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 3: June 25, 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

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- **Areas of Expertise:** Sandata EVV Appications 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	*April 30, 2026*	*10am – 11am ET*	
Session #2	*June 4, 2026*	*2pm – 3pm ET*	
Session #3	*Today* *June 25, 2026*	*2pm – 3pm ET*	

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 Suspension of Claims Workflow

2 How to Research Mismatches

3 Rejection Reports

4 Common Roadblocks Review

5 Compliance Timeline

6 Resources

Claims Suspension Workflow

High-Level Claims to Visit Matching

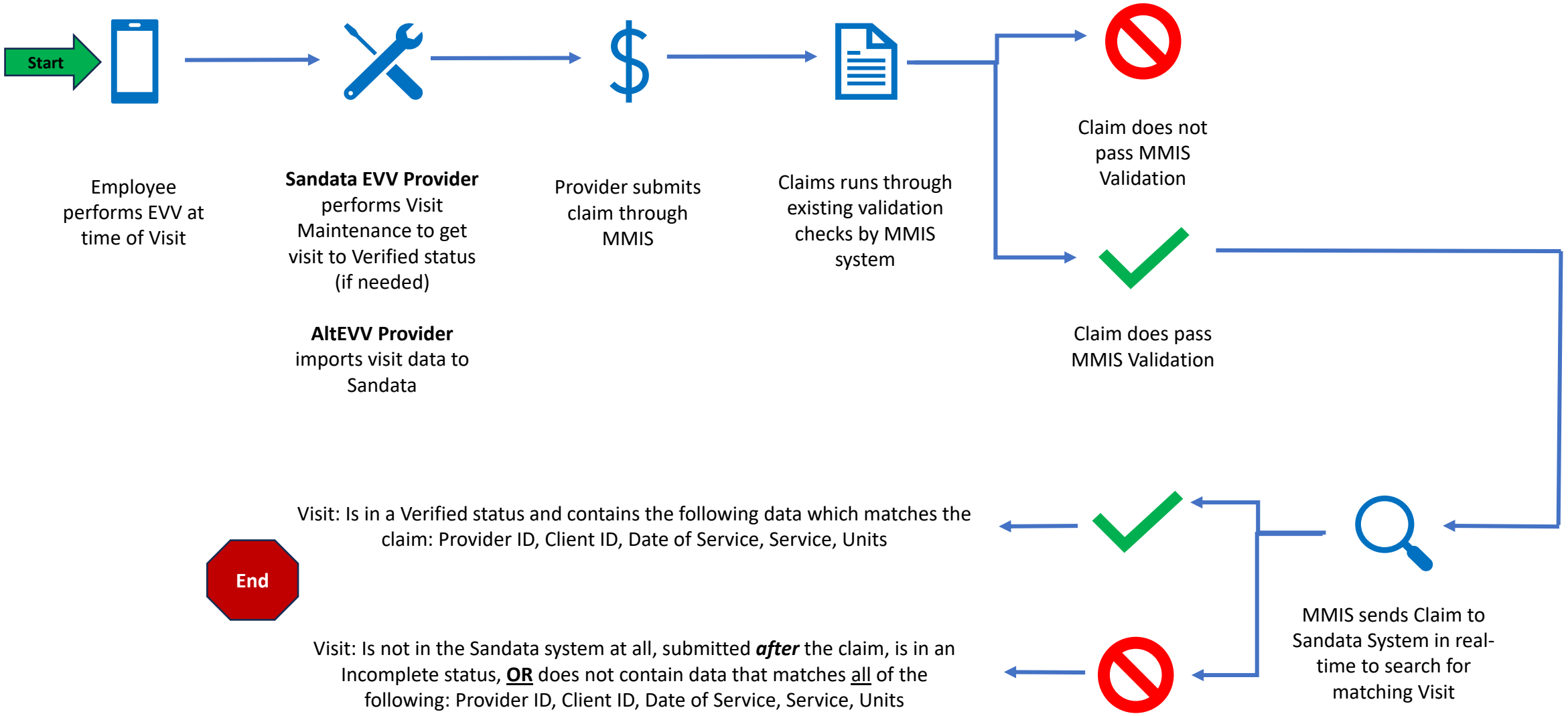
The EVV claims matching process ensures that claims submitted for EVV services are matched to verified EVV visit transactions. This is critical for confirming that a service visit occurred.

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 <= 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



Claims Suspension Overview

The EVV claims 30-day suspension process will be used as a temporary holding period before a claim is denied to allow for correction of the visit and/or the corresponding claim.

