Fee for Service Electronic Visit Verification Administrator Training: Claim Edits

August 2024

WISCONSIN DEPARTMENT of HEALTH SERVICES

P-03570 (08/2024)

Welcome to Fee for service Electronic Visit Verification: Claim edits for Personal Care Services and Home Health Care Services. After hard launch on October 1, 2024, EVV will have an impact on claims. We want to make sure you use soft launch to make this transition as easy as possible. Knowledge is power!

Objectives

- Understand how EVV policy impacts the claims process
- Recognize and understand EVV claim edits
- Learn how edits are resolved
- Understand when a claim should be resubmitted
- Learn how EVV impacts span billing
- Use best practices to avoid EVV claim edits
- Learn where to find additional resources and assistance

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Today, we're going to focus on fee-for-service EVV claims. By the end of this session, you will:

- Understand how Wisconsin Department of Health Services (DHS) EVV policy impacts the claims process.
- Recognize EVV claim edits and understand what each edit means.
- Learn how edits are resolved.
- Understand when a claim should be resubmitted.
- Learn how EVV impacts span billing.
- Use best practices to avoid EVV claim edits.
- Learn where to find additional resources and assistance.

Agenda

- EVV Lifecycle
- EVV Fee-for-Service Claim Processing
- EVV Best Practices
- Resources
- Questions

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To achieve those objectives, we'll:

Go through the EVV Lifecycle. How does EVV fit into the claims process?

Then we'll go over the fee-for-service claims edit process: What causes denials and what can a provider do to resolve them?

We'll go over best practices to avoid denials and save you time.

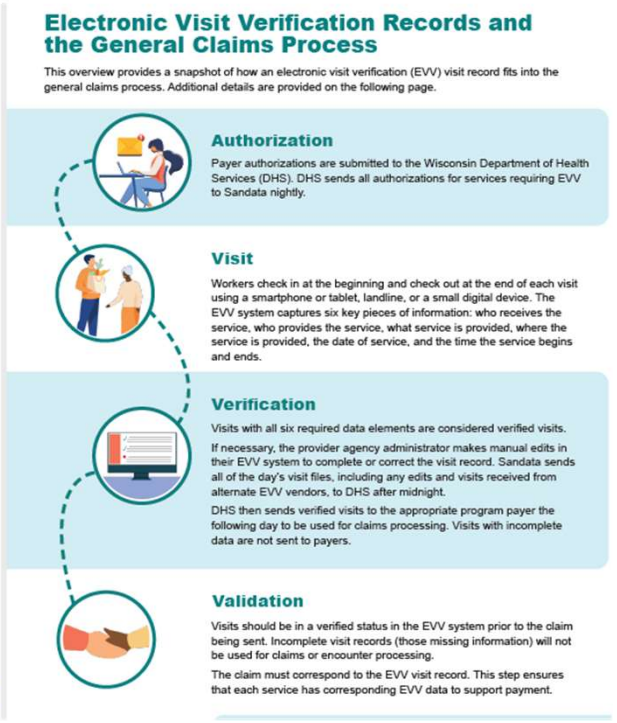
Let's begin!

EVV Lifecycle

Let's get started with the EVV Lifecycle.

Lifecycle Flyer

https://dhs.wisconsin.gov/publications/p03124.pdf



Electronic Visit Verification Records and the General Claims Process

This overview provides a snapshot of how an electronic visit verification (EVV) visit record fits into the general claims process. Additional details are provided on the following page.

Authorization

Payer authorizations are submitted to the Wisconsin Department of Health Services (DHS). DHS sends all authorizations for services requiring EVV to Sandata nightly.

Visit

Workers check in at the beginning and check out at the end of each visit using a smartphone or tablet, landline, or a small digital device. The EVV system captures six key pieces of information: who receives the service, who provides the service, what service is provided, where the service is provided, the date of service, and the time the service begins and ends.

Verification

Visits with all six required data elements are considered verified visits.

If necessary, the provider agency administrator makes manual edits in their EVV system to complete or correct the visit record. Sandata sends all of the day's visit files, including any edits and visits received from alternate EVV vendors, to DHS after midnight.

DHS then sends verified visits to the appropriate program payer the following day to be used for claims processing. Visits with incomplete data are not sent to payers.

Validation

Visits should be in a verified status in the EVV system prior to the claim being sent. Incomplete visit records (those missing information) will not be used for claims or encounter processing.

The claim must correspond to the EVV visit record. This step ensures that each service has corresponding EVV data to support payment.

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This flyer answers the question, "How does EVV fit into the general claims process?" Be sure to save this flyer for future reference!

Let's go over the information in it:

