

ForwardHealth **UPDATE**

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NEW ELECTRONIC VISIT VERIFICATION POLICY AND REMINDERS FOR HARD LAUNCH

Electronic visit verification (EVV) has been required in Wisconsin since November 2, 2020. Hard launch for personal care and applicable supportive home care services will begin on May 1, 2023. Hard launch is when the Wisconsin Department of Health Services (DHS) will begin imposing financial and programmatic consequences if EVV information is not captured for required services (services authorized under service codes T1019, T1020, S5125, and S5126). Consequences include claim denial, exclusion from future capitation rate setting development, possible provider enrollment sanctions, and possible IRIS (Include, Respect, I Self-Direct) participant disenrollment.

New Electronic Visit Verification Policy

Power Outage and Electronic Visit Verification System Outage Policy

DHS understands that there are times when personal care workers cannot collect EVV information because of reasons outside their

AFFECTED PROGRAMS

BadgerCare Plus, BadgerCare Plus HMOs, Family Care, Family Care Partnership, IRIS, Medicaid, SSI HMOs

TO

Home Health Agencies, Personal Care Agencies, HMOs and Other Managed Care Programs

CUSTOMER CARE

Wisconsin EVV Customer Care is here to help providers with any EVV issues. Contact EVV Customer Care at 833-931-2035 or VDXC.ContactEVV@wisconsin.gov.

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control, including unexpected power outages and EVV system outages. For dates of service (DOS) on and after May 1, 2023, provider agencies are not required to manually create EVV visits that occur during a power or system outage that lasts more than 24 hours. Provider agencies must be able to show proof of an outage upon request. This policy does not change existing EVV-related policies or documentation requirements, including billing, record of care, or timesheets.

A power outage is defined as a utility failure where electricity or telephone service is unexpectedly unavailable. Acceptable proof of a power outage may include documentation from the local utility company or from a publicly available database.

An EVV system outage is defined as any widespread technological failure that prevents multiple workers from using the collection methods available with their EVV system. This policy applies both to Sandata and to alternate EVV systems. Sandata can provide documentation of system outages upon request. Provider agencies using alternate EVV should contact their alternate EVV system vendor for proof of outages.

Billing for Visits During Outages

Fee-for-Service, BadgerCare Plus and Medicaid SSI HMOs, Family Care, and Family Care Partnership

Providers submitting claims for visits that occurred during a widespread power or EVV system outage that lasted more than 24 hours are required to include the UC modifier on the detail line item for that visit. The UC modifier will allow the claim to bypass the EVV claim edits and be paid even though there is no corresponding EVV information associated to it.

IRIS

IRIS provider agencies must submit the [IRIS Electronic Visit Verification \(EVV\) System or Power Outage Exception Notification](#) form, F-03117 (12/2022), to the fiscal employer agency (FEA) with any invoice that includes visits on DOS to be exempted from EVV because of an extended system or power outage. Participant-hired workers should communicate directly with their FEA if an outage lasting longer than 24 hours prevents them from collecting EVV information.

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For participant-hired worker claims and applicable provider agency claims where EVV information was not recorded due to a power or system outage lasting more than 24 hours, FEAs will enter an E indicator in the Support Indicator field on the detail line item when submitting encounters to DHS. The E indicator will allow the claim to bypass EVV edits during claims and encounter processing.

Changes to Live-In Worker Policy

DHS has updated permanent residency definitions and documentation requirements for live-in workers for EVV. Permanent residency is determined by the worker being able to produce documentation that shows the worker's name and current residential address and demonstrates that they meet one of the definitions of a live-in worker. Providers should check with their HMO, managed care organization (MCO), IRIS consultant agency (ICA), or FEA regarding specific documentation requirements.

Expanded Definition of Permanent Residency

For the purposes of EVV, a live-in worker is a worker who meets one of the following requirements:

- The worker permanently resides in the same residence as the member or participant receiving services.
- The worker permanently resides in a two-residence dwelling (such as a duplex) where the member or participant receiving services lives in the other half of the dwelling **and** is a relative of the member or participant receiving services. A relative is defined as a person related, of any degree, by blood, adoption, or marriage, to the member or participant.

