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# Purpose

This resource is to support providers with submitting clean claims for EVV services to ensure payment. It is also intended to assist with troubleshooting any denials received due to EVV reasons.

# Overview

## What is EVV?

EVV electronically verifies authorized services were provided. Claim denials can occur when the six required data points are not recorded in Sandata at the time of claim submission.

* Who receives the service
* Who provides the service
* What service is provided
* Where the service is provided
* The date of service
* The time the service begins and ends

**Federal Requirement**

Inclusa implemented the EVV requirement to comply with the Federal 21st Century Cures Act, which mandates all states require EVV for all Medicaid personal care services and home health services that require an in-home visit by a provider. The Centers for Medicare & Medicaid Services (CMS) will fine state programs if they do not implement EVV.

Failure to comply with EVV requirements may result in contract termination with Inclusa.

## EVV Procedure Codes and Services

Hard launch for Supportive Home Care and Personal Care services began on May 1, 2023, and Home Health services hard launch began on October 1, 2024.

**Personal care and supportive home care (SHC) service codes that require EVV in Wisconsin**

| **Service** |
| --- |
| **T1019: Personal care services; per 15 minutes** |
| **T1020: Personal care services; per day** |
| **S5125: Supportive home care; per 15 minutes** |
| **S5126: Supportive home care; per day** |
| **99509: Nurse supervisory visit; Home visit for assistance with activities of daily living and personal care; per visit** |

**Home health care service codes that require EVV in Wisconsin**

| **Service** |
| --- |
| **92507: Treatment of speech, language, voice, communication, and/or auditory processing disorder; per visit** |
| **97139: Unlisted therapeutic procedure – Occupational therapy; per visit** |
| **97799: Unlisted physical medicine/rehabilitation service or procedure – Physical therapy; per visit** |
| **99504: Home visit for mechanical ventilation care; per hour** |
| **99600: Unlisted home visit service or procedure; per visit** |
| **S9123: Non-vent private duty nursing care in the home – by registered nurse; per hour** |
| **S9124: Non-vent private duty nursing care in the home – by licensed practical nurse; per hour** |
| **T1001: Nursing assessment/evaluation; per visit** |
| **T1021: Home health aide or certified nurse assistant; per visit** |
| **T1502: Administration of oral, intramuscular and/or subcutaneous medication by health care agency/ professional; per visit** |

# EVV Best Practices Prior to Claim Submissions

## EVV Sandata Visit Status

* Prior to submitting claims to WPS, providers should ensure the EVV visits are in Sandata and in a verified status.
* All visits must be on file at WPS at the time the claim is processed to avoid denials.
* Due to the time it takes for visit keys to electronically flow through systems, there may be a delay in the data being received at WPS.
	+ If using Sandata to record visits, claims should be billed 3-10 days after all visits are verified.
	+ If an alternate system (not Sandata) is used to record visits, providers should wait at least 10 days before submitting claims.
* To view visits in Sandata, providers can use the Visit Review report to identify visits that are in a Verified or Incomplete status.
* To identify if visits are in a verified status, providers can run the Sandata visit review report and filter on “All Visits.”



* To only view those visits that are not verified and not ready to be billed against, filter the report on “All Exceptions” and this will show you any visits that are Incomplete and need to be addressed by the provider’s Admin.
* An “Incomplete” visit means the visit is missing required information. Missing information is indicated on the visit grid as exceptions (red dots).

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* To determine why a visit is incomplete, hover the mouse pointer over the red dot and a pop up will appear. In this case, there is no authorization on file in the Sandata system. If it has been more than 3 business days since the authorization was entered and in the Inclusa provider portal, contact Authorization and Claims Support (ACS) at acs-shc-sds-homehealth@inclusa.org or 888-544-9353, option 7 for assistance.



