



TexMedConnect User Guide
for Managed Care Organization (MCO) Long-
Term Services and Supports (LTSS) Providers



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Overview

TexMedConnect is a free, online claims submission application provided by Texas Medicaid & Healthcare Partnership (TMHP). Managed care organization (MCO) Long-term Services and Supports (LTSS) providers can use TexMedConnect to submit claims, perform Claim Status Inquiries (CSI), and submit appeals.

An MCO LTSS provider is any provider who provides LTSS services under a specific National Provider Identifier (NPI) and taxonomy combination and submits claims through Medicaid Managed Care. An MCO LTSS provider will have to enroll through this process when the NPI combination they bill LTSS services does not have an active, associated Texas Provider Identifier (TPI) through TMHP or an Atypical Provider Identifier (API) through this process.

TexMedConnect:

- Delivers an integrated, web-based application.
- Provides a stable and secure environment for claims submission.
- Is accessible from any computer with Internet access.

TexMedConnect for MCO LTSS providers supports Institutional Outpatient claims (837I) and Professional claims (837P) for Health Insurance Portability and Accountability Act (HIPAA) - compliant transactions. Institutional Outpatient claims are used for services rendered in a hospital. Professional claims are used for services rendered by an individual provider.

Basic knowledge of browsing the web and using other web-based applications is helpful when using TexMedConnect.

Requirements

TexMedConnect is a web-based application and requires Internet capabilities as follows:

- Internet service provider (ISP)
- Internet browser Microsoft® Internet Explorer® (version 11.0 and later)
- Google Chrome® (version 48 and later)

A broadband connection is recommended but not required.

Getting Support

This section explains whom at TMHP to contact for assistance with technical issues and claims questions.

Technical Support

Contact the TMHP Electronic Data Interchange (EDI) Help Desk at 888-863-3638, Option 4, for MCO LTSS provider's technical issues. The TMHP EDI Help Desk provides technical assistance with troubleshooting TexMedConnect and TMHP EDI Gateway system issues.

Contact your system administrator for assistance with modem, hardware, Internet connectivity, or phone line issues.

Claims Support

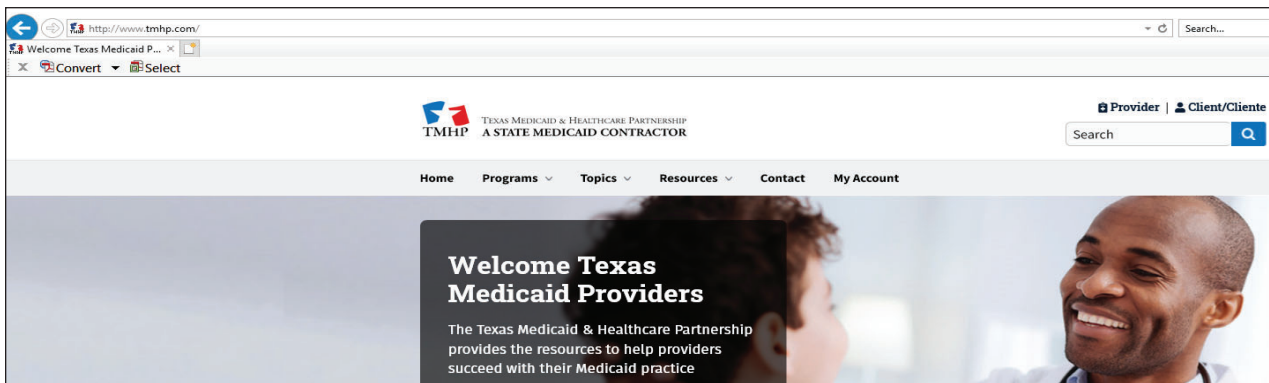
Call the TMHP Contact Center at 800-925-9126 with questions about MCO LTSS electronic claims.

Accessing TexMedConnect

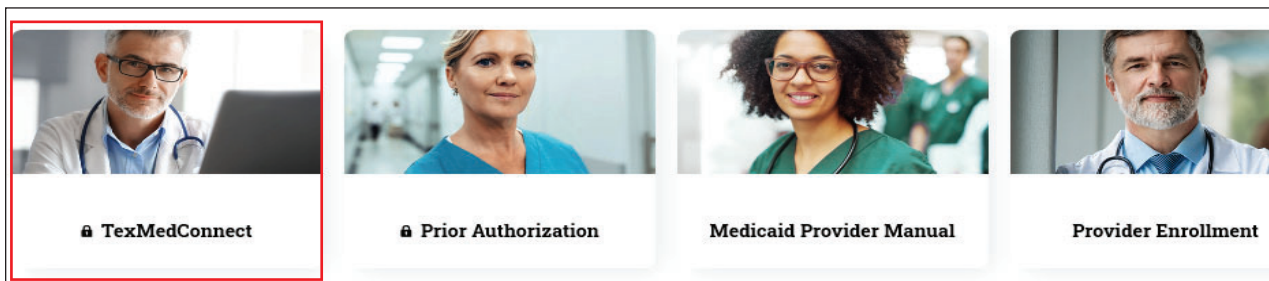
Access TexMedConnect through the TMHP website. To use TexMedConnect, you must already have an account on the TMHP website. If you do not have an account, set one up using the information provided in the [TMHP Website Security Provider Training Manual](#).

