Sandata

MO DSS: Vendor Claims Validation Town Hall

November 6, 2025

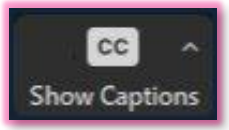
The intended audience for this Town Hall is EVV Vendors doing business in the State of Missouri. Personal Care Service (PCS) and Home Health Care Service Providers (HHCS) are welcome to attend but should be aware that additional guidance specific to providers will be shared in the near future.

Agenda

- Introductions (State and Sandata)
- Claims Validation
- Accrued Minutes
- Scenario Review
- Timeline
- Questions

Housekeeping

- 📽️ This session is being recorded and will be available on Sandata On-Demand, our knowledge base
  - Portions of this recording may serve as a training resource
- 🔗 We will include a link to the MO DSS webpage with this content
- ❗Enable captions by selecting 'Show Captions' on your toolbar



- ❓For questions, please use the 'Q&A' feature at the bottom of your screen
  - Questions will be addressed during today's session as time permits.
  - All questions will also be documented in Q&A documents on the MO DSS webpage and Sandata On-Demand
  - You can also email questions directly to MO DSS at Ask.EVV@dss.mo.gov

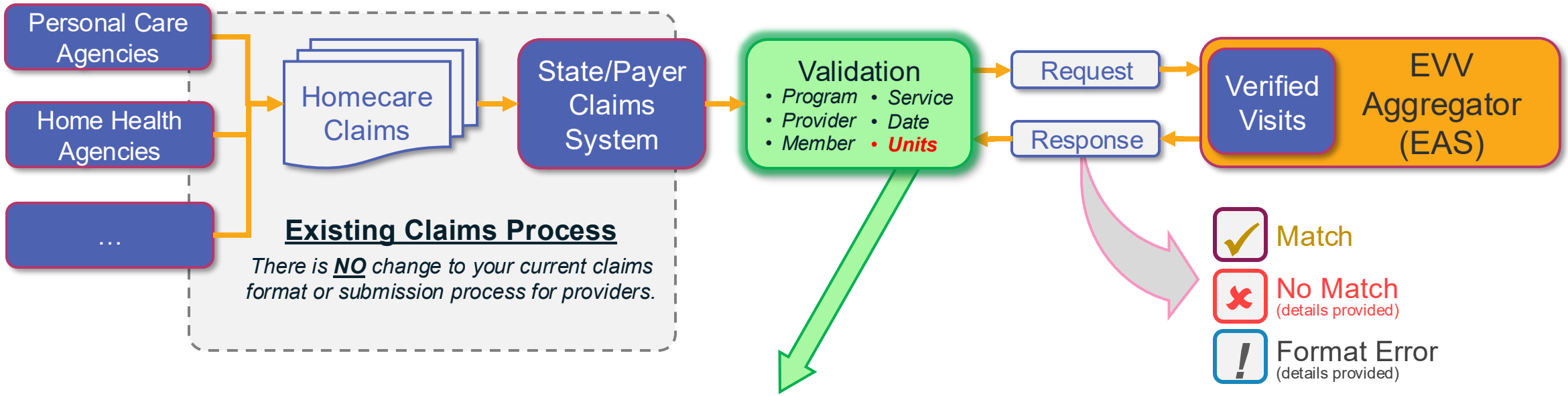
Claims Validation

Claims Validation

How does this work?

- Verified Visits

Sandata collects EVV data from all sources and evaluates them all against the state's program rules, every time. All visits must meet 21st Century Cures Act and state requirements. Verified visits are available to Claims Validation to align Units on the claim with Units in EAS.



Note for the units validation: The visits in EAS must contain units Equal or Greater than the units on the claim/service line for validation to return success.

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13 CSR 70-91.010 – CODE OF STATE REGULATIONS

(4) Reimbursement.

(A) Payment will be made in accordance with the fee per unit of service as defined and determined by the MO HealthNet Division.