In addition, for DOS on and after April 14, 2023, the following may also describe a live-in worker:

- If a member or participant has parents or guardians that live in separate homes, and the member or participant resides in each home at regularly scheduled intervals, each parent or guardian is considered a live-in worker for EVV purposes.

Workers who do not meet the definition described above are not considered live-in workers. For example:

- Workers who **temporarily** reside with the member or participant receiving services for only a short period of time are not considered live-in workers.
- Workers who work 24-hour shifts but are not residing with the member or participant on a permanent basis are not considered live-in workers.

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Additional Live-In Worker Proof of Residence Documentation Options

DHS has expanded the list of acceptable proof of residence for live-in workers. For DOS on and after April 14, 2023, DHS will accept any household bill (for example, gas, electric, phone service, cable, internet, water, trash, or other similar bill) as one of two documents to prove residency. Additionally, the household bill may be from the current month or up to three months previous.

As a reminder, to establish permanent residence, live-in workers are required to show either one document from the left column in the table below or any two different types of documents from the right column of the table. For example, a live-in worker may present a residential lease **or** a household bill **and** a bank statement. Two bank statements would **not** be acceptable proof. Two **different** household bills (for example, a gas bill and a water bill), **would** be acceptable proof. Documents proving residency must show the worker's name and current address.

ONE OF THE FOLLOWING	TWO TYPES OF THE FOLLOWING
<ul style="list-style-type: none">• Current and valid State of Wisconsin driver's license or state ID card• Other current official ID card or license issued by a governmental body or unit• Real estate tax bill or receipt for the current year• Residential lease for the current year• Check or other document issued by a unit of government within the last three months	<ul style="list-style-type: none">• Household bill (for example, gas, electric, phone service, cable, internet, water, trash, or similar bill) from the past three months• Current or past month's bank statement• Current or past month's paycheck or paystub

Revised Live-In Worker Identification Forms

The [Electronic Visit Verification Live-In Worker Identification](#) form, F-02717 (04/2023), and the [IRIS Participant-Hired Worker Relationship Identification](#) form, F-01201A (03/2023), have been revised to reflect the changes to documentation and the definition of live-in workers as described above.

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Existing prior authorizations (PAs) do not need to be resubmitted with the new versions of the live-in worker forms. Agencies and participants should use the new form going forward for renewals and for new PA submissions.

Reminders

The sections below are reminders of previously published policy.

Fee-for-service providers should check the [ForwardHealth Online Handbook](#) for the most current, up-to-date policy. The Online Handbook is updated whenever new policy becomes effective and reflects the guidance that providers should follow today.

Family Care and Family Care Partnership providers may refer to the Electronic Visit Verification topic ([#22483](#)) of the Online Handbook.

IRIS FEAs, ICAs, and participants should reference the [IRIS Electronic Visit Verification Policy](#), P-03053 (02/2023), publication.

Live-In Workers

Because of their unique circumstances, live-in workers are not required by DHS to use EVV. However, claim details for services that require EVV information are denied unless a live-in worker is identified on the PA. Worker IDs are required for this identification process, even if the live-in worker is not required to use EVV.

Note: HMOs, MCOs, and provider agencies may independently decide to require live-in workers to use an EVV system. IRIS FEAs cannot require participant-hired live-in workers to use an EVV system.

Live-in worker status must be established between each member/participant and worker. When a worker provides services to more than one member/participant with whom they permanently reside, live-in worker status must be validated for each member or participant. EVV has not changed PA amendment and end-dating policy.

KX Modifier

For fee-for-service members, PA requests with live-in workers are approved with separate line items: one with the KX modifier to use for services provided by a live-in worker, and one without the KX modifier to use for services not provided by a live-in worker. (The total number of approved units can be used for either a live-in worker or a non-live-in worker.)

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Once a PA is on file with a live-in worker identified, fee-for-service claims for services provided by a live-in worker must include the KX modifier when the payer and provider agency do not require live-in workers to use EVV systems. If the PA on file does not identify a live-in worker, claims with a KX modifier indicating a live-in worker will not match the authorization and will be denied.

For all program areas, provider agencies should use the KX modifier to identify services provided by a live-in worker when the payer and provider agency do not require live-in workers to use EVV systems. Claims with the KX modifier do not require EVV.

Conversely, provider agencies should submit claims for services provided by non-live-in workers, or by live-in workers who are required to capture EVV by the payer or provider agency, without the KX modifier. Claims without the KX modifier **do** require EVV.

