Missouri Department of Social Services

MoHealth Net

Provider Bulletin

Volume 47 Number 49 https://mydss.mo.gov/mhd May 28, 2025

Electronic Visit Verification (EVV) Claims Validation

Applies to: Providers of Personal Care and Home Health Care Services required to use EVV

Effective date: Fall 2025

- **Claims Validation**
- **Claims Validation Soft Launch**
- **Claims Validation Full Implementation**
- **Provider Responsibilities**

Claims Validation

As of November 8, 2021, for Personal Care providers, and May 17, 2023, for Home Health Care providers, EVV is required to document the delivery of personal care services per the 21st Century Cures Act. A list of applicable services can be found on the EVV webpage.

Per guidance from the Centers for Medicare & Medicaid Services (CMS), the next phase of EVV implementation requires the validation (matching) of claims to the data entered for each visit in the EVV Aggregator Solution (EAS) before payment of the claim.

System updates to implement claims validation will have an impact on the payment of claims for services that require the use of EVV. To minimize the risk of denied claims following these changes, providers are strongly encouraged to be fully compliant with existing EVV requirements. For more information on these requirements, refer to the Provider Responsibilities below and the EVV webpage.

Following full implementation of this enhancement, claims that do not have a matching visit in EAS will be denied and payment will not be issued.

Claims Validation Soft Launch

A soft launch of EVV claims validation is planned for Fall 2025 to familiarize and provide education to providers regarding the process, and to assist in preventing denial of claims following the full implementation. The soft launch is expected to be a period of approximately three months. **Throughout the soft launch**, claims will continue to pay even if there is not a matching visit in EAS.

The method used for submitting claims will remain unchanged. An additional systematic validation step will occur comparing the claim to the visit data in EAS. Each claim for EVV services must align with a 'verified' visit in EAS, matching the following data elements:

- Individual/Participant ID (DCN)
- Date (s) of Service
- Provider Medicaid ID
- Procedure Code/Modifier
- Number of Units

If the information in EAS does not match the information submitted on the claim, providers will receive an informational exception on their Remittance Advice (RA). These claims will be denied once the full implementation of claims validation begins.

It is critical for providers to address the Informational Exceptions on the RA by determining what caused the information not to match and correcting the issue. Providers must determine if the error is in EAS or on the claim. If the error was in EAS, providers should make corrections in their EVV system and resend to EAS using their current process.

Accrual of minutes will continue to be allowed. Additional details will be provided as they become available.

Claims Validation Full Implementation

Following the soft launch, claims validation will be fully implemented. Once implemented, any claim submitted without a corresponding visit in EAS or claims that do not match all the data elements listed above, will be denied and will not pay. Visits in EAS must be in a 'verified' status. Providers will receive notification of a denial on their RA. The provider must log into EAS to identify any missing or inaccurate information. Corrections must be made in the provider's EVV system, then resent to EAS. At that time, the claim must be resubmitted for payment.

Provider Responsibilities

To prepare for this change and continue to be paid for claims without interruption after claims validation is fully implemented, providers must take the following actions:

- Ensure EVV is used for all visits for any service requiring the use of EVV, entered at the time services are provided. A list of services can be found on the EVV webpage.

- Confirm visits are being displayed in the appropriate accounts based on the Provider Medicaid ID using the following:
  - Personal Care Provider Services Reference Table
  - Home Health Care Provider Services Reference Table

- Ensure the provider's chosen EVV system is sending the visit data to EAS at least once a day.

- Login to EAS at least once a week, as required by 13 CSR 70-3.320 (2)(K) and ensure all visits are 'verified', correct any errors found, and resubmit corrected information to

EAS. After full implementation of claims validation, visits must be in a 'verified' status to be considered for payment.

For a breakdown of the process flow for claims validation during the soft launch, refer to the Process Flow for Soft Launch EVV Claims Validation.

For questions, visit the EVV webpage or contact Ask.EVV@dss.mo.gov.

APPLICABILITY

The information in this bulletin applies to the MO HealthNet (MHD) Fee-For-Service (FFS) program and may apply to the MHD Managed Care (MC) program, as well. MHD's FFS policies set the basic coverage policies for benefits and limitations in the MC program. The MC health plans have additional flexibilities in operating their respective programs, such as determining which services require prior authorization and details required for claims submission. Certain services, such as pharmacy, are "carved out" of MC and will be paid through the FFS program. To ensure your understanding of this bulletin's applicability to each MC health plan, please **contact your health plan** directly. If you are unable to resolve a MC issue directly with a health plan contact a MC Liaison by completing a **Managed Care Provider Request for Information**.

Bulletins will remain on the **MO HealthNet News** page only until incorporated into the **provider manuals** as appropriate, then moved to the appropriate **Provider Manual Archives**.

Providers and other interested parties are urged to **subscribe** to **MO HealthNet News** email list to receive automatic notifications of provider bulletins, provider hot tips, provider manual updates, and other official MO HealthNet communications.

Before delivering a service, please check the patient's eligibility status by swiping their MO HealthNet card, calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and choosing Option One or using the Participant Eligibility option in **eMOMED**. Questions regarding MO HealthNet MC benefits should be directed to the patient's MO HealthNet **MC health plan**.

MHD Education and Training offers interactive web-based training for providers and general and program-specific educational resources. Visit our **Provider Training Calendar** to register for an upcoming training.

Provider Communications
573-751-2896
or via Provider Communications Management in eMOMED