AETNA BETTER HEALTH OF TEXAS ®

STAR Kids EVV (Electronic Visit Verification) Provider, FMSA & CDS Employer Training & NEW Guidance

September 2019

Objectives

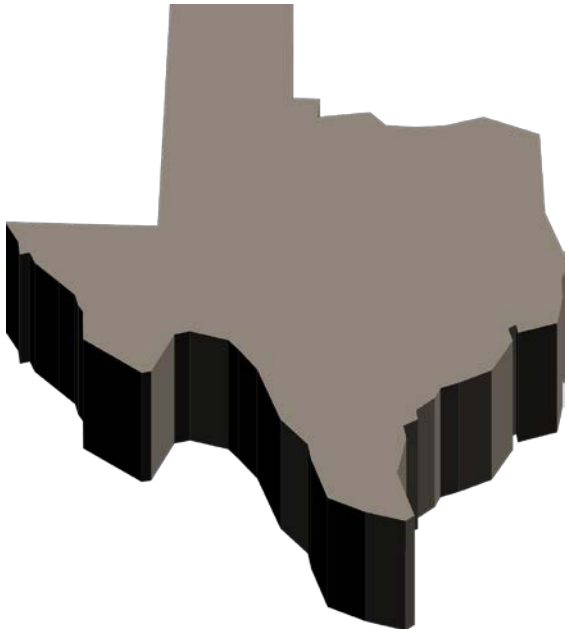
As a result of this training session, you will be able to:

- Who participates in EVV?
- Describe EVV Participants Roles & Responsibilities
- 21st Century Cures Act Implementation & What is EVV?
- Learn the required elements for EVV Data & visit verification
- Understand the different approved EVV methods to call in and out
- Visit Maintenance and Reason Codes
- Describe contracted providers EVV Compliance Requirements, policies & procedures
- Understand the new EVV Data Aggregator & its purpose
- Know EVV Provider rights and responsibilities
- Learn about EVV claims submission and EVV billing codes
- Review the process for EVV Denials, Appeals & Best practices
- 21st Century Cures Act and how it impacts CDS Employers
- Locate additional resource information & helpful tools and about EVV
- Learn the importance of updating provider demographic data
- Access what State directed resources & guidance is available – web links

Overview

- Aetna contracts with the Texas Health and Human Services Commission (HHSC) to administer the Medicaid Managed Care, CHIP and STAR Kids programs in the Bexar and Tarrant service areas. **Aetna STAR Kids is administered in the Tarrant service area only.**
- Managed Care includes the member assignment to an in-network PCP to establish a medical home. The PCP coordinates the member's medical care and the health plan works with the PCP, specialists, etc. to ensure appropriate care.
- HHSC determines and provides member eligibility for the Medicaid, CHIP and STAR Kids programs to Aetna Better Health.
- Aetna Better Health does not sell or market these programs directly.

Aetna Better Health STAR Kids & EVV Service Area



Tarrant Service Delivery Area

- Denton
- Hood
- Johnson
- Parker
- Tarrant
- Wise

EVV Participants

The 5 **EVV participants** are:

Contracted provider

- Provider agency/ Financial Management Services Agency (FMSA)

Member/Consumer Directed Services (CDS) employer

- A member is a person receiving a program and service required to use EVV
- A CDS employer is a member or a Legally Authorized Representative (LOA) of a member who has selected the CDS option waiver program

EVV vendor(s)

- An EVV vendor provides an HHSC-approved EVV system that an Aetna contracted provider and a CDS employer must use for EVV.

Payer

- A payer, such as Aetna, whose contracted provider or FMSA is required to use EVV.

EVV Aggregator

- A centralized database that collects, validates, and stores EVV visit data submitted from the EVV system(s)
- Operated by the Texas Medicaid Claims Administrator (TMHP)
- EVV Portal –allows users to perform searches and view reports associated with the EVV visit information in the EVV Aggregator
- EVV reports –Information stored in the EVV aggregator accessible for users

EVV Participants Roles & Responsibilities

- **Contracted Provider Role-** The role of a contracted provider is to follow all EVV Policies, Processes and State Requirements

- **Member/Consumer Directed Services (CDS) employer Role**- The role of a Member/CDS employer is to allow your attendant to use one of the acceptable methods to clock in and clock out of the EVV system at the beginning and ending of service delivery.

- **EVV vendor(s) Role-** Ensures the HHSC-approved EVV system operates at all times.

  Captures EVV visit data and provides the ability to correct visit data. Transmits confirmed EVV visit data to the Data Aggregator.

- **Payers Role -** Provides EVV policies, processes, and procedures. Pays or denies EVV claims after the claims matching process & monitors EVV compliance.

- **EVV Aggregators Role -** Provides member eligibility and provider contract or enrollment data to EVV vendors. Receives and stores confirmed visit data transmitted by EVV vendors. Provides an EVV online portal for reports and queries.

Contracted Provider Role & Responsibilities

A contracted provider is a Medicaid provider that provides services to a Medicaid recipient and has a contract with Aetna and is required to use EVV.

Their role is to follow all EVV 1) Policies 2) Processes and 3) Requirements

The Contracted Provider is responsible for:

- Training their staff on the use of EVV.
- Completing all required EVV training.
- Using the EVV Vendor system and determine if it suits your agency's business needs.
- Meeting all EVV requirements.
- Signing up for EVV notices through GovDelivery via the State website
- Knowing where to submit EVV-related claims.
- Understanding all EVV policies, processes, and requirements.
- Most importantly, asking questions.

Providers should identify which staff will be using the EVV system, who will need EVV training and schedule appropriately for the onboarding process. Familiarize your practice with the EVV Vendors policy when a member refuses to allow his or her attendant to use EVV.

Contracted Provider Responsibilities cont'd

- Understand Aetna's policies, processes and procedures for EVV compliance & claims adjudication.
- Obtain Prior Authorization for services to be rendered when applicable:
- Review our website regularly for EVV-related materials.
- Attend Aetna provided trainings.
- Know who to contact if you have questions.
- Attend the Data Aggregator provided training sessions.
- Review the TMHP website for EVV-related materials including online training.

TMHP is responsible to train provider agencies and FMSA's on the use of the Data Aggregator

- Visit Aetna's website for EVV-related material and reference provider handbooks and manuals. Contact us at EVVMailbox@Aetna.com for questions.
- Verify every Aetna members eligibility prior to rendering services

Member Eligibility Verification

- Use the Aetna website at www.aetnabetterhealth.com/texas

- Aetna Better Health Member Services

Service Area	Medicaid	CHIP
Bexar	**1-800-248-7767**	**1-866-818-0959**
Tarrant – Medicaid **Tarrant – STAR Kids**	**1-800-306-8612** **1-844-STRKIDS** **(844-787-5437)**	**1-800-245-5380**

*These numbers provide access to a **Behavioral Health Hotline** that operates **24 hours** a day / **7 days** a week.*

Assessments and Authorizations

Aetna Better Health (ABH) will assess the need for PCS, Respite, PDN, CFC, and MDCP.

- ABH is responsible for functional and medical assessments.
- Existing authorizations for LTSS are honored until the end of the current authorization, or until ABH does a new assessment.
- Existing authorizations for acute care services are honored until the end of the current authorization, or until ABH does a new assessment.

Please visit our website for additional information surrounding our access to care guidelines (STAR Kids)

EVV Prior Authorization Update!

EVV Authorization Pilot has discontinued effective June 1, 2019

Electronic authorizations are no longer being sent to the EVV vendor system by Aetna as of May 31, 2019.

Program providers will continue to receive Prior Authorization approvals from Aetna's Medical Management department via fax and must enter the data into the EVV system.

- Please submit the following with each authorization request:
  - Member Information, e.g., correct and legible spelling of name, ID number, date of birth, etc.
  - Diagnosis Code(s)
  - Treatment or Procedure Codes
  - Anticipated start and end dates of service(s) if known
  - All supporting relevant clinical documentation to support the medical necessity
  - Include an office/department contact name, telephone and fax number

Prior Authorization Decision Timeframes

Decision	Decision/Notification Timeframe	Notification to	Notification Method
Urgent pre-service approval	Within 24 hours of receipt of necessary information, but no later than 72 hours from receipt of request	Practitioner / Provider	Telephone and in writing
Non-urgent pre-service approval	Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed decision	Practitioner / Provider	Telephone and in writing
Continued / extended services approval (non-ED/acute inpatient)	1 business day of receipt of necessary information	Practitioner / Provider	Telephone and in writing
Post-service approval of a service for which no pre-service request was received.	30 calendar days from receipt of the necessary information	Practitioner / Provider	Telephone and in writing

EVV Related STAR Kids Medical Prior Authorization

- You may submit prior authorization requests to us **24-hours-a-day, 7-days-a-week** through one of the options below:

Medicaid Prior Authorization FAX only

- Acute/DME: fax requests to **1-866-835-9589**
- Concurrent review: Fax requests to **1-866-706-0529**

STAR Kids Prior Authorization FAX only

- Acute/DME: fax requests to **1-866-835-9589**
- Long Term Services and Supports (LTSS) fax: **844-275-5728**

Member Role & Responsibilities

The Member is responsible for:

- Allowing the attendant to use the EVV system to clock in when services begin and clock out when services end.
- Notifying your contracted provider if you are asked by the attendant to clock in or clock out of the EVV system for them.
- Asking questions.

Understand your EVV rights and responsibilities. Ask your contracted provider your questions about EVV.

CDS Employer Role & Responsibilities

A CDS employer is an Aetna member who has elected to participate in the Consumer Directed Services waiver option or their Legally Authorized Representative (LAR) of a member who has selected the CDS option.

The role of the CDS employer is to follow all EVV:

- Policies.
- Processes.
- Requirements

The CDS Employer is responsible for:

- Ensuring the attendant uses the EVV system to clock in when services begin and clock out when services end.
- Completing all required EVV visit maintenance.
- Meeting all EVV requirements.
- Signing up for EVV notices through GovDelivery on the State's website.
- Understanding all of the EVV policies, processes, and requirements.
- Asking questions.

CDS Employers will not use the Data Aggregator

EVV Vendor Role & Responsibilities

The EVV vendor is approved and contracted by HHSC to provide the software system used to collect and transmit EVV visit data to the EVV Aggregator.

The EVV vendor:

- Ensures the HHSC-approved EVV system operates at all times.
- Captures EVV visit data and provides the ability to correct visit data.
- Provides technical support for the EVV system.
- Transmits confirmed EVV visit data to the EVV Aggregator at TMHP.

The EVV vendor is responsible for training provider agency staff, FMSAs, and CDS employers on their EVV system, including how to use devices.

They will:

- Provide all software tools required to use their EVV system.
- Provide small alternative devices (SAD).
- Provide technical support for the EVV system.

Aetna’s Role & Responsibilities

Aetna’s Role is to:

- Provide EVV policies, processes, and procedures training to contracted providers.
- Answer EVV related questions about EVV policies, processes, and procedures.
- Pay, Deny or research EVV claims
- Monitor EVV compliance on a quarterly basis and communicate findings to Providers

Aetna will:

- Train contracted providers, FMSAs, and CDS employers on EVV requirements.
- Answer EVV related questions about EVV policies, processes, and procedures.
- Conduct EVV compliance oversight
- Communicate results of EVV claims matching to providers and troubleshoot discrepancies
- Providers contracted with Aetna will receive an explanation of payment (EOP).