To submit claims for a day when both a live-in worker exempt from using an EVV system and a worker who is not exempt provide services on the same day, the claim should be submitted as two separate detail line items, with the KX modifier for the exempt (live-in) worker only. The detail line items will not deny due to duplication because one of the lines will have the KX modifier and the other will not.

Claims Processing

Plans for processing claims after hard launch have not changed.

BadgerCare Plus and Medicaid SSI HMOs, Family Care, and Family Care Partnership

HMOs and MCOs have the authority to deny provider claims with missing EVV data. Provider agencies should contact their HMO or MCO for guidance on claim policies and procedures.

Personal care and applicable supportive home care encounters submitted to DHS without matching EVV data may be excluded from future capitation rate setting development.

IRIS

IRIS is a fully self-directed program. Participants, as the employer of record, have a responsibility to ensure participant-hired workers are using EVV as required in order to remain enrolled in the IRIS program. Refer to the [IRIS Electronic Visit Verification Policy](#) for details on the process that will be used

REMINDER

Claims for services provided by live-in workers must use the KX modifier for them to be paid without matching EVV information.

If a provider agency, HMO, or MCO requires live-in workers to use an EVV system, the claim should be billed as normal, with no KX modifier.

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to assist participants in this responsibility. FEAs will pay participant-hired workers' claims in a timely manner and work with participants and participant-hired workers to resolve missing or inaccurate EVV data prior to submitting encounters to DHS. Provider agencies are expected to correct EVV exceptions and enter manual visits prior to sending claims to the FEA. FEAs will deny provider agency claims without corresponding EVV data.

Newly Enrolled IRIS Participant Grace Period for Non-Live-In Participant-Hired Workers

While it is best to get workers to use an EVV system as soon as possible, DHS recognizes that newly enrolled IRIS participants need time to adjust to the responsibilities of a self-directed program. Therefore, DHS will grant a 60-day grace period to newly enrolled participants before their participant-hired workers' rates of accurate EVV system use will be counted toward the participants' compliance with program requirements. This grace period applies only to services provided by workers who are hired and trained by an IRIS participant. For more information, refer to the IRIS Electronic Visit Verification Policy.

BadgerCare Plus and Medicaid Fee-for-Service

Fee-for-service claims for services that require EVV must have required EVV data in order to be paid. Detail units billed exceeding the verified EVV visit units collected will be denied.

BadgerCare Plus and Medicaid Fee-for-Service Claim Editing Error Messages

Validation Criteria

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:

1. The first EVV claim edit compares:
 - Billing provider
 - Member Medicaid ID
 - Detail procedure code
 - DOS
2. The second EVV claim edit compares the units of time billed to the units of time captured by EVV.

THE KEY MESSAGE

The 60-day grace period applies to **newly enrolled IRIS participants** only, not to new workers or provider agencies.

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All other policy regarding fee-for-service claim submission remains unchanged.

Additional Details for the First Claim Edit

If there is no EVV data corresponding to the criteria required in the first edit, the claim detail will suspend and the claim will recycle through the system for up to two days.

IF...	THEN...
There is corresponding EVV data found before the end of the recycle process,	The detail will continue to process to the next EVV claim edit.
There is no corresponding EVV data found by the end of the recycle process,	The detail will deny with explanation of benefits (EOB) message #1047, "Electronic visit verification system visit not found," and it will not continue to the second EVV claim edit.

Note: To avoid delays in claim adjudication, provider agencies should confirm that all applicable EVV visits for claims are in a verified status prior to submitting a claim.

Additional Details for the Second System Edit

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

IF...	THEN...
The billed detail units are the same as or less than the calculated EVV visit units,	The detail will continue to process as normal.
The billed detail units are greater than the calculated EVV units,	The detail will deny with EOB message #1048, "Electronic visit verification system units do not meet requirements of visit."

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Span Billing

EVV has not changed existing DHS span billing policy. Provider agencies should check with their HMO, MCO, or IRIS FEA for span billing requirements.

Span billing is when one claim detail is submitted for services given over multiple consecutive days. DHS requires that certain conditions be met in order for claims using span billing to be processed correctly. This is especially important when billing for services that require EVV information, because the units of service captured using an EVV system must be equal to or greater than the units of service billed on the claim.