Once you have an account for the TMHP website:

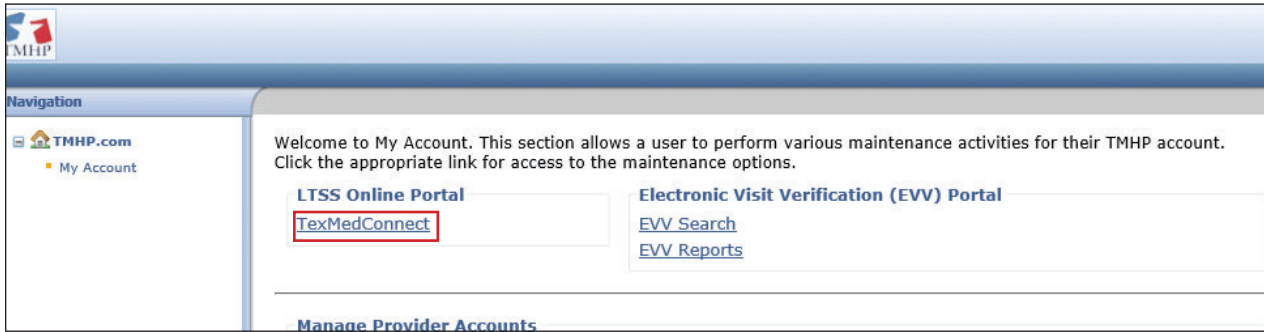
- 1) Access the TMHP website at tmhp.com.



- 2) Click **TexMedConnect**. Enter your user name and password.



3) The My Account page will open to display website features you have access to. Click **TexMedConnect**.



Navigation Panel

All of the available menu options for MCO LTSS providers are located under Acute Care in the left navigation panel. A user's access privilege determines which options appear. You can select the activity you would like to perform from the navigation panel.



Eligibility

You have the ability to verify a client's eligibility, create a list of clients for whom you would like to verify eligibility, and create eligibility batch reports by NPI or API.

Eligibility Verification (EV)

To verify a client's eligibility, follow these steps:

- 1) Select **Eligibility** from the navigation panel.



- 2) Use the Provider NPI/API drop-down list to select an NPI or API.

A screenshot of the 'Eligibility Verification' form. The title 'Eligibility Verification' is at the top. Below the title is a instruction: 'Please enter the required information and click "Submit" to view the eligibility of the client.' The form contains three input fields: 'Provider NPI/API:' with a red box around the dropdown menu, 'Eligibility From Date:' with a text box and a calendar icon, and 'Eligibility Through Date:' with a text box and a calendar icon. Each field has a red asterisk indicating it is required. The format for the date fields is specified as 'mm/dd/yyyy'.


- 3) Enter an Eligibility From Date and Eligibility Through Date manually, or use the calendar icon.

A screenshot of the 'Eligibility Verification' form, identical to the previous one. In this view, a red rectangular box highlights the 'Eligibility From Date:' and 'Eligibility Through Date:' fields, including their respective text boxes and calendar icons.


- 4) You must also enter information in the Medicaid/CSHCN ID field or Social Security Number field and either the Date of Birth, Last Name, or First Name fields. Click **Submit**.

Please enter one of the following valid field combinations:

- Medicaid/CSHCN ID and Date of Birth
- Medicaid/CSHCN ID and Last Name
- Medicaid/CSHCN ID and Social Security Number
- Social Security Number and Last Name
- Social Security Number and Date of Birth
- Date of Birth and Last Name and First Name

Medicaid/CSHCN ID: Format: 123456789
 Social Security Number: Format: 123-45-6789 or 123456789
 Date of Birth:  Format: mm/dd/yyyy
 Last Name:
 First Name:

- 5) Eligibility verification results appear. Click the PDF icon in the top right corner of the Eligibility Verification Results page to view and print results.

[Print Options ::](#) 

Eligibility Verification Results

[New Lookup](#) [Return with Search Criteria](#)

| Patient Information | | Inquiry Information | |
|------------------------|------------|------------------------|-----------|
| Client No./Trainee SSN | | NPI/API | |
| DOB | | Eligibility From | 9/1/2019 |
| Gender | F | Eligibility Through | 9/30/2019 |
| SSN | | Medicaid /Client No. | |
| Name | | Social Security Number | |
| Address | | Date of Birth | |
| County | Garza | Last Name | |
| Medicare No. | | First Name | |
| Base Plan | INDIV OUTS | | |

| Segment Dates | Medical Coverage | Program Type | Program | Benefit Plan | Spend-down Indicator |
|---|------------------|----------------------------|----------------|--------------------------------|--|
| EFF : 1/1/2012 TRM : 7/31/2020 ADD : 11/22/2011 | R - REGULAR | 54 - MQMB (SSI, RECIPIENT) | 100 - MEDICAID | 140 - MCAID QUAL MEDICARE BENE | Q - MQMB - CATEGORY 01, 03, OR 04 CLIENT WHO IS DUALY ELIGIBLE FOR MAO AND QMB |

| Segment Dates | Medicare Type | Contract Number | Plan ID | Contract Number Link |
|--|---------------|-----------------|---------|----------------------|
| EFF : 4/1/1992 TRM : 7/31/2020 ADD : 4/14/1992 | A | | | |
| EFF : 4/1/1992 TRM : 7/31/2020 ADD : 4/20/1992 | B | | | |

Lock-In Segments
No Lock-In Segments found

TPR Segments
No TPR Segments found

TPL Segments
No TPL Segments found

| Segment Dates | Organization | Plan Code | Line Of Business | Name | Phone |
|--|--------------|-----------|------------------|------|-------|
| EFF : 9/1/2013 TRM : 7/31/2020 ADD : 7/23/2013 | | 58 | STAR+PLUS | | |

| Dental | Hearing Aid | Eye Exam | Eye Glasses | Medical |
|--------|-------------|-----------|-------------|---------|
| | | 4/26/1990 | 1/16/2012 | |

- 6) Click **New Lookup** to return to the Eligibility Verification screen. Click **Return with Search Criteria** to return to the Eligibility Verification screen with the last search criteria in the fields.