EVV Data Aggregator Role & Responsibilities

The EVV Aggregator is a centralized database that collects, validates, and stores EVV visit data submitted from the EVV system(s).

The EVV Data Aggregator will:

- Validate contracted providers and members eligibility information.
- Accept or reject confirmed EVV visits

The EVV Data Aggregator will:

- Validate contracted providers and members eligibility information.
- Accept or reject confirmed EVV visit transactions and transmit results to EVV vendors.
- Match accepted EVV visit transactions to EVV claims submitted through the Data Aggregator and transmit results to each appropriate payer (Aetna).
- Produce EVV reports.
- Provide technical assistance for the EVV online portal which allows users to :
  - Pull Provider lists & access EVV Reports

21st Century Cures Act
Texas Implementation Jan. 1, 2021

In order for Providers to adhere to this guidance, we must first understand how the newer regulations originated.

The 21st Century Cures Act Section 12006 (Cures Act), is a federal law requiring all states to use Electronic Visit Verification (EVV) for Medicaid personal care services (PCS) and home health services; including services delivered through the Consumer Directed Services (CDS) option and the Service Responsibility Option (SRO).

States must implement EVV or risk a loss of federal Medicaid matching dollars.

- PCS must start by Jan. 1, 2021.
- Home health services must start by Jan. 1, 2023.

HHSC Requests Exemption to Delay EVV Start Date Per Federal Law
Effective Aug. 2, 2019

The 21st Century Cures Act is a federal law that requires all states to use electronic visit verification for Medicaid personal care services by Jan. 1, 2021, and home health care services by Jan 1, 2023.

States must implement EVV or risk a loss of federal Medicaid matching dollars. The Centers for Medicare and Medicaid Services allows states to request a one-year exemption from funding losses.

On Aug. 2, 2019, HHSC requested this exemption for personal care services.

- All implementation activities will continue as planned until further notice.
- CMS should notify HHSC of the outcome of the exemption request within one month.
- HHSC is exploring other options to address implementation concerns if the exemption request is not approved.
- HHSC will communicate a new timeline for EVV personal care services implementation activities once CMS's decision is made.
- Providers currently required to use EVV must continue to use EVV in accordance with state law and HHSC policy.

What is EVV?

EVV (Electronic Visit Verification) replaces paper timesheets for the affected services. It electronically verifies that service visits occur and documents the precise time the service provision begins and ends by attendants rendering services to our members.

EVV is a computer-based system that electronically:

1)Verifies that service visits occur

2)Documents:

- The Member receiving the services
- The Attendant providing those services
- The Location of service delivery
- Date of the service delivery
- Time that the attendant/staff begins and ends service delivery

EVV Visits are required for EVV claim payments.

Changes to EVV Training Policy

Program Providers and Financial Management Service Agencies (FMSAs) must take the following training:

- HHSC-approved EVV vendor training conducted by the EVV vendor
- TMHP EVV Aggregator and EVV Portal training conducted by TMHP
- Aetna offered EVV Policy training

- EVV training is provided in a variety of formats; including, but not limited to:
- Computer-based training
- Instructor-led training
- Webinars

EVV vendor access will not be granted until the EVV vendor training has been completed.

If the current program provider changes EVV vendors, the EVV vendor training must occur prior to using the new HHSC-approved EVV System

Providers can train with either the State or Aetna, however, they are not required to train with each MCO plan separately.

Vendor training is Mandatory as well as TMHP Portal training!

Required EVV Data Elements

Visit Data that is electronically verified by an EVV System includes:

- The Contracted Provider and/or FMSA
- The types of services being rendered
- The members information that is receiving the service
- The Date(s) of Service and the Time of those services
- The location of service delivery
- The individual/attendant that provided the service

Breakdown of Required EVV Data Elements

Visit Data Category	Required Elements to Verify the Visit
The Provider Agency:	• Taxpayer Identification Number (TIN) • National Provider Identifier (NPI) or Atypical Provider Identifier (API) • Texas Provider Identifier (TPI) (only applicable in Fee-For-Service) • Providers Legal name • Provider address, city, zip
Type of Service Rendered:	• Service Authorization Information • HCPCS Code and Modifiers
The Member receiving the service:	• First and Last Name • Medicaid ID • DOB • Address, City & Zip Code • Landline Phone Number (if applicable) • Medicaid Eligibility Start & End • Payer (Aetna) • HHS Contract Number(s) • Payer Plan Code (MCO Service Delivery Area) • EVV Client ID (assigned by EVV vendor)
The Date and Time of the Services:	• Actual Date In & Date Out • Actual Clock In & Clock Out
The Location of Service Delivery:	• GPS Coordinates of clock in and out only (if using mobile method) • Caller ID (Landline) • Token ID (Alternative Device)
The Individual providing the service:	• Employee First and Last Name • Phone Number (if applicable) • EVV Worker ID (assigned by the EVV vendor) • Employee Start Date (start date of employment with provider) • Employee End Date (end date of employment with provider)

EVV Aggregator Validation

The EVV Vendors will use data from the EVV Aggregator to validate the following:

- Provider contract/enrollment information
- Member eligibility
- Member authorization

EVV vendors are required to notify contracted providers/FMSAs when mismatches are identified.

Reminder: The EVV Aggregator is a centralized database that collects, validates, and stores statewide EVV visit data transmitted by an EVV system. Providers should be aware that EVV Aggregator validation and claims EVV visit matching does not guarantee claims reimbursement. Other standard claims review, audits and edits will be considered for claims payment as usual.

Identification Data

Before an attendant can provide an initial service to a member, certain identification data must be in the EVV system for the contracted provider or FMSA:

Some examples of identification data include:

- Contracted Provider/FMSA
  - NPI or API
  - TIN
- Member/CDS employer
  - Medicaid ID
  - Date of Birth
- Attendant
  - Name
  - EVV Worker ID

EVV Visit Data

Along with Identification Data, the following Visit Data is captured by the EVV system:

- **Clock In Time** of the Attendant rendering services
- **Clock Out Time** of the Attendant rendering services
- **Visit Date** of the services

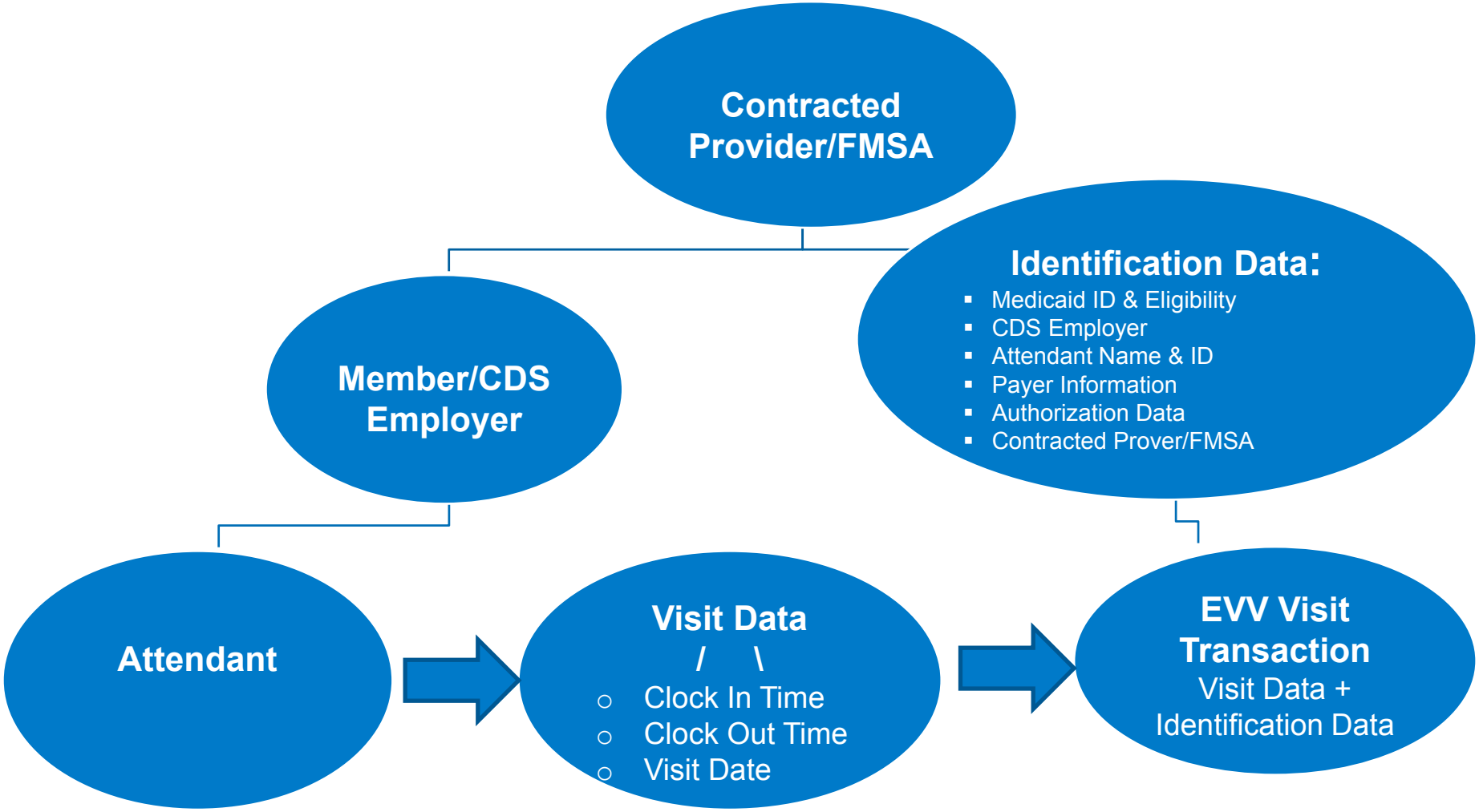
Visit Transactions

- An EVV visit transaction is a complete & verified visit that consists of all the required data elements needed to verify a service delivery visit.

- An EVV visit transaction may also be created manually if an attendant was unable to clock in and/or clock out of the system. This is referred to as a Graphical User Interface (GUI) visit transaction.

- Once the provider agency/CDS employer verifies the data elements associated to a visit transaction are correct, and the EVV vendor system performs required validation edits, the transaction is then exported to the EVV Aggregator.

EVV Visit Transaction Flow Chart



EVV – Clock In/Clock Out Methods

When an attendant provides services to an Aetna member in the home or community, they will use one of the three HHSC approved EVV time recording methods to clock in when service delivery begins and clock out when service delivery ends.

1) Mobile Application – is available by using a free downloadable application on smart device. It captures the location of the clock in/out. No PHI (Personal Health Information) is transmitted. The benefits of using the EVV mobile application include:

- It can be used out in the community.
- It Increases the auto-verification of visits.
- It reduces visit maintenance.
- Allows faster and easier clock in and clock out by the attendant.
- Limits data entry that is required by the attendant.
- And, it only records the location when the attendant clocks in and clocks out. The Mobile Application doesn't track the attendant during the visit.

EVV Mobile Application Policy

Effective April 1, 2019, the **EVV mobile application** is a standard option for clocking in and clocking out of the EVV vendor systems for service providers and their attendants.

