Missouri Department of Social Services

MoHealthNet

Provider Bulletin

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Electronic Visit Verification (EVV) Claims Validation Readiness

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

Effective date: June 26, 2025

- **Monitor EVV visits in the EVV Aggregator Solution (EAS)**
- **Adjustments need to be noted with a name or email address**
- **EAS changes June 26, 2025**
  - **Removal of "999-Other" as a reason code**
  - **Rejected visits due to submission under the wrong EAS account**

Monitor EVV visits in the EVV Aggregator Solution (EAS)

As work continues toward the implementation of claims validation with visits in the EAS, it is critical for providers of personal care services and home health care services to be fully compliant with existing EVV requirements. For more information on the announcement of EVV Claims Validation, review MO HealthNet Provider Bulletin 47-49.

Per 13 CSR 70-3.320(2)(K) providers must be logging into EAS at a minimum of once a week to ensure all visits are 'verified' and accurate. Providers must correct any errors found and resubmit corrected information to EAS through their EVV system. EVV visits must match the claims data which includes the Participant Designated Client Number (DCN), date of service, procedure code and/or modifier combination and Medicaid Provider ID. It is recommended providers pay particular attention to recently deployed system changes or clarifications, including but not limited to those indicated in this communication.

Adjustments need to be noted with a name or email address

As stated in 13 CSR 70-3.320 and clarified in this Hot Tip any adjustment or manual entry related to call in or call out times must be made by a provider agency supervisor or administrator. The purpose of this requirement is to ensure adjustments are not made by the caregiver that provided the service. To help monitor compliance, only a name or email address should be entered into the provider agency's EVV system to identify the user making the change. Numeric entries and system generated user identifiers are not acceptable. Providers who are using identifiers other than names or email addresses should contact their EVV vendor to ensure they are in compliance with the EVV regulation referenced in this section.

EAS changes June 26, 2025

Effective June 26, 2025, the following EAS system changes are in effect:

- **Removal of "999-Other" as a reason code**
  Providers must select a reason code in their EVV system when a visit is manually entered or updated and resubmitted. Reason code "999-Other" has been eliminated from EAS and should no longer display as an option for the documentation of manually entered or updated visits. Visits submitted to EAS with the reason code of "999-Other" will be rejected. If a rejection occurs, the visit must be resubmitted to EAS using a valid reason code as listed in Appendix 3 of the most recent version of EVV Vendor Specifications.

- **Rejected visits due to submission under the wrong EAS account**
  Providers must make sure they submit visit data into the right EAS account based on the type of service provided. Visits submitted to the incorrect EAS account will be rejected. The procedure code and/or modifier combination on the EVV visits should match the appropriate provider type as defined in the reference tables below:

    - personal care services
    - home health care services

  If submitted visits are not displayed in EAS, providers should contact their EVV vendor to determine whether the issue is related to this system change. For more information, review the current version of EVV Vendor Specifications.

Refer to the EVV provider page for additional information and resources. For questions, 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