Missouri Department of Social Services

MoHealth Net

Provider Bulletin

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Electronic Visit Verification (EVV) Aggregator Solution (EAS) – Accrued Minutes

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

Effective date: November 19, 2025

- **Accrued Minutes Process**
- **New Reason Code**
- **Accrual Minute Scenario**
- **Claims Validation Soft Launch**
- **Claims Validation Hard Launch**

This Bulletin is intended to inform providers about upcoming changes so they can prepare for the new claim validation process. The goal is to ensure that personal care service and home health care service providers continue to receive payment for accrued units once claims validation in the EAS is implemented.

Accrued Minutes Process

Providers must continue to monitor accrued minutes and determine when they reach a full unit. In accordance with state regulation 13 CSR 70-91, a unit is defined as 15 minutes of service. **Beginning November 19, 2025,** the following rules will apply for Providers/Vendors to submit accrued minutes visits.

- Reason code 280 (Accrued Minutes Visit) must be used when submitting the accrued minutes visit to EAS
- Accrued minutes visits must be submitted for the month it was accrued; minutes do not carry over from month to month
- Only 1 accrued minutes visit is allowed per day, per client, per procedure code/modifier
- There is no unit restriction, duration must be divisible by 15 (e.g., 30 minutes, 45 minutes)
- Visits must include all required data elements to be in a verified status
    - The caregiver submitted on the accrued minutes visit must be a caregiver associated with the client DCN

- Start and end time for any time period may be used as long as it is divisible by 15 (e.g., 30 minutes, 45 minutes) and does not overlap with an existing visit for the same service
- For visits requiring tasks, a new task titled “Accrued Minutes Visit” must be submitted when reason code 280 is used. No other tasks are required for accrued minutes visits
- For visits requiring a memo, providers may use a default memo “This is an accrued minutes visit” when reason code 280 is used

New Reason Code

A new reason code (Accrued Minutes Visit) has been created in the EAS to identify visits with manual submissions due to accrual. This new reason code is designed to prevent any negative impact on the provider’s overall automatic versus manual visit verification metrics. When this reason code is used correctly, it will not affect the providers manually verified percentage. It is important for this code to be used only in instances of accrued minutes, as any other use could lead to inaccurate reporting. **The new reason code will be available in the EAS effective November 19, 2025.** Providers are encouraged to consult with their EVV vendor to ensure they are aware of this change.

While it's not required, it's strongly recommended that you use the Memo field associated with the accrued minutes visit to document the exact date(s) when minutes were accrued. This information is valuable for audits or when responding to billing questions.

Accrued Minute Scenario

An EAS example of an accrued minutes scenario:

Visit Date	Procedure Code/Modifier	Call In/Call Out Time	Minutes	Units	Minutes Accrued	EAS Memo
June 1	T1019/U2	10:00 a.m. to 11:40 a.m.	100 minutes	6	10 minutes	
June 4	T1019/U2	10:00 a.m. to 11:05 a.m.	65 minutes	4	5 minutes	
June 4	T1019/U2	12:00 p.m. to 12:16 p.m.	16 minutes	1	1 minute	Minutes accrued from June 1st (10 minutes) and June 4th (5 minutes)

When billing for payment, providers should add up the units for visits that occurred on the same day and bill them together on a single claim line. In the above example, the following would be billed:

Date of Service	Procedure/ Modifier	Units
June 1	T1019/U2	6
June 4	T1019/U2	5

Claims Validation Soft Launch

On January 7, 2026, the MO HealthNet Division (MHD) will implement a soft launch of claims validation. At this time MHD will begin to match submitted claims for personal care and home health care services to visits in the EAS. During the soft launch period, claims submitted with information that does not match the information on visits entered in the EAS **will not be denied**; however, providers will be notified on their Remittance Advice (RA) via an alert that states; "In the near future we are implementing new policies/procedures that would affect this determination," indicating that a match could not be made.

Claims Validation Hard Launch

It is anticipated that hard edits for claims validation will be applied as follows:

Hard Edit Date	Provider Type (s)
April 1, 2026	26 and 28
May 1, 2026	58
June 1, 2026	85

Following the implementation of hard edits, claims not matching visits in the EAS will be denied for payment.

Refer to the EVV program page for more information and updates. For questions, contact MHD.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