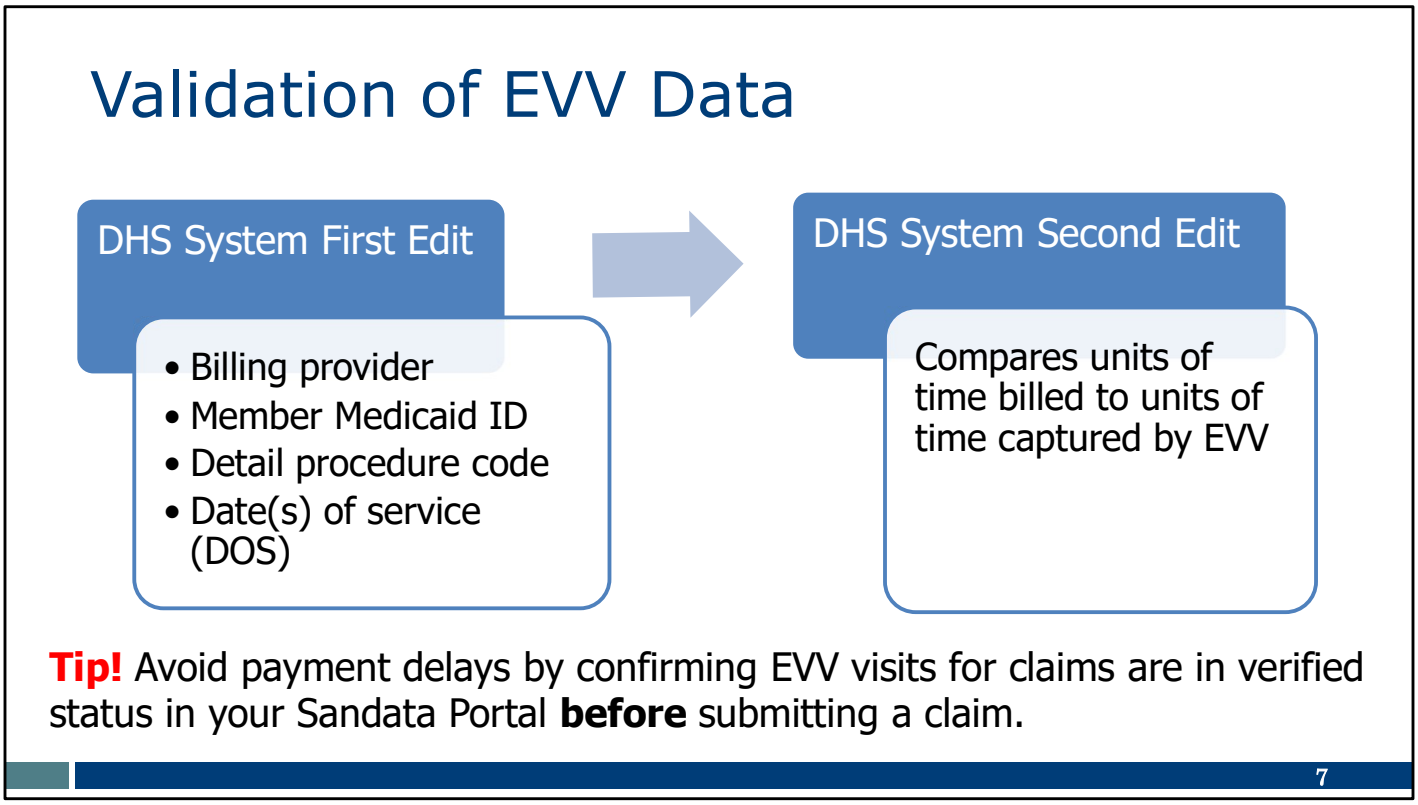
- Authorizations are the beginning. The information in the authorization is used to connect the member, approved service codes, providers (including independent nurses), and payer in the EVV system.
- Then--EVV Visit information is collected at the time of the visit. Some of this information will sound familiar to what's in the authorization:
    - Who receives the service
    - Who provides the service (the agency, or independent nurse, and the worker)
    - What service (the service code) is provided
    - Where service is provided
    - Date of service
    - Duration of service (time in and out)
- Next is Verification that all EVV information was captured accurately. This is done by YOU, the provider administrator, in the EVV system—either Sandata or an alternate EVV system. Visits with complete visit information—those with a "verified" status-- are sent to payers, including DHS as fee-for-service payer, daily. Only "verified" visits are used in the next step.
- That last step is Validation – the payer confirming that the EVV data collected pairs with the claim detail. For fee-for-service, DHS pairs the claim detail data to

EVV visit data. Once we transition to hard launch, if EVV data is not found within two business days, the detail will be denied.

This flyer provides great background information. You can see how all the steps build on each other.

EVV Fee-for-Service Claim Processing

Let's move on to fee-for-service claim processing and the EVV edits.



When DHS receives a claim or encounter detail that requires EVV, the DHS system will confirm that EVV data exists for the claim and will validate that data for each applicable detail on the claim. There are two system edits that look for corresponding data:

- The first edit compares:
  - Billing provider
  - Member Medicaid ID
  - Detail procedure code
  - Date(s) of service (DOS)
- The second edit compares the units of time billed to the units of time captured by EVV.

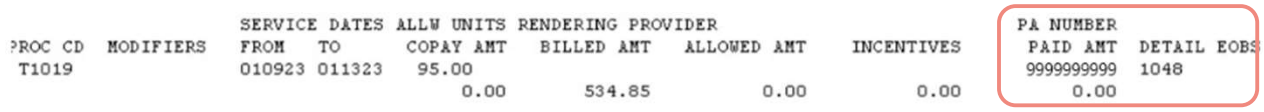
Only verified EVV visits are used for claim processing. As a provider, you can avoid delays by confirming EVV visits for claims are in verified status in your Sandata Portal before submitting a claim.

Explanation of Benefits (EOB)

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB codes and descriptions for any claim submitted to ForwardHealth on the ForwardHealth Portal. The EOBs help providers determine why a claim did not process successfully, so providers may correct the error online and resubmit the claim. The EOB appears on the bottom of the screen and references the applicable claim header or detail.



		SERVICE DATES		ALLW UNITS	RENDERING PROVIDER			PA NUMBER	
PROC CD	MODIFIERS	FROM	TO	COPAY AMT	BILLED AMT	ALLOWED AMT	INCENTIVES	PAID AMT	DETAIL EOBS
T1019		010923	011323	95.00				9999999999	1048
				0.00	534.85	0.00	0.00	0.00	