1. A unit of service is fifteen (15) minutes.

2. Documentation for services delivered by the provider must include the following:

A. The participant's name and Medicaid number;

B. The date of service;

C. The time spent providing the service which must be documented in one (1) of the following manners:

(I) When a personal care aide is providing services to one (1) individual in a private home setting and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services for that visit shall be documented as the start time, and the actual clock time the aide finished the care for the visit shall be documented as the stop time per Electronic Visit Verification (EVV) regulation 13 CSR 70-3.320; and

(II) When the personal care services are provided in a congregate living setting, such as RCFs I and II or ALFs, when on-site supervision is available and personal care aide staff will divide their time among a number of individuals, the following must be documented: all tasks performed for each participant by date of service and by staff shifts during each twenty-four- (24-) hour period;

D. A description of the service; and E. The name of the personal care aide who provided the service.

3. A provider may not bill time spent in the delivery of service of less than one (1) unit of service for any participant. However, time spent in the delivery of service of less than one (1) full unit for any participant may be accrued by the provider to establish *a unit of service*. *In no event may time spent in the delivery of service be accrued beyond the last day of the calendar month* in which such services were rendered.

Why this Matters

- **Unit Calculations**
  - In Missouri, unit-based services are calculated using a flat 15-minute rule with no rounding.
  - This means that for billing, total minutes are billed to the previous 15-minute breakpoint (15, 30, 45, etc.).
    - Examples:
      - 60-minute visit: Billed at 4 units (60 / 15 = 4 Units)
      - 59-minute visit: Billed at 3 Units (59 / 15 = 3 Units with 14 minutes remaining)
      - 72-minute visit: Billed at 4 Units (72 / 15 = 4 Units with 12 minutes remaining)
  - The additional minutes can be carried until one or more full unit(s) is reached, and then the “Accrued Unit(s)” can be billed.
  - Any additional minutes beyond the “Accrued Unit(s)” are carried forward and this continues until the end of the month.
  - At the end of the month, any remaining minutes after all Accrued Units have been accounted for are lost; and the count resets at the start of the next month.

Accrued Minutes Visit

“Accrued Minutes Visit”

The EVV interface will allow the submission of “Accrued Minutes Visit” (AMV) starting on 11/19/2025

- To accommodate billing for accrued minutes in the EAS, Providers (or their EVV Vendor) will need to create a corresponding Accrued Minutes Visit in your EVV system using new reason code 280 (“Accrued Minutes Visit”) which will be used to match when the claim is validated
- Accrued Minutes Visits must include all data elements required for a verified visit:
  - DCN
  - Provider Medicaid ID
  - Employee FCSR (can be any caregiver involved in that participant’s care during the accrual period)
  - Service type: Procedure code and modifier submitted with the original visits
    - For visits that require tasks, a new task 0280 (Accrued Minutes Visit) may be selected. This task should be utilized only for accrued minutes visits.
  - Visit date used must match date of service submitted on the claim.
  - Start and end time: 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.

“Accrued Minutes Visit”

The EVV interface will allow the submission of “Accrued Minutes Visit” (AMV) starting on 11/19/2025

- Reason Code 280 (Accrued Minutes Visit) - This reason code should be utilized only for accrued minutes visits.
- Whether created systematically by your EVV vendor or manually entered by the provider, all accrued minutes visits must be identified as a manual call type.
- Although a manual call type, accrued minutes visits will not be included in the Auto Verification reports in EAS or considered in the auto versus manual verification statistics.
- A report will be added to the Aggregator showing minute accruals on visits in EAS, and if AMVs have been received, they will subtract from the remaining minutes allowing providers to track the accrual of minutes and the use of AMVs.

Services Which Require Tasks

Table 1 - Services which require tasks

Payer	Program	HCPCS Code	Mod 1	Mod 2	Service Description	Task Required?
MODSS	DSDS	S5120			DSDS - Chore	Yes
MODSS	DSDS	S5130			DSDS - Homemaker	Yes
MODSS	DSDS	T1019	U2		DSDS - CDS Personal Care	Yes
MODSS	DSDS	T1019			DSDS - Personal Care	Yes
MODSS	DSDS	T1019	TF		DSDS - Advanced Personal Care	Yes
MODSS	DSDS	T1019	U6		DSDS – ILW Personal Care	No*
		** T1019:U6 will require one or more tasks starting on 12/18/2025. Adding this new AMV task (280) will have no impact or dependency on that change.*				

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Accrued Minutes Visits Rules

The rules below apply to Accrued Minutes Visits effective November 19, 2025:

- Providers/Vendors must submit the accrued minutes visit for the month it was accrued
- There is no unit restriction, duration must be divisible by 15 (e.g., 30 minutes, 45 minutes)
- Accrued Minutes Visits are allowed to be submitted **once per day, per client, per procedure code/modifier**
- Visits must include all required data elements to be in a verified status

Note: Failure to make these configuration changes may result in claims validation denials.

