective 9/1/2019 Dates of Service

Payer	Program	Service Short Description	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Procedure Effective Begin Date	Procedure Effective End Date	EVV Claims Match Begin Effective Date	EVV Claims Match End Effective Date
MCO	STAR+PLUS, MMP	CFC HAB, HCBS / Agency	HC	T2017	U3	U7			per 15 min	9/1/2019	12/31/9999	9/1/2019	12/31/9999
MCO	STAR+PLUS, MMP	CFC HSB, Non-HCBS / Agency	HC	T2017	U5	U7			per 15 min	9/1/2019	12/31/9999	9/1/2019	12/31/9999
MCO	STAR+PLUS, MMP	CFC HAB, HCBS / CDS	HC	T2017	U3	UC	U7		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	CFC HAB Non-HCBS /CDS	HC	T2017	U5	UC	U7		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	CFC HAB, HCBS / SRO	HC	T2017	U3	UD	U7		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	CFC HAB, Non-HCBS / SRO	HC	T2017	U5	UD	U7		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	CFC PAS, HCBS / Agency	HC	S5125	U3	U7			per 15 min	9/1/2019	12/31/9999	9/1/2019	12/31/9999
MCO	STAR+PLUS, MMP	CFC PAS, Non-HCBS / Agency	HC	S5125	U5	U7			per 15 min	9/1/2019	12/31/9999	9/1/2019	12/31/9999
MCO	STAR+PLUS, MMP	CFC PAS, HCBS / CDS	HC	S5125	U3	UC	U7		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	CFC PAS, Non-HCBS / CDS	HC	S5125	U5	UC	U7		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	CFC PAS, HCBS / SRO	HC	S5125	U3	UD	U7		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	CFC PAS, Non-HCBS / SRO	HC	S5125	U5	UD	U7		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	PAS, HCBS / Agency	HC	S5125	U3				per 15 min	9/1/2019	12/31/9999	9/1/2019	12/31/9999
MCO	STAR+PLUS, MMP	PAS, Non-HCBS / Agency	HC	S5125	U5				per 15 min	9/1/2019	12/31/9999	9/1/2019	12/31/9999
MCO	STAR+PLUS, MMP	PAS, HCBS / CDS	HC	S5125	U3	UC			per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	PAS, Non-HCBS / CDS	HC	S5125	U5	UC			per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	PAS, HCBS / SRO	HC	S5125	U3	UD			per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	PAS, Non-HCBS / SRO	HC	S5125	U5	UD			per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	Protective Supervision, HCBS / Agency	HC	S5125	U3	U1			per 15 min	9/1/2019	12/31/9999	9/1/2019	12/31/9999
MCO	STAR+PLUS, MMP	Protective Supervision, HCBS / CDS	HC	S5125	U3	UC	U1		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	Protective Supervision, HCBS / SRO	HC	S5125	U3	UD	U1		per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	In Home Respite, HCBS / Agency	HC	T1005	U3				per 15 min	9/1/2019	12/31/9999	9/1/2019	12/31/9999
MCO	STAR+PLUS, MMP	In Home Respite, HCBS / CDS	HC	T1005	U3	UC			per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999
MCO	STAR+PLUS, MMP	In Home Respite, HCBS / SRO	HC	T1005	U3	UD			per 15 min	9/1/2019	12/31/9999	1/1/2020	12/31/9999

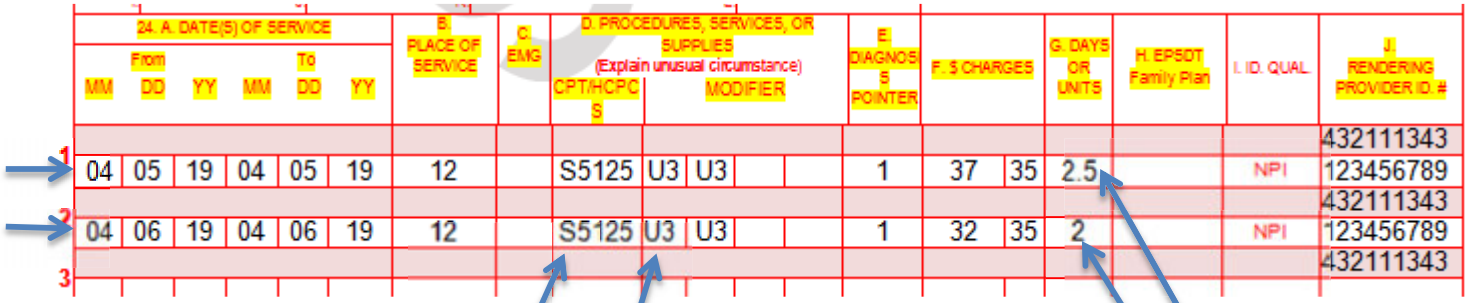
Note: Those highlighted in yellow have EVV claim matching effective date of 1/1/2020 dates of service