To be compliant with existing DHS span billing policy, the procedure code, revenue code, modifier, and units billed must all be the same for each date included in the date span. Unless the billed units for every day in the date span are identical, provider agencies should bill each DOS separately to avoid denials.

When processing claims using span billing, DHS calculates the units billed per day by dividing the total units in the date span by the number of days in the span. The result is the calculated units for every day of the span.

DHS policy requires that, for each day in the span, there be at least as many EVV units as calculated units.

For example, if a provider agency bills 15 units for three days, there must be at least five EVV units for **each** of the three days in the date span. If the EVV units were captured as six units on Monday, five units on Tuesday, and four units on Wednesday, the date span detail would not be compliant with DHS policy because Wednesday does not have at least five EVV units. Therefore, the entire claim would be denied.

HMOs, MCOs, and IRIS FEAs may deny payment for claims that are not compliant with DHS policy.

Alternate Electronic Visit Verification

Provider agencies choosing to use an alternate EVV system are not exempt from the consequences of hard launch. All alternate EVV systems must be

QUICK LINKS

Fee-for-service providers should refer to the Visits With Multiple Dates of Service topic ([#21718](#)) of the Online Handbook for the most up-to-date policy.

“The units of service captured using an EVV system must be equal to or greater than the units of service billed on the claim. [...] The procedure code, revenue code, modifier, and units billed must all be the same for each date included in the date span.”

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certified with Sandata prior to use. If an alternate EVV system will not be fully certified with Sandata before hard launch, the Sandata EVV system must be used to ensure no interruption in payments. Provider agencies will not be exempt from using EVV while going through the certification process with Sandata.

Provider agencies can only use one system (either the Sandata EVV system or an alternate EVV system) at a time. Provider agencies may switch from using the Sandata EVV system to their alternate EVV system when they are ready.

For guidance on how to get an alternate EVV vendor certified or training for the Sandata aggregator (which connects alternate EVV systems to DHS), refer to the DHS [Alternate EVV](#) webpage.

Resources

DHS is committed to supporting provider agencies, payers, participants, members, and workers in using EVV systems. DHS offers several resources for answering questions and solving problems with EVV use.

Key Conversations

Key Conversations are informal, monthly drop-in sessions for provider agency administrators. Members of the DHS EVV team, Wisconsin EVV Customer Care, and Sandata staff are available to answer questions about EVV. Information on when the next session will be held and a link to join the event can be found on the [DHS EVV homepage](#).

Wisconsin Electronic Visit Verification Customer Care

Wisconsin EVV Customer Care is available to answer questions by email at vdxc.contactevv@wisconsin.gov or by phone (in English, Hmong, and Spanish, among other languages) at 833-931-2035, Monday–Friday 7 a.m.–6 p.m. Central time.

Personalized office hours are also offered for provider agencies or payers that need ongoing or detailed support. Contact Wisconsin EVV Customer Care to schedule a one-on-one appointment with an EVV specialist who will talk through your agency's specific challenges. Due to an expected increase in call volume close to hard launch, provider agencies are encouraged to set their appointments as soon as possible.

QUICK LINKS

DHS is offering virtual training on EVV claim edits for fee-for-service EVV administrators. Visit the [DHS EVV Training Administrators](#) page for details.

The Wisconsin Department of Health Services Electronic Visit Verification Webpage

The [DHS EVV webpage](#) offers resources for anyone using EVV, including provider agencies, payers, workers, members, and IRIS participants. The EVV webpage is a great place to find trainings on a wide range of topics, simple explanations of EVV, and summaries of DHS EVV policy. These resources include flyers, written materials, and videos. Many materials have been translated into Spanish and Hmong and can be translated into other languages upon request. Translation requests should be submitted to Wisconsin EVV Customer Care.

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § [DHS 106.02\(9\)](#). Providers are required to produce or submit documentation, or both, to DHS upon request. Per Wis. Stat. § [49.45\(3\)\(f\)](#), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify the actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in sanctions including, but not limited to, termination from the Medicaid program.

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This Update was issued on 04/14/2023 and information contained in this Update was incorporated into the Online Handbook on 05/01/2023.

The ForwardHealth Update is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Medicaid Services within the Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health within DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.