



Our Webinar Will Begin Shortly

Note: This session is for Massachusetts Fee-For-Service (FFS) providers in Home Health (HH), Group Adult Foster Care (GAFC), and Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver programs.



Massachusetts – EVV FFS Program Hard Edits Preparation

Session 1: April 30, 2026

Session Logistics



- This webinar is being recorded. The recording and slides will be made available after the session.
- Your camera and mics are turned off.
- Q&A will be answered throughout the presentation. Please submit your questions in the Q&A box by selecting the Q&A button at the bottom of the screen to pop out this box.
- Please do not submit Personal Information (PI) in the Q&A. Any questions including PI can be submitted to the MA EVV Inbox: EVVfeedback@MassMail.State.MA.US
- This webinar is Closed Caption enabled. Please proceed by selecting Show Captions option at the bottom of your screen to enable feature.

Session Presenters



Jim O'Brien



- **Title:** Director of Federal EVV Compliance MassHealth
- **Areas of Expertise:** EOHHS State Program

Kristin Davidson



- **Role:** EVV Business Solution Architect
- **Areas of Expertise:** EVV Business Rules, EVV Compliance

Leah Klein



- **Title:** Customer Success Manager
- **Areas of Expertise:** Sandata EVV Applications and Sandata EVV Aggregator



Am I in the Right Place?

This session is designed for Providers who:

1. Are Fee-For-Service (FFS) providers in Home Health (HH), Group Adult Foster Care (GAFC), or Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver programs
2. Are already capturing EVV
3. Have their 3rd Party System integrated (if applicable)
4. Need to boost their EVV Claims Matching to EVV Visits in preparation for Claims Denials for mismatches (Hard Edits)

Special Note: *Thresholds of EVV Compliance will continue to be set and announced through each MA program area (Home Health, Group Adult Foster Care, ABI and MFP Waivers).*



MA EVV FFS Live Webinar Schedule

Session	Date	Time	Registration Link
Session #1	<i>Today</i> April 30, 2026	10am – 11am ET	Webinar Registration - Zoom
Session #2	June 4, 2026	2pm – 3pm ET	Webinar Registration - Zoom
Session #3	June 25, 2026	2pm – 3pm ET	Webinar Registration - Zoom

Special Note: Any additional live training opportunities post Session #3 will continue to be communicated via program channels to support providers in the transition to hard edits.



Agenda

1 Compliance Timeline

2 EVV Program Review

3 Provider Expectations – Preparing for Hard Edits

4 Common Roadblocks

5 Helpful Resources

6 Feedback Survey



Compliance Timeline



FFS Programs Compliance Phases



Phase 1

Registration/Onboarding

In this phase of compliance, providers take the first step in the EVV process which is to register for EVV (making the determination if they are using the state-sponsored system, Sandata, or an Alt EVV) and beginning the necessary training to understand and set-up EVV.

The goal for this phase is that providers have registered and declared their EVV system so that they can begin training, system and technology setup, and roll out the processes to their organizations to support EVV.

Jan 2025 – Sep 2025

Phase 2

EVV Usage/Visit Monitoring

In this phase of compliance, providers have advanced from the initial Registration and onboarding to capturing visit information electronically. This includes capturing EVV via mobile devices or other available technologies and performing visit maintenance to document visits appropriately.

The goal for this phase is that providers are using their chosen EVV system and are capturing and maintaining visit data electronically.

April 2025 – Ongoing

Phase 3

Claims to EVV Match/Implementation of Claims Edits

In this phase of compliance, providers are experienced in documenting their visits electronically and are now refining their systems and processes so that their claims and visits match.

The goal for this phase is for the EVV visit data to support the provider billing by matching on the 6 key CMS data elements prior to claims payment.

July 2026 – Ongoing

Description

Goal



Why is Compliance Phase 2 Based on Auto-Verified %?

EVV Phase 2 Compliance is calculated by analyzing Auto-Verified visits:

- Massachusetts focuses on the auto-verification visits percentage for EVV Compliance calculations.
- $\text{Auto-Verified Visits} \div (\text{Auto-Verified Visits, Manually Verified Visits, and Incomplete Visits}) = \text{EVV Compliance \%}$
- **Auto-Verified Visits:** An Auto-Verified Visit is defined as having the 6 required Cures Act elements captured electronically when a Employee clocks in and clocks out of their visit. An Auto-Verified Visit is not manually entered or edited after the fact by the Provider.