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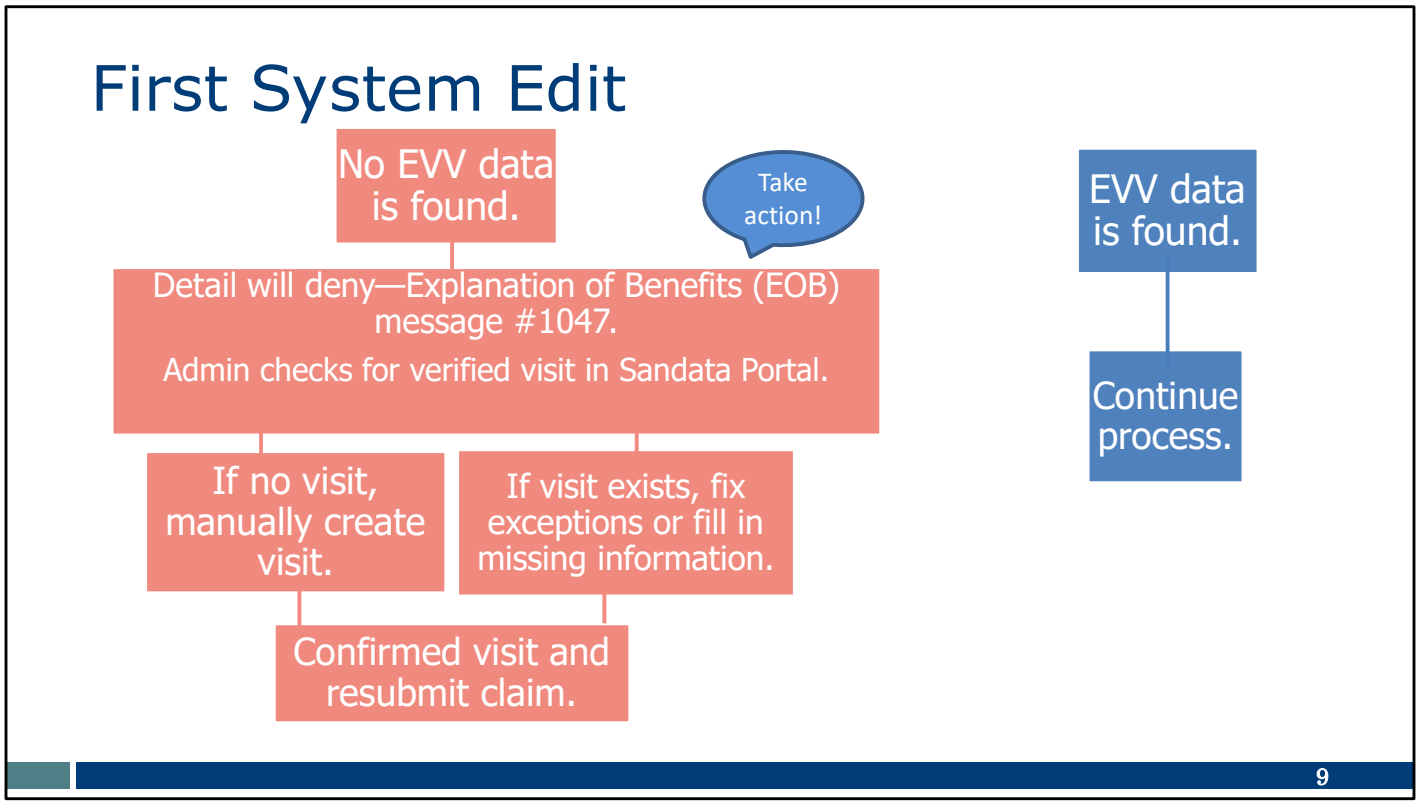
If a claim does not pass one of the edits, you'll see an "explanation of benefits" (EOB) code.

EOBs provide information about why a claim did not process successfully. Once you know the reason behind the error, you can correct the error and resubmit the claim.

At the bottom is an example of an EOB code. There are two codes unique to EVV, and we'll cover these codes—and what to do in response--in the next few slides.



Remember the two system edits that look for corresponding data in the DHS system?

Let's take a deeper dive into each of those edits. Here's the first one. There are two outcomes from the first system edit. If there is no EVV data to pair with the criteria required in the first edit, the claim detail will suspend once we transition to hard launch. Maybe you needed more time to get the EVV visit verified. We built in this "suspend" with this in mind! The claim will recycle through the system for up to two business days looking for matching EVV visit data.

After two business days, if there is no EVV data found, the fee-for-service claim will deny with EOB message #1047, which states, "Electronic Visit Verification system visit not found." That means the visit information is either not in a verified status or was not captured at all.

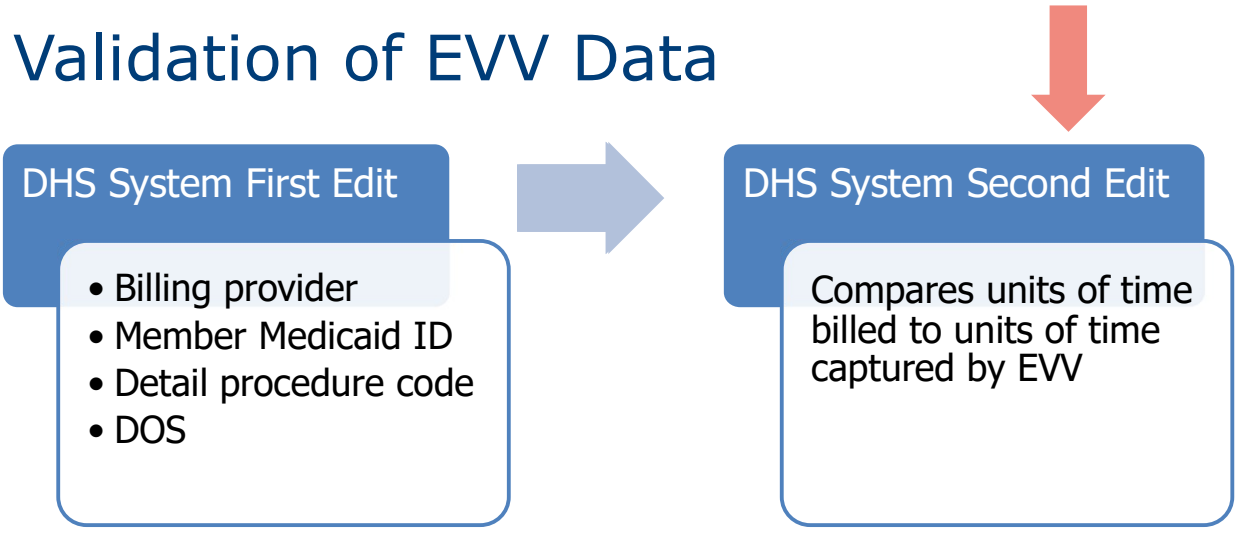
- The administrator should check the Sandata EVV Portal.
- If there isn't a visit in the EVV system, the administrator should confirm the service was indeed provided. With that confirmation, they can go ahead and manually create the visit in the EVV system you use.
- Or, if the visit is there, the administrator should fix any exceptions.
- Once the exceptions have been fixed or a manual visit has been created, the administrator should confirm that the visit is now in verified status. If yes, the claim should be resubmitted.

Note: Specific to soft launch--you may see this error in soft launch if you bill very soon after providing your visit (same day of service or day after). This is because verified EVV visits take one to two days to transfer to DHS depending on time of care.
You will see this error during hard launch if you bill immediately after providing care (on the same day of service or the day after), your claim will suspend for two days until EVV data arrives.

Tip! Avoid payment delays by confirming that EVV visits for claims are in verified status in your Sandata Portal before submitting a claim.

By making corrections where needed, you can be sure you get paid.