1. **Provider Submits Visit**	Visit is received by MassHealth
2. **Provider Submits Claim**	Claims is received by MassHealth
3. **Claim-to-visit Matching**	System attempts to match the claim to an approved EVV visit
4. **Mismatch Identified**	If the claim cannot be matched, it is not immediately denied, instead it's placed into a **suspended status** for 30 days
5. **Provider Correction Period**	Resolve exceptions, update or correct EVV visit records Resubmit corrected claims if required by program rules
6. **Reprocessing**	If a successful match is found before the suspension period ends, the claim proceeds to adjudication & payment
7. **End of Suspension Period**	If the mismatch remains unresolved after the 30-day period: • The claim may be denied • An explanation of benefits/remittance advice code is issued

Claims Suspension Example Timeline

Day 0

Provider submits claim for a MA EVV-required service

Day 1-2

Claim fails visit matching and enters 30-day suspension status

Day 3

Claim fails visit matching and enters 30-day suspension status

Day 4-25

Provider:

- Reviews EVV record
- Corrects visit data
- Resolves exceptions
- Updates mission information

Day 26-29

System reprocesses and attempts claim-to-visit matching weekly

Day 30

If matched, claim proceeds to adjudication/payment.

If unresolved, claim may be denied and require correction/resubmission per program policy

How to Research Claims Mismatches

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: PROCEESSED 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 UNTS > 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: PROCEESSED 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

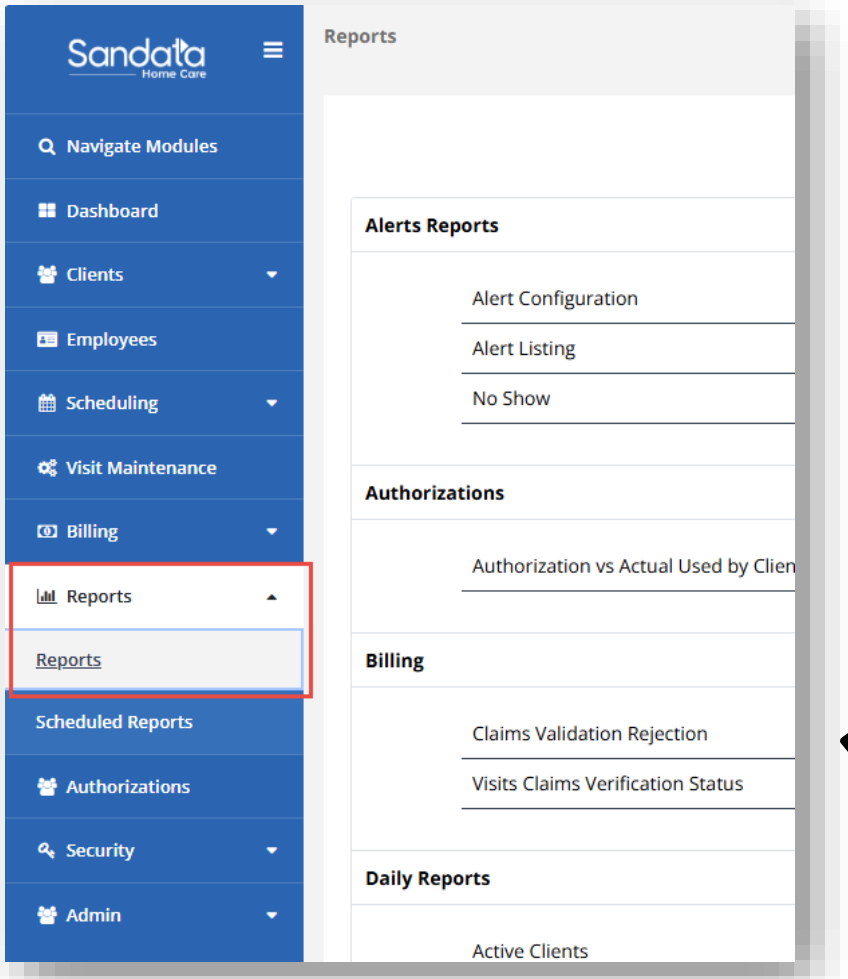
If the visit needs updating:

- 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

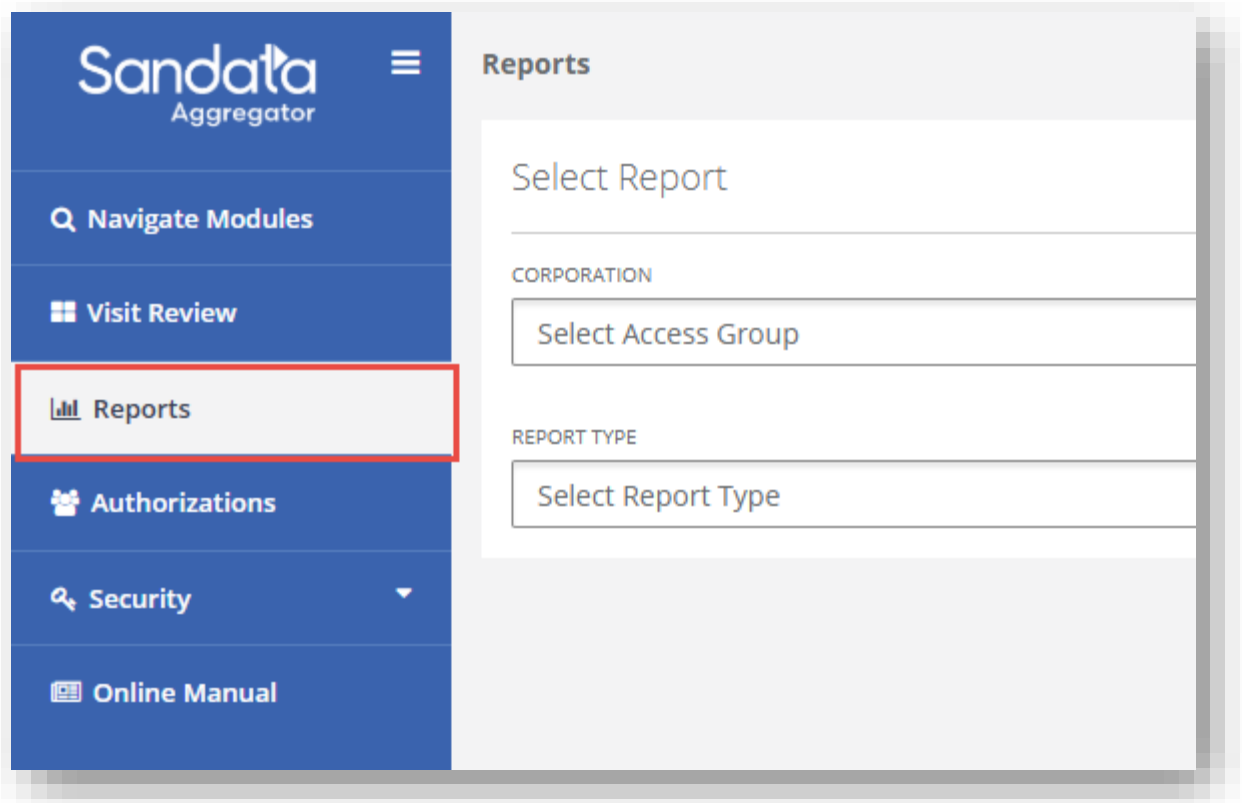
Note: *If there is an EVV record submitted with all 6 CMS required elements that does not have an associated claim, providers may need to resubmit the claim through current processes and/or confirm the visit submission date is received prior to the claim.*

Accessing Reports

Log into your **Sandata EVV Account** or **Aggregator** (AltEVV)



Reports Module
Sandata EVV Providers



Reports Module
AltEVV Providers

What Metrics to Look For

On your **Sandata EVV Account** or **Aggregator** (AltEVV), these are the most helpful metrics to look for when researching visit data for claims to visit match:

- Payer
- Client Identifier (e.g., Client MassHealth/Medicaid ID)
- HCPCS Service Code
- Visit Date
- Clock in & Clock out times
- Units
- Visit Status (e.g., Incomplete, Verified, etc.)
- Timestamp of visit entry

Claims Validation Rejection Reports

Claims Rejection Reports in Sandata

Where:

- Available in both Sandata EVV and Aggregator
- Housed within the Billing section of the Reports Module

What:

- **CV Rejection – Max 31 Days – By Visit Date:** Displays claims that did not match to a visit based on date of service in the filtered date range
- **CV Rejection – Single Account – Max 31 Days:** Displays claims that did not match to a visit based on date of claim submission in the filtered date range

Notes:

- If you have multiple accounts, even if the account is unused, claims that do not match to visits are often reflected in more than one account Report. **You will need to run the report in each account you have to see all claims that did not match to a visit in the filtered date range.**
- Scroll through the pages of the Report to see claims that did not match to visits for reasons: "No Visit Found" and "Unmatched Units"

Steps to View CV Rejection Reports

Sandata EVV Provider

Step 1 Log into Sandata EVV Account

Step 2 Navigate to the Reports module

Step 3 Scroll to Billing reports section and select desired CV Rejection Report

Step 4 Select desired date range

Step 5 Filter to "MAHEA" Payer and the applicable programs: "ABI-MFP," "GAFC," "HH" then click Run Report

Step 6 Scroll through pages to see all Claims rejections.