Compliance Phase 2 is based on auto-verified visit percentages so that providers are using their chosen EVV system and are accurately **maintaining visit data electronically**. The auto-verified visit percentage tracking works in tandem with claims to visit matching compliance to ensure visits are correctly captured electronically and matching on the 6 key CMS data elements prior to claims payment.



What is Phase 3 Compliance?

EVV Phase 3 Compliance compares MassHealth EVV claims with EVV Visits.

- MassHealth created edits during claims processing to look at the Sandata Aggregator for matching visit records
- Beginning in July 2026, Phase 3 will only apply to FFS (MassHealth) paid claims for Home Health, Group Adult Foster Care (GAFC) and MassHealth Home and Community Based (HCBS) Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver prog

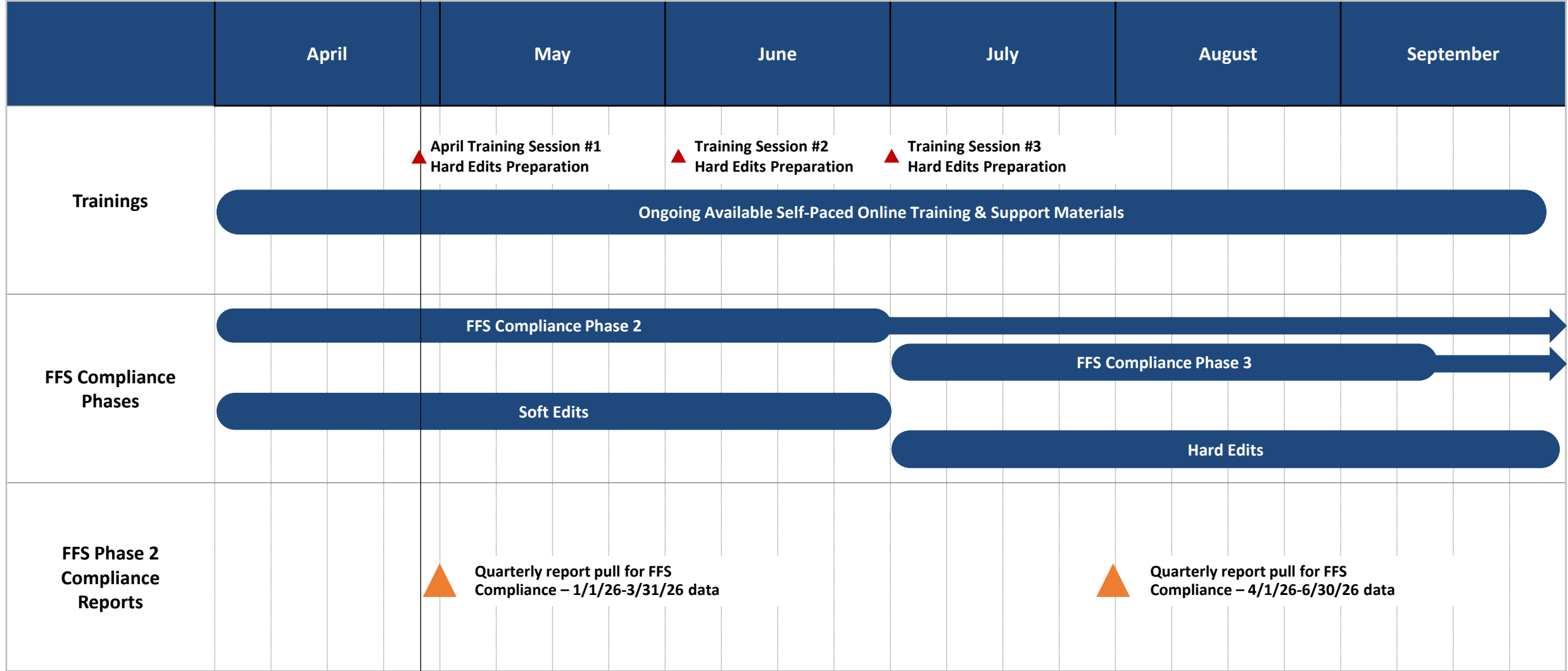
Compliance Phase 3 is focused on only paying for claims with a matching EVV visit. As the visit is the verification of service provided, claims are only paid for verified services.