The EVV mobile application records the following:

- The location of the clock in and clock out
- The date of the visit
- The precise clock in and clock out time of the visit

HHSC-approved EVV vendors provide a mobile application for clocking in and out of the EVV system that must comply with the following:

- Only records the location when the attendant clocks in and clocks out
- Cannot track the location before, during, and after the visit
- Cannot use minutes from the user's cellular plan*
- Cannot store Protected Health Information (PHI)

*Aetna Better Health of Texas eligible members can get Lifeline cell service PLUS an Android™ Smartphone at NO COST! Visit our website for more information!

https://www.aetnabetterhealth.com/texas/members/cell

EVV Mobile Application Policy cont'd

EVV Mobile Application Policy Clock In and Clock Out Requirements

- The attendant uses the EVV mobile application to clock in before starting authorized services in the home or community & to clock out once the authorized services are completed in the home or community.
- The mobile device must be operational to use the mobile application. Failure to keep the mobile device operational will result in the attendant not being able to clock in and clock out. Not clocking in or clocking out of the EVV system is a failure to use the EVV system.

User Requirements

- The EVV mobile application may be used by the attendant if they live in the same home or apartment complex as the member.
- An attendant must not use the member's mobile device to access the mobile application.
- Users must not share login credentials used to access the mobile application.

EVV Mobile Application Policy specifics

Mobile Device Specifications

- Device must use the Apple iOS or Android operating system.
- Device must not be rooted or jailbroken.
  - Rooting is the process of getting around Android's security architecture and gaining access to the Android operating system code.
  - Jailbreaking is the process of removing the limitations put in place by a device's manufacturer.

Please contact the EVV vendor for a full list of mobile device specifications.

EVV Mobile Application User Liability

- HHSC, TMHP, EVV vendors as well as Aetna will not liable for:
- Any cost incurred while using the EVV mobile application
- Any viruses on the device
- A hacked, broken, damaged, lost, or stolen device
- A non-working device

EVV – Clock In/Clock Out Methods cont'd

Alternative Device – is an HHSC approved device provided by the EVV vendor.

- It's provided at no cost to the contract provider or CDS employer
- It must remain in the members home continuously.
- The device generates visible codes that indicate the clock in/out time of the EVV system.
- The codes must be entered into the EVV system within 7 days from the date of the visit.

Member's Home Phone Landline – a member may permit an attendant to use their home landline to clock in/out of the EVV system.

- The landline must be located in the primary residence,
- The member may allow the attendant to access a toll free number of the EVV Vendor, to clock in/out.

Allowable Phone Types

Allowable Phone Types

- Wired phone connected to a phone jack in the wall

- Cable internet provider; such as but not limited to: o AT&T
  - Comcast
  - Grande
  - Spectrum (Time Warner)

- Non-Fixed Voice over Internet Protocol (VoIP) that are portable alternative phone services that use VoIP; such as but not limited to:
  - MagicJack
  - Vonage
- Fixed VoIP

Unallowable Phone Types

Mobile phone carrier; such as but not limited to:

- AT&T
- Boost Mobile
- Cricket Wireless
- Metro PCS
- Sprint
- Straight Talk
- Spectrum (Time Warner)
- T-Mobile
- Verizon
- Virgin Mobile

Cellular-enabled device or tablet; such as but not limited to:

- iPad Tablet
- Galaxy Tablet
- Smart Watch

Clocking In & Out cont'd

A visit record is created with the clock in and clock out time. Once the visit record has been completed, verified, and confirmed the following data is used to create an EVV visit transaction:

- Contract Provider identification data
- CDS employer identification data
- Member identification data
- Attendant identification data
- EVV visit data

Please Note!

Cell phones are not allowed to be used in place of a home phone landline, unless you are a CDS employer*. If a home landline is not available, the provider agency will have to select either an alternative device or mobile method be used for that member.

*CDS employers are allowed to let their attendants use the CDS employer's cell phone for clocking in and clocking out of the EVV system.

EVV Visit Maintenance

Certain EVV visit data must be corrected to accurately reflect the delivery of service. This process is referred to as “completing visit maintenance.”

EVV visit maintenance allows designated staff of a contracted provider and the CDS employer to edit certain data element(s) of an EVV visit:

- If the EVV vendor system cannot auto-verify an EVV visit transaction? An exception is generated for each part of the visit that could not be auto-verified.
- Exceptions are indicated in the EVV vendor system.
- For a single visit, there may be more than one exception generated.
- Visit maintenance must then be performed.

- Contracted providers/CDS employers must select the most appropriate reason codes and enter any required free text to explain and clear each exception before confirming the visit.

EVV Visit Maintenance Exceptions

Examples of visit exceptions include, but are not limited to when an attendant:

- Fails to clock in or clock out
- Works more or less hours than scheduled
- Delivers services outside the home and does not use the mobile application method to clock in and clock out
- Calls from a phone number not registered in the EVV system
- Makes multiple or incomplete calls

Exceptions are indicated in the EVV system. Correcting exceptions is similar to correcting an attendant's paper time sheet.

- For a single visit, there may be more than one exception generated.
- Contracted providers must select the *most appropriate* reason code(s) and enter any required free text in the comment field in order to explain and clear each exception before confirming the visit.

EVV Visit Maintenance Exceptions cont'd

Certain elements cannot be changed during the Visit Maintenance process. Those are called '**Fixed Data Elements**'.

Fixed Data elements that are not allowed to be changed include:

- Actual time in
- Actual time out
- Actual hours
- Actual visit date

Also, Reason Codes cannot be removed. A **new reason code can be added**, but not removed.

EVV Visit Maintenance Unlocking

Providers have 60 days from the date of the visit(s) to perform visit maintenance in the EVV vendor system. If the 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

The visit record is locked after 60 days and cannot be unlocked and edited without Aetna approval. The **EVV Visit Maintenance Unlock Policy requires a** State approved Excel form be requested from the respective payer by the Provider. Providers should send a request to unlock visit maintenance to: **EVVMailbox@Aetna.com**

Approvals and denials to open visit maintenance are at the Aetna's discretion and are determined on a case-by-case basis. Requests are processed in the order they are received and may take up to two weeks to complete. There are no expedited requests. The contracted provider must indicate which visits they wish to correct and why the unlock is being requested.

Making corrections in the EVV system after 60 days will not change billing guideline requirements or any type of contract action. The following are reasons for automatic denials to open visit maintenance:

- Requests containing private health information sent insecurely via email
- The secure email is missing the required subject line "Unlocking Visit Maintenance Request"
- Spreadsheet fields that are incomplete or missing data
- Spreadsheet contains inaccurate information

EVV Visit Maintenance Requirements Cont'd

The contracted provider or CDS employer/FMSA must complete visit maintenance prior to submitting a claim associated with the EVV visit.

Claims are subject to denial if they are submitted **before** all required visit maintenance has been completed in the EVV system and received by the EVV Data Aggregator

EVV Visit Maintenance Exceptions

Examples of visit exceptions include, but are not limited to when an attendant:

- Fails to clock in or clock out.
- Works more or less hours than scheduled.
- Delivers service outside the home and does not use the EVV mobile application to clock in and clock out.
- Calls from a phone number not registered in the EVV system.
- Makes multiple or incomplete calls.
- Exceptions are indicated in the EVV vendor system.

EVV Reason Codes

An EVV reason code is a standardized HHSC-approved three-digit number and description that is used during visit maintenance to explain the specific reason a change was made to an EVV visit record.

- Contracted providers and CDS employers must use the **most appropriate** EVV reason code(s) when clearing each exception generated by the EVV system. Certain EVV reason codes require the user to enter free text such as the actual clock in and clock out time.

- Once a reason code is saved to a visit, it cannot be deleted.

- Some EVV reason codes require the user to enter **free text**, such as the actual clock in and clock out time. However each EVV reason code allows free text to be entered in the comments section of a visit. The EVV reason code and required free text policy requires program providers to select the most appropriate EVV reason code number(s) and description option and enter any free text when performing visit maintenance in the EVV System.
  - Failure to enter required free text could result in recoupment of the visit.
  - Several EVV reason codes require specific free text
  - Free text requirements are listed in bold on the HHSC Reason Code List

Misuse of EVV Reason Codes

Aetna Better Health of TX will periodically monitor and review EVV reason codes to ensure:

- The EVV reason code(s) has not been misused
- The required and correct free text has been entered

If determined that the contracted provider or CDS employer has misused EVV reason code(s), Aetna may take one of the following actions:

- Require additional training;
- Be placed on a corrective action plan;
- Imposition of contract actions; and/or
- Referral to the Inspector General's Office for fraud, waste, or abuse.

Misuse of EVV Reason Codes

Program providers must select the most appropriate EVV Reason Code number(s) and reason code description (A,B,C etc.) to explain why the EVV System could not electronically verify the service delivery visit.

Providers must select the EVV non-preferred reason code and most appropriate reason code description option when attendants fail to use the EVV System to clock in/clock out.

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 a misuse of reason codes. If this occurs, the program provider must document the situation that caused the use of the same reason code number and description option.

Reason codes are required in the EVV system to clear visit exceptions, however Program providers will not be assessed for misuse of reason codes for visits with dates spanning between September 1, 2019 through August 31, 2020.

During this **Grace Period**, program providers will be required to:

Use the EVV system

Complete visit maintenance before billing

Train/re-train their staff on using the most appropriate reason code/descriptions

Review the EVV Reason Code Usage and Free Text Report and become familiar with the data.

Current Reason Codes prior to September 1, 2019

- **100 - Schedule Variation -** RC 100 is selected when the attendant or assigned staff provides more or fewer hours of service than scheduled or provides services at a different time of day than scheduled, as requested by the individual/member. All situations that require documentation must be documented according to program policy.
  - This reason code cannot be used when an attendant or assigned staff fails to clock in and/or clock out, unless the appropriate non-preferred reason code (RC 900, 905 or 910) is also saved to visit. Misuse of this preferred reason code may result in contract action(s). This is a preferred reason code. -Preferred Variation
- **105 -Services Provided Outside the Home** – Supported By Service Plan - RC 105 is selected when the attendant or assigned staff cannot call in and/or call out because some or all of the scheduled services were provided outside of the home in accordance with program policy. This is a preferred reason code.- Preferred Variation
- **110- Fill-in for Regular Attendant or Assigned Staff-** RC 110 is selected when someone other than the scheduled attendant or assigned staff provides services. This is a preferred reason code. -Preferred Variation
- **115 -Individual/Member Agreed or Requested Attendant or Assigned Staff Not Work Schedule** -RC 115 is selected when the attendant or assigned staff does not work and the individual/member was contacted and agreed, or the individual/member contacted the agency and requested the attendant or assigned staff not work. All situations that require documentation must be documented according to program policy. This is a preferred reason code. -Preferred Variation
- **120 -Invalid Attendant or Assigned Staff or Individual/Member ID Entered –** Verified Services Were Delivered- RC 120 is selected when an attendant or assigned staff does not accurately or completely enter his/her employee ID and/or the individual's/member's EVV ID into the EVV system. This is a preferred reason code.- Preferred Variation
- **121- Attendant or Assigned Staff - No Call and No Show (NEW) -**RC 121 is selected when there is a planned schedule entered in the EVV system and the attendant or assigned staff failed to report to work and did not inform the provider agency until after the missed scheduled visit. All situations that require documentation must be documented according to program policy. This is a preferred reason code.- Preferred Variation
- **125 -Multiple Calls For One Visit -**RC 125 is selected when an attendant or assigned staff makes multiple calls for a single scheduled visit. RC 125 is not used if technical issues with the phone prevent the attendant or assigned staff from calling in. RC 300 should be used for technical problems with the phone. This is a preferred reason code. -Preferred Variation