Steps to View CV Rejection Reports

AltEVV Provider

Step 1 Log into the Sandata Aggregator

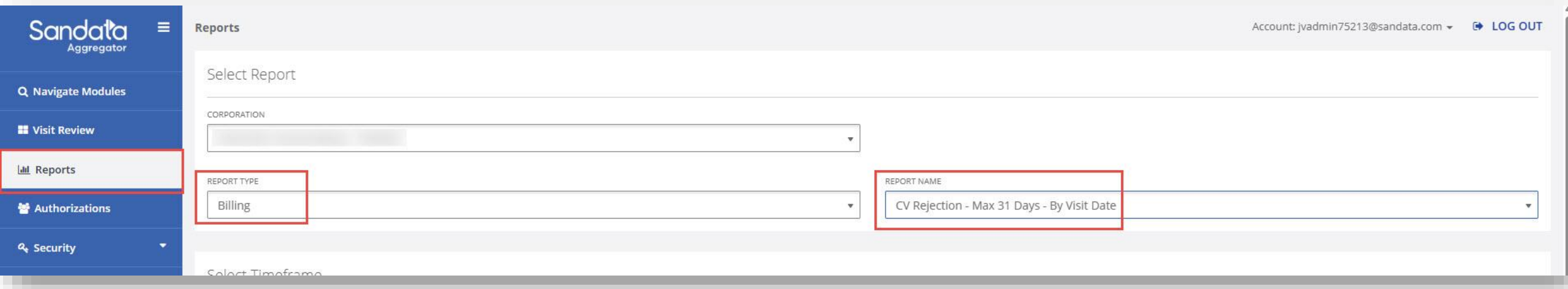
Step 2 Navigate to the Reports module

Step 3 Select 'Corporation' - If you have multiple accounts, you will need to run multiple Reports

Step 4 Select "Billing" from Report Type and the desired CV Rejection Report

Step 5 Filter to applicable date range

Step 6 Filter to "MAHEA" Payer and the applicable programs: "ABI-MFP," "GAFC," "HH" then click Run Report



CV Rejection Report

This report is filtered based on **date of service.**

Error Message: No Visit Found may mean the Provider ID, Patient ID, and or service code on the claim didn't match the claim. It could also mean that the claim was received before the visit.

Report Parameters

CV Rejection - Max 31 Days - By Visit Date

Account:
Provider:
Error Message: No Visit Found
Total: 2503

RECEIVED	BATCH ID	TRANS ID	INVOICE CONTROL NO	LINE NO	CLIENT ID	VISIT RANGE	PAYER	PROGRAM	SERVICE	BILL UNITS	PROVIDER MEDICAID ID	CLIENT MEDICAID ID	CLIENT NAME	UNITS FOUND	VISITS	ERROR REASON
3/12/2026 6:00:56 PM		1		1		03/05/2026 03/05/2026	MAHEA		G0299	1				0	0	
3/12/2026 6:01:20 PM		3		3		03/01/2026 03/01/2026	MAHEA		T1502	1				0	0	
3/12/2026 6:01:22 PM		1		1		03/02/2026 03/02/2026	MAHEA		G0300	1				0	0	
3/12/2026 6:01:32 PM		2		2		03/01/2026 03/01/2026	MAHEA		T1502	1				0	0	
3/12/2026 6:01:35 PM		1		1		03/03/2026 03/03/2026	MAHEA		G0153	1				0	0	
3/12/2026 6:01:35 PM		2		2		03/04/2026 03/04/2026	MAHEA		G0153	1				0	0	
3/12/2026 6:01:41 PM		2		2		03/07/2026 03/07/2026	MAHEA		G0299	1				0	0	
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3/12/2026 6:01:41 PM		4		4		03/02/2026 03/02/2026	MAHEA		T1502	1				0	0	
3/12/2026 6:01:41 PM		5		5		03/03/2026 03/03/2026	MAHEA		T1502	1				0	0	
3/12/2026 6:01:41 PM		6		6		03/04/2026 03/04/2026	MAHEA		T1502	1				0	0	
3/12/2026 6:01:41 PM		7		7		03/05/2026 03/05/2026	MAHEA		T1502	1				0	0	
3/12/2026 6:01:41 PM		8		8		03/06/2026 03/06/2026	MAHEA		T1502	1				0	0	
3/12/2026 6:02:40 PM		1		1		03/02/2026 03/02/2026	MAHEA		G0299	1				0	0	
3/12/2026 6:02:40 PM		2		2		03/03/2026 03/03/2026	MAHEA		T1502	1				0	0	
3/12/2026						03/04/2026										