Scenario Review

EVV - Carryover Accrued Minutes Scenario - Raw Visits

DOS	Service	Client	Caregiver	Start	End	Actual Minutes	Billed Minutes	Billable Units	Accrued Minutes	Remaining Minutes	Amount
2/1/26	T1019	Doe, John	Rose, Lola	8:01	9:11	70	60	4	10	10	$ 39.00
2/2/26	T1019	Doe, John	Reese, Charlie	7:58	9:02	64	60	4	4	14	$ 39.00
2/3/26	T1019	Doe, John	Reese, Charlie	8:05	9:01	56	45	3	11	25	$ 29.25
2/3/26	T1019	Doe, John	Barkley, Ali	17:17	18:59	102	90	6	12	37	$ 58.50
2/4/26	T1019	Doe, John	Reese, Charlie	8:00	9:06	66	60	4	6	43	$ 39.00
2/5/26	T1019	Doe, John	Reese, Charlie	8:05	8:55	50	45	3	5	48	$ 29.25
2/5/26	T1019	Doe, John	Barkley, Ali	14:58	16:12	74	60	4	14	62	$ 39.00
2/6/26	T1019	Doe, John	Reese, Charlie	8:00	8:59	59	45	3	14	76	$ 29.25
2/7/26	T1019	Doe, John	Rose, Lola	8:11	9:07	56	45	3	11	87	$ 29.25
						597	**510**	**34**	**87**		**$ 331.50**

This example shows visits over the course of a week and illustrates how units round down and the impact to minutes if accrued minutes are not billed.

While the total amount of time worked is 597 minutes, the rounded units from each day result in 510 billable minutes (34 Units).

This leaves 87 minutes unaccounted for which rounds to 5 units not billed without the use of Accrued Minutes.

837 Claim SV1 line billing scenario (Raw)

DOS	Service	Client	Billable Units	Amount
2/1/26	T1019	Lawson, Brian	4	$ 39.00
2/2/26	T1019	Lawson, Brian	4	$ 39.00
2/3/26	T1019	Lawson, Brian	9	$ 87.75
2/4/26	T1019	Lawson, Brian	4	$ 39.00
2/5/26	T1019	Lawson, Brian	7	$ 68.25
2/6/26	T1019	Lawson, Brian	3	$ 29.25
2/7/26	T1019	Lawson, Brian	3	$ 29.25
			34	**$ 331.50**

EVV - Carryover Accrued Minutes Scenario - with Accrued Minutes Visits

(this example uses the AMV at the end of the week/month)

DOS	Service	Client	Caregiver	Start	End	Actual Minutes	Billed Minutes	Billable Units	Accrued Minutes	Remaining Minutes	Amount
2/1/26	T1019	Doe, John	Rose, Lola	8:01	9:11	70	60	4	10	10	$ 39.00
2/2/26	T1019	Doe, John	Reese, Charlie	7:58	9:02	64	60	4	4	14	$ 39.00
2/3/26	T1019	Doe, John	Reese, Charlie	8:05	9:01	56	45	3	11	25	$ 29.25
2/3/26	T1019	Doe, John	Barkley, Ali	17:17	18:59	102	90	6	12	37	$ 58.50
2/4/26	T1019	Doe, John	Reese, Charlie	8:00	9:06	66	60	4	6	43	$ 39.00
2/5/26	T1019	Doe, John	Reese, Charlie	8:05	8:55	50	45	3	5	48	$ 29.25
2/5/26	T1019	Doe, John	Barkley, Ali	14:58	16:12	74	60	4	14	62	$ 39.00
2/6/26	T1019	Doe, John	Reese, Charlie	8:00	8:59	59	45	3	14	76	$ 29.25
2/7/26	T1019	Doe, John	Rose, Lola	8:11	9:07	56	45	3	11	87	$ 29.25
2/7/26	***T1019***	***Doe, John***	***Rose, Lola***	***0:00***	***1:15***		***75***	***5***	***(75)***	***12***	***$ 48.75***
						597	**585**	**39**	**12**		**$ 380.25**

This is the same example, however, Accrued Minutes Visits are held and billed at the end of the week/month.

There are still 75 additional minutes that translate to an additional 5 units that can now be billed. The service lines on the claim now take these into account and will match visit totals in EAS.

These 5 Units now allow us to bill for 39 total units (with a remainder of 12 minutes that carry into next week).

