Missouri Department of Social Services

MoHealth Net

# Provider Bulletin

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# Electronic Visit Verification (EVV) Claims Validation: Key Updates for Providers

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

## Effective date: Publication of Bulletin

- **Soft Launch - Common Trends**
- **Remittance Advice (RA) Reasons for Receiving an Alert**
- **First Phase of Hard Launch**

### Soft Launch - Common Trends

This Bulletin is intended to provide details regarding the soft launch of claims validation for EVV that was initiated on January 7, 2026. Refer to the Hot Tip posted December 17, 2025, and the Hot Tip posted January 27, 2026, for additional information on the launch.

A large number of claims have been considered for the matching process and the majority of them have contained all needed information to successfully match with visits in the EVV Aggregator Solution (EAS).

For those claims that do not have a corresponding visit in EAS, the following trends have been identified:

- Claims are being submitted before the EVV vendor sends the visit to the EAS
- EVV is not being used by the provider for each member for all required services
- The provider's EVV vendor is not sending visits to the EAS daily or at all
- Visits in the EAS are not in a verified status

### Remittance Advice (RA) Reasons for Receiving an Alert

Providers are encouraged to review their RA to assist in the identification of claims that would be denied following the hard launch. A generic alert (N363) is displayed on the RA during the soft launch period. N363 code means that "In the near future, we are implementing new

policies/ procedures that would affect this determination." If this code appears on the Remittance Advice (RA), it indicates a discrepancy between the claim and the EVV visit in EAS. Providers are required to log into the EAS system to verify the accuracy and completeness of visit records and to determine the cause of any mismatches.

The alert may be due to any of the following reasons:

- Provider ID does not match: The Provider ID from the claim did not match a Provider ID in the aggregator solution
- Participant DCN does not match: The Participant DCN from the claim did not match a Participant DCN in the identified provider's EAS account
- Unmatched Units: A visit was found for the given criteria, but the units in the EAS were less than the units on the claim
- Visit not found for the procedure code and date range
    - A verified visit was not found in the EAS for the dates of service on the claim
    - A verified visit was not found for the procedure codes
- Visit was not in a verified status

To prepare for the hard launch of claims validation, providers must be diligent in logging into the EAS frequently to verify accuracy and completeness of visits.

**First Phase of Hard Launch**

The first phase of the hard launch of claims validation is scheduled for April 1, 2026. At that time, claims submitted for services requiring EVV and authorized by the Department of Health and Senior Services, Division of Senior and Disability Services (DSDS) (provider types 26 and 28), with no matching visits in the EAS will be denied.

Note: The second and third phases of the hard launch will impact claims for services requiring EVV provided by Home Health Care Service providers (provider type 58) and Department of Mental Health, Division of Developmental Disabilities (DDD) (provider type 85). The timeline for these phases will be provided at a later date.

For information regarding the EVV claims validation process, visit the EVV website at https://mydss.mo.gov/mhd/evv. 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**