

Health and Human Services Commission (HHSC) Electronic Visit Verification (EVV) Billing Policy (New)

Policy

Effective Sept. 1, 2019, the HHSC EVV Billing Policy requires program providers to follow the billing guidelines of their payer for EVV claims.

EVV Claims with Span Dates

If the payer allows EVV claims to be submitted with span dates, the program provider must ensure that:

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

EVV claims with span dates that start prior to Sept. 1, 2019 will be rejected by TMHP.

Program providers can review accepted EVV visits in the EVV Portal before submitting EVV claims.

For questions regarding EVV claims billing contact your payer.

EVV Claims with Single Line Item

If the payer requires that a single claim line item represents a single EVV visit, then the EVV claim(s) must be billed according to that requirement.

EVV claim line items must have a matching EVV visit.

Program providers can review accepted EVV visits in the EVV Portal before submitting EVV claims.

For questions regarding EVV claims billing contact your payer.

**Health and Human Services Commission (HHSC)
Electronic Visit Verification (EVV) Claims Matching Policy (New)**

Policy

Effective Sept. 1, 2019, the HHSC EVV Claims Matching Policy requires that all claims for EVV services be matched to an accepted EVV visit transaction in the EVV Aggregator, prior to payment of a claim, to confirm that a service visit occurred.

An EVV claim that does not match an accepted EVV visit transaction will be denied by all payers.

EVV Claims Matching

EVV Claims Matching will be conducted when the claim is received by TMHP (see EVV Claim Submission policy for more information). The claim is matched against the EVV visit transaction previously sent by an EVV system and accepted in the EVV Aggregator. The critical data elements used by the EVV Claims Matching process to determine a successful match are:

- **Medicaid ID** on the EVV Visit Transaction compared to the EVV Claim
- **EVV Visit Date** on the EVV Visit Transaction compared to the date of service on the EVV Claim
- **National Provider Identifier (NPI) or Atypical Provider Identifier (API)** on the EVV Visit Transaction compared to the EVV Claim
- **Healthcare Common Procedure Coding System (HCPCS) code** to identify the service on the EVV Visit Transaction compared to the EVV Claim
- **HCPCS modifiers**, if applicable for the service on the EVV Visit Transaction compared to the EVV Claim
- **Billed units** on the EVV Transaction compared to the billed units on the EVV Claim

If any of the critical data elements do not match, the claim will be denied by the payer.

Once the EVV Claims Matching process has been performed, all claims will be forwarded to the appropriate payer for final claims processing. All communication concerning the outcome of the final claims processing will be from the payer.

Program providers using a third-party submitter must notify them of the EVV claims matching policy.

The EVV Claims Matching process supports claims submitted with a single date of service and claims submitted with a span of service dates.

Program providers may use the EVV Portal to:

- Ensure the EVV visit has been accepted by the EVV Aggregator before submitting the associated claim.
- View the results of the EVV Claims Matching process.

EVV Claims Denial

EVV claims will be denied if:

- Critical data elements do not match the claim.
- The claim was not submitted according to the payer's guidelines regarding span dates.
- The payer allows span date billing and:
 - A date within the span of dates does not have a matching EVV visit.
 - The total units of the matched EVV visit of a date span does not match the units billed on the EVV claim.

The following list of EVV claim match result codes will be used to inform program providers of matching results:

- 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)
- EVV06 – Unit Mismatch

EVV claims with a successful match can be denied for other reasons by the payer.

Program providers will continue to receive explanation of benefits (EOBs) from TMHP or explanation of payment (EOPs) from their MCO.

For additional questions regarding your EVV claim denial contact TMHP for Fee-for Service claims or your MCO for Managed Care claims.

**Health and Human Services Commission (HHSC)
Electronic Visit Verification (EVV) Claims Submission Policy (New)**

Policy

Effective Sept. 1, 2019, the HHSC EVV Claims Submission Policy requires that program providers, who are required to use EVV, submit EVV claims to Texas Medicaid & Healthcare Partnership (TMHP) for the following programs and services:

Long-Term Care (LTC) Fee-for-Service (FFS) Programs and Services

Program	Services
Community Attendant Services	<ul style="list-style-type: none"> • Personal Assistance Services (PAS)
Community Living Assistance and Support Services (CLASS)	<ul style="list-style-type: none"> • Community First Choice (CFC) PAS/Habilitation (HAB) • In-Home Respite
Family Care	<ul style="list-style-type: none"> • PAS
Primary Home Care	<ul style="list-style-type: none"> • PAS

Long-Term Support Services (LTSS) Managed Care Programs and Services

Program	Services
STAR Health	<ul style="list-style-type: none"> • CFC HAB • CFC PAS • Personal Care Services (PCS)
STAR Kids	<ul style="list-style-type: none"> • CFC HAB • CFC PAS • PCS
STAR Kids – MDCP	<ul style="list-style-type: none"> • Flexible Family Support • In-Home Respite
STAR+PLUS	<ul style="list-style-type: none"> • CFC HAB • CFC PAS • PAS
STAR+PLUS Home and Community Based Services	<ul style="list-style-type: none"> • In-Home Respite • PAS • Protective Supervision

EVV Claims Submission

LTC FFS Claims Submission

- Acute Care FFS EVV claims must be submitted through TexMedConnect or through Electronic Data Interchange (EDI) using an existing Compass21 (C21) Submitter ID.
- LTC FFS EVV claims must be submitted through TexMedConnect or through EDI using an existing Claims Management System (CMS) Submitter ID.

LTSS Managed Care Claims Submission

- Claims for Managed Care EVV services must be submitted to TMHP through TexMedConnect or through EDI using a C21 Submitter ID.
- Managed Care EVV claims will be forwarded to the appropriate Managed Care Organization (MCO) for further claims processing, after the EVV claims matching process is performed at the EVV Aggregator.
 - EVV claims for managed care services with dates of service on or after Sept. 1, 2019 submitted directly to an MCO will be rejected or denied.
 - Program providers will receive a response from the MCO informing them to submit EVV claims to TMHP.

Program providers using a third-party submitter must notify them of the EVV claims submission policy.

Program providers can access TMHP's EDI homepage for basic information needed to submit claims electronically including:

- User guides
- Forms
- Technical information intended for billing agents that file claims for program providers.

For additional information and assistance in setting up C21 or CMS Submitter IDs call TMHP EDI Help Desk at 1-888-863-3638, Option 4.

For a list of programs and services currently required to use EVV refer to the [HHSC EVV](#) webpage or to your MCO.