Keystone First
Family of Health Plans

Electronic Visit Verification

Reimbursement Policy ID: RPC.0090.0100

Recent review date: 08/2024

Next review date: 07/2026

Keystone First reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

Section 12006 of the 21st Century CURES Act required states to implement an electronic visit verification (EVV) system for all Medicaid Personal Care Services (PCS) and for Home Health Care Services (HHCS) that require an in-home visit by a provider. The potential benefits of EVV include improved program efficiencies, strengthening quality assurance for PCS and HHCS, and a reduction in potential fraud, waste, and abuse (FWA).

Exceptions

N/A

Reimbursement Guidelines

EVV includes the use of electronic technology to verify the services delivered, delivery dates and times of PCS and HHCS to the individuals needing those services. EVV uses multiple technologies such as telephonic, mobile applications, and web portal verification inputs to help electronically validate services and prevent fraudulent claims.

The Centers for Medicare and Medicaid Services (CMS) requires the electronic verification of a minimum of the following six data elements:

1. The service performed
2. The individual receiving the service
3. The individual(s) providing the service
4. The location(s) of the service
5. The date(s) of the service
6. The time the service begins and ends.

EVV must be used to record all PCS and all HHCS that require an in-home visit. Providers must register their visits with the EVV Vendor in order to be reimbursed for services. Claims will deny if the provider does not register their visits with the EVV vendor. If the information in the EVV record does not match information in the claim received from the provider, payment on the claim will be denied.

Definitions

Electronic Visit Verification (EVV) is to track and monitor timely service delivery and help to ensure access to care for Medicaid beneficiaries.

Personal Care Services (PCS) services consist of supporting activities related to personal care such as movement, dressing, personal hygiene. Services may also include meal preparation, shopping for groceries or housework.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)
VI. Corresponding Keystone First Clinical Policies.
VII. Applicable Keystone First manual reference.
VIII. Commonwealth of Pennsylvania Medicaid Program guidance.

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
08/2024	Reimbursement Policy Committee Approval

04/2024	Revised preamble
08/2023	Removal of policy implemented by Keystone First from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section