Client Group List

The client group list allows you to create a list of clients for whom you would like to verify eligibility. You can create up to 100 groups for each NPI or API. Each client group can contain up to 250 clients.

To verify eligibility through the client group list, follow these steps:

- 1) Select **Client Group List** from the navigation panel.



- 2) Select the NPI or API on the EV Client Group List screen. Click **Continue**.

EV Client Group List

Select NPI/API and related data

| NPI | Taxonomy | Address | Zip | Benefit Code |
|----------------------------------|----------|---------|-------|--------------|
| <input checked="" type="radio"/> | | | 77642 | LTSS |
| <input type="radio"/> | | | 77642 | LTSS |
| <input type="radio"/> | | | 77642 | LTSS |

Continue >>

- 3) Click the name of the group to view the client list. Click **Delete** to remove an existing client group list. You can also type a group name and click **Add Group** to create a new client group list.

Client Group List

NPI/API

Add Group

| Name of the group | User ID | Created Date | Last Updated Date | |
|---|--------------|--------------|-------------------|------------------------|
| TEST | TESTING_USER | 08/04/2020 | 08/04/2020 | Delete |
| TEST 4 | TESTING_USER | 08/04/2020 | 08/04/2020 | Delete |
| LTSS client Group Test_0805 | TESTING_USER | 08/05/2020 | 08/05/2020 | Delete |
| New LTSS Group 2_0805 | TESTING_USER | 08/05/2020 | 08/05/2020 | Delete |

- d) To create a group, enter a Client number or social security number and date of birth, last name, or first name. Click **Lookup**. Then, click **Add to Group**.

Add Client

Client #:

SSN:

DOB:

Last Name:

First Name:

Lookup

Lookup Criteria
 Combination of Client # and DOB
 or Client # and Last Name
 or Client # and SSN
 or SSN and Last Name
 or SSN and DOB
 or DOB and Last Name and First Name.

- 5) You can click **Add Client** to add more clients to the group.

Client List

- 6) Enter a date range in the From Date of Service and To Date of Service fields manually, or use the calendar icon. Click **Eligibility** to view the Eligibility Verification Results.

Client List Print Options ::

NPI/API

From Date of Service Format mm/dd/yyyy

To Date of Service Format mm/dd/yyyy

| Select All <input type="checkbox"/> | First Name | Last Name | Client # | SSN | | |
|-------------------------------------|------------|-----------|-----------|-------------|--------------------|--------|
| <input type="checkbox"/> | JOHN | SMITH | 123456789 | ***-**-**** | Eligibility | Delete |
| <input type="checkbox"/> | JANE | DOE | 987654321 | ***-**-**** | Eligibility | Delete |

- 7) Eligibility verification results appear. Click the PDF icon in the top right corner of the Eligibility Verification results page to view and print results. Click **Return to List** to return to the Client List screen.

Return to List

| Patient Information | | Inquiry Information | |
|------------------------|------------|------------------------|-----------|
| Client No./Trainee SSN | | NPI/API | |
| DOB | | Eligibility From | 9/1/2019 |
| Gender | M | Eligibility Through | 9/30/2019 |
| SSN | | Medicaid /Client No. | |
| Name | | Social Security Number | |
| Address | | Date of Birth | |
| County | Dallas | Last Name | |
| Medicare No. | | First Name | |
| Base Plan | INDIV OUTS | | |

| Segment Dates | Medical Coverage | Program Type | Program | Benefit Plan | Spend-down Indicator |
|--|------------------|----------------------------|----------------|--------------------------------|--|
| EFF : 12/1/2011 TRM : R - REGULAR 7/31/2020 ADD : 10/25/2011 | | 54 - MQMB (SSI, RECIPIENT) | 100 - MEDICAID | 140 - MCAID QUAL MEDICARE BENE | Q - MQMB - CATEGORY 01, 03, OR 04 CLIENT WHO IS DUALY ELIGIBLE FOR MAO AND QMB |

| Segment Dates | Medicare Type | Contract Number | Plan ID | Contract Number Link |
|--|---------------|-----------------|---------|-----------------------------|
| EFF : 5/1/2011 TRM : A 7/31/2020 ADD : 4/6/2011 | | | | |
| EFF : 2/1/2011 TRM : B 7/31/2020 ADD : 5/24/2011 | | | | |
| EFF : 4/1/2011 TRM : C | | | | CMS ID Info |

- 8) To submit an eligibility report for one or more clients in a client group list to batch, enter a date range in the From Date of Service and To Date of Service fields manually, or use the calendar icon. Click individual check boxes to select clients for a batch report, or click **Select All** to create a batch report for all members of the client group list. Click **Submit EV Batch**.