EVV Claims Matching Results

Definition:
EVV01 – EVV Match
EVV02 - Medicaid ID Mismatch
EVV03 - Date(s) of Service Mismatch
EVV04 - Provider Mismatch (NPI/API)
EVV05 - Service Mismatch (HCPCS and Modifiers if applicable)
EVV 6 - Unit Mismatch (except for CDS)

Note: EVV claims with a successful match from TMHP can be denied for other reasons by Cigna STAR+PLUS.

Examples of claim scenarios (correct match)



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstance) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
																			432111343
1	04	05	19	04	05	19	12		S5125	U3	U3		1	37	35	2.5		NPI	123456789
																			432111343
2	04	06	19	04	06	19	12		S5125	U3	U3		1	32	35	2		NPI	123456789
																			432111343
3																			

EVVHCPCSCode	EVVModifier	EVVVisitDate	EVVCreatedDateTime	EVVPhone	EVVCallInTime	EVVCallOutTime	EVVPayHours
S5125	U3:U3	20190405	04052019 (	UNKNOW	04052019 (	04052019 (	2.5
S5125	U3:U3	20190406	04062019 (	UNKNOW	04062019 (	04062019 (	2

The data elements from the claim and EVV transaction(s) all match – this claim would pay. Not shown but Medicaid ID and Provider NPI must match as well

What to do if I get the following Denials EVV 02 - 04

EVV 02- There are no matching EVV visits with the Medicaid ID	EVV 03 -There are no matching EVV visits with the Medicaid ID on the Date of Service	EVV 04 -There are no matching EVV visits with the NPI/API
• Billed before EVV transactions were received (Check EVV Portal before submitting Claim) • Validate Medicaid ID is correct	• Check the Date of Service on the claim and EVV transactions match • If billed in a date span, make sure there is an EVV transaction for EVERY date within date span.	• Verify the provider NPI/API # on the transaction matches the claim.

On all claim denials ALWAYS CHECK in addition to the edit: NPI/API, Date(s) of Service, HCPCS/Modifiers, Units match visit prior to submitting claim

Examples of claim scenarios (date span)

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstance) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	01	19	04	15	19	12		S5125	U3	U3	U3	1	670	50	50		NPI	123456789
																			43211343

EVVHCPCSCode	EVVModifier	EVVVisitDate	EVVCreatedDateTime	EVVCallInTime	EVVCallOutTime	EVVPayHours
S5125	U3:U3:U3	20190401	04012019	04012019	04012019	5
S5125	U3:U3:U3	20190402	04022019	04022019	04022019	5
S5125	U3:U3:U3	20190403	04032019	04032019	04032019	5
S5125	U3:U3:U3	20190404	04042019	04042019	04042019	5
S5125	U3:U3:U3	20190405	04052019	04052019	04052019	5
S5125	U3:U3:U3	20190408	04082019	04082019	04082019	5
S5125	U3:U3:U3	20190409	04092019	04092019	04092019	5
S5125	U3:U3:U3	20190410	04102019	04102019	04102019	5
S5125	U3:U3:U3	20190411	04112019	04112019	04112019	5
S5125	U3:U3:U3	20190412	04122019	04122019	04122019	5

This claim would deny and EOP would say *"There are no matching EVV visits for one or more of the dates in the claim date span range"*
- Missing DOS 4/6&4/7; 4/13-4/15.