Current Reason Codes cont'd

- **130 -Disaster or Emergency -**RC 130 is selected when an attendant or assigned staff is unable to provide all or part of the scheduled services to an individual/member due to a disaster (e.g., flood, tornado, ice storm, fire, etc.) or other emergency (e.g., EMS must be called). Free text is required in the comment field; the provider must document the nature of the disaster or emergency and the actual time service delivery begins and/or ends in the comment field. This is a preferred reason code.-Preferred Variation
- **135 -Confirm Visits with No Schedule (NEW) -**RC 135 is selected when the attendant or assigned staff provides services, as requested by the individual/member, but there was no schedule in the EVV system. All situations that require documentation must be documented according to program policy. This is a preferred reason code.-Preferred Variation
- **200 -Small Alternative Device Has Been Ordered –** (Initial or Replacement Order) -RC 200 is selected when a small alternative device has been ordered, but the provider has not yet received the device. Misuse of this preferred reason code may result in contract action(s). This is a preferred reason code. -Small Alternative Device
- **205 -Small Alternative Device Pending Installation -**RC 205 is selected when a small alternative device has been received by the provider, but the provider has not yet installed the device in the individual's/member's home. Use of RC 205 for the same individual/member over a period greater than 14 calendar days may constitute misuse of this preferred reason code. This is a preferred reason code. -Small Alternative Device
- **210 -Missing Small Alternative Device -**RC 210 is selected when the small alternative device cannot be located in the individual's/member's home. If the small alternative device is not located within 14 calendar days, the provider agency must request a replacement. This is a preferred reason code. -Small Alternative Device
- **215 -Reversal of Call In/Out Times (New) -**RC 215 is selected when an attendant or assigned staff reverses a call in for a call out or a call out for a call in. This is preferred reason code. -Small Alternative Device (or landline)

Current Reason Codes cont'd

- **300 -Phone Lines Not Working –** Attendant or Assigned Staff Not Able to Call – Verified Services Were Delivered -RC 300 is selected when call in or call out is not possible due to technical problems with landline phone (e.g., individual's/member's phone not working, phone line is disconnected or EVV vendor system issues). Continuous vendor system issues must be reported to your EVV vendor. Please notify Aetna within 48 hours of unresolved vendor system issues. This is a preferred reason code. -Technical Issue
- **305 -Malfunctioning Small Alternative Device or Invalid Small Alternative Device Value –** Verified Services Were Delivered -RC 305 is selected when a small alternative device malfunctions or provides invalid values. Free text is required in the comment field; the provider must document the actual time service delivery begins and/or ends. If the EVV system is missing the start or end time of a visit, the provider must document the missing time in the Free Text. If RC 305 is used for the same individual/member over a period greater than 14 calendar days, a replacement small alternative device should be ordered. This is a preferred reason code. -Technical Issue
- **310 -Malfunctioning Mobile Application -**RC 310 is selected when the EVV mobile application malfunctions and prevents an attendant or assigned staff from documenting the time service delivery begins and/or ends in the EVV system. Free text is required in the comment field; the provider must document the nature of the problem with the mobile application AND the actual time service delivery begins and/or ends in the comment field. This is a preferred reason code. -Technical Issue
- **400 -Individual/Member Does Not Have Home Phone –** Verified Services Were Delivered -RC 400 is selected when an individual/member does not have a home landline phone and requires the use of a small alternative device, but one has not yet been requested by the individual/member. Provider has 14 calendar days to submit a completed Medicaid EVV Small Alternative Device Agreement and Order form to the EVV vendor after learning an individual/member requires a small alternative device. Use of RC 400 for the same individual/member over a period greater than 14 calendar days may constitute misuse of this preferred reason code. This is a preferred reason code. -Phone Not Accessible
- **405 -Phone Unavailable – Verified Services Were Delivered -**RC 405 is selected when the attendant or assigned staff cannot use the phone to call-in and/or call-out because the phone is in use when the service provision begins or ends (e.g., the individual/member is on the phone with his/her doctor) Use of RC 405 for the same individual/member over a period greater than 14 calendar days may constitute misuse of this preferred reason code. If this becomes a routine issue, a small alternative device should be ordered. This is a preferred reason code. -Phone Not Accessible

Current Reason Codes cont'd

- **405 -Phone Unavailable –** Verified Services Were Delivered -RC 405 is selected when the attendant or assigned staff cannot use the phone to call-in and/or call-out because the phone is in use when the service provision begins or ends (e.g., the individual/member is on the phone with his/her doctor) Use of RC 405 for the same individual/member over a period greater than 14 calendar days may constitute misuse of this preferred reason code. If this becomes a routine issue, a small alternative device should be ordered. This is a preferred reason code. -Phone Not Accessible
- **410 -Individual/Member Refused Attendant or Assigned Staff Use of Phone –** Verified Services Were Delivered -RC 410 is selected when an attendant or assigned staff cannot use the phone to call in or call out of the EVV system because the individual/member refuses to allow the attendant or assigned staff to use the phone in this particular instance (e.g., the individual/member does not trust the fill-in attendant or assigned staff) Use of RC 410 for the same individual/member over a period greater than 14 calendar days may constitute misuse of this preferred reason code. If this becomes a routine issue, a small alternative device should be ordered. This is a preferred reason code. -Phone Not Accessible
- **500 - In-Home Respite Services -**RC 500 is selected when unscheduled in-home respite services are provided. This is a preferred reason code. -Special Service Situation
- **505 -Consumer Directed Services (CDS) Employer Time Correction -**RC 505 is ONLY selected by individuals/members self-directing their services using the CDS option who need to correct an EVV entry. This reason code should only be used by CDS employers or Financial Management Services Agencies (FMSAs). This is a preferred reason code.-Special Service Situation
- **600 -Service Suspension -**RC 600 is selected when the provider has suspended the individual's/member's services per program policy (e.g., the individual/member is in the hospital or temporarily in a nursing facility). All situations that require documentation must be documented according to program policy. This is a preferred reason code. -Suspension/ Reinstatement

Current Reason Codes cont'd

- **700 -Downward Adjustment to Billed Hours -**RC 700 is selected when the time billed is adjusted downward to offset rounding. The EVV system applies rounding rules to the total actual hours for each visit. Each visit is rounded to the nearest quarter hour (0, 15, 30 or 45 minutes past the hour) based on the total actual hours. As a result of the rounding rules, providers must sometimes round hours down, causing an exception that must be cleared. MCO-Contracted provider agencies should contact their contracted MCOs for detailed information regarding MCO rounding policy. Misuse of this preferred reason code may result in contract action(s). Free text is not required. This is a preferred reason code.- Billing
- **900 -Attendant or Assigned Staff Failed to Call In – Verified Services Were Delivered** -RC 900 is selected when an attendant or assigned staff fails to use the EVV system to call in. Free text is required in the comment field to document the actual "call in" time. This is a NON-preferred reason code. -NON-Preferred
- **905 -Attendant or Assigned Staff Failed to Call Out – Verified Services Were Delivered** -RC 905 is selected when an attendant or assigned staff fails to use the EVV system to call out. Free text is required in the comment field to document the actual "call out" time. This is a NON-preferred reason code. -NON-Preferred
- **910 -Attendant or Assigned Staff Failed to Call In and Out – Verified Services Were Delivered -**RC 910 is selected when an attendant or assigned staff fails to use the EVV system to call in and call out (e.g., the attendant or assigned staff fails to call in and call out on the individual's/member's home landline, or the attendant or assigned staff fails to enter the small alternative device values in the EVV system). Free text is required in the Comment field; the provider must record the actual time service delivery begins and ends in the Comment field. This is a NON-preferred reason code.- NON-Preferred
- **915 -Wrong Phone Number – Verified Services Were Delivered -**RC 915 is selected when calls for a visit are received from a number that is not recognized by the EVV system. This is a NON-preferred reason code. -NON-Preferred
- **999 –Other -**RC 999 is selected when a provider must address an EVV system exception that cannot be addressed using any of the other reason codes. Free text is required in the comment field explaining why use of this code was required. This is a NON-preferred reason code. -NON-Preferred

The current EVV reason codes will be revised effective Sept 1, 2019.

HHSC EVV Reason Codes – Effective September 1, 2019

Reason Code	Number	Reason Code Description
Overnight Visit (If applicable)	000	This reason code is a system-generated reason code used by the EVV vendor when the EVV system auto-generates a clock out at 11:59 pm and a clock in at 12:00 am for overnight visits. This reason code is not available for program provider use.
Service Variation	100	The program provider will select this reason code and the appropriate reason code description when acceptable service variations occur. A - Staff hours worked differ from schedule B - Downward adjustment of pay hours C - Authorized services provided outside of home D - Fill-in for regular attendant E - Member agreed or requested staff not work F - Attendant failed to show up for work G - Confirm visits with no schedule H - Overlap visits I - Split schedules J - In-home respite: used when an in-home respite visit occurs and there is no schedule in the EVV system Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system.

HHSC EVV Reason Codes – Effective September 1, 2019

Reason Code	Number	Reason Code Description
Disaster	130	The program provider will select this reason code and the appropriate reason code description when all or part of the scheduled services were unable to be delivered due to a natural disaster. A - Flood B - Hurricane C - Ice/snow storm D – Tornado E – Wildfire Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system.
Emergency	131	The program provider will select this reason code when all or part of the scheduled services were unable to be delivered due to an emergency with the member. Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system.
Alternative Device	200	The program provider will select this reason code and the appropriate reason code description when an assigned alternative device could not be used to clock in and/or clock out. A - Alt device ordered B - Alt device pending placement C - Alt device missing Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system.

HHSC EVV Reason Codes – Effective September 1, 2019

Reason Code	Number	Reason Code Description
Mobile Device	201	The program provider will select this reason code and the appropriate reason code description when an assigned mobile device could not be used to clock in and/or clock out. A - Mobile device ordered B - Mobile device pending placement C - Mobile device missing Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system.
Technical Issues	300	The program provider will select this reason code and the appropriate reason code description when technical issues prevented staff from clocking in and/or clocking out of the EVV system. A - Phone lines not working B - Malfunctioning alternative device C - Incorrect alternative device value D - Incorrect employee ID entered E - Incorrect member EVV ID entered F - Malfunctioning mobile device/application G - Multiple calls for one visit H - Reversal of call in/out time Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system.

HHSC EVV Reason Codes – Effective September 1, 2019

Reason Code	Number	Reason Code Description
Landline Not Accessible	400	The program provider will select this reason code and the appropriate reason code description when the member's home landline phone was not accessible, which prevented staff from clocking in and/or clocking out of the EVV system. A - Member does not have home phone B - Member phone unavailable C - Member refused staff use of phone Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system.
Service Suspension	500	The program provider will select this reason code when the member's services are suspended.
Other	600	The program provider will select this reason code when an EVV system exception cannot be addressed using any other reason codes and reason code descriptions. Free text is required: The program provider must document why use of this reason code was required and document any missing actual clock in or clock out time not electronically captured by the EVV system.

HHSC EVV Reason Codes – Effective September 1, 2019

Reason Code	Number	Reason Code Description
Non-Preferred	900	The program provider will select this reason code and the appropriate reason code description when staff failed to clock in and/or clock out of the EVV system. A - Failure to call in B - Failure to call out C - Failure to call in and out D - Wrong phone number Free text is required: The program provider must document any missing actual clock in or clock out time not electronically captured by the EVV system.