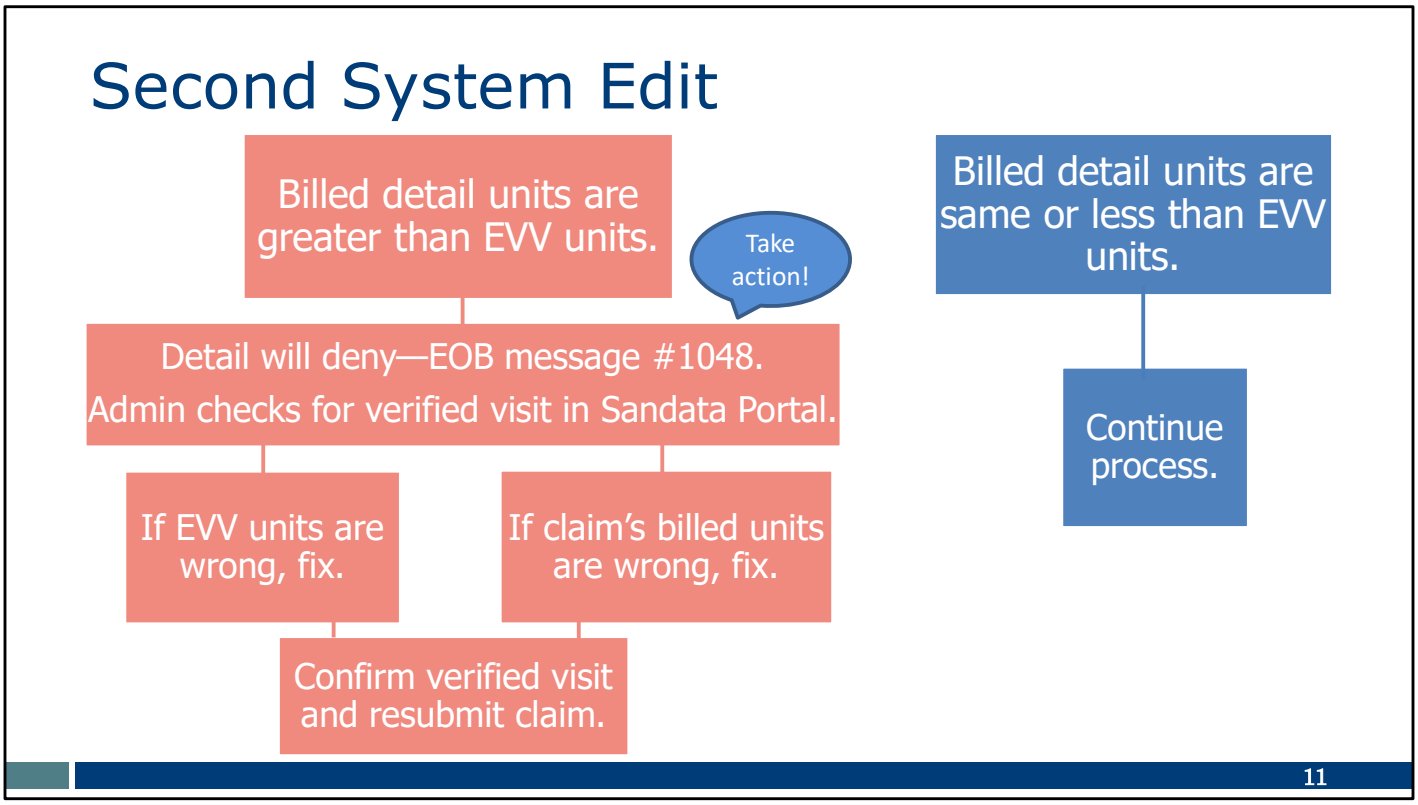
Validation of EVV Data



Tip! Avoid payment delays by confirming that EVV visits for claims are in verified status in your Sandata Portal **before** submitting a claim.

We just talked through the first edit in the DHS system. Now we are going to talk about the second edit.

If a claim passes the first EVV system edit, it will continue to the second system edit where the units of time billed are compared to the units of time captured in EVV.



Once again, there are two possible outcomes from the second system edit.

If the billed detail units are greater than the EVV units.

- The detail will deny with EOB message #1048.
- 1048 means, "Electronic visit verification system units do not meet requirements of visit." In other words, the units in the EVV visit were less than the number of units billed. Units should be equal to or greater than the number of units billed.

When this happens, the administrator should compare claim billed units to EVV units.

- If the claim billed units are wrong, the administrator should fix the claim and resubmit.
- If EVV units are wrong, fix them in the Sandata Portal or alternate EVV, and confirm that the visit has a verified status. If yes, the claim should be resubmitted.

The desired outcome in the second system edit is for the billed detail units to be the same as or less than the EVV visit units.

- When that happens, the detail will continue to process as normal.

Second System Edit

EOB message #1048, "EVV system units do not meet requirements of visit."

Topic #2479

Units of Service

Personal Care Services

Accumulated time	Unit(s) billed
1-22 minutes	1.0
23-37 minutes	2.0
38-52 minutes	3.0
53-67 minutes	4.0
68-82 minutes	5.0
83-97 minutes	6.0
98-112 minutes	7.0
113-127 minutes	8.0
Etc.	9.0+

Topic #1085

Units of Service

Conversion Chart for Billing Private Duty Nursing Services

Time Worked in Minutes							Billable Units (Hours)
≥	0	&	<	6	=		0
≥	6	&	<	12	=		0.1
≥	12	&	<	18	=		0.2
≥	18	&	<	24	=		0.3
≥	24	&	<	30	=		0.4
≥	30	&	<	36	=		0.5
≥	36	&	<	42	=		0.6
≥	42	&	<	48	=		0.7
≥	48	&	<	54	=		0.8
≥	54	&	<	60	=		0.9
≥	60	&	<	66	=		1
≥	66	&	<	72	=		1.1

Time Worked in Minutes							Billable Units (Hours)
≥	186	&	<	192	=		3.1
≥	192	&	<	198	=		3.2
≥	198	&	<	204	=		3.3
≥	204	&	<	210	=		3.4
≥	210	&	<	216	=		3.5
≥	216	&	<	222	=		3.6
≥	222	&	<	228	=		3.7
≥	228	&	<	234	=		3.8
≥	234	&	<	240	=		3.9
≥	240	&	<	246	=		4
≥	246	&	<	252	=		4.1
≥	252	&	<	258	=		4.2

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As mentioned in the last slide, the administrator should compare claim billed units to EVV units. Let's look at the rounding table for units of service. You can find this on the ForwardHealth Portal's Online Handbook, Topic #2479, for personal care. Topic #1085, on the right, is the chart in the Online Handbook that is specific to private duty nursing.

Standing Medicaid rounding rules apply to EVV. This chart converts minutes to units.

As an example: If a personal care worker clocks in at 3:01 and clocks out at 3:58, that equals 58 minutes of EVV minutes.