Phase 2 and Phase 3 measure different aspects of EVV with Phase 2 focuses on capturing data electronically and Phase 3 focusing on paying only for verified services.



FFS Programs Compliance Timeline

★ We Are Here





Compliance Plans by Program

Please refer to the individual Program area compliance plans to understand compliance expectations.

Program/Plan	Bulletins/Posted Resources
Group Adult Foster Care (GAFC)	<ul style="list-style-type: none">• Adult Foster Care Bulletin 33• GAFC Compliance Checkpoints
Home Health (HH)	<ul style="list-style-type: none">• Home Health Bulletin 94• HH Compliance Checkpoints
Home and Community Based Services (HCBS) Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver	<ul style="list-style-type: none">• HCBS Waiver Bulletin 24• HCBS Waiver Compliance Checkpoints
Aging & Independence (AGE)	<ul style="list-style-type: none">• <i>Providers need to work with their ASAPs to understand EVV Compliance.</i>
Managed Care Entities (MCE)	<ul style="list-style-type: none">• <i>Providers need to work with their MCEs to understand EVV Compliance for their payer.</i>



EVV Program Review





What are the 6 required Cures Act Elements?

Passed by Congress in December 2016, the 21st Century Cures Act requires that providers of Personal Care Services confirm visits via Electronic Visit Verification (EVV) by January 1, 2021.

The six data elements required to be collected to meet the Cures Act EVV requirement:

 Type of Service Performed

 Location of the Service

 Individual Receiving the Service

 Individual Providing the Service

 Date of the Service

 Time the Service Begins and Ends



What are Exceptions?

Exceptions are the reasons a visit will not be compliant. It is critical to ensure all necessary EVV data elements are collected and available to match to claims.

There are 8 Exceptions in Massachusetts:

1. Unknown Client
2. Unknown Employee
3. Missing Service
4. Missing Location
5. Visits without an In-Call
6. Visits without an Out-Call
7. Visits without Any Calls
8. Missing Payer



To be in a manually verified state, these exceptions must be resolved.

Visits in Auto-Verified and Manually Verified status will be available to match to a submitted Claim.



Visit Statuses in Sandata

- **Scheduled:** The visit has not yet occurred and has a scheduled start date/time in the future
- **In-Progress:** The visit is in progress. Scheduled visits are placed in this status if the scheduled start time has passed or the system has received a call. Unscheduled visits are placed in this status if the system has received a call-in, but not a call out and is less than 24 hours since the call-in was received.
- **Incomplete:** The visit is missing required information. Required information is based on the state-designated configuration. Missing information is indicated on the visit maintenance grid as exceptions (red dots).
- **Verified:** The visit has no exceptions. A visit in this status is eligible to be returned for claims validation
 - **Auto-Verified:** An Auto-Verified Visit is defined as having the 6 required Cures Act elements captured electronically when an Employee clocks in and clocks out of their visit. An Auto-Verified Visit is not manually entered or edited after the fact by the Provider.
 - **Manually Verified:** A visit that was manually entered into the EVV system by the Provider or edited after the fact.
- **Processed:** The visit was returned to the adjudication system during claims validation (*indicating either a partial or full match of a visit to a claim*)
- **Omit:** A visit marked (by the Provider) to be ignored. These visits are not expected to be submitted for billing or claims validation and do not require exceptions management.



High-Level Claims to Visit Matching Workflow

The EVV claims matching process ensures that claims submitted for EVV services are validated against verified EVV visit transactions. This is critical for confirming that a service visit occurred.