Correct way to bill if you choose to date span bill:

	From MM	DD	YY	To MM	DD	YY	PLACE OF SERVICE	EMG	(Explain unusual circumstance) CPT/HCPCS	MODIFIER			DIAGNOSIS POINTER	F. $ CHARGES		OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	RENDERING PROVIDER ID. #
1	04	01	19	04	05	19	12		S5125	U3	U3	U3	1	335	35	25		NPI	123456789
																			432111343
2	04	08	19	04	12	19	12		S5125	U3	U3	U3	1	335	35	25			123456789
																			432111343

What to do if I get the following Denials EVV 05 & 06

EVV 05 -There are no matching EVV visits for the HCPCS/Modifier combination	EVV 06 -Claim billed units do not match EVV units
• Verify the HCPCS code AND modifier match the MCO authorization AND claim billed	• Verify the units match the claim line item per DOS or the total matches the date span EXACTLY(having more EVV pay hours will cause claim denial) • CDS claims are excluded from unit matching logic

On all denials ALWAYS CHECK in addition to the edit: NPI/API, Date(s) of Service, HCPCS/Modifiers, Units match visit prior to submitting claim

Examples of claim scenarios (units do not match)

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstance) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	01	19	04	01	19	12		S5125	U3	U3	U3	1	67	50	5		NPI	123456789
																			43211343
2	04	02	19	04	02	19	12		S5125	U3	U3	U3	1	46	94	3.5			123456789
																			43211343
3	04	03	19	04	03	19	12		S5125	U3	U3	U3	1	53	64	4			123456789
																			43211343
4	04	04	19	04	04	19	12		S5125	U3	U3	U3	1	70	40	5.25			123456789
																			43211343
5	04	05	19	04	05	19	12		S5125	U3	U3	U3	1	63	70	4.75			123456789
																			43211343

EVVHCPCSCode	EVVModifier	EVVVisitDate	EVVCreatedDateTime	EVVCallInTime	EVVCallOutTime	EVVPayHours	
S5125	U3:U3:U3	20190401	04012019	04012019	04012019	5	This line would pay
S5125	U3:U3:U3	20190402	04022019	04022019	04022019	3	This line would deny due to units not matching
S5125	U3:U3:U3	20190403	04032019	04032019	04032019	4.25	This line would deny due to units not matching
S5125	U3:U3:U3	20190404	04042019	04042019	04042019	3	This line would deny due to units not matching
S5125	U3:U3:U3	20190405	04052019	04052019	04052019	4.75	This line would pay

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstance) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	04	01	19	04	05	19	12		S5125	U3	U3	U3	1	335	25	25		NPI	123456789
																			43211343

If claim is billed on date span, the entire claim would deny for "*Claim billed units do not match EVV units*"

Examples of claim scenarios (mismatched modifiers)

	From MM	From DD	From YY	To MM	To DD	To YY	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER			DIAGNOSIS POINTER	$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL	RENDERING PROVIDER ID. #
1	04	01	19	04	01	19	12		S5125	U3	U3	U3	1	67	05	5		NPI	123456789
																			43211343
2	04	02	19	04	02	19	12		S5125	U3	U3	U3	1	40	23	3			123456789
																			43211343
3	04	03	19	04	03	19	12		S5125	U3	U3	U3	1	56	99	4.25			123456789
																			43211343
4	04	04	19	04	04	19	12		S5125	U3	U3	U3	1	40	23	3			123456789
																			43211343
5	04	05	19	04	05	19	12		S5125	U3	U3	U3	1	63	70	4.75			123456789
6																			43211343

EVVHCPCSCode	EVVModifier	EVVVisitDate	EVVCreatedDateTime	EVVCallInTime	EVVCallOutTime	EVVPayHours
S5125	U7:U5	20190401	04012019	04012019	04012019	5
S5125	U7:U5	20190402	04022019	04022019	04022019	3
S5125	U7:U5	20190403	04032019	04032019	04032019	4.25
S5125	U7:U5	20190404	04042019	04042019	04042019	3
S5125	U7:U5	20190405	04052019	04052019	04052019	4.75

This claim will deny for “There are no matching EVV visits for the Modifier”

Examples of claim scenarios (mismatched HCPCS code)