## Provider and Worker ForwardHealth Enrollment

* Ensure you are using the correct ForwardHealth provider ID in Sandata or alternate system.
* Ensure the worker providing the service is enrolled to do so on ForwardHealth.
* If you are unsure, contact Wisconsin EVV Customer Care at 833-931-2035 or vdxc.contactevv@wisconsin.gov Monday-Friday, 7 a.m.– 6 p.m. Central Time.

## Live-in Caregivers

* If the worker is a verified live-in caregiver, ensure you are using the KX modifier on your claim to bypass EVV edits at WPS.

## SHC Travel Time

* There are times SHC travel time is authorized separately from the hands-on SHC service. If you are billing for SHC travel time, ensure you are adding the U3 modifier to bypass EVV edits.

# EVV Claim Denials and Troubleshooting

The purpose of this section of the guide is to walk through each EVV claim denial reasons and recommended steps to correct the visits or claims prior to resubmission.

* This table shows the different claim denial reasons providers can receive.



### FA1; 95 / N818; MA31

**Definition:**

* EVV claims with a date range are not accepted.

**Provider action:**

* Resubmit claims as single line item per date of service.

### FA2; 95/N821

**Definition:**

* No EVV visit key found; EVV claims without a matching visit key are not payable.

**Provider action:**

1. Check that visit is in a verified visit status in Sandata. If so, be sure you have waited the recommended time before submitting your claim again. Reminder: Due to the time it takes for visit keys to electronically flow through systems, there may be a delay in the data being received at WPS.
	1. If using Sandata to record visits, claims should be billed 3-10 days after all visits are verified.
	2. If an alternate system (not Sandata) is used to record visits, providers should wait at least 10 days before submitting claims.
2. Check to be sure you are using the correct data on your claim.
	1. Is the member’s WPS alt ID correct?
	2. Are you using the correct authorization ID?
	3. Is this a live-in caregiver? If so, did you submit your claim with the KX modifier to bypass EVV edits?
	4. Is this for SHC travel time? If so, did you submit your claim with the U3 modifier to bypass EVV edits?
3. Ensure the worker providing the service is registered on ForwardHealth.
* NOTE: All visits must be on file at the time the claim is processed to avoid denials.
1. If no visit key is found at the time of processing, WPS will pend claim, checking for a visit key each day up until 10 calendar days before applying a FA2 denial.
2. If WPS has not received all visits at the time of processing, WPS will use the visits WPS has on file which may result in an FA3 or FA4 denial for no/not enough units.

**Examples of No Visit Key Denials:**

1. Visit key found, claim data submitted is correct, and manual entry/adjustment did not occur and/or provider waited 3-10 days to submit.
2. Visit key found, but is not in verified status, WPS will deny claims for FA2.
3. Is authorization in Sandata?
	1. Yes: Edit the visit key in Sandata; wait 3-10 days and then submit new claims to WPS.
	2. No: Contact Authorization and Claims Support (ACS) at acs-shc-sds-homehealth@inclusa.org or 888-544-9353, option 7 for assistance. Inclusa may need to resend the authorization file to Sandata.
4. No visit key found, but provider states there is a visit key entered and visible to them.
5. The provider will need to contact DHS EVV Support for troubleshooting with Sandata and/or their alternate EVV system.
* Wisconsin EVV Customer Care is available at 833-931-2035 or vdxc.contactevv@wisconsin.gov Monday-Friday, 7 a.m.– 6 p.m. Central Time.

### FA3; 119/N640

**Definition:**

* + The number of units billed for this date of service exceeds the number of remaining EVV visit key units. Claim lines are denied FA3 when there are not enough EVV units available to process the full units billed on the claim line.

**Provider action:**

1. Access “Visit Review” in Sandata to verify EVV Visit Key entry, status (verified / Incomplete), and date of entry/manual adjustments, found in the history tab of the visit key.
	1. If the visit key is entered or visit key was manually entered/adjusted less than 10 days before claim submission to WPS, this could result in an FA3 denial.
	2. Check the billable units on the visit key on Sandata and compare to the units submitted on the claim. Are the units billed more than what is on the visit key?