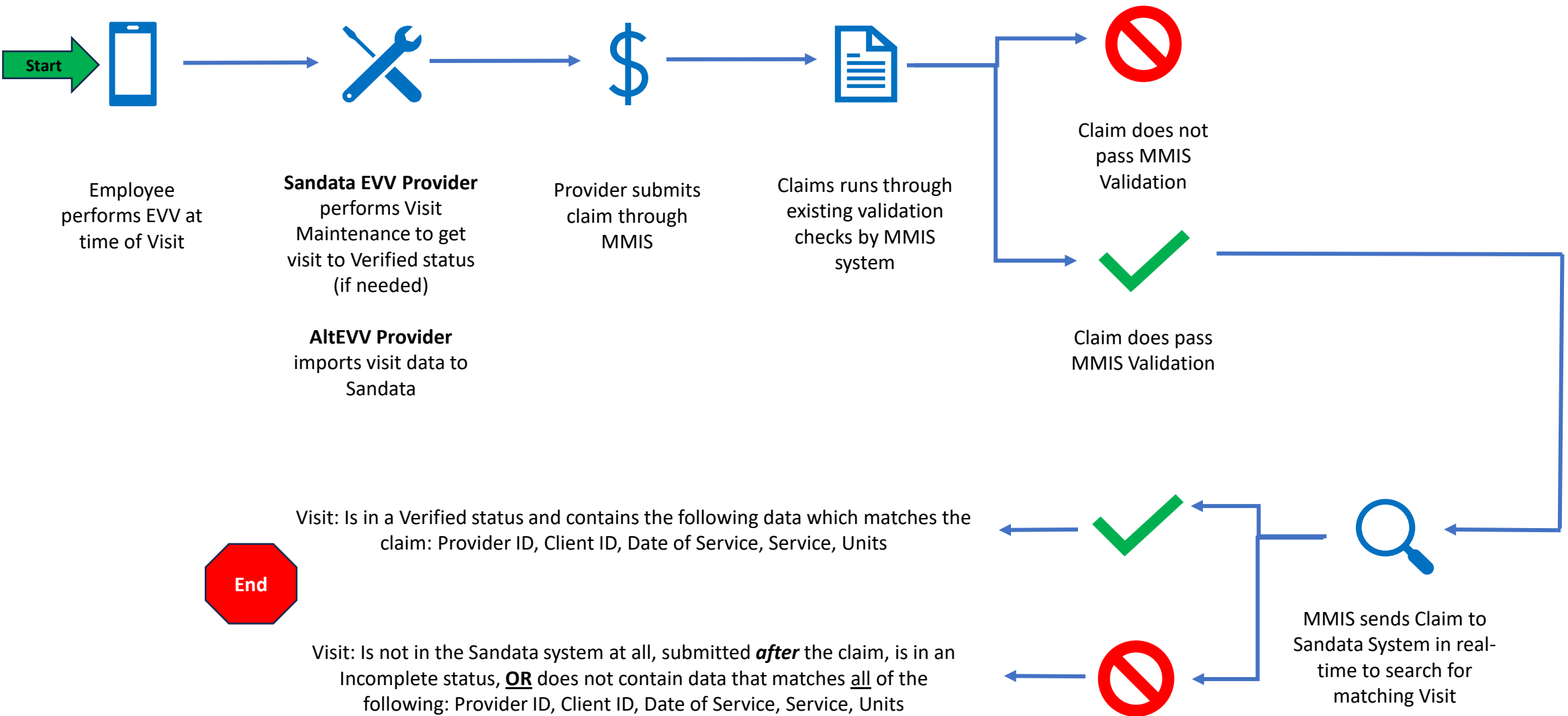
The State's claims system matches claims against criteria before deciding to pay/deny a claim.

For EVV services, the matching process compares critical data elements which includes:

- Provider ID (PID) from the Billing Provider (even if billed at PID/SL level) matches the Provider ID (PID) on the Visit
- Client ID (Medicaid ID) Billed = Client ID of Visit
- EVV Service Code/HCPCS Code Billed = EVV Service Code of Visit (excluding billing modifiers)
- Billed Units are \leq Visit Units
- Date of Service = Date of Visit
- Visit is in a "Verified" state (visit has all required data elements of the above as well as Payer, Employee and Location to be able to be matched to a claim)



High-Level Claims to Visit Matching Workflow





Current Visits to Claims Matching – Soft Edits

“Soft Edits” refers to the preparation phase prior to “Hard Edits,” where claims will continue to be paid/processed regardless of the EVV claim to EVV match result. Providers should utilize this phase to practice identifying mismatches and how to resolve mismatches.

- Beginning in October 2025, claims submitted to MassHealth (through Provider Online Service Center or POSC) have been matched for visits and an informational code will be provided on the Remittance Advice (RA) indicating if there was a mismatch.
- Providers should continue to submit their claims to their payers using the processes provided by those payers.
- Providers must ensure that all EVV visits transactions are accepted in the EVV Aggregator and in a "Verified" state before claims are submitted.



Upcoming Visits to Claims Matching – Hard Edits

“Hard edits” refers to claims denials when there is a mismatch between the EVV visit information and claims submitted.