- What if the claim billed 4 units of service? If you look at the chart for personal care (Topic #2479), you'll see the EVV minutes will convert to 4 units of service. That matches. The claim will pass.
- If the claim billed for 5 units of service, it would hit the edit. The claim would deny, and the provider would need to correct the information.

If you bill to an HMO or MCO, contact them for their rounding rules.

Second System Edit

The EVV time units should be the *same as* or *greater than* the units on the claim.

EVV units are less than claim units = FAIL

EVV units are same as or more than claim units = PASS

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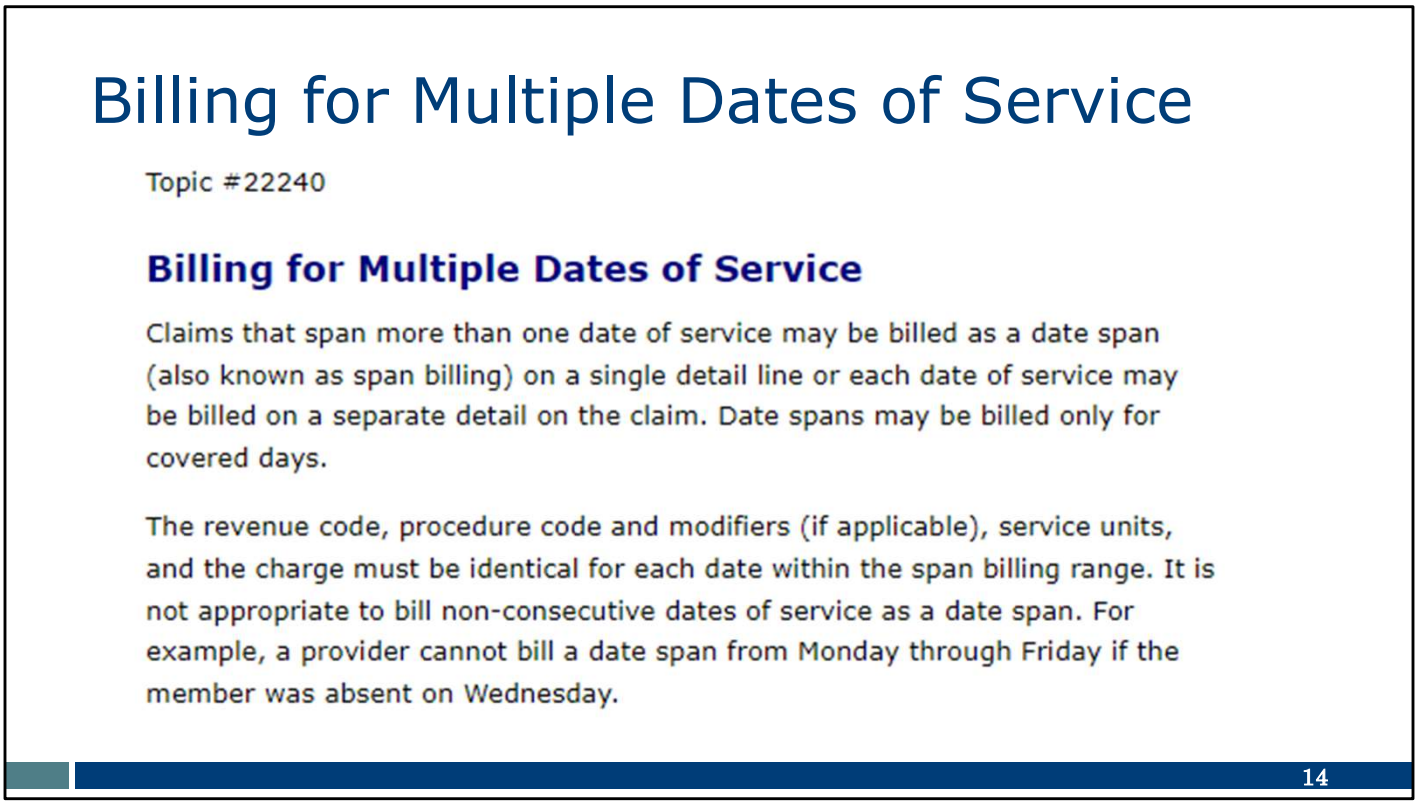
Here's a visual way to understand how EVV time units and claim units relate to each other.

Think of EVV as your "evidence" that work was done for a certain amount of time.

- If the EVV units provide less evidence than your claim is requesting, it will FAIL the billed units edit.
- If the EVV units provide sufficient evidence—the same as or more units than required—compared to what your claim is requesting, it will PASS.

We'll refer to this again later.



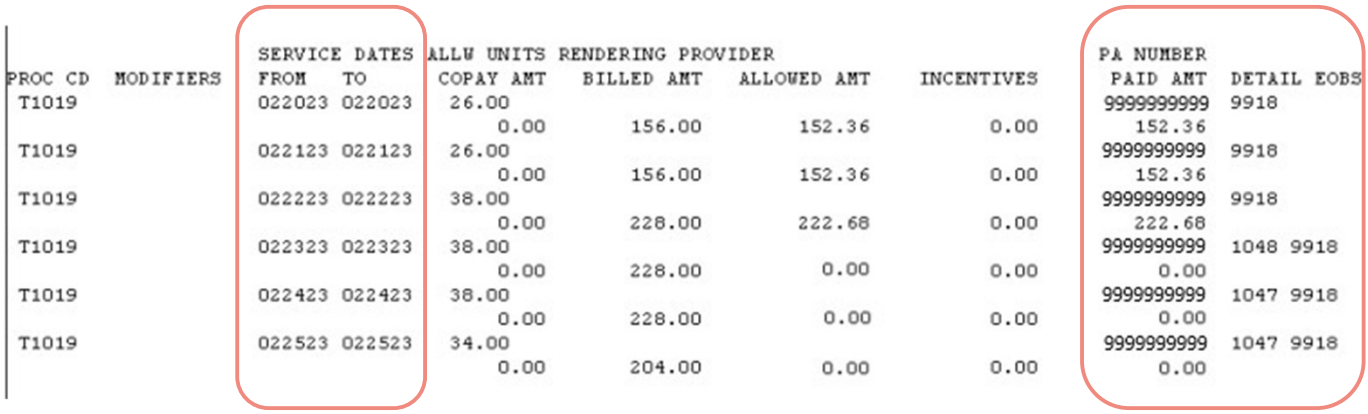
What happens when a provider needs to bill for several days of service?