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstance) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04	01	19	04	01	19	12		S5151	U3	U3			1	67	05	5		NPI	123456789
																				43211343
2	04	02	19	04	02	19	12		S5151	U3	U3			1	40	23	3			123456789
																				43211343
3	04	03	19	04	03	19	12		S5151	U3	U3			1	56	99	4.25			123456789
																				43211343

EVVHCPCSCode	EVVModifier	EVVVisitDate	EVVCreatedDateTime	EVVCallInTime	EVVCallOutTime	EVVPayHours
S5125	U3:U3	20190401	04012019	04012019	04012019	5
S5125	U3:U3	20190402	04022019	04022019	04022019	3
S5125	U3:U3	20190403	04032019	04032019	04032019	4.25

This claim would deny for “There are no matching EVV visits for the HCPCS code”

Examples of claim scenarios (provider portal claim entry)

- Claim Line Information

* Start Date	* End Date	* Performing Provider #	Spec	* Place Code	Type Code	* Proc	Mods				* ICD Pointers	* Unit Type	* Unit Qty	* Charges
04/01/2019	04/01/2019	NPI:Test Office,	003	12		S5125	U3	U3			1	Units	2.3	$44.00
04/05/2019	04/05/2019	NPI:Test Office,	003	12		S5125	U3	U3			1	Units	2.8	$43.00
		NPI:Test Office,	003	11								Units		$0.0
		NPI:Test Office,	003	11								Units		$0.0

More Line(s)...

Total $44.00

EVVHCPCSCode	EVVModifier	EVVVisitDate	EVVCreatedDateTime	EVVCallInTime	EVVCallOutTime	EVVPayHours
S5125	U3:U3	20190401	04012019	04012019	04012019	2.25
S5125	U3:U3	20190405	04052019	04052019	04052019	2.75

This claim would be considered a match and pay

NOTE: If provider entered 2.5 for units on claim line item #1; the claim line would deny for *"Claim billed units do not match EVV units"*

How do I resubmit my claim now that I received one of the EVV denials?

Did the entire claim deny?

- Submit a CORRECTED claim ONLY if a CHANGE is needed on the claim itself
- If not, make the necessary corrections and submit the same claim to TMHP

Did claim partially deny?

- Submit only denied claim lines as a NEW submission
- Paid claim lines will deny as duplicate if resubmitted
- Submit corrected claim only if a CHANGE is needed on claim itself

ALL CLAIMS-- CORRECTED, NEW, or ORIGINAL MUST GO TO TMHP FIRST FOR EVV MATCHING

Tips and advice – if a claim denies

- Any changes to your data will need to be made by the provider agency into your vendor system
- Per HHSC, providers must complete any and all required visit maintenance in EVV within 60 days of the date of service. After 60 days, visit maintenance will only be allowed via Cigna's STAR+PLUS approval and on a case-by-case basis
- Any data updates made outside the defined visit maintenance window will continue to deny, regardless if EVV vendor system allows such changes. Only Cigna-approved changes will e allowed and re-exported by the vendor.

EVV Aggregator and Portal

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

- EVV TMHP Learning Management System: https://learn.tmhp.com/
  - Create an account to access training on EVV aggregator, portal, vendor selection and more.