837 Claim SV1 line billing scenario

DOS	Service	Client	Billable Units	Amount
2/1/26	T1019	Lawson, Brian	4	$ 39.00
2/2/26	T1019	Lawson, Brian	4	$ 39.00
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2/4/26	T1019	Lawson, Brian	4	$ 39.00
2/5/26	T1019	Lawson, Brian	7	$ 68.25
2/6/26	T1019	Lawson, Brian	3	$ 29.25
2/7/26	***T1019***	***Lawson, Brian***	***8***	***$ 78.00***
			39	**$ 380.25**

EVV - Carryover Accrued Minutes Scenario - with Accrued Minutes Visits

(this example uses the AMV as it is accrued)

DOS	Service	Client	Caregiver	Start	End	Actual Minutes	Billed Minutes	Billable Units	Accrued Minutes	Remaining Minutes	Amount
2/1/26	T1019	Doe, John	Rose, Lola	8:01	9:11	70	60	4	10	10	$ 39.00
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2/3/26	T1019	Doe, John	Barkley, Ali	17:17	18:59	102	90	6	12	37	$ 58.50
2/3/26	***T1019***	***Doe, John***	***Barkley, Ali***	***0:00***	***0:30***		***30***	***2***	***(30)***	***7***	***$ 19.50***
2/4/26	T1019	Doe, John	Reese, Charlie	8:00	9:06	66	60	4	6	13	$ 39.00
2/5/26	T1019	Doe, John	Reese, Charlie	8:05	8:55	50	45	3	5	18	$ 29.25
2/5/26	T1019	Doe, John	Barkley, Ali	14:58	16:12	74	60	4	14	32	$ 39.00
2/5/26	***T1019***	***Doe, John***	***Barkley, Ali***	***0:00***	***0:30***		***30***	***2***	***(30)***	***2***	***$ 19.50***
2/6/26	T1019	Doe, John	Reese, Charlie	8:00	8:59	59	45	3	14	16	$ 29.25
2/6/26	***T1019***	***Doe, John***	***Reese, Charlie***	***0:00***	***0:15***		***15***	***1***	***(15)***	***1***	***$ 9.75***
2/7/26	T1019	Doe, John	Rose, Lola	8:11	9:07	56	45	3	11	12	$ 29.25
						597	**585**	**39**	**12**		**$ 380.25**

This is the same example, however, Accrued Minutes Visits are added once the total minutes sum up to 1 or more even units.

There are now 75 additional minutes that translate to an additional 5 units that can now be billed. The service lines on the claim now take these into account and will match visit totals in EAS.

These 5 Units now allow us to bill for 39 total units (with a remainder of 12 minutes that carry into next week).

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2/3/26	***T1019***	***Lawson, Brian***	***11***	***$ 107.25***
2/4/26	T1019	Lawson, Brian	4	$ 39.00
2/5/26	***T1019***	***Lawson, Brian***	***9***	***$ 87.75***
2/6/26	***T1019***	***Lawson, Brian***	***4***	***$ 39.00***
2/7/26	T1019	Lawson, Brian	3	$ 29.25
			39	**$ 380.25**

Timeline

Timeline

- While the logic to capture AMVs starts on 11/19/2025, there will be time for vendors to work through this process:
  - Accrued Minute Visits will be accepted by EAS starting on 11/19/2025
  - The initial launch of Claims Validation will be a “Soft Edit”, meaning claims will receive messages/warnings if the units do not match between EAS and Claims, but they will not Deny due to it.
  - The “Hard Edit” mode of Claims Validation will roll out in phases based on Provider Type, and at that time, Claims will be denied if the units do not match between EAS and the Claim.

Soft Edit Phase

Soft Launch Commences on **January 7, 2026.**

During the soft launch period, **claims without matching visits in EAS will not be denied,** however, providers will be notified on their Remittance Advice (RA) via a Remittance Advice Remark Code or Claim Adjustment Remark Code.

Submitted claims must match the following verified visit data elements in EAS:

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

Hard Edit Phase

The Soft Launch phase will allow providers an opportunity to become familiar with the Claims Validation process.

During the **Hard Edit Phase**, **payment will be denied** if the claim **does not have matching visit data**.

Hard Edit Implementation Dates (Rolled out by Provider Type):

- **April 1, 2026:**
  - Provider Type 26 (Personal Care)
  - Provider Type 28 (Aged & Disabled Waiver Homemaker/Chore and Respite)
- **May 1, 2026:**
  - Provider Type 58 (Home Health Agency)
- **June 1, 2026:**
  - Provider Type 85 (Community Based Developmental Disabilities)

Questions