As we began EVV in Wisconsin, we knew our EVV solution needed to support existing claims policies. EVV has not changed existing claims policy. What you see on this slide, Topic #22240, is from the ForwardHealth Portal's Online Handbook. It describes two ways providers can submit claims when there are several dates of service.

1. As a date span on a single detail line (also known as "span billing") **OR**
2. Each date of service billed as separate detail lines on the claim.

Let's look at an example of the second one, dates of service billed as separate detail lines on a claim.

EVV Fee-for-Service Claim Processing



PROC CD	MODIFIERS	SERVICE DATES FROM	TO	ALLW UNITS COPAY AMT	RENDERING PROVIDER BILLED AMT	ALLOWED AMT	INCENTIVES	PA NUMBER PAID AMT	DETAIL EOBS
T1019		022023	022023	26.00				9999999999	9918
				0.00	156.00	152.36	0.00	152.36	
T1019		022123	022123	26.00				9999999999	9918
				0.00	156.00	152.36	0.00	152.36	
T1019		022223	022223	38.00				9999999999	9918
				0.00	228.00	222.68	0.00	222.68	
T1019		022323	022323	38.00				9999999999	1048 9918
				0.00	228.00	0.00	0.00	0.00	
T1019		022423	022423	38.00				9999999999	1047 9918
				0.00	228.00	0.00	0.00	0.00	
T1019		022523	022523	34.00				9999999999	1047 9918
				0.00	204.00	0.00	0.00	0.00	

Take a moment to look at this fee-for-service claim. The entire list is the "claim." Each row is called a "detail."

Here we have six rows—a separate row for each date of service, from February 20 to February 25.

Look especially at the last columns, where the amount paid and detail EOB code are located.

If this was a quiz, I'd ask you two questions:

- How many details were denied?
  - The answer is three—the bottom three show $0 paid.
- Why were they denied?
  - Two were denied with the first code we talked about, EOB 1047: the provider will need to make sure the visit exists and is in a verified status.
  - One was denied with the second code we talked about, EOB 1048: the provider will need to compare the units in the EVV visit to the amount of units billed.

So here we have a "claim" (the whole list you see here), with three details that were denied. These 3 are where the provider needs to

take action.

EVV Fee-for-Service Claim Processing

Denied details

EOB Code	What it means	What you can do
1047	EVV system visit not found	Ensure a "verified visit" in your EVV system Use KX modifier if live-in visit is excluded from EVV Resubmit the details that denied
1048	EVV units do not meet requirements of visit	Compare the EVV time to the billed units and make corrections Resubmit the details that denied

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The administrator will need to make corrections, either in the EVV system or the claim, and resubmit only the details (the individual rows) that denied.

This chart summarizes the EOB codes that will show up for EVV reasons, a reminder of what they mean, and a reminder of the actions the administrator should take.

You want to get paid. We want you to get paid, too!

Fee-for-Service Span Billing Requirements

Each day in the date span must have matching:

- Procedure codes
- Revenue codes
- Modifiers
- Service units

PROC CD	MODIFIERS	SERVICE DATES FROM	TO	ALLW UNITS COPAY AMT	BILLED AMT	ALLOWED AMT	INCENTIVES	PA NUMBER PAID AMT	DETAIL EOBS
T1019		010923	011323	95.00				9999999999	1048
				0.00	534.85	0.00	0.00	0.00	

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Now let's take a look at span billing. That's when several days are combined on one detail line, as shown here. The single detail "spans across" several days.

EVV more closely monitors span billing. Providers can continue to use span billing *where it makes sense.*

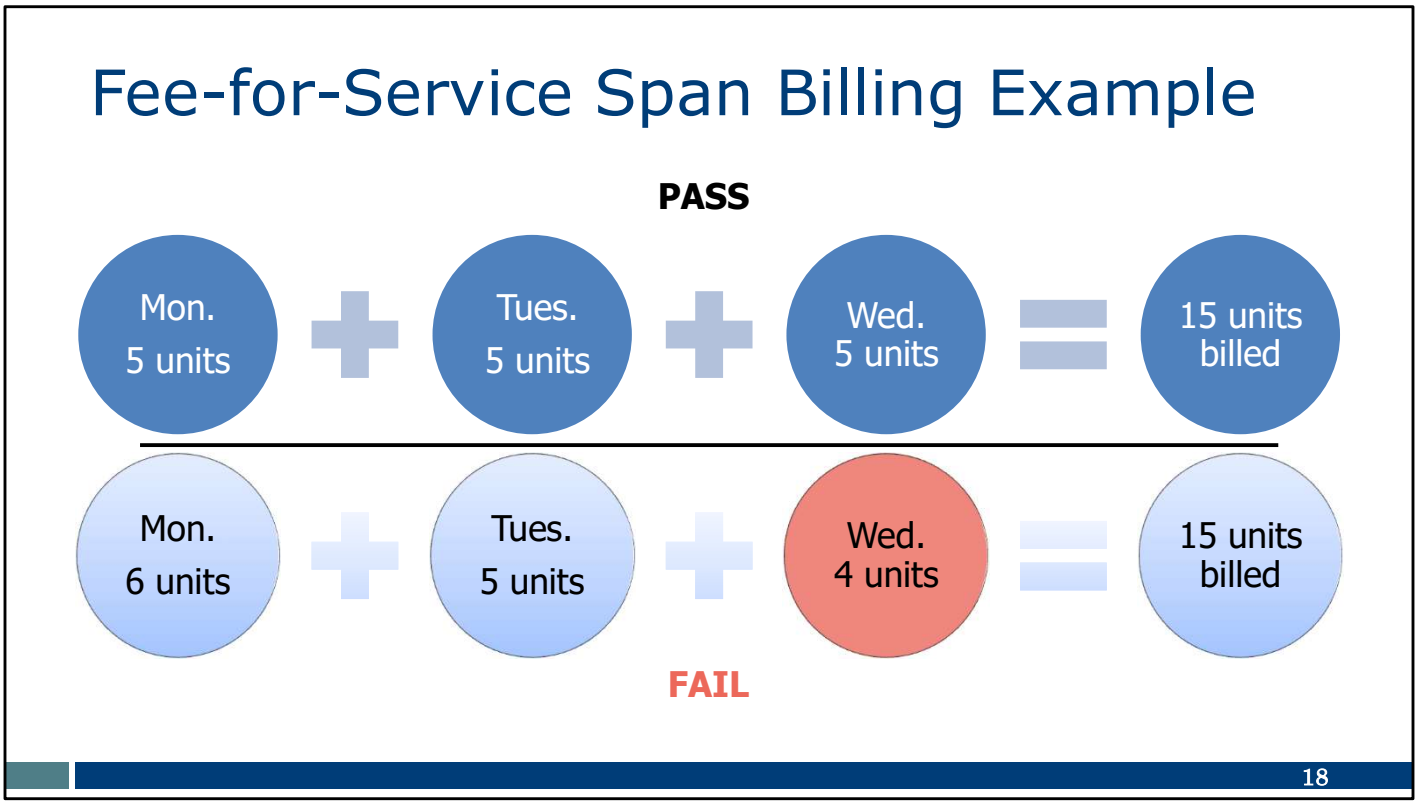
To be compliant with existing DHS span billing policy, the procedure code, revenue code, modifiers, and service units billed must all be the same *for each date included in the date span.*