Common Roadblocks Review

EVV Compliance Best Practices

Prior to Claims Submission

- Send EVV data to the Aggregator timely and with valid data and format
- Verify visits contain **all 6 CMS required elements**
- Clear any exceptions on visits
- Managing Sandata schedules, if used
- Check visits are sent from an Alt EVV Vendor **AND** in a Verified state
- Check visits are captured in Sandata portal **AND** in a Verified state
- Confirm providers with subcontractors:
    1. Understand where visits are being reported to.
    2. know who is submitting the claim under which Provider Medicaid ID
- Ensuring **client**, **Provider Medicaid ID**, **units**, and **service code match** the **visit verified in the Sandata System** as is submitted on the claim

Post Claims Submission

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

Common Roadblocks

In reviewing claims that do not have a matching EVV visit, there are some common reasons for the mismatch:

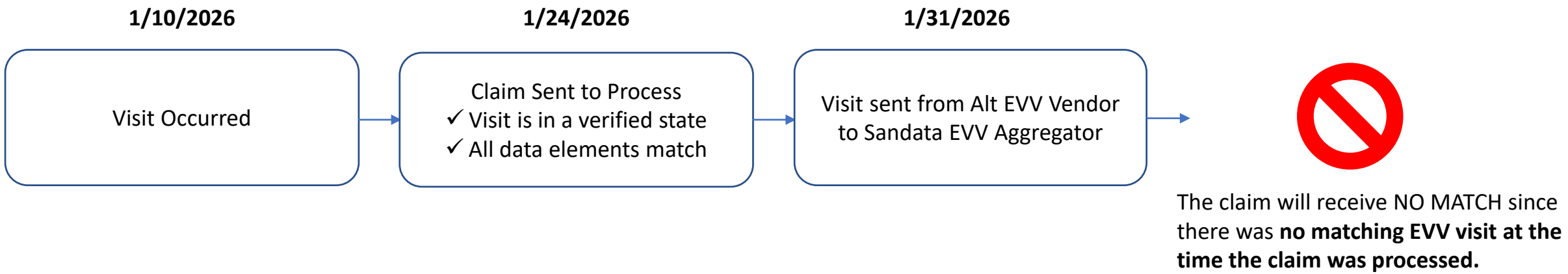
- Visits not importing –"Client Not Found"
- Visits not importing – Invalid Service Code
- Visit is submitted after the claim (therefore the visit was not present when the claim is submitted)
- Visit is not in a "Verified" state at the time the claim is submitted
- Service Code on the claim does not match the service code on 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.
- Units on the claim do not match or are more than the units on the visit

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 of No Match due to timing error:



The claim will receive NO MATCH since there was **no matching EVV visit at the time the claim was processed.**

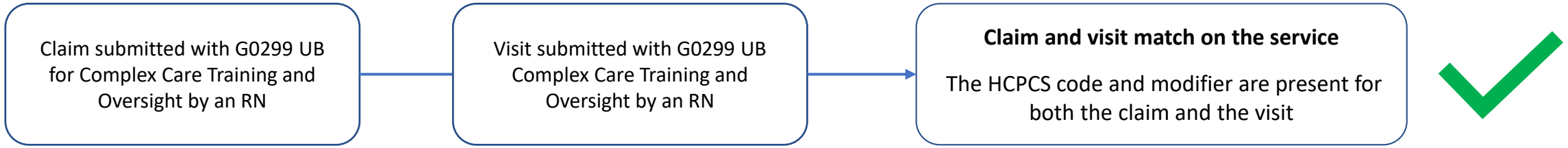
Common Roadblocks - Service Code Matching

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.