- Match result will affect payment when MassHealth begins claims denials for EVV mismatches.
- **July 1, 2026**, claims submitted to MassHealth (through Provider Online Service Center or POSC) for FFS program areas not correctly matched for visits will result in claims denial.
- Information will continue to be communicated to impacted FFS Providers prior to claims denials.



Provider Expectations – Preparing for Hard Edits





EVV Compliance Best Practices

Prior to Claims Submission:

- Sending EVV data to the Aggregator timely and with valid data and format
- Ensuring visits contain all of the 6 CMS required elements
- Clearing any exceptions on visits
- Managing Sandata schedules, if used
- Ensuring visits are sent from an Alt EVV Vendor AND in a Verified state prior to claims submission
- Ensuring visits are captured in Sandata portal AND in a Verified state prior to claims submission
- Providers with subcontractors understanding where their visits are being reported to and who is submitting the claim under which Provider Medicaid ID
- Ensuring client, Provider Medicaid ID, units, and service code are the same as the visit verified in the Sandata System as is submitted on the claim

Post Claims Submission:

- Checking Remittance Advice (RA) for any EVV edits or reason codes and determine if the claim or visit needs to be updated
- Running reports in the Sandata Aggregator to ensure EVV data is correctly captured and matching claims data

Reason Codes & Edits on Remittance Advice (RA)



Edit	Edit Description	EOB Health Care Claim Status Code	Adjustment Reason Code	Remark Code
2105: EVV Claim matches EVV Visit	The EVV units cover the claim detail.	20 – ACCEPTED FOR PROCESSING	193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.	N883 - ALERT: PROCESSED ACCORDING TO STATE LAW
2106: EVV Visit Units Less Than EVV Claim Units	The EVV units are less than the billed units and do not cover the detail lines.	784- ELECTRONIC VISIT VERIFICATION CRITERIA DO NOT MATCH	272- COVERAGE/PROGRAM GUIDELINES WERE NOT MET	N820: EVV SYSTEM UNITS DO NOT MEET REQUIREMENTS OF VISIT
2107: EVV UNITS > UNITS ALLOWED	The EVV units are more than enough to cover the billed units.	20- ACCEPTED FOR PROCESSING	193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.	N883 - ALERT: PROCESSED ACCORDING TO STATE LAW
2108: No EVV Visit Found to match the EVV Claim	The EVV visit not found.	784- ELECTRONIC VISIT VERIFICATION CRITERIA DO NOT MATCH	272- COVERAGE/PROGRAM GUIDELINES WERE NOT MET	N821- ELECTRONIC VISIT VERIFICATION SYSTEM VISIT NOT FOUND.
2109: EVV visit to EVV Claim Mismatch	At least one of the 6 required visit elements not matching.	784- ELECTRONIC VISIT VERIFICATION CRITERIA DO NOT MATCH	272- COVERAGE/PROGRAM GUIDELINES WERE NOT MET	N820: EVV SYSTEM UNITS DO NOT MEET REQUIREMENTS OF VISIT

For more detailed information on MA EVV claims errors and examples of what codes may be visible on the RA, please reference the [Massachusetts Electronic Visit Verification \(EVV\) Edits and Reason Codes](#).



Conduct Visit Maintenance for EVV Related Errors

Providers can update visits with correct information that will allow claims identified with errors to match. Make sure to first identify the point of data that is incorrect and needs to be updated.

For Claims that have EOB 784 Error on the RA: ?

- Navigate to your Sandata EVV or Aggregator platform
- Search for the visit in the Visit Maintenance section or pull the Detail Visit Maintenance Report

If the claim needs updating:

- Providers may need to resubmit the claim through current processes and/or confirm the visit submission date is received prior to the claim

If the visit needs updating:

- If there is no visit associated with the claim in the EVV system, create or send a visit for the service rendered for this claim
- If there is a visit associated with the claim, ensure the visit has no listed exceptions and is in a verified status
- Once the visit in question has been updated to a “Verified” status, then the claim can be resubmitted through current processes

Note: *If there is an EVV record submitted with all 6 CMS required elements that does not have an associated claim, providers may need to resubmit the claim through current processes and/or confirm the visit submission date is received prior to the claim.*



Common Roadblocks





Common Roadblocks - Timing

The EVV Visit must be in a Verified status in the Sandata EVV Aggregator at the time the claim is processed.