If one of the dates in the span has different information, span billing is not appropriate. The entire detail line is denied.

We know providers across the state provide services based on the real-life needs of the member each day. Real life means each day may not be the

same. It may be difficult to meet the conditions of span billing.

Let’s take a look at two examples on the next slide.



Usually, span billing runs into a problem with the service units being different.

Here we have a span of three consecutive dates, billed for a total of 15 units.

DHS first needs to know units per day. So, we divide the total units in the date span (in this example, 15) by the number of days in the span (in this example, 3 days). In this example, we'd expect 5 units per day. The math tells us what is expected each day for all these days to have matching amounts of time.

In the top example, the EVV units for each of the three days is 5 units.

- Will this pass the test?
- Yes! This span billing claim detail will pass. For each day, the EVV units are

at least the 5 units required.

In the bottom example, the EVV units for Monday is more than the 5 units expected. That's okay—we want EVV to show *at least* 5 units, and it does. Tuesday shows exactly 5 units. Perfect. But Wednesday shows 4 EVV units. That is less than the expected 5 units. This bottom example will fail the edit.

- A span bill of these three dates will be denied.

Let's take a look at the Explanation of Benefits that shows a span of dates in a single detail line.

Billing for Multiple Dates of Service

PROC CD	MODIFIERS	SERVICE DATES FROM	TO	ALLW UNITS	RENDERING PROVIDER COPAY AMT	BILLED AMT	ALLOWED AMT	INCENTIVES	PA NUMBER PAID AMT	DETAIL EOBS
T1019		010923	011323	95.00					9999999999	1048
					0.00	534.85	0.00	0.00	0.00	

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Here's January 9 to January 13 (highlighted on the left) on a single detail line. If this was a quiz, I'd ask you:

- Did this claim pay?
  - The answer is no. $0 was paid.
- Why didn't it pay?
  - You can see in the final column: EOB code 1048. "EVV units do not meet requirements of visit"
  - That means, between January 9 and 13, one or more of the dates had an EVV visit that was less than the math told us to expect. (Here, the 95 units divided by 5 days tells us 19 units are expected each day.)
  - Span billing was used, but the matching conditions were not met.

To summarize:

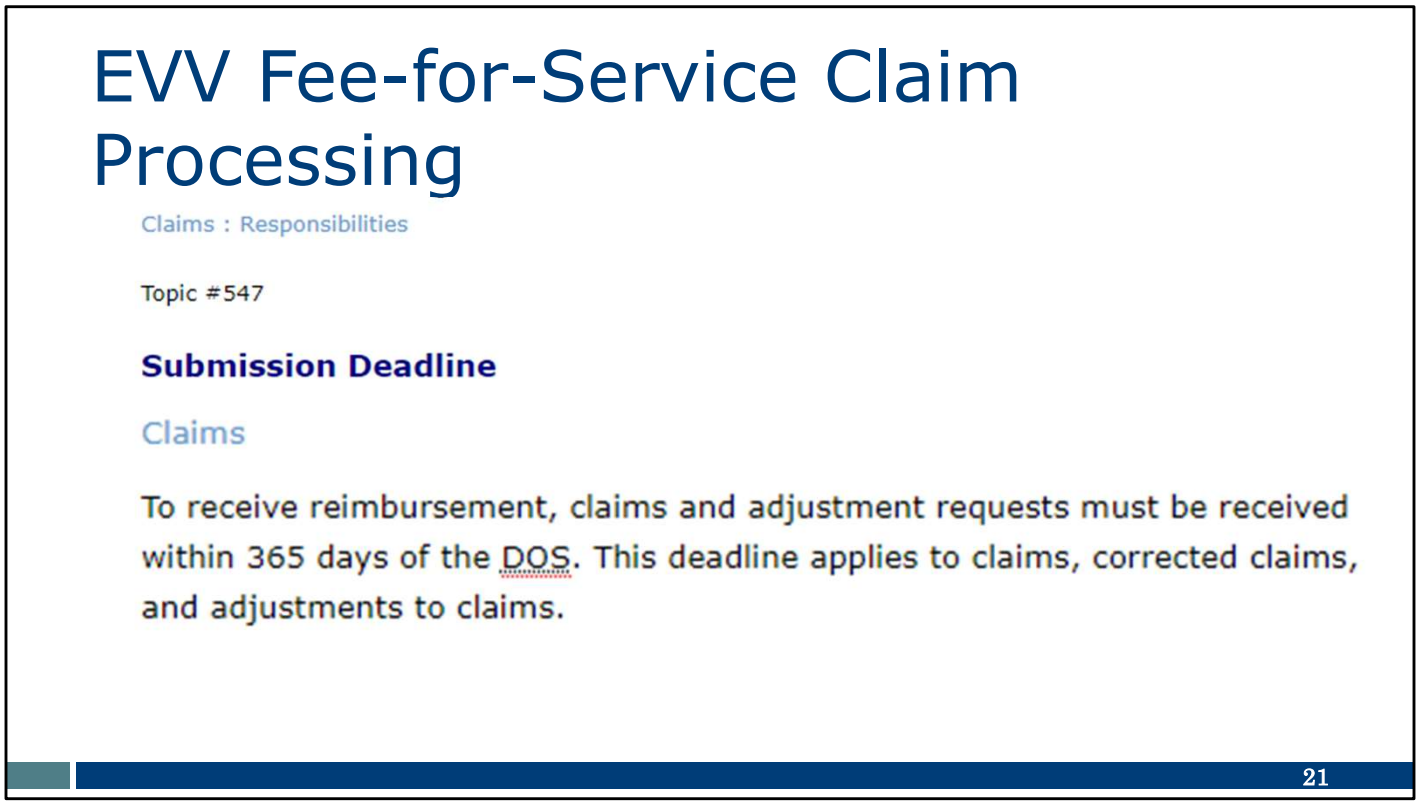
- Real life does not work well with span billing.
- It's more realistic to bill each date of service on a separate detail line to avoid denials.
- Only submit a span of dates on one detail line if all the conditions, including units for every day in the date span, match.