Client List

Go Back Add Client

NPI/API

From Date of Service Format mm/dd/yyyy

To Date of Service Format mm/dd/yyyy

| Select All | First Name | Last Name | Client # | SSN | Eligibility | Delete |
|--------------------------|------------|-----------|----------|-------------|-------------|--------|
| <input type="checkbox"/> | | | | ***-**-**** | Eligibility | Delete |
| <input type="checkbox"/> | | | | ***-**-**** | Eligibility | Delete |

Submit EV Batch

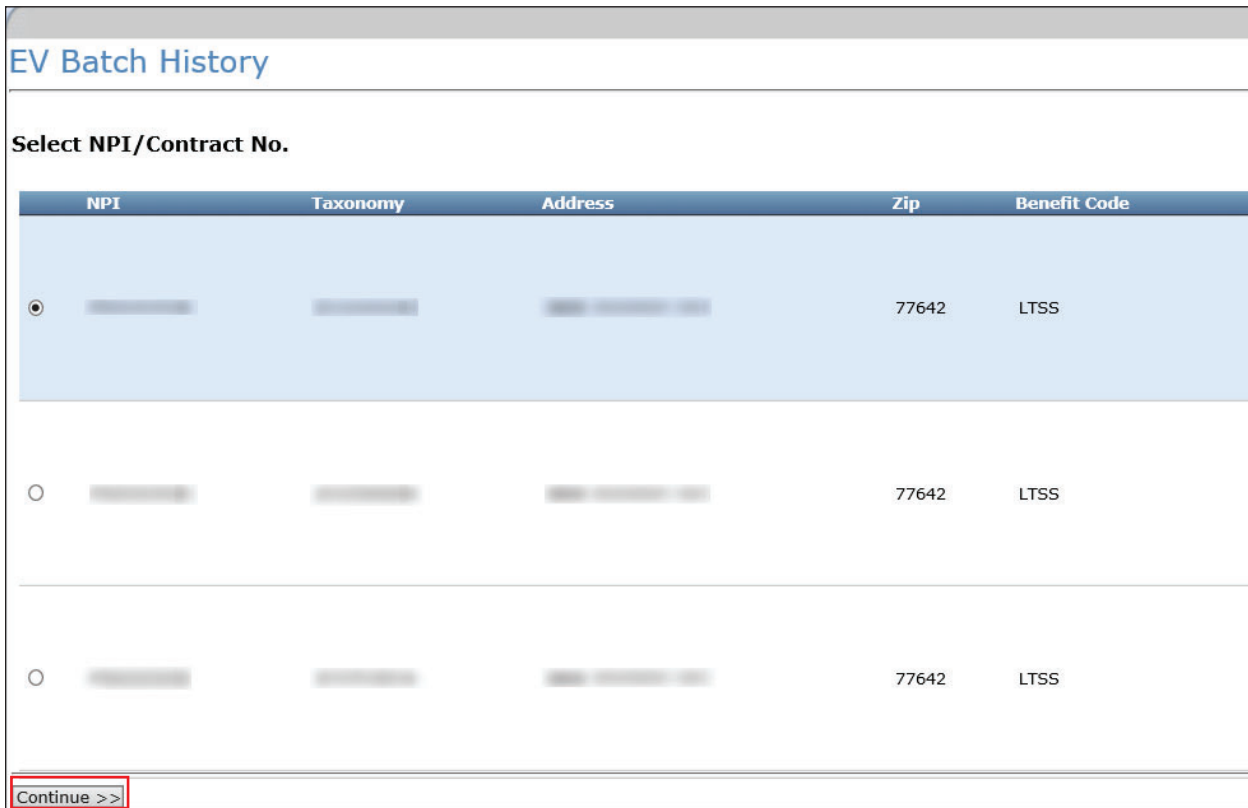
EV Batch History

To view eligibility batch reports, follow these steps:

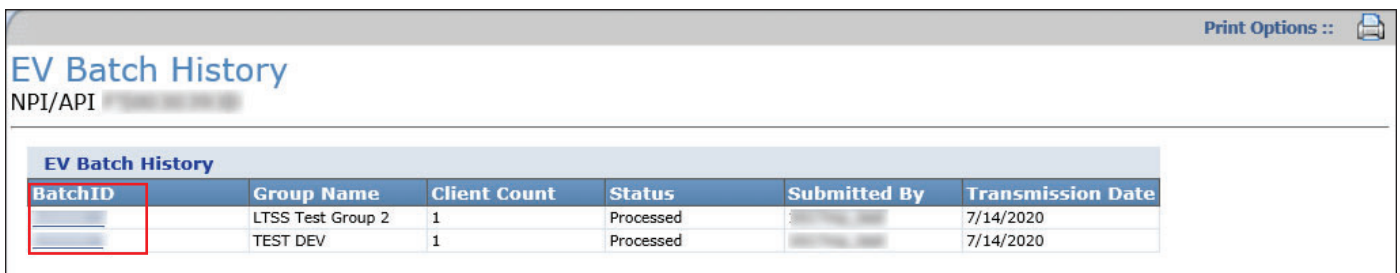
1) Select **EV Batch History** from the navigation panel.