- EVV Portal URL: **https://securereg.tmhp.org/evv**

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

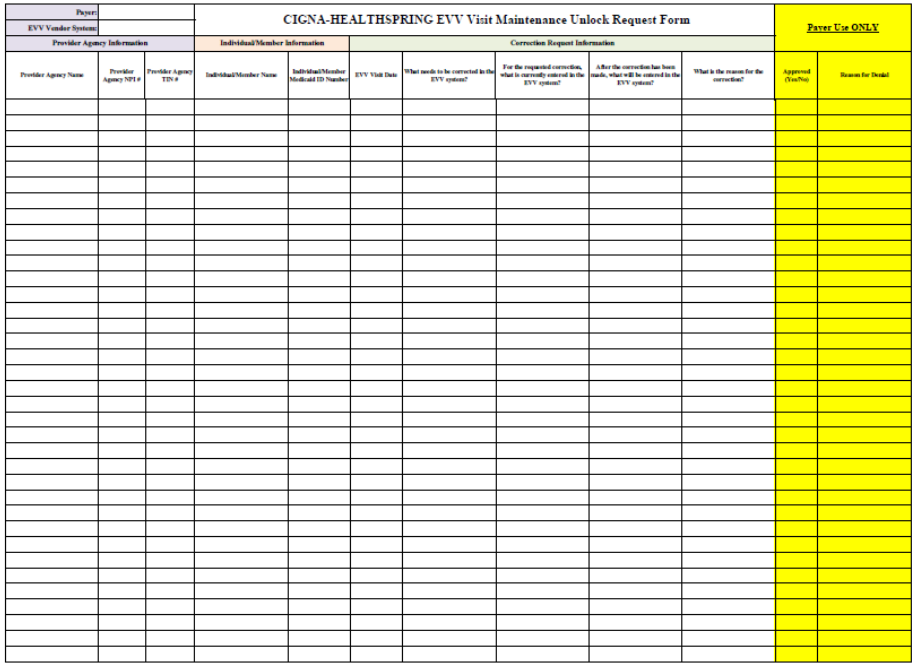
For more information on EVV Aggregator and Portal can be found in **EVV Module 7**: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-module-7-aggregator.pdf

RESOURCES

EVV Visit Maintenance Unlock Request Form

Purpose:

- Providers have 60 days from the date of the visit(s) to perform visit maintenance in the EVV vendor system.
- If a provider did not make the correction to the visit(s) within the allotted 60 days, the Visit Maintenance Unlock Request Form is used to request approval to open visit maintenance from their payer for the visit(s) the provider wishes have opened



Payer:		CIGNA-HEALTHSPRING EVV Visit Maintenance Unlock Request Form								Payer Use ONLY	
EVV Vendor System:											
Provider Agency Information			Individual/Member Information		Correction Request Information						
Provider Agency Name	Provider Agency NPI #	Provider Agency TIN #	Individual/Member Name	Individual/Member Medicaid ID Number	EVV Visit Date	What needs to be corrected in the EVV system?	For the requested correction, what is currently entered in the EVV system?	After the correction has been made, what will be entered in the EVV system?	What is the reason for the correction?	Approved (Yes/No)	Reason for Denial

EVV Visit Maintenance Unlock Request Form

- EVV Visit Maintenance Unlock Request Form

NOTE: approval is at MCO's Discretion. Common reasons we would approve VM unlocks:

  - Retro or late authorizations
  - Retro eligibility of member
  - Providers requesting payer change (if provider submits EVV visit log with confirmed visits as proof)
  - Other reasons outside of provider control – will be reviewed on case-by-case basis

- Visit our website at: https://www.cigna.com/starplus/health-care-professionals/provider-resources/forms

Resources

Provider Manuals:

- STAR+PLUS: https://www.cigna.com/starplus/health-care-professionals/provider-resources/provider-manuals
- CarePlan: https://www.cigna.com/starplus/health-care-professionals/provider-resources/provider-manuals

Prior Authorization Forms:

- STAR+PLUS: https://www.cigna.com/static/docs/starplus/starplus-pr-list-authorizations-required.pdf
- CarePlan: https://www.cigna.com/assets/docs/careplantx/hcp/txmmp-prior-auth-outpatient-form.pdf
- EVV Visit Maintenance Unlock Request Form (*NOTE*: approval is at MCO's Discretion.)

Prior Authorization List:

https://www.cigna.com/static/docs/starplus/starplus-pr-list-authorizations-required.pdf

HHSC Notifications:

- Subscribe to receive email notifications/alerts at: HHSC Subscribe

Contact List

Provider Relations Central Team:

- providerrelationscentral@healthspring.com

Provider Services:

- 1-877-653-0331

Service Coordination:

- 1-877-653-0327

Utilization Management:

- 1-877-725-2688

EVV Dispute Team:

- CHS_EVV@healthspring.com

DataLogic(Vesta) Software, Inc.

Phone: 1-844-880-2400

Fax: 1-956-412-1464

Website: www.vestaevv.com

EVV System Information:

DataLogic Vesta EVV

First Data Government Solutions

Phone: 877-829-2002

Fax: 402-991-9340

Website: fdgs.com/authenticare-tx

EVV System Information:

Firstdataautheniccare.pdf

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