**Example:**

1. EVV duration = 82 minutes = 5.4 = 5 units
2. Claim line billed units = 6 units
3. WPS will deny FA3 as there are not enough units on the EVV record(s) to process 6 units.
	1. Provider should manually correct the visit key in Sandata or on the claim as appropriate. And resubmit new claim to WPS after waiting the recommended 3-10 days.

### FA4; 119/N640

**Definition:** There are no remaining EVV visit key units for this date of service. Claim lines are denied FA4 when there are no remaining EVV units available to process the units billed on the claim line. There are no remaining EVV visit key units for this date of service. Rebill claim when visit key units are updated.

**Additional Notes:**

* + The FA4 denial can occur when providers submit multiple claim lines for multiple visits within the same date of service.
	+ This is allowed if the provider uses EDI or paper claim submissions but not encouraged or suggested in our communication to providers.
	+ If the units run out, similar to the FAE denial code for an authorization running out of units, the FA4 denial indicates the visit key does not support all claim lines and available units for that date of service and partial payment was made but not in its entirety.
	+ The Claim Spreadsheet submitted via MoveIt cannot be used if submitting this way.



**Example:**

* EVV duration = 299 minutes = 19.9 = 20 units
* Claim line 1 billed units = 20 units – WPS paid
* Claim line 2 billed units = 2 units – WPS denied FA4; 119/N460 as there are no units remaining on the EVV record(s) to process 2 units.

**For all denial reasons:**

* Claims denied in full: Are required to be billed as a new claim after the EVV visit key has been adjusted or the claim adjusted to match the EVV visit key, whichever is appropriate.
* Corrected claims: The EVV visit key should be verified to ensure all units, dates, codes are updated to cover the corrected claim information.

# Community Supported Living (CSL) – S5136 UC and S5126 UA – Per Day Services

The majority of the contents of this billing guide do apply to CSL services, with some exceptions as follows:

* CSL services are authorized as a daily rate and billed as 1 single unit per date of service. 1 unit is billed per day regardless of the how many visit keys or cumulative time is entered for any given date of service. As a result of this, the following EVV denials and requirements would not apply to CSL providers:
	+ FA3 denials
	+ FA4 denials
	+ Rounding Rules (only applies to quarter hours services)
	+ Travel time (this is already included in the single daily unit per day rate)
* Information contained within this document regarding the Authorization flow to Sandata, Overnight care, as well as FA1 (date span billing) & FA2 (missing visit keys) do apply to CSL providers.
* CSL providers continue to partner with the member, Member’s legal decision maker if applicable, and the member’s care team to complete a CSL assessment initially, every 6 months thereafter, and with changes in condition. The EVV tab of the CSL assessment is used to identify the frequency of hands on care involvement. The care team or their manager complete an internal rate tool using the daily rate from the CSL Assessment. This rate tool generates a rate agreement to the Provider and to our internal authorization and claims team to prompt authorization entry. The authorizations are entered based on the frequency of hands on care noted on the EVV tab of your assessment.
	+ If NO Hands on care is being provided, one authorization is entered for S5136 UC Companion care. Authorization includes total # of units needed to cover 1 unit per day billing from the start date of the authorization to the end date of the authorization.
	+ If DAILY hands on care is being provided, one authorization is entered for S5126 Attendant Care. Authorization includes total # of units needed to cover 1 unit per day billing from the start date of the authorization to the end date of the authorization.
	+ If the member receives a combination of both hands on and non-hands on care, an authorization is entered under each code (S5126 UA Attendant care and S5136 UC Companion care). The rate is the same on both authorizations. The sum of the units available between both authorizations will equal the total # of days for the authorized date span.
		- Example: EVV tab indicates Hands on care is provided 2 x per week.
			* Start date of auth is 1/1/2025. End date is 12/31/2025. (365 days)
			* S5126 UA Attendant care auth will contain 105 units.
			* S5136 UC Companion care auth will contain 260 units.
		- Providers should only submit a claim for each date of service using 1 of the authorizations and not both. If 1 unit is billed on both authorizations for the same date of service, claims may start denying for FAE-Insufficient units due to overbilling. Refunds will be required in this situation.
		- If your authorizations do not accurately reflect the frequency of hands on care, we would advise that you notify the care team and provide them with an updated CSL assessment so they can facilitate updates to your authorizations.
		- We anticipate there will be scenarios where members may have an **intermittent** need for more or less hands on care than authorized. **Please alert Inclusa ACS via email for these scenarios to request an authorization adjustment.** **ACS-Residential-CSL-NH@inclusa.org** This will ensure that you have the appropriate number of units on each authorization to prevent claim denials for (FAE-Insufficient units) and to ensure EVV compliance.
			* **Example:** Member receives 2 days of hands-on care weekly. Member has two authorizations in place:
			* S5126 UA - Attendant Care (based on 2 x weekly)
			* S5136 UC – Companion Care (based on 5 x weekly)
			* The member experienced a flare up of their Multiple Sclerosis and required daily hands-on care for 1 week.
			* ACS will add 5 additional units to the S5126 UA authorization.
			* ACS will reduce the S5136 UC authorization by 5 units.
* A CSL Billing Pilot is currently in progress involving 5 providers who have volunteered to participate. The CSL Pilot was developed to address the challenges regarding changes in the member’s hand on care frequency resulting in unit adjustment issues and claim denials. If you are currently not a participating pilot provider and would like more information about the pilot, please contact: **ACS-Residential-CSL-NH@inclusa.org**