Billing for Multiple Dates of Service

Providers should check with their HMO, managed care organization, or IRIS (Include, Respect, I Self-Direct) fiscal employer agency for span billing requirements.

As a reminder, we're focusing on fee-for-service today, because that's the program DHS processes.

Providers should also check with their HMO, MCO, or IRIS FEA for the specific span billing requirements of those payers.



We've talked about correcting information and resubmitting claims. How long do providers have to do this? Let's look at the ForwardHealth Portal's Online Handbook.

Providers have 365 days from the date of service to submit claims, correct claims, or adjust claims.

Providers also have 365 days to make any manual edits in the Sandata portal.

Be sure to check with HMOs, MCOs, and FEAs you bill for their deadlines.

You want to get paid. We want you to get paid, too! Make your corrections and resubmit claims!

Best Practices

Let's change gears and talk about our recommended best practices.

Best Practices

- Confirm client authorizations are current in your EVV system.
- Review EVV visits in your EVV system regularly to look for exceptions.
- Correct exceptions and confirm all visits are in verified status before claim submission.
- Remind workers to use the EVV system at every visit.

What are the best practices when it comes to EVV claim submission? How can you save time and effort?

If you are using the DHS-supplied Sandata EVV system, you can use Sandata's reports and other tools to:

- Confirm client prior authorizations are in your EVV system.
- Review EVV visits in your EVV system regularly to look for errors.
- Correct exceptions and confirm all visits are in verified status before claim submission.

You can also remind workers to use the EVV system at every visit. Follow up if a worker seems to have difficulties in recording their visit. Help them be successful so you can be successful!

(A reminder: Independent nurses, you are also the worker here.)

We also encourage you to use our EVV Customer Care team as a best practice!

Resources

Know that we are here to help, and providers, including independent nurses, have many resources available.

Questions

Wisconsin EVV Customer Care

One-on-one office hours support:

- Phone: **833-931-2035**
- Email: vdxc.contactevv@wisconsin.gov
- Monday–Friday: 7 a.m.–6 p.m. CT

If you have specific questions regarding claims or exceptions, a one-on-one office hours session could be a great opportunity for you. Use the QR code to capture the email address.

To use the QR code: Open you cell phone camera, and hover it over the QR code box. A text box will appear. Tap on the text box; it will take you directly to an email addressed to EVV Customer Care that you can save or send with your questions.

During office hours, providers and independent nurses can set up a one-on-one appointment with an EVV specialist who will talk through specific challenges and help them find solutions. The EVV specialist will come to the appointment with an understanding of where the provider is in the process, what issues they may be facing, and suggested solutions.

Office hours can be a one-time tool for getting started with EVV or solving a specific issue, or providers can schedule regular office hour sessions with the same EVV specialist for ongoing support.

To schedule personalized support, call Wisconsin EVV Customer Care at 833-931-2035 or email vdxc.contactevv@wisconsin.gov and ask to set up an office hours appointment. Please consider setting up an office hours appointment today.

EVV Customer Care is available Monday to Friday, 7 a.m. to 6 p.m. Central time.

Fee-for-Service Claims Resources

- ForwardHealth Portal Resubmitting a Denied Claim: Searching for, making changes to, and resubmitting a claim
- ForwardHealth Portal Claim Status Information: Searching for a claim and viewing the status of Pay, Deny, Suspend, Adjust
- ForwardHealth Provider Service Call Center:
  1-800-947-9627
  Monday through Friday, 7:00 a.m. - 6:00 p.m. Central Time
  Enrollment, policy, and billing questions
- ForwardHealth provider relations representatives: Assist with complex billing and claims processing questions

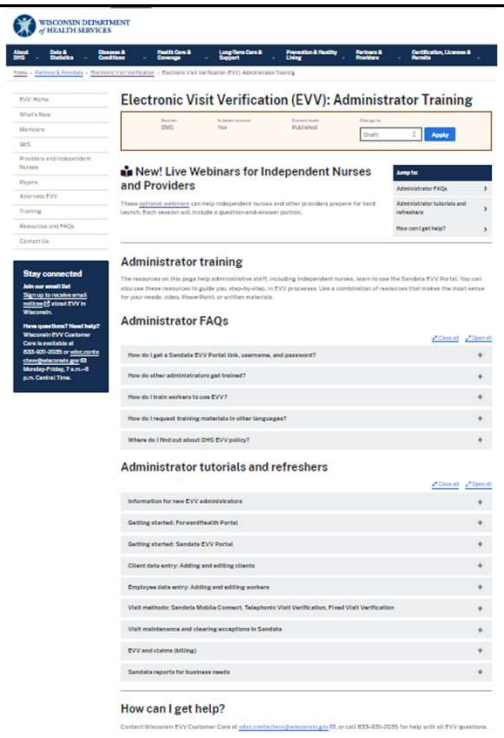
While our EVV Customer Care team is the best resource for EVV questions, you may have questions that are specific to fee-for-service claims and billing.

You can access existing resources from the ForwardHealth Portal, shown here. There are brief information sheets that can be helpful.

If you'd rather talk through your claims and billing questions, ForwardHealth's Provider Service Call Center is available. In addition, ForwardHealth provider relations representatives are also able to offer help. Find the field rep assigned to your part of Wisconsin in the link provided.

Resources

www.dhs.wisconsin.gov/evv/training-administrators.htm



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For additional resources you may refer to the link above or to the QR code to take you to Administrator Training on the EVV DHS website.

Scroll down to Visit Maintenance and you'll see these training resources:

- The Visit Maintenance PowerPoint covers how to use the Sandata EVV Portal to make corrections or additions to visit data, including how to clear exceptions and how to prevent exceptions.
- Or, if you prefer to learn through videos, there are several videos that go through segments of that PowerPoint.

Thank You

Thank you for the important services you provide to members.

WISCONSIN DEPARTMENT of HEALTH SERVICES

Thank you.