- The visit must be free of exceptions and in a "Verified" status (not Incomplete or Omit) to be matched to a claim
- The visit must be received by the Sandata EVV Aggregator BEFORE the claim is received and processed by MassHealth. MassHealth will not "hold" a claim awaiting an EVV visit record.
- If the visit record comes in after the claim is processed, the disposition of the claim will not change, i.e the claim would still be rejected.

Example

- Claim has a date of service of 1/10/2026 and is sent for processed 2 weeks later on on 1/24/2026
 - Visit has a date of 1/10/2026 and is in a verified state and all data elements match the claim BUT the visit is sent from the Alt EVV Vendor to the Sandata EVV Aggregator on 1/31/2026.
- > The claim will receive NO MATCH since there was no matching EVV visit at the time the claim was processed



Common Roadblocks - Service Code Matching

The EVV service code on the claim is matched against the EVV service code on the visits in a Verified status in the EVV Sandata Aggregator at the time the claim is processed/adjudicated.

- There is no change to the way that services are billed through MassHealth, only that visits are in a Verified state in the EVV Sandata Aggregator before the claim is submitted.
- For EVV services that have a HCPCS code AND a modifier, both should continue to be included on the claim.
- In instances where the modifier is only used in billing (i.e. the service provided is the same regardless of modifier), Sandata does not include the modifier in the visit.
- In the instances where the modifier is included in Sandata where the modifier represents a completely different service. The service code should be selected based on the service provided.



Service Code Matching - Example

Example of Claim Matching with a Service Code and Service Modifier

- Claim submitted with G0299 UB for Complex Care Training and Oversight by an RN
- Visit submitted with G0299 UB Complex Care Training and Oversight by an RN
- ----> Claim and visit match on the service because both the HCPCS code and modifier are present for both the claim and the visit

Example of Claim Matching with a Service Code and Billing Modifier

- Claim submitted with G0299 UD U1 for Direct Skilled Nursing Services of an RN
- Visit submitted with G0299 Direct Skilled Nursing Services of an RN
- ----> Claim and visit match on the service because the billing modifier are not used in the match

Example of Claim Mismatch on Service Code

- Claim submitted with G0299 UD U1 for Direct Skilled Nursing Services of an RN
- Visit submitted with G0299 UB Complex Care Training and Oversight by an RN
- ----> Claim and visit do not match as the modifier on the visit indicates a different service than the service billed on the claim



Common Roadblocks – Unit Matching

The Units Billed on the Claim must be equal to or less than the visit.

- If a Claim has more billed units than the visit, the claim will receive the **2106: EVV Visit Units Less Than EVV Claim Units** and therefore 784- ELECTRONIC VISIT VERIFICATION CRITERIA DO NOT MATCH
- Example: The claim has 24 units, but the visit has only 12 units. The visit does not have enough units to match the claim.
- The Unit of Measure can either be a Per Diem (once per day service) or a 15-minute Service
- In instances where the Unit of Measure is a Per Diem (once per day service) the units should always be 1.
- Example of a Per Diem Service = H0043 (GAFC- Per Diem Visit). For this service the unit is always 1 regardless of the length of the service.
- In instances where the Unit of Measure is a 15-minute service, and there are multiple visits, the visit units will be summed.

Example of a 15 Minute Service = G0156 (Services of HH Aide in Home Health Setting)

- If there are multiple visits for the same provider, same client, same service, same date in a verified status, the visits will be summed.
- Example: Claim has 24 units. There are 2 visits for the same provider, client, service, and date in a verified status and each visit is for 15 units. The claim will receive a match as the summed visit units are greater than the claim.



Common Roadblocks – Rounding Rules

Rounding rules define how the **total duration of a home care visit is converted into billable units** by grouping time into fixed intervals. The visit's total seconds are compared against predefined time ranges, with each range corresponding to a specific number of units. Using clearly defined, non-overlapping ranges ensures visits are billed consistently, accurately, and fairly based on actual time worked. Note the clock in and clock out times are captured independently - the billable units are calculated by rounding the total visit duration.