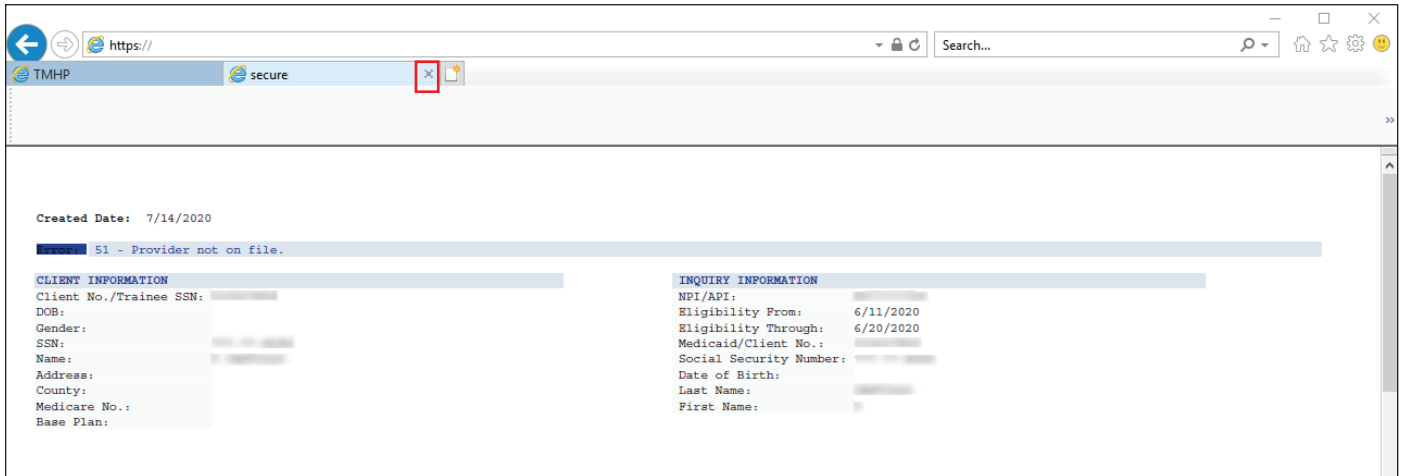
2) Select an NPI or API on the EV Batch History screen. Click **Continue**.



3) Select a **Batch ID** to review the eligibility report results. The report opens in a new browser window in a PDF format.



- 4) Use your browser print functions to print the report results. Click the **X** on the browser tab to close the report and return to the EV Batch History results screen for the selected NPI or API.



Filing a Claim

You have the ability to submit the following claim types for a selected NPI or API:

- Institutional Outpatient
- Professional

Required data must be entered on each claim submission tab for the selected claim type. Click each tab to navigate through the screens. Ensure the data entered meets field edit requirements (such as social security number [SSN] must be nine digits, and future dates are not allowed for the patient date of birth or date of death).

After the claim information is entered, you can either submit the claim, save a draft, or save the individual claim as a template. Once a claim is submitted successfully, you will receive information about claim routing and a TMHP EDI Transaction Number (ETN).

Claims Entry

To enter the details of a claim, follow these steps:

- 1) Select **Claims Entry** from the navigation panel.



- 2) Use the NPI drop-down list to select an NPI or API. A list of NPIs or APIs and related data (such as taxonomy, physical address, and benefit code selections) is displayed based on the user's access.

| NPI | Taxonomy | Address | Zip | Benefit Code |
|----------------------------------|----------|---------|-------|--------------|
| <input checked="" type="radio"/> | | | 77642 | LTSS |
| <input type="radio"/> | | | 77642 | LTSS |
| <input type="radio"/> | | | 77642 | LTSS |

- 3) Enter the client number for the claim (optional). The client number is the Medicaid ID number. When a client number is entered, the system populates most of the required fields on the Client tab. If you do not enter the client number, you must enter all required fields manually on the Client tab.

- 4) Use the Claim Type drop-down menu to select **Outpatient** or **Professional**. Click **Proceed to Step 2**.

Professional Claim

The Claims Entry screen appears for the Professional claim type. Required fields (indicated by a red dot) must always be completed on each tab. If you entered the client number on the Claims Entry screen, many of these fields are pre-populated, but can still be edited.

You can use the Next and Previous buttons on each tab to save claim data and move through the claims entry steps.

Patient Tab

On the Patient tab, complete all required fields. Make sure to enter a nine-digit ZIP code in the ZIP+4 field.

The screenshot shows the 'Patient' tab selected in the 'Claim Submission - Step 2' interface. The interface includes a navigation bar with tabs for PATIENT, PROVIDER, CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The Patient tab is active. The form contains three main sections: 'Patient Identification Numbers' with fields for Account No., SSN, and Client Number; 'Name and Address' with fields for Last Name, First Name, MI, Suffix, Street, City, State, and ZIP+4; and 'Patient General Information' with fields for Gender, Patient Date of Birth, and Patient Date of Death. At the bottom, there are buttons for 'Save Draft', 'Save Template', 'Previous', and 'Next'.

Provider Tab

On the Provider tab, complete all required fields. Some billing provider fields pre-populate. All other required data (such as ID Type) must be entered manually.

The screenshot shows the 'Provider' tab selected in the 'Claim Submission - Step 2' interface. The interface includes a navigation bar with tabs for PATIENT, PROVIDER, CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The Provider tab is active. The form contains four main sections: 'Billing Provider' with fields for NPI, Taxonomy, Benefit Code, Last/Organization Name, First Name, MI, Suffix, Address, Address2, City, State, ZIP+4, ID Type, EIN/SSN, and Phone No.; 'Facility Provider' with fields for NPI/API, Name, Address, City, State, Zip+4, and Service Location; 'Referring/Other Provider' with fields for NPI/API, Last Name, First Name, MI, and Suffix; and 'Referring/Other Supervising Provider' with fields for NPI/API, Last Name, First Name, MI, and Suffix. At the bottom, there are buttons for 'Save Draft', 'Save Template', 'Previous', and 'Next'.