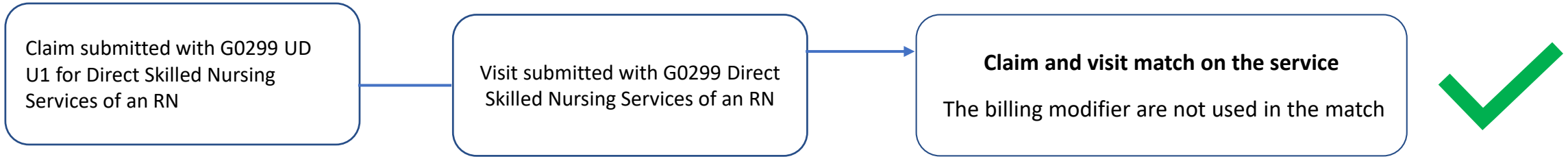
- There is no change to the way that services are billed through MassHealth, only that visits are in a Verified state in the EVV Sandata Aggregator before the claim is submitted.
- For EVV services that have a HCPCS code AND a modifier, both should continue to be included on the claim.
- In instances 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 - Examples

1. Example of Claim Matching with a Service Code and Service Modifier

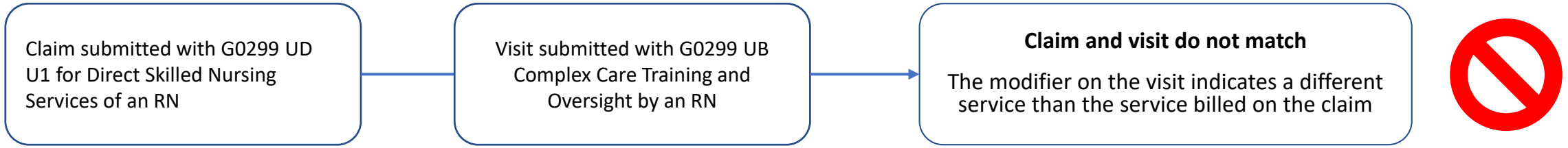


2. Example of Claim Matching with a Service Code and Billing Modifier



Service Code Matching – Examples Continued

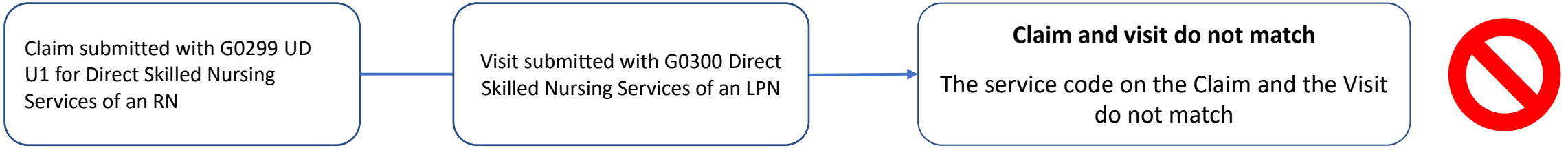
3. Example of Claim Mismatch on Service Code



Service Codes differ for LPN vs. RN

There are different service codes for delivery of services by an LPN or RN for some services. These codes must match on both the visit and the claim for a successful match.

4. Example of Claim Mismatch on Service Code for LPN and RN



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 Example #1

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 Example #2

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 Example #3

Some services are always 1 unit regardless of the duration of the visit per existing State billing policies.

Example of units calculation for a Per Diem/Visit Based 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.

EVV Per Diem/Per Visit Based Service Codes

Sandata Service Code	Service Description
T1503	Administration of Medication Other than Oral and/or Injectable
T1502	Admin of Oral, Intramuscular, Subcutaneous Med
T1502_GT	Telehealth-Admin of Oral Med
S9129_UB	Home Safety/Independence Evaluation by an OT
H0043	GAFC - Per Diem Visit
G0493	HH - RN Observation and Assessment Visit HH ADL Only
G0300	Direct Skilled Nursing Services of an LPN
G0300_UB	Complex Care Training and Oversight by an LPN
G0300_GT	Telehealth-Direct Skilled Nursing Services of an LPN
G0299	Direct Skilled Nursing Services of an RN
G0299_UB	Complex Care Training and Oversight by an RN
G0299_GT	Telehealth-Direct Skilled Nursing Services of an RN
G0153	Speech Language Pathologist in Home Health Setting
G0152	Occupational Therapist in Home Health Setting
G0151	Physical Therapist in Home Health Setting
S9129	ABI-MFP - Occupational Therapy
S9131	ABI-MFP - Physical Therapy
S9128	ABI-MFP - Speech Therapy

Units/Rounding Rules – Overnight Billing

Per State policies, services must be billed on the date of service they occurred. If a service spans midnight, the units are split between the 2 dates of service per the time for each day.