[**Electronic Visit Verification EVV Message for New CSL Providers.docx**](https://www.inclusa.org/wp-content/uploads/Electronic-Visit-Verification-EVV-Message-for-New-CSL-Providers.docx)

EVV Contacts for Questions:

1. EVV visit key, Sandata system and other related EVV questions:
	1. The Wisconsin Department of Health Services (DHS) offers Wisconsin Electronic Visit Verification Customer Care. Trained customer service representatives provide specialized assistance for the EVV program.
	2. Provider agencies, members, participants, workers, and program payers can call 833-931-2035 or email VDXC.ContactEVV@Wisconsin.gov for help with technical and program-related questions.
		1. Wisconsin EVV Customer Care hours are Monday-Friday, 8 a.m. – 5 p.m.
2. Emails should be sent to FAMCEVV@wpsic.com after a claim has been denied and the following has occurred:
	1. The verified visit(s) is not cancelled or inactive.
	2. The claim was billed 10 days after the visit(s) was verified.
	3. There is an Inclusa approved authorization on file and submitted on the claim.
	4. All claim detail matches the Inclusa approved authorization and the verified visit(s) matches the billed claim information and approved authorization.

# Resources

[Electronic Visit Verification (EVV) Billing Facts](https://www.wpshealth.com/resources/files/36499_electronic-visit-verification-provider-billing-facts.pdf)

[Electronic Visit Verification EVV Rounding Table Reference](https://www.inclusa.org/wp-content/uploads/Electronic-Visit-Verification-EVV-Rounding-Table-Reference-Website-Portal.docx)

[EVV Rounding Table .xlsx](https://cccw.sharepoint.com/%3Ax%3A/s/AuthorizationandClaimsSupportResources/EQTS6wdLXj1FqMkMROstSzcBGKXl2g8D_j4pjyLJ4vCFBQ?e=ZDmaHb)

[Electronic Visit Verification (EVV) | Wisconsin Department of Health Services](https://www.dhs.wisconsin.gov/evv/index.htm)

[Family Care Claim Explanation Codes](https://www.wpshealth.com/resources/files/33233-famc-claim-ex-codes.pdf)

[Inclusa Claim and Payment Question and Issue Contacts](https://www.inclusa.org/wp-content/uploads/Inclusa-Claim-and-Payment-Question-and-Issue-Contacts-2.docx)