Claim Tab

On the Claim tab, complete all required fields when applicable.

Home :: TMHP.com :: My Account
 Logged in as: [User] | Log Off
 Print Options :: [Print]

Claim Submission - Step 2

Please disable pop-up blocker to print.

| Claim Type | Patient | Provider | Status | Claim No. |
|--------------|---------|----------|--------|-----------|
| Professional | | | New | |

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM

Claim

General

Date Of Current Condition: [Field] AutoAccident Employment Related THSteps Related Other Accident

Authorization No.: [Field]

Outside Lab?: [Dropdown]

Charges: \$ [Field]

Dates patient unable to work in current occupation
 From: [Field] To: [Field]

Value Codes

Value Amount: [Field]

Save Draft Save Template Previous Next

Diagnosis Tab

On the Diagnosis tab, complete all required fields.

Home :: TMHP.com :: My Account
 Logged in as: [User] | Log Off
 Print Options :: [Print]

Claim Submission - Step 2

Please disable pop-up blocker to print.

| Claim Type | Patient | Provider | Status | Claim No. |
|--------------|---------|----------|--------|-----------|
| Professional | | | New | |

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM

Diagnosis

Qualifier: [Dropdown]

Code: [Field] [Magnifying Glass Icon] Description: [Field]

Number of Details To Add: [Field] Add New Diagnosis Code Row(s)
 There is a maximum of 12 Diagnosis code rows available for entry.

Save Draft Save Template Previous Next

Use the Qualifier drop-down list to select International Statistical Classification of Diseases and Related Health Problems (ICD-9) or ICD-10 to ensure the correct ICD diagnosis code is found in the Code lookup field. The qualifier selected must be valid for the diagnosis code entered, based on the date of services. Input the diagnosis code to the highest degree of specificity. Click the magnifying glass icon to look up the code description.

To add additional diagnosis code rows, enter the **Number of Details To Add** (up to 12) and click **Add New Diagnosis Code Row(s)**.

Details Tab

On the Details tab, complete all required fields.

Home :: TMHP.com :: My Account
 Logged in as: [] Log Off
 Print Options []
Please disable pop-up blocker to print.
 Claim Type Patient Provider Status Claim No.
 Professional [] [] New []
PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM
General Details

| | D05 | P05 | Proc ID | Proc | Remarks | Meds | | | | Ane. Min. | OB.Ane.Units | Diag Ref | Qty/Units | Unit Price | |
|---|-----|-----|---------|------|---------|------|---|---|---|-----------|--------------|----------|-----------|------------|--------|
| | | | | | | 1 | 2 | 3 | 4 | | | | | | |
| 1 | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | Delete |
| 3 | | | | | | | | | | | | | | | Delete |
| 4 | | | | | | | | | | | | | | | Delete |
| 5 | | | | | | | | | | | | | | | Delete |

 Number of Details to Add: [] Add New Detail Row(s) Copy Row
Totals
 Total Charges: \$0.00 Other Insurance Paid: \$0.00 Net Billed: \$0.00
 Save Draft Save Template Previous Next

The Total Charges on each row are automatically calculated based on the Qty/Units x Unit Price. It is important to note that for EVV claims, the units on the EVV claim must match the units on the EVV transactions for the date of service, or the claim will be denied.

Consult the current [HHSC published list of EVV services](#) to know which services are set to bypass the EVV06 claims units match edit. In the list, find your service. Go to the Units Matched During EVV Claims Matching? column to determine if the units on the EVV claim must match the units on the EVV visit transactions for that service.

Additionally, the Total Charges at the bottom of the screen is automatically calculated, based on the Total Charges for each row entered.

To add additional detail rows, enter the **Number of Details To Add** (up to 28) and click **Add New Detail Row(s)**. To duplicate a detail row, click on the row number and click **Copy Row**.

Click **Delete** in the far right column to remove a row.

Other-Insurance/Submit Claim Tab

On the Other-Insurance/Submit Claim tab, you can select an option from the **Source of Payment** drop-down list. Enter insurance information into all required fields. Click **Add Another Insurance Plan** to create new insurance that is not on file.

Home :: TMHP.com : My Account
 Logged in as: | Log Off
 Print Options :
 Please disable pop-up blocker to print.

| Claim Type | Patient | Provider | Status | Claim No. |
|--------------|---------|----------|--------|-----------|
| Professional | | | New | |

CLAIM SUBMISSION - STEP 2

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS **OTHER-INSURANCE / SUBMIT CLAIM**

Other Insurance 1

Source of Payment

Source of Payment
 XXX NONE

Add Another Insurance Plan

Certification, Terms And Conditions

Please Review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Provider and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

We Agree

Save Draft Save Template Save to Batch **Submit** Previous Next

After reviewing the Certification, Terms, and Conditions, check **We Agree** to enable the Submit button. Click **Submit** for the claim information to be automatically verified by TexMedConnect.

If there is any missing or invalid information, an error message will display the location of the error. Click each tab to view the error message detailing fields that must be corrected and correct them. The claim will not submit until the errors are corrected.