- Example of a visit that crosses over midnight:
  - A Visit = Clock In: 4/15 11pm Clock Out: 4/16 2am, Units = 12
- Example of claim billing:
  - Claim should have 4/15 4 units and a claim for 4/16 for 8 units

Sandata Users:

- In Sandata, the Sandata system will systematically split the visit data above into 2 visits:
- Visit for 4/15 from 11pm – 11:59pm = 4 units
- Visit for 4/16 from 12am – 2am = 8 units

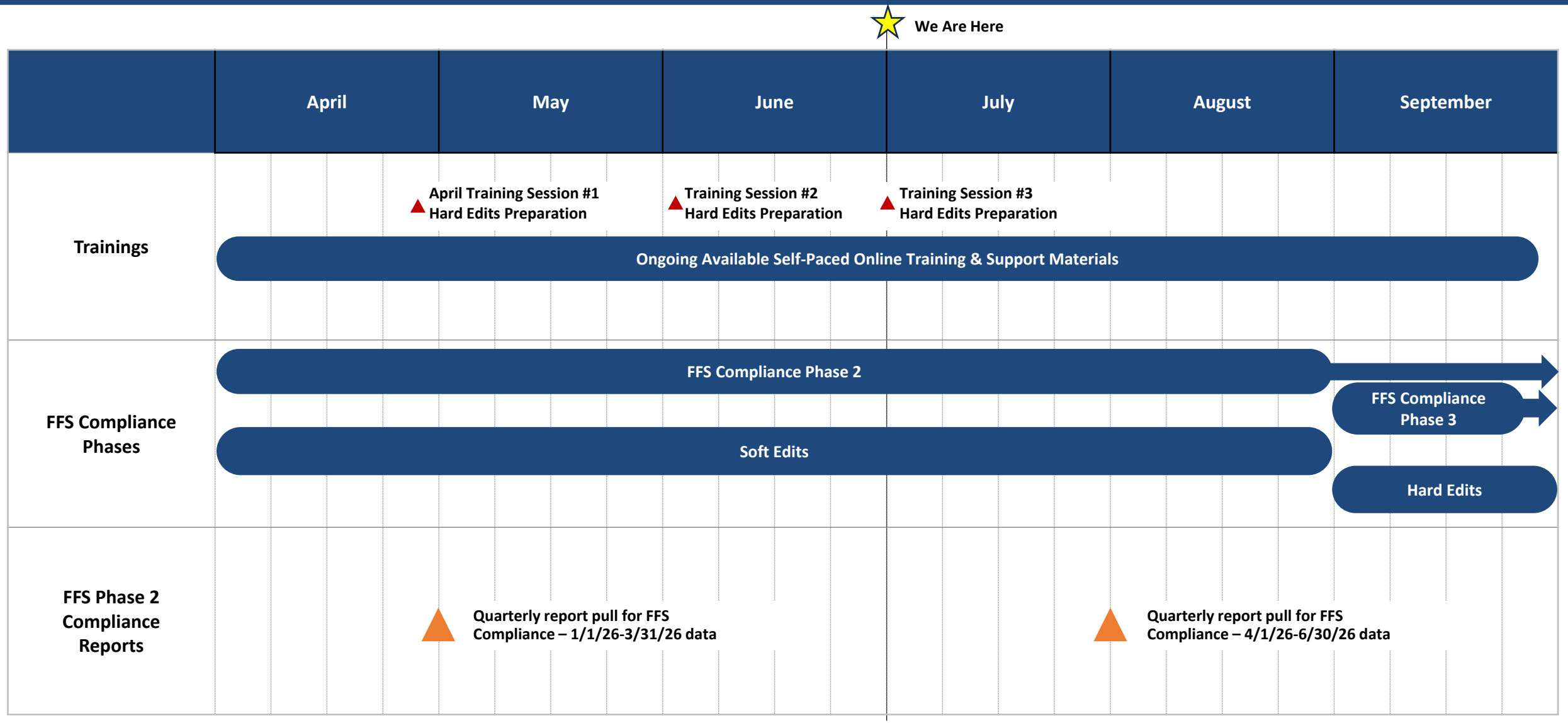
Alt EVV Users:

- Alt EVV users should either force a clock out at midnight OR split the visit into the 2 dates of service when the visit is submitted to the Sandata EVV Aggregator.

Note: To match to the claim, the visit must be split as the claim has 2 dates of service so the visit data must have 2 dates of service with the corresponding units for each date.

