Update to March 15, 2019 Billing Policy Changes for Providers Required to Use EVV

Beginning September 1, 2019, EVV relevant claims will be subject to the EVV claims matching process to confirm that a service visit occurred prior to payment of a claim.

The EVV claims matching process supports claims submitted with a single date of service and claims submitted with a span of service dates. Providers must bill claims according to their payer's billing requirements.

If your payer requires that a single claim line item represent a single EVV visit, then the EVV claim(s) must be billed according to that requirement. EVV relevant claim line items must have a matching EVV visit.

If your payer allows span dates for billing EVV services, then the EVV claim(s) may be billed as span dates.

- If the provider is allowed to 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.
- 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.

HHSC and managed care organizations will adhere to the following:

- Claims not submitted according to the guidelines for the payer will be denied by the payer.
- Claims submitted without a matching EVV visit transaction for the specified date(s) of service will be denied by the payer.
- Payers will no longer pay any unmatched claims.

For questions regarding your payer's billing guidelines, please contact your payer.

For questions regarding this alert please contact HHSC EVV Operations.