The screenshot shows the 'Claim Submission - Step 2' page. At the top right, there is a navigation bar with 'Home :: TMHP.com :: My Account', 'Logged in as: [user]', and 'Log Out'. Below this is a 'Print Options' link. The main header area contains a red box with the following text: 'Please fix these errors. The page will not submit until these are corrected.' followed by a bulleted list: 'There are errors in PATIENT tab', 'There are errors in PROVIDER tab', 'There are errors in DIAGNOSIS tab', and 'There are errors in DETAILS tab'. Below the error box is a tabbed interface with tabs for 'PATIENT', 'PROVIDER', 'CLAIM', 'DIAGNOSIS', 'DETAILS', and 'OTHER-INSURANCE / SUBMIT CLAIM'. The 'OTHER-INSURANCE / SUBMIT CLAIM' tab is selected. Under this tab, there is a 'Source of Payment' dropdown menu set to 'NONE'. Below that is a link 'Add Another Insurance Plan'. A section titled 'Certification, Terms And Conditions' contains a paragraph of text and a 'We Agree' checkbox. At the bottom of the page are buttons for 'Save Draft', 'Save Template', 'Submit', and 'Previous/Next'.

Once all errors are corrected, return to the Other-Insurance/Submit Claim tab. Read the Terms and Conditions, then check the **We Agree** box. Click **Submit** to submit the claim.

Once a claim is submitted successfully, you can view information about claim routing and a TMHP ETN. Click the ETN number to open the CSI screen to view claim routing information and the status of the claim, such as *Pending*, *Accepted*, or *Rejected*.

The screenshot shows the 'Claim Submission - Step 2' page after successful submission. The main content area is a green box with the following text: 'The TMHP EDI Transaction Number is 1094', 'Submitted at 11/15/2019 2:51:53 PM by [user]', and 'Cigna-HealthSpring has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at 1-877-653-0331 for questions about processing of this claim.' Below this is a link 'Enter Another Claim'. At the bottom, the 'OTHER-INSURANCE / SUBMIT CLAIM' tab is selected, and a table shows the claim status: 'Claim Type: Professional', 'Patient: Forwarded', 'Provider: L1994', and 'TMHP EDI Trans No: 1094'.

Institutional Outpatient Claim

The Claims Entry screen appears for an Outpatient claim type. Required fields (indicated by a red dot) must always be completed on each tab. If you entered the client number on the Claims Entry screen, many of these fields are pre-populated but can still be edited.

Use the Next and Previous buttons at the bottom of each tab to save claim data and move through the claims entry steps.

Patient Tab

On the Patient tab, complete all required fields.

The screenshot shows the 'Patient' tab selected in the 'Claim Submission - Step 2' interface. The 'PATIENT' tab is highlighted with a red box. The form contains the following sections:

- Patient Identification Numbers:** Fields for Account No., SSN, and Client Number.
- Name and Address:** Fields for Last Name, First Name, MI, Suffix, Street, City, State, and ZIP+4.
- Patient General Information:** Fields for Gender and Patient Date of Birth.

Buttons for 'Save Draft', 'Save Template', 'Previous', and 'Next' are visible at the bottom.

Provider Tab

On the Provider tab, complete all required fields. Some billing provider fields pre-populate. All other required data (such as ID Type) must be entered manually.

The screenshot shows the 'Provider' tab selected in the 'Claim Submission - Step 2' interface. The 'PROVIDER' tab is highlighted with a red box. The form contains the following sections:

- Billing Provider:** Fields for NPI, Taxonomy, Benefit Code, Last/Organization Name, Address, Address2, City, State, ZIP+4, EIN, and Phone No.
- Attending Provider:** Fields for Attending Provider NPI/API, Last Name, First Name, MI, and Suffix.
- Operating Provider:** Fields for Operating Provider NPI/API, Last Name, First Name, MI, and Suffix.
- Referring/Other Provider:** Fields for NPI/API, Last Name, First Name, MI, and Suffix.
- Rendering Provider:** Fields for NPI, Last Name, First Name, MI, and Suffix.

Buttons for 'Save Draft', 'Save Template', 'Previous', and 'Next' are visible at the bottom.

Claim Tab

On the Claim tab, complete all required fields.

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there are navigation tabs: PATIENT, PROVIDER, CLAIM (highlighted with a red box), DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. Below the tabs, the 'Claim' section is expanded to show several input fields:

- General:** Patient Discharge Status (dropdown), Authorization No. (text), Type of Bill (dropdown).
- Admission Information:** Date (calendar), Hour (dropdown), Priority (Type) of Admission or Visit (dropdown), Point of Origin for Admission or Visit (dropdown).
- Discharge Information:** Hour (dropdown).
- Occurrence Codes:** Occurrence Code (dropdown), Occurrence Date (calendar), and an 'Add New Occurrence Code' button (highlighted with a red box).
- Value Codes:** Value Code (dropdown), Value Amount (text), and an 'Add New Value Code' button (highlighted with a red box). A note below states: 'There is a maximum of 24 Value Code rows available for entry'.
- Condition Codes:** Condition Code (dropdown), a 'Remove' button (highlighted with a red box), and an 'Add New Condition Code' button (highlighted with a red box).

At the bottom of the form, there are buttons for 'Save Draft', 'Save Template', 'Previous', and 'Next'.

To add occurrence code rows, click **Add New Occurrence Code**. There is a maximum of four occurrence code rows.

To add value code rows, click **Add New Value Code** (up to 24 rows) and click **Add New Diagnosis Code Row(s)**.

To add condition codes, click **Add New Condition Code**.

To delete any added rows, click **Remove**.

Diagnosis Tab

On the Diagnosis tab, complete all required fields.

Use the Qualifier drop-down list to select ICD-9 or ICD-10 to ensure the correct ICD diagnosis code is found in the Code lookup field. The qualifier selected must be valid for the diagnosis code entered, based on the date of services.

Input the diagnosis code to the highest degree of specificity. Click the magnifying glass icon to look up the code description.

To add additional diagnosis code rows, enter the **Number of Details To Add** (up to 12) and click **Add New Diagnosis Code Row(s)**.

Details Tab

On the Details tab, complete all required fields.

The Total Charges on each row are automatically calculated based on the Qty/Units x Unit Price. It's important to note that for EVV claims, the units on the EVV claim must match the units on the EVV transactions for the date of service, or the claim will be denied. Additionally, the Total Charges at the bottom of the screen is automatically calculated, based on the Total Charges for each row entered.

To add additional detail rows, enter the **Number of Details To Add** (up to 28) and click **Add New Detail Row(s)**. To duplicate a detail row, click on the row number and click **Copy Row**.

To remove a row, click **Delete** in the far right column.

Other-Insurance/Submit Claim Tab

On the Other-Insurance/Submit Claim tab, you can select an option from the **Source of Payment** drop-down list. Enter insurance information into all required fields. Click **Add Another Insurance Plan** to create new insurance that is not on file.

Home :: TMHP.com :: My Account

Logged in as: | Log Off

Print Options ::

Claim Submission - Step 2

Please disable pop-up blocker to print.

| Claim Type | Patient | Provider | Status | Claim No. |
|------------|---------|----------|--------|-----------|
| Outpatient | | | New | |

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS **OTHER-INSURANCE / SUBMIT CLAIM**

Other Insurance 1

Source of Payment

Source of Payment
XX NONE

Add Another Insurance Plan

Certification, Terms And Conditions

Please Review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

We Agree

Save Draft Save Template Save to Batch **Submit** Previous Next

After reviewing the Certification, Terms, and Conditions, check **We Agree** to enable the Submit button. Click **Submit** for the claim information to be automatically verified by TexMedConnect.

If there is any missing or invalid information, an error message will display the location of the error. Click each tab to view the error message detailing fields that must be corrected. The claim will not submit until the errors are corrected.

The screenshot shows the 'Claim Submission - Step 2' page. At the top right, there is a navigation bar with 'Home :: TMHP.com :: My Account', 'Logged in as: [User]', and 'Log Out'. Below this is a 'Print Options' button. The main header area contains the title 'Claim Submission - Step 2' and a table with columns: 'Claim Type' (Outpatient), 'Patient', 'Provider', 'Status' (New), and 'Claim No.'. A red-bordered box contains an error message: 'Please fix these errors. The page will not submit until these are corrected.' followed by a list of errors: 'There are errors in PATIENT tab', 'There are errors in PROVIDER tab', 'There are errors in CLAIMS tab', 'There are errors in DIAGNOSIS tab', and 'There are errors in DETAILS tab'. Below the error box is a tabbed interface with tabs for 'PATIENT', 'PROVIDER', 'CLAIM', 'DIAGNOSIS', 'DETAILS', and 'OTHER-INSURANCE / SUBMIT CLAIM'. The 'OTHER-INSURANCE / SUBMIT CLAIM' tab is active. Under this tab, there is a section for 'Other Insurance 1' with a 'Source of Payment' dropdown menu set to 'XX NONE' and an 'Add Another Insurance Plan' link. Below that is a 'Certification, Terms And Conditions' section with a 'We Agree' checkbox. At the bottom, there are buttons for 'Save Draft', 'Save Template', 'Submit', and 'Previous/Next'.

Once all errors are corrected, return to the Other-Insurance/Submit Claim tab. Read the Terms and Conditions, then check the **We Agree** box. Click **Submit** to submit the claim.

Once a claim is submitted successfully, you can view information about claim routing and a TMHP ETN. Click the ETN number to open the CSI screen to view claim routing information and the status of the claim, such as *Pending*, *Accepted*, or *Rejected*.

The screenshot shows the 'Claim Submission - Step 2' page after successful submission. The navigation bar and header are the same as in the previous screenshot. The main content area is a yellow box with the following text: 'The TMHP EDI Transaction Number is 11994', 'Submitted at 11/15/2019 2:51:53 PM by [User]', and 'Cigna-HealthSpring has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at 1-877-653-0331 for questions about processing of this claim.' Below this text is a link 'Enter Another Claim'. At the bottom, the tabbed interface is the same, but the 'OTHER-INSURANCE / SUBMIT CLAIM' tab is now highlighted in blue.

Saving a Claim

MCO LTSS provider claims can be saved as a draft or saved as a template.

Click **Save Draft** to add the claim to the Draft list for completion at a later time.

Click **Save Template** to add claims to the Individual Template list for quicker claims creation in the future.

Saving as a Draft

You can save incomplete claims in a draft status for later submission. To save a claim as a draft, follow these steps:

- 1) Click Save Draft.

- 2) Enter a draft name in the blank field that appears. The draft name can include both numbers and letters.

- 3) Click Save to save the draft. Click Cancel to close the draft name field.

The claim is saved to the Draft screen for completion at a later time.