Compliance Timeline

FFS Programs Compliance Timeline



FFS Programs Compliance Phases

	Phase 1	Phase 2	Phase 3
	Registration/Onboarding	**EVV Usage/Visit Monitoring**	**Claims to EVV Match/Implementation of Claims Edits**
Description	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.	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.	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.
Goal	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.	The goal for this phase is that providers are using their chosen EVV system and are capturing and maintaining visit data electronically.	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.
	Jan 2025 – Sep 2025	**April 2025 – Ongoing**	**Sept 2026* – Ongoing**

*Updated from July 2026

Phase 2 VS Phase 3 Compliance Phases

What is the difference between Phase 2 and Phase 3 EVV Compliance Phases?

Phase 2 EVV Usage/Visit Monitoring:

- EVV Compliance is an assessment and measurement of a Provider's overall EVV performance across a reporting period (Quarterly).
- A Provider must attain a certain established % threshold of visits that are fully EVV Compliant.
- For Phase 2, a visit is fully EVV Compliant when it includes all required data elements and is not manually entered or edited after the fact.
  - *Required data elements: Date, Time, Employee, Client, Location, Service, and Payer*
- Penalties for Provider non-compliance are enforced by program/contracting entity.

Phase 3 Claims to Visit Match/Implementation of Claims Edits:

- Claims edits are a pre-payment review of the Provider's visits on a 1:1 claim-to-visit level.
- For each claim a Provider submits, there must be a matching Verified (Auto Verified or Manually Verified) visit in the Sandata system.
- A Verified visit is one that include all required data elements. Required data elements are either automatically captured by EVV when the employee clocks in and clocks out or manually entered by the Provider after the visit has occurred.
- Penalties for a Provider not having a matching visit in the Sandata system when a claim is submitted is a denial for that claim.

Although Auto-Verification Percentage and Claims Edits are different, they compliment and support one another. A Provider who is performing well overall with capturing auto-verified visits will increase their success with Claims Edits.

Phase 3 Update

- MassHealth has extended the implementation date of EVV-related hard edits/claims denials **from July 2026 to September 2026**
  - Important Note: This is only impacting 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 in which MassHealth (MAHEA) is the payer.

- Primary reason is **State Readiness**
  - Awaiting a few technical changes to be implemented to improve experience for providers and claims matching, including the proper handling of overnight shifts for Sandata users (no impact to Alt EVV).
  - Majority of provider agencies are ready/prepared to go live on July 1st.

- **Two extra months** for provider agencies in scope for hard edits/claims denials to prepare
  - Ensure your agency is refining visit maintenance processes, viewing data available in reports, and making any necessary corrections prior to September 2026 when claims denials will be implemented.

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

Alt EVV Providers

- Sandata Aggregator
- Visit Review
- Reports Listing
- Massachusetts EOHHS Alternative EVV Technical Specifications
- Vendor Solutions FAQs

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)	• Adult Foster Care Bulletin 33 • GAFC Compliance Checkpoints
Home Health (HH)	• Home Health Bulletin 94 • HH Compliance Checkpoints
Home and Community Based Services (HCBS) Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver	• HCBS Waiver Bulletin 24 • HCBS Waiver Compliance Checkpoints
Aging & Independence (AGE)	• *Providers need to work with their ASAPs to understand EVV Compliance.*
Managed Care Entities (MCE)	• *Providers need to work with their MCEs to understand EVV Compliance for their payer.*

Contacts & Resources

- For the FFS HH, GAFC, and ABI/MFP Waivers Programs Hard Edits Cheat Sheet, presentation from the Hard Edits Preparation Training Session, and other helpful materials, navigate to Electronic Visit Verification for Agency-based Providers | Mass.gov.

- For technical help in using the Sandata EVV portal or Aggregator, please contact Customer Support through at Contact and Support | HHAeXchange Knowledge Base. You may also call the Customer Support line at 833.511.0164.

- For virtual training for both Sandata EVV and the Aggregator, please sign in to the HHAeXchange University, HHAeXchange University.

- For general questions about the Massachusetts EVV program, please email EVVfeedback@Mass.gov. You can also visit the MA-EOHHS EVV website for more information.

- For assistance with your Remittance Advice or claim processing, please contact the LTSS Provider Service Center at (844) 368-5184 or email support@masshealthltss.com.

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 to prepare for Hard Edits
- Quickly identify the root causes of exceptions and take prompt corrective action
- Seek information on provided resources
- Continue checking email for updates and future live training opportunities

Feedback Survey

Thank You!