EVV Reason Codes Effective Sept. 1, 2019 cont'd

EVV Reason Code Free Text Requirements

Free text is required for ANY missing (applies to all reason codes):

- 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.

When the EVV system cannot electronically capture the actual clock in or clock out time, the program provider must verify actual time worked and document any missing actual clock in or clock out time in the free text field.

Examples of required free text:

- "Actual clock in was 8:05 am" or "8:05 am"
- "Actual clock out was 1 pm" or "1 pm"
- "Actual clock in was 10 am, and actual clock out was at 4 pm" or "10 am-4 pm"

Free text is also required whenever the following reason codes are used:

- **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.

Compliance

Failure to document any required free text may result in enforcement actions; including recoupment of associated claim(s).

Refer to the EVV Compliance Oversight Reviews policy for additional information.

EVV Provider Compliance

Electronic Visit Verification (EVV) Compliance Oversight Reviews

State mandated EVV Compliance Oversight reviews and monitors program providers use of an EVV vendor to electronically document authorized service delivery visits. Aetna Better Health of TX Compliance department is required to periodically monitor and report EVV provider usage and appropriate use of reason codes.

- Aetna program providers will be reviewed on a regular basis to ensure they are following EVV policies in the following areas:
  - **EVV Usage (NEW)**
    - Program providers will be reviewed for manually entered visits and rejected visit transactions.
  - **EVV Reason Codes and Required Free Text (REVISED)**
    - Program providers will be reviewed for use of most appropriate reason codes and required free text.
  - **EVV Allowable Phone Identification (EXISTING)**
    - Program providers will be reviewed for landline numbers used to clock in and out.

EVV Provider Compliance Review Changes

Aetna Better Health EVV Compliance Policy will align with the State guidance posted March 21, 2019 by HHSC's EVV Resources page: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification

Effective September 1, 2019, the HHSC Electronic Visit Verification (EVV) provider compliance review period will change for all contracted providers currently required to use EVV.

- The EVV Provider Compliance review schedule will align with the state's fiscal quarters beginning with visits on or after September 1, 2019. The new EVV Compliance review quarters are:
  - Quarter 1 = September/October/November
  - Quarter 2 = December/January/February
  - Quarter 3 = March/April/May
  - Quarter 4 = June/July/August

All other EVV Provider Compliance requirements remain the same.

EVV Compliance Requirements cont'd

EVV USAGE REVIEWS (NEW)

Effective for visits on or after **September 1, 2019**, the EVV Usage Review will monitor:

- Graphical User Interface (GUI) EVV visit transactions; and
- Rejected EVV visit transactions.
  - A **GUI visit transaction** is a manually entered visit into the EVV system.
  - A **Rejected EVV visit transaction** is an EVV visit transaction submitted to the EVV Aggregator from an EVV Vendor that is not accepted because it does not pass visit validation edits.

Compliance Standard

All program providers must achieve and maintain a minimum EVV Usage score of eighty percent (80%) per quarter; unless otherwise notified by HHSC. This score applies for both HHSC Fee for Service and MCOs programs.

Grace Period

Program providers currently required to use EVV will receive a grace period for visits between September 1, 2019 through August 31, 2020.

- The grace period is a time for program providers to:
  - Train/re-train their staff on how to use the EVV system.
  - Pull the *EVV Usage Report* and become acclimated to the data.
-

What is the EVV Aggregator & its Purpose?

The EVV Aggregator is a centralized database that collects, validates, and stores statewide EVV visit data transmitted by an EVV system effective Sept.1, 2019.

The Texas Medicaid & Healthcare Partnership (TMHP), the Texas Medicaid claims administrator, is responsible for operating and maintaining the EVV Aggregator and EVV Portal.

The EVV Aggregator:

- Provides validated provider contract(s) or enrollment data to the EVV vendors.
- Accepts or rejects confirmed EVV visit transactions using standardized validation edits and returns these results to the EVV vendors.
- Stores all accepted and rejected EVV visit transactions.
- Matches EVV claim line items to accepted EVV visit transactions in the EVV Aggregator and sends matching results to Aetna and other payers for EVV claims processing.

How will this improve EVV?

The EVV Aggregator improves data quality with standardized validations against state data. It reduces the need for manual entry, which then decreases data element errors on visit transactions.

- Consistent visit data validation will be performed on all EVV visit transactions.

- EVV claims matching is standardized. The same critical data elements will be used for EVV claims matching for all EVV payers.

- The EVV Aggregator stores accepted and rejected EVV visit transactions from the EVV vendors and allows review of top rejection issues and percent of rejections by EVV vendor and provider.

What is the EVV 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.

Program providers, FMSAs and Aetna health plan are able to search, view, print, and export:

- EVV visit data (accepted and rejected EVV visit transactions).
- EVV visit transaction to EVV claim line items matching results.
- Provider identification data.

Note: CDS employers will not use the EVV Portal. However, they will have access to visit logs and related reports in the EVV vendor system.

Users can:

- View EVV visit transactions ready for billing.
- Access standard EVV reports and run queries on EVV visit data.
- Check the status and identify reasons for rejection of submitted EVV visit transactions.

What is the EVV Portal cont'd

Check the EVV Portal before submitting EVV claims.

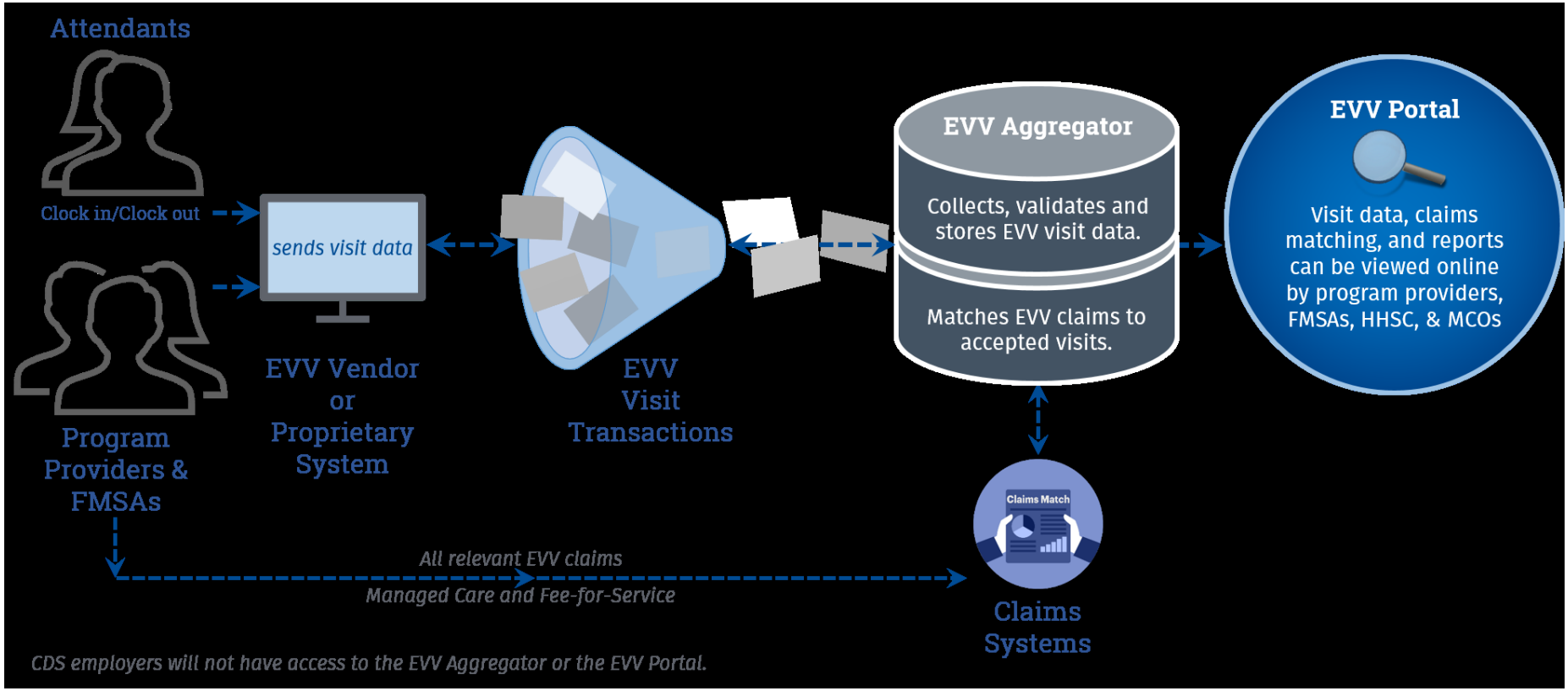
EVV Portal users can view accepted EVV visit transactions that are ready for billing and ensure the EVV visit transactions were accepted prior to submitting EVV claim line items.

When TMHP receives an EVV claim, the EVV claim line items will be matched against the accepted EVV visit transactions.

EVV Portal users can use the "Accepted Visit Search," "History/Rejected Visit Search," and "EVV Claim to Visit Search" tabs to select specific criteria to run searches for:

- Accepted EVV visit transactions.
- Rejected EVV visit transactions.
- History of updates made to EVV visit transactions.
- EVV claims to EVV visit transaction match results.

EVV Systems Overview of the EVV Aggregator



EVV Claims Submission

HHSC will implement a new claims matching process **effective Sept. 1, 2019**, for current program providers required to use EVV.

➢ This is for visits with Date of Service on or after Sept. 1, 2019

Effective Jan. 1, 2021, the claims matching process will begin for new program providers and FMSAs required to use EVV. This is for visits with Date of Service on or after Jan. 1, 2021

Claims for Aetna Better Health of TX EVV services will be submitted to **TMHP** through TexMedConnect or through Electronic Data Interchange (EDI) using a Compass 21 (C21) Submitter ID.

Program providers and FMSAs that need help setting up C21 or CMS Submitter IDs should contact the TMHP EDI Help Desk at 1-888-863-3638, Option 4

- When an EVV claim is received by TMHP, the EVV claim line items will be matched against the accepted EVV visit transactions, previously sent by the EVV vendor systems.
- Once the matching process has been performed, all EVV claims will be forwarded to Aetna for normal review and consideration for final EVV claims processing.

Please note!

EVV claim line items without matching EVV visit transactions are denied upfront (prepayment review) by Aetna Better Health.

EVV Claims Submission cont'd

EVV claims with dates of service on or after Sept. 1, 2019 submitted directly to Aetna Better Health of Texas will be rejected or denied. Program providers will receive a response from the health plan informing them to submit EVV claims to TMHP.

Aetna Program providers and FMSAs can submit EVV claims with a range of service dates (span dates), or by single date of service.

If a Provider submits span dates, please ensure that:

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

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

- Aetna Program providers and FMSAs can view accepted EVV visits in the EVV Portal before submitting their EVV claims.
- If a Provider submits a span claim that includes Dates of Service before Sept. 1, 2019 to TMHP and after (or on) Sept. 1, 2019 to Aetna, the claim lines with Dates of Service prior to Sept. 1, 2019 will be denied. Claims prior to Dates of Service before 9/1/19, should be submitted to Aetna Better Health directly.
- Aetna Program providers and FMSAs should always check the EVV Portal to ensure the EVV visit has been accepted by the EVV Aggregator before submitting the associated claim.

Claims Filing Instruction Change as of 7/1/19

Effective 7/1/2019, Aetna Better of Health of Texas will require rendering and billing taxonomies on the claims submitted electronically or via paper.

Required Data Element	Paper CMS 1500	Electronic – CMS 1500
Billing Provider Taxonomy	Box 33b with qualifier ZZ	Loop ID – 2000A Segment – PRV03
Rendering Provider Taxonomy	Box 24j - shaded area with qualifier ZZ in 24i	Loop ID – 2310B Segment – PRV03 Loop ID – 2420A Segment – PRV03
Required Data Element	**CMS 1450 (UB-04)**	**Electronic – CMS 1450 (UB-04)**
Billing Provider Taxonomy	Box 81CC with qualifier B3	Loop ID – 2000A Segment – PRV03
Rendering Provider Taxonomy	Not Applicable (n/a)	Not Applicable (n/a)

If these data elements are missing or invalid, claim will be rejected with a remit message of:
N255 – if billing taxonomy is invalid or missing
N288 – if rendering taxonomy is invalid or missing

Claims Filing Instruction Change as of 7/1/19 cont'd

- Provider taxonomy (rendering and billing) will be considered invalid if the submitted taxonomy is not one of the taxonomies with which the provider record is enrolled with Texas Medicaid & Healthcare partnership (TMHP). It is critical that the taxonomy code selected as the primary or secondary taxonomy code during a provider's enrollment with TMHP is included on all electronic and paper transactions.

Note that rejected claims do not count as clean claims; please ensure that claims are submitted within 95 days from the date of service.

- A clean claim must have all the necessary data for the claim processor to adjudicate and accurately report the claim. It must meet all the requirements for accurate and complete data as defined in the appropriate claim type encounter guides.
- For any questions please reach out to Provider Relations at:

Medicaid STAR Kids Tarrant: **1-844-787-5437**

Reminder

Providers must ensure that **all taxonomies used** to bill LTSS services are attested to their NPI through the Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System (NPPES). Additionally, all NPI/taxonomy combinations currently used to bill Medicaid LTSS services must be enrolled through either the Texas Medicaid and Healthcare Partnership (TMHP) via the LTSS Provider Enrollment Process.

- ***The Texas Medicaid enrollment process is a separate and distinct process from contracting and credentialing with an Aetna Better Health of TX. Even if you are currently contracted and credentialed with our plan, your contract will become invalid if you have not completed the Medicaid enrollment process for all NPIs and taxonomies used to bill LTSS services and been approved by either HHSC or TMHP.***

Claims Submission Helpful Hints

The following scenarios impact claim payment delays and/or denials:

- Offices submit claims/bills with different NPI/TPI numbers vs. what is listed on the state's master file causing claim denials.
- Attestation is not updated or completed (please contact TMHP if you receive any correspondence and remember to act immediately).
- Diagnosis/procedure codes do not support modifiers billed-see your manual for additional guidance.
- Provider's address is listed incorrectly in our system resulting in payments being distributed to the incorrect address. Please send any address changes or demographic changes to: **TXProviderEnrollment@aetna.com**.

EVV Claims Matching Process

The EVV Aggregator will match the EVV claim line item with the accepted EVV visit transactions using the following critical data elements:

- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Date of service
- Medicaid ID
- Healthcare Common Procedure Coding System (HCPCS)
- Modifiers, if applicable
- Units

EVV claim line items that are not successfully matched with EVV visit transactions will be denied by Aetna Better Health of TX.

EVV Claim Match Result Codes

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

Program providers and FMSAs will be able to view matching results in the EVV Portal:

- EVV01- EVV Match
- EVV02- Medicaid ID Mismatch
- EVV03- Visit Date Mismatch
- EVV04- Provider Mismatch (National Provider Identifier (NPI) or Atypical Provider Identifier (API) Mismatch)
- EVV05- Service Mismatch (Healthcare Common Procedure Coding System (HCPCS)/Modifier Mismatch)
- EVV06- Units Mismatch
- EVV07- EVV Claims match not performed per State direction.
- EVV08 - EVV Claims match not performed due to a Natural Disaster.

Aetna EVV Updates as of 6/1/19

June Release by HHSC - EVV Transaction Edits

EVV visits with Dates of Service on or after 6/1/19 will be subject to new edits; existing TMHP validation edits will be applied for visits with Dates of Service prior to 6/1/19. Aetna Better Health of TX understands during this transition, we may see fewer accepted visits as providers work to correct rejected transactions.

- Aetna Better Health of TX has opted to receive TMHP EVV validation edit response files allowing EVV Transaction data to be more accurate due to vendor updates.

Please note: All EVV transactions with dates of service on or after 9/1/2019 will be validated by TMHP and subject to the new validation edits as part of the centralized matching process.

EVV Portal Effective 9/1/19 & EVV Reports

Program providers, FMSAs, Aetna Better Health of TX will have access to standard EVV reports in the EVV Portal for dates of service on or after September 1, 2019.

- EVV standard reports only include EVV visit transactions accepted by the EVV Aggregator and be considered the source of truth and used for contract monitoring, recoupments, and enforcement purposes.
  - Can be used to conduct contracting and billing audits.
  - EVV compliance monitoring.
  - Medicaid fraud investigations.
  - Texas Medicaid data analysis.
- Current program providers using the DataLogic vendor system will continue to pull EVV standard reports for dates of service prior to September 1, 2019, from DataLogic's Vesta EVV system.
- The EVV Portal will only display visits with dates of service on or after September 1, 2019.

Please note!

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

EVV Portal Standard Reports

The EVV Portal will include the following standard reports available for access by Aetna Providers:

- EVV Visit Log
- Units of Service Summary (FFS only)
- EVV Usage Report
- EVV Reason Code Usage and Free Text

The list of HHSC approved EVV standard reports is subject to change. Providers may access HHSC's resource link on slide 71 for additional information and detail of the EVV Standard Reports that are available.

New EVV Validation Process by HHSC

EVV Visit Transaction Validation Enhancements affect program providers required to use EVV.

On June 1, 2019, the Health and Human Services Commission (HHSC) will implement a visit validation process to standardize and improve accuracy of EVV visits and reduce data corrections by program providers.

- The visit validation process will help program providers prepare for the new claims matching process that will begin Sept. 1, 2019, by ensuring visit data is complete, correct and accepted by the EVV Aggregator.

- EVV visit transactions with a date of service on or after June 1, 2019 with incomplete or incorrect visit data will be rejected at the EVV Aggregator. This process does impact Aetna STAR Kids Providers who submit EVV claims.

EVV Billing Recap & Best practices

- Aetna providers should use the period between June 1, 2019 and August 31, 2019 to clean up relevant data in the DataLogic EVV system
- Get prepared for the new claims matching process effective **Sept. 1, 2019**
- An accepted EVV visit transaction is required for the new claim matching process.
- Without an accepted EVV visit transaction in the EVV Aggregator, EVV claims will be denied
- EVV relevant claims are subject to the matching process to confirm that a service visit occurred prior to the payment of a claim.
- Both claims submitted with a single date of service and claims submitted with a span of service dates will be permitted.

Please Note!

Aetna Better Health of Texas will allow span dates for billing EVV services. If our Program providers submit span dates for billing EVV services, the following criteria must be met for the EVV matching process:

- Each date within the span of dates must have one or more associated EVV visit(s) and;
- The total units on the claim must match the combined total units of the matched EVV visits for the span dates.

EVV Billing Recap & Best practices cont'd

- If a date within the span does not have an associated EVV visit, the claim will deny for no EVV match.
- If the total units of the matched EVV visits for the date span does not match the units billed on the claim, the claim will deny.
- Claims submitted without a matching EVV visit transaction for the specified date(s) of service will be denied.
- Aetna Better Health of Texas, as a prepayment claims reviewer, does not pay EVV claims without any matching EVV transaction
- Become familiar with the EVV system and operations
- Set a date prior to the 60 day deadline to complete any required visit maintenance.

For additional details about this new process, please visit our website at: https://www.aetnabetterhealth.com/texas/providers/info/evv

Program providers and FMSA's may also access State mandated guidance regarding this new process at: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/21st-century-cures-act

EVV Codes Billing Matrix – STAR Kids New Matrix link

https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-service-bill-codes-table.pdf

Then click on: EVV Service Bill Codes Table – August 2019 PDF

EVV Codes Billing Matrix – STAR Kids New Matrix link below

https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-service-bill-codes-table.pdf

Then click on: EVV Service Bill Codes Table – August 2019 PDF

Service	Procedure Code Qualifier	HCPC Codes	CPT4 Codes	Rev Codes	Mod 1	Mod 2	Mod 3	Mod 4	Units	Service Description	Effective Date
State Plan Services											
CCP- Community First Choice for Children under 21											
CFC Attendant Care Only (CFC-PCS)											
REQUIRED for EVV	HC	T1019			UD				15 minutes = 1 unit	CFC PCS Attendant care only- Agency Model	November 1, 2016
Optional for EVV	HC	T1019			U1				15 minutes = 1 unit	CFC PCS Attendant care only- Service Responsibility Option Model	November 1, 2016
Optional for EVV	HC	T1019			U3				15 minutes = 1 unit	CFC PCS Attendant care only- Consumer Directed Services Model	November 1, 2016
Attendant Care and Habilitation (CFC- HAB)											
REQUIRED for EVV	HC	T1019			U9				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Agency Model	November 1, 2016
Optional for EVV	HC	T1019			U2				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Service Responsibility Option Model	November 1, 2016
Optional for EVV	HC	T1019			U4				15 minutes = 1 unit	CFC Attendant care and habilitation, HAB- Consumer Directed Services Model	November 1, 2016
Personal Care Services (PCS)											
REQUIRED for EVV	HC	T1019			U6				15 minutes = 1 unit	PCS - Agency Model	November 1, 2016
Optional for EVV	HC	T1019			US				15 minutes = 1 unit	PCS - Service Responsibility Option Model	November 1, 2016
Optional for EVV	HC	T1019			UC				15 minutes = 1 unit	PCS - Consumer Directed Services Model	November 1, 2016
REQUIRED for EVV	HC	T1019			UA	U6			15 minutes = 1 unit	PCS, BH Condition - Agency Model	November 1, 2016
Optional for EVV	HC	T1019			UA	US			15 minutes = 1 unit	PCS, BH COndition - Service Responsibility Option Model	November 1, 2016
Optional for EVV	HC	T1019			UA	UC			15 minutes = 1 unit	PCS, BH Condition - Consumer Directed Services Model	November 1, 2016

EVV Codes Billing Matrix – STAR Kids

Service	Procedure Code Qualifier	HCPC Codes	CPT4 Codes	Rev Codes	Mod 1	Mod 2	Mod 3	Mod 4	Units	Service Description	Effective Date
MDCP Services											
In Home Respite											
REQUIRED for EVV	HC	H2015			U1				15 minutes= 1 unit	Attendant, Agency Model	November 1, 2016
Optional for EVV	HC	H2015			U1	US			15 minutes= 1 unit	Attendant, Service Reposibility Option	November 1, 2016
Optional for EVV	HC	H2015			U1	UC			15 minutes= 1 unit	Attendant, CDS Option	November 1, 2016
REQUIRED for EVV	HC	H2015			U1	UA			15 minutes= 1 unit	Attendant with RN delegation, Agency Model	November 1, 2016
Optional for EVV	HC	H2015			U1	UA	US		15 minutes= 1 unit	Attendant with RN delegation, Service Reposibility Option	November 1, 2016
Optional for EVV	HC	H2015			U1	UA	UC		15 minutes= 1 unit	Attendant with RN delegation, CDS Option	November 1, 2016
Not required for EVV	HC	H2015			U3				15 minutes= 1 unit	LVN, Agency Model	November 1, 2016
Not required for EVV	HC	H2015			U3	US			15 minutes= 1 unit	LVN, Service Reponsibility Option	November 1, 2016
Not required for EVV	HC	H2015			U3	UC			15 minutes= 1 unit	LVN, CDS Option	November 1, 2016
Not required for EVV	HC	H2015			U3	UA			15 minutes= 1 unit	Specialized LVN, Agency Model	November 1, 2016
Not required for EVV	HC	H2015			U3	UA	US		15 minutes= 1 unit	Specialized LVN, Service Reposibility Option	November 1, 2016
Not required for EVV	HC	H2015			U3	UA	UC		15 minutes= 1 unit	Specialized LVN, CDS Option	November 1, 2016
Not required for EVV	HC	H2015			U5				15 minutes= 1 unit	RN, Agency Model	November 1, 2016
Not required for EVV	HC	H2015			U5	US			15 minutes= 1 unit	RN, Service Reponsibility Option	November 1, 2016
Not required for EVV	HC	H2015			U5	UC			15 minutes= 1 unit	RN, CDS Option	November 1, 2016
Not required for EVV	HC	H2015			U5	UA			15 minutes= 1 unit	Specialized RN, Agency Model	November 1, 2016
Not required for EVV	HC	H2015			U5	UA	US		15 minutes= 1 unit	Specialized RN, Service Reposibility Option	November 1, 2016
Not required for EVV	HC	H2015			U5	UA	UC		15 minutes= 1 unit	Specialized RN, CDS Option	November 1, 2016
Flexible Family Support Services											
REQUIRED for EVV	HC	H2015			99	U1			15 minutes= 1 unit	Attendant, Agency Model	November 1, 2016
Optional for EVV	HC	H2015			99	U1	US		15 minutes= 1 unit	Attendant, Service Reposibility Option	November 1, 2016
Optional for EVV	HC	H2015			99	U1	UC		15 minutes= 1 unit	Attendant, CDS Option	November 1, 2016

EVV Codes Billing Matrix – STAR Kids

Service	Procedure Code Qualifier	HCPC Codes	CPT4 Codes	Rev Codes	Mod 1	Mod 2	Mod 3	Mod 4	Units	Service Description	Effective Date
REQUIRED for EVV	HC	H2015			99	U1	UA		15 minutes= 1 unit	Attendant with RN delegation, Agency Model	November 1, 2016
Optional for EVV	HC	H2015			99	U1	UA	US	15 minutes= 1 unit	Attendant with RN delegation, Service Reposibility Option	November 1, 2016
Optional for EVV	HC	H2015			99	U1	UA	UC	15 minutes= 1 unit	Attendant with RN delegation, CDS Option	November 1, 2016
Not required for EVV	HC	H2015			99	U3			15 minutes= 1 unit	LVN, Agency Model	November 1, 2016
Not required for EVV	HC	H2015			99	U3	US		15 minutes= 1 unit	LVN, Service Reponsibility Option	November 1, 2016
Not required for EVV	HC	H2015			99	U3	UC		15 minutes= 1 unit	LVN, CDS Option	November 1, 2016
Not required for EVV	HC	H2015			99	U3	UA		15 minutes= 1 unit	Specialized LVN, Agency Model	November 1, 2016
Not required for EVV	HC	H2015			99	U3	UA	US	15 minutes= 1 unit	Specialized LVN, Service Reposibility Option	November 1, 2016
Not required for EVV	HC	H2015			99	U3	UA	UC	15 minutes= 1 unit	Specialized LVN, CDS Option	November 1, 2016
Not required for EVV	HC	H2015			99	U5			15 minutes= 1 unit	RN, Agency Model	November 1, 2016
Not required for EVV	HC	H2015			99	U5	US		15 minutes= 1 unit	RN, Service Reponsibility Option	November 1, 2016
Not required for EVV	HC	H2015			99	U5	UC		15 minutes= 1 unit	RN, CDS Option	November 1, 2016
Not required for EVV	HC	H2015			99	U5	UA		15 minutes= 1 unit	Specialized RN, Agency Model	November 1, 2016
Not required for EVV	HC	H2015			99	U5	UA	US	15 minutes= 1 unit	Specialized RN, Service Reposibility Option	November 1, 2016
Not required for EVV	HC	H2015			99	U5	UA	UC	15 minutes= 1 unit	Specialized RN, CDS Option	November 1, 2016

EVV Codes Billing Matrix – STAR Kids

Service	Procedure Code Qualifier	HCPC Codes	CPT4 Codes	Rev Codes	Mod 1	Mod 2	Mod 3	Mod 4	Units	Service Description
CFC-Personal Care Services (PCS), attendant care only for members 20 and younger										
REQUIRED for EVV	HC	T1019			UD				15 minutes = 1 unit	CFC PCS Only- Agency Model
Optional for EVV	HC	T1019			U1				15 minutes = 1 unit	CFC PCS Only- Service Responsibility Option Model
REQUIRED for EVV	HC	T1019			U6				15 minutes = 1 unit	PCS - Agency Model
Optional for EVV	HC	T1019			U3				15 minutes = 1 unit	CFC PCS Only- Consumer Directed Services Model
Habilitation and PCS (HAB) for members 20 and younger										
REQUIRED for EVV	HC	T1019			U9				15 minutes = 1 unit	CFC HAB- Agency Model
Optional for EVV	HC	T1019			U2				15 minutes = 1 unit	CFC HAB- Service Responsibility Option Model
Optional for EVV	HC	T1019			U4				15 minutes = 1 unit	CFC HAB- Consumer Directed Services Model

Checking Claim Status

Our HIPAA compliant web portal is available 24-Hours a day. The portal supports the functions and access to information related to:

- Prior authorization submission and status
- Claim payment status
- Member eligibility status
- Referrals to other registered providers
- Member and provider education and outreach materials

If you're interested in using this secure online tool, you can register on our "For Providers" then "Portal" page at **aetnabetterhealth.com/texas**.

To register for the provider portal contact our Provider Services Department at **1-800-306-8612** (Tarrant) or **1-800-248-7767** (Bexar) to sign up over the phone. Keep in mind that Internet access with a valid email is required for registration.

EVV Claims Denial

EVV claim line items will be denied if:

- Critical data elements do not match the EVV claim.
- The claim is not submitted according to our guidelines regarding span dates.
- A date within the span of dates does not have a matching EVV visit.
- The total units of the matched EVV visit for a date span doesn’t match the units billed on the EVV claim.
- EVV claims can be denied for other valid reasons by Aetna (Example: Prior Authorization, timely filing or eligibility)

These changes will not affect the current formatting of your Explanation of Benefits

Claims Appeals (cont.)

Appeals:

1. Appeals should be sent with the Appeal Form. Clearly defined requests will ensure that appeals are reviewed in the most appropriate way. Please include claim forms, EOB (or copy) , appropriate documentation and *specifically* indicate what services are being appealed.
2. A revised Appeals/Reconsideration form is available on our website: https://www.aetnabetterhealth.com/texas

3. Appeal requests must be received within 120 calendar days from the resolution date on the most recently reviewed claim's EOB.

4. Appeal requests should be mailed to the following address:

Aetna Better Health

Appeals and Correspondence

PO Box 569150

Dallas, TX 75356

Claims Appeals cont'd and Reconsiderations
Medicaid & STAR Kids

Reconsiderations:

Reconsiderations should be sent with *at least* the following info.:

1. Claim form for each reconsideration.
2. EOB (or copy) for each resubmitted claim, with indications of which claim is being resubmitted
3. Any information that was previously requested from the Health Plan.

Reconsiderations requests (other than Coordination of Benefits (COB) related resubmissions) must be received within 120 days of the resolution date on the original (clean) claim's EOB.

1. COB related resubmission:
   - Are identified as claims previously denied for other insurance information, or originally paid as primary without coordination of benefits.

Administrative Appeals

Provider agencies may contact Aetna Better Health for information about their administrative appeal processes.

Claims

- Provider agencies must ensure claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System that has been approved by HHSC.

- Claims are subject to denial or recoupment if they are submitted before all of the required visit maintenance has been completed in the EVV System and if the services are not supported by an EVV transaction.

- Claims that are not supported by the EVV system will be subject to denial or recoupment.

Please Note!

It's the Provider agency's responsibility to ensure all required data elements and visit maintenance is completed prior to billing the claim to the health plan.

‘Standard’ Aetna Better Health Claim Submission

Reminder!

NON-EVV related claims submission processes are not changing and remain the same.

Aetna Better Health encourages participating providers to electronically submit claims through Change Healthcare (formerly Emdeon). You can submit claims by visiting Change Healthcare at https://www.changehealthcare.com/ . Before submitting a claim through your clearinghouse, please ensure that your clearinghouse is compatible with Change Healthcare.

- Please use the following Payer ID when submitting claims to Aetna Better Health:
- Change Healthcare (formerly Emdeon) – Use Payer ID 38692

- If your electronic billing vendor is unable to convert to 38692, you may have them continue to use the Aetna commercial Payer ID 60054. If using this payer ID, we recommend that you use “MC” prior to the member number to make sure the claims are processed correctly.

EVV Visit Maintenance Reconsideration Process

EVV (Electronic Visit Verification)

Purpose: If a provider agency needs to access and conduct visit maintenance for claims reconsideration, provider agencies may submit a request to Aetna regarding the affected individual or member.

The EVV Reconsideration process applies to State approved data element changes to EVV visit(s) outside of the 60 days after the Date of Service. It is at Aetna's discretion to approve or deny the request. All requests are reviewed on a case-by-case basis.

Providers normally 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, a **Visit Maintenance Unlock Request Form** is used to request approval to open visit maintenance from Aetna Better Health of Texas for the visit(s) the provider wishes to correct.

EVV Visit Maintenance Reconsideration Process cont'd

Instructions for requesting the EVV Visit Maintenance Unlock for Reconsideration are below.

The Requestor: Must submit a request in writing **securely** via email to the Aetna Better Health of Texas at: EVVMailbox@Aetna.com

The request must include all required information and supporting documentation listed below. If a request is not sent **securely** or if any required information is missing, the request will not be considered.

Required Information:

- Provider Name
- Payor's Name
- EVV Vendor Name
- HHSC (DADS) Contract Number
- National Provider Identification Number (NPI)
- Tax Identification Number (TIN)
- Individual/member(s) Name
- Individual/member(s) Medicaid ID
- Date access is needed and requested timeframe for access
- What fields are needing changed (i.e. HCPCs, modifiers)

The Requestor should include an explanation of why access to visit maintenance past 60 days is needed. Please include any supporting documentation.

EVV Visit Maintenance Reconsideration cont'd

Timeliness Acknowledgement: Upon receiving the EVV Visit Maintenance Reconsideration request via secure email, Aetna will acknowledge receipt of the request within 48 hours. We will email the State approved **EVV Unlock Visit Maintenance** Excel spreadsheet form to the Provider agency to complete fully. When the EVV Unlock Visit Maintenance form is received by the health plan, please allow 5-7 business days for review and further instruction.

- Aetna will review the case and determine if we are going to unlock visit maintenance. If the request is **approved**, Aetna will reach out to your EVV Vendor and ask to unlock VM setting a specific time limit of how long VM will remain open to make corrections.
- Aetna will generate an approval notification email to alert you that a response should be forwarded by the EVV Vendor regarding the request.
- Your EVV Vendor should outreach to you within 7 calendar days allowing you to conduct visit maintenance on State approved data elements for the time frame that was decided by Aetna.
- Once EVV Visit Maintenance has been completed and an updated transaction file has been received from the EVV Vendor, a Reconsideration claim may be submitted to the EVV Aggregator for claims matching
- If your EVV Unlock Visit Maintenance request is **not approved** after review, Aetna will send an email notification to advise why the request could not be approved.

21st Century Cures Act and EVV News!

HHSC Informational Letter issued May 13, 2019

Information Letter No. 19-10–The 21st Century Cures Act and the Required use of the Electronic Visit Verification System

The information contained in this letter is applicable to program provider agencies, financial management services agencies and employers directing services through the Consumer Directed Services (CDS) option.

The 21st Century Cures Act, a federal requirement, mandates all states use Electronic Visit Verification (EVV) for all Medicaid Personal Care Services (PCS) and home health services or risk a loss of Federal Financial Participation (FFP), also referred to as Medicaid matching dollars. The implementation of EVV for PCS is required by January 1, 2021, and January 1, 2023, for home health services.

Prior to the Cures Act, Texas instituted EVV in certain programs which included state plan PCS programs like Primary Home Care and Community Attendant Services, as well as Community Living Assistance and Support Services (CLASS) waiver in-home respite and residential habilitation services.

With the passage of the Cures Act, Home and Community-based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind with Multiple Disabilities (DBMD) program providers will also be required to use EVV. The Cures Act also extends EVV to the CDS option. Historically under state rules, CDS employers could choose to use EVV, but were not mandated to do so.

21st Century Cures Act & CDS Employers

The following HHSC programs and services are not currently required to use EVV and thus will be impacted by the expansion of EVV. The first phase of the EVV expansion related to PCS will be implemented by January 1, 2021.

Program	Services and Service Delivery Options Requiring Electronic Visit Verification (January 1, 2020)
1915(c) Deaf-Blind with Multiple Disabilities Waiver	Community First Choice (CFC) Personal Assistance Services (PAS)/Habilitation (HAB) and In-Home Respite (Agency and CDS)
1915(c) Home and Community-based Services Waiver	CFC PAS/HAB, In-Home Respite, and Day Habilitation - provided in the home (Agency and CDS)
1915(c) Texas Home Living Waiver	CFC PAS/HAB, In-Home Respite, and Day Habilitation - provided in the home (Agency and CDS)
1915(c) Youth Empowerment Services Waiver	In-Home Respite (Agency)[2]
1915(i) Home and Community Based Services (HCBS) Adult Mental Health	Supported Home Living-Habilitative Support and In-Home Respite (Agency)[2]

21st Century Cures Act & CDS Employers cont'd

Program	Services and Service Delivery Options Requiring Electronic Visit Verification (January 1, 2020)
1915(k) Community First Choice (including STAR Members who receive these services through the traditional Medicaid model)	CFC PAS and CFC HAB (Agency, CDS and the Service Responsibility Option (SRO))
Personal Care Services provided under the Texas Health Steps Comprehensive Care Program (including STAR members who receive these services through traditional Medicaid model)	Personal Care Services (Agency, CDS, and SRO)
STAR Health - MDCP Covered Services	In-Home Respite and Flexible Family Supports (Agency, CDS, and SRO)

21st Century Cures Act and CDS Employers cont'd

The following HHSC programs and services are currently required to use EVV; however, as of January 1, 2020, individuals using the SRO/CDS option must use EVV.

Programs and Services Currently Required to Use EVV		Services and Service Delivery Options Requiring EVV (January 1, 2020)
1915(c) Community Living Assistance and Support Services waiver	CFC PAS/HAB and In-Home Respite (Agency)	CFC PAS/HAB and In-Home Respite (CDS)
Community Attendant Services	PAS (Agency)	PAS (CDS and SRO)
Family Care	PAS (Agency)	PAS (CDS)
Primary Home Care	PAS (Agency)	PAS (CDS and SRO)
STAR Health	CFC PAS, CFC HAB and Personal Care Services (Agency)	CFC PAS, CFC HAB and Personal Care Services (CDS and SRO)

21st Century Cures Act & CDS Employers cont'd

STAR Kids	CFC PAS, CFC HAB and Personal Care Services (Agency)	CFC PAS, CFC HAB and Personal Care Services (CDS and SRO)
STAR Kids - MDCP Covered Services	In-Home Respite and Flexible Family Supports (Agency)	In-Home Respite and Flexible Family Supports (CDS and SRO)
STAR+PLUS	CFC PAS, CFC HAB, and Personal Assistance Services (Agency)	CFC PAS, CFC HAB, and Personal Assistance Services (CDS and SRO)
STAR+PLUS Home and Community Based Services	Personal Assistance Services, In-Home Respite, and Protective Supervision (Agency)	Personal Assistance Services, In-Home Respite, and Protective Supervision (CDS and SRO)

Electronic Visit Verification – Contact Information

Questions regarding…	Contact…
• EVV Policies, processes & procedures • Claims inquiries, questions or rework • EVV Compliance monitoring & findings • EVV Unlock requests • Provider training & education	**Aetna Better Health of Texas** EVVMailbox@Aetna.com 1-844 STRKIDS (1-844-787-5437)

• EVV Aggregator
• EVV Portal
• EVV Training on the Following:
  ○ EVV Aggregator
  ○ EVV Portal
  ○ EVV Reports in the EVV Portal
  ○ EVV Claims Submission Process
• EVV Vendor Complaints
	TMHP EVV Mailbox: EVV@tmhp.com

TexMedConnect Account Setup • Creation or Modification of Submitter IDs • Submitting Claims for EVV Using TexMedConnect • Submitting Claims for EVV Using Electronic Data Interchange (EDI) • File Submission Errors • PIMS Assistance • Claim Rejections (excluding Long-Term Care [LTC] claim rejections with error code F, RJ, and/or AC) • Form Processing (i.e. EDI Agreement, TPA, and TPAEF)	**TMHP EDI Helpdesk:** P: 1-888-863-3638, Option 4

Cultural Competency – Medicaid & STAR Kids

- Effective health communication is as important to health care as clinical skill. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities. The Aetna Better Health Cultural competency program is geared toward:
  - **Improving health care access and utilization**
  - **Enhancing the quality of services within culturally diverse and underserved communities**
  - **Promoting cultural and linguistic competence as essential approaches in the elimination of health disparities.**

- Additional provider-focused Cultural Competency resources can be found on the U.S. Department of Health and Human Services (HRSA) website at: http://www.hrsa.gov/culturalcompetence/index.html

Member Rights & Responsibilities

- It is our policy not to discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please review the list of member rights and responsibilities in the Provider Manual. Please see that your staff is aware of these requirements and the importance of treating members with respect and dignity.

- In the event that we are made aware of an issue with a member not receiving the rights as identified above, we will initiate an investigation into the matter and report the findings to the Quality Management Committee and further action may be necessary.

- For a complete list of member's right and responsibilities, please review the Provider Manual.

Fraud, Waste & Abuse

Fraud	Abuse
The intent to abuse the system. The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit.	The misuse of the Medicaid and/or CHIP program without the intent to commit fraud. Business, medical or recipient practices that result in unnecessary reimbursement/cost to the program.

What is waste?

Less than fraud and less than abuse
Involves practices that are not cost efficient such as ordering medical services or supplies beyond a patient's needs.

Reporting Provider/Clients Waste, Abuse and Fraud is available in the Aetna Better Health Provider Manual.

- Fraud and Abuse program overview is available in Aetna Better Health Provider Manual.
- Aetna Better Health Provider Manual is located at www.aetnabetterhealth.com/texas

Member Abuse and Neglect and Exploitation

IDENTIFYING & REPORTING ABUSE, NEGLECT & EXPLOITATION OF A MEMBER

Aetna Better Health's policy is to promote the education of network providers including long term care facilities on the identification and reporting of actual and suspected abuse, neglect, and exploitation of our members.

Definitions

Neglect means intentional or unintentional failure to fulfill a caregiver's obligation or duty to an elderly person. "Self neglect" can also occur when an elderly person is unable or unwilling to make provision for proper care for themselves.

Abuse constitutes the intentional infliction of physical harm, causing injury as a result of negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault of an individual 18 years of age or older who is unable to protect himself or herself from abuse, neglect or exploitation by others because of a physical or mental impairment.

Aggravating circumstances (such as cruelty, recklessness, and malice in causing injury to others) are often considered by the courts in imposing more severe sentence than a typical sentence for similar offenses.

Neglect

Types of Neglect

- The intentional withholding of basic necessities and care
- Not providing basic necessities an care because of lack of experience, information , or ability

Signs of Neglect

- Malnutrition or dehydration
- Unkempt appearance; dirty or inadequate
- Untreated medical condition
- Unattended for long periods or having physical movements unduly restricted

Examples of Neglect

- Inadequate provision of food, clothing, or shelter
- Failure to attend health and personal care responsibilities, such as washing, dressing, and bodily functions

Abuse

Examples of Abuse

- Bruises (old and new)

Reporting Waste, Abuse and Fraud by a Provider or Client

Please contact the following:

Aetna Better Health
Attention: SIU Coordinator
PO Box 569150
Dallas, TX 75356-9150
1-888-761-5440

- Provider manual is located on the Aetna website www.aetnabetterhealth.com/texas
- Fraud and Abuse reporting information is found on page 124 on the provider manual.

To report providers:

Office of Inspector General
Medicaid Provider Integrity/Mail Code 1361
PO Box 85200
Austin, TX 78708-5200

To report clients:

Office of Inspector General
General Investigations/Mail Code 1362
PO Box 85200
Austin, TX 78708-5200

- If you do not have internet access, call the HHSC Office of Inspector General Fraud Hotline at 1-800-436-6184.

Fraud, Waste & Abuse cont'd – STAR Kids

Do you want to report Waste, Abuse, or Fraud? Examples such as:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184**;
- Visit **https://oig.hhsc.state.tx.us**/ Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to Aetna Better Health:

Maintaining Contact Information

- Network providers must inform Aetna Better Health and

HHSC's administrative services contractor of any changes to your address, telephone number, group affiliation and/or any other relevant contact information for the purposes of:

- The production of an accurate provider directory
- The support of an accurate online provider lookup function
- The ability to contact you or your office with requests for additional information for prior authorization or other medical purposes, or on behalf of a member's PCP
- The guarantee of accurate claim payment delivery information

Provider Services Call Center

- Medicaid STAR **1-800-248-7767** (Bexar)
- **1-800-306-8612** (Tarrant)
- Medicaid STAR Kids **1-844-STRKIDS** (**1-844-787-5437**)

Additional resources & helpful links

Aetna Better Health of Texas Website
www.aetnabetterhealth.com/texas

Aetna EVV Updates, Training & Resources – Training revisions will be notated in Red and updated on our website periodically

https://www.aetnabetterhealth.com/texas/providers/info/evv

Also, Providers may access **HHSC EVV resources below** to see up-to-date information about EVV changes!

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

EVV Rights and Responsibilities Form -Electronic Visit Verification Rights and Responsibilities

https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2307-rights-responsibilities

Sign up on GovDelivery for email alerts at:

https://public.govdelivery.com/accounts/TXHHSC/subscriber/new?topic_id=TXHHSC_247

Questions???