How Visit Time Rounding Works:

- Visit time is measured in total seconds from check-in to check-out
- Time is converted into billable units using fixed time bands
- Each band represents a 15-minute interval, starting after an initial minimum threshold
- This ensures accurate reimbursement and consistent billing across visits

Units	Seconds	Minutes
0 Units	0 – 479	< 8 min
1 Units	480 – 1379	8–22.99 min
2 Units	1380 – 2279	23–37.99 min
3 Units	2280 – 3179	38–52.99 min
4 Units	3180 – 4079	53–67.99 min



Units/Rounding Rule Examples

Example of units calculation and rounding 15 minute services - Rounding Down

A visit with a 15 minute unit of measure G0156 (Services of HH Aide in Home Health Setting) has:

Clock In Time at 1:08pm and a Clock Out Time at 2pm

The total duration for this visit is 52 and therefore 3 units

The total duration was rounded down to 3 units instead of 4 because the visit minutes were less than 53 minutes (see the table on the previous slide)

The claim would need to have units that were 3 or less to match this visit.

Note: The visit's total duration is rounded (not rounded at the individual clock in and clock out times).



Units/Rounding Rule Examples

Example of units calculation and rounding 15 minute services – Rounding Up

A visit with a 15 minute unit of measure G0156 (Services of HH Aide in Home Health Setting) has:

Clock In Time at 1:06pm and a Clock Out Time at 2pm

The total duration for this visit is 54 and therefore 4 units

The total duration was rounded up to 4 units even though the visit was less than an hour as the visit minutes were greater than or equal to 53 minutes (see the table on the previous slide)

The claim would need to have units of 4 or less to match this visit.

Note: The visit's total duration is rounded (not rounded at the individual clock in and clock out times).



Units/Rounding Rule Examples

Example of units calculation for a Per Diem service

A visit with a Per Diem/Per Visit unit of measure S9131 (ABI-MFP - Physical Therapy) has:

Clock In Time at 9:12am and a Clock Out Time at 10:47pm. The total duration for this visit is 95 minutes, but since it is a per visit service, the unit is 1 regardless of the total duration length.

The claim would have 1 unit and the visit would have 1 unit and the claim and visit would match.



Helpful Resources



Sandata Knowledge Base – Helpful, Quick Links

Sandata EVV Providers

- [Sandata EVV Enhanced](#)
- [Adding Clients](#)
- [Adding Mobile App Device Access for Employee](#)
- [Sandata Mobile Connect \(SMC\) Resources](#)
- [Visit Maintenance](#)
- [Reports Listing](#)

AltEVV Providers

- [Sandata Aggregator](#)
- [Visit Review](#)
- [Reports Listing](#)
- [Massachusetts EOHHS Alternative EVV Technical Specifications](#)
- [Vendor Solutions FAQs](#)

Provider Resources



Sandata Learn is:

- Sandata EVV System LMS (Account Required)

HHaEXchange University Sign In

Sandata Users: You're in the right place.
HHaEXchange University is the new home for Sandata Learn.

HHaEXchange University credentials are not the same as platform credentials.

Don't have an account? [Sign up here.](#)

Work Email

Password

Sign In

[Forgot Password?](#)

State Resources



- EOHHS will continue to provide any EVV program updates on the [MA-EOHHS EVV website](#).
- For more information on claims edits and reason codes, check out the [MA EVV Edits and Reason Codes Guide](#).
- Review how to run MA EVV Compliance reporting on the [MA-EOHHS EVV website](#).
- Specific program updates can be found on the [MassHealth provider bulletins by provider type D - H | Mass.gov](#).
- If you need assistance with your Remittance Advice or claim processing, please contact MassHealth at (800) 841-2900 or provider@masshealthquestions.com.
- For policy questions on the Massachusetts EVV program, please email EVVfeedback@Mass.gov.

Key Takeaways



- Know your Massachusetts Payer and Program specific EVV Compliance requirements
- Review your RA for EVV reason codes and edits and take corrective action if needed to prepare for Hard Edits
- Quickly identify the root causes of exceptions and take prompt corrective action
- Seek information on provided resources
- Attend the upcoming Live Training Sessions 2 & 3



Feedback Survey



MA EVV FFS Live Webinar Schedule

Session	Date	Time	Registration Link
Session #1	<i>Today</i> April 30, 2026	10am – 11am ET	
Session #2	June 4, 2026	2pm – 3pm ET	Webinar Registration - Zoom
Session #3	June 25, 2026	2pm – 3pm ET	Webinar Registration - Zoom

Special Note: Any additional live training opportunities post Session #3 will continue to be communicated via program channels to support providers in the transition to hard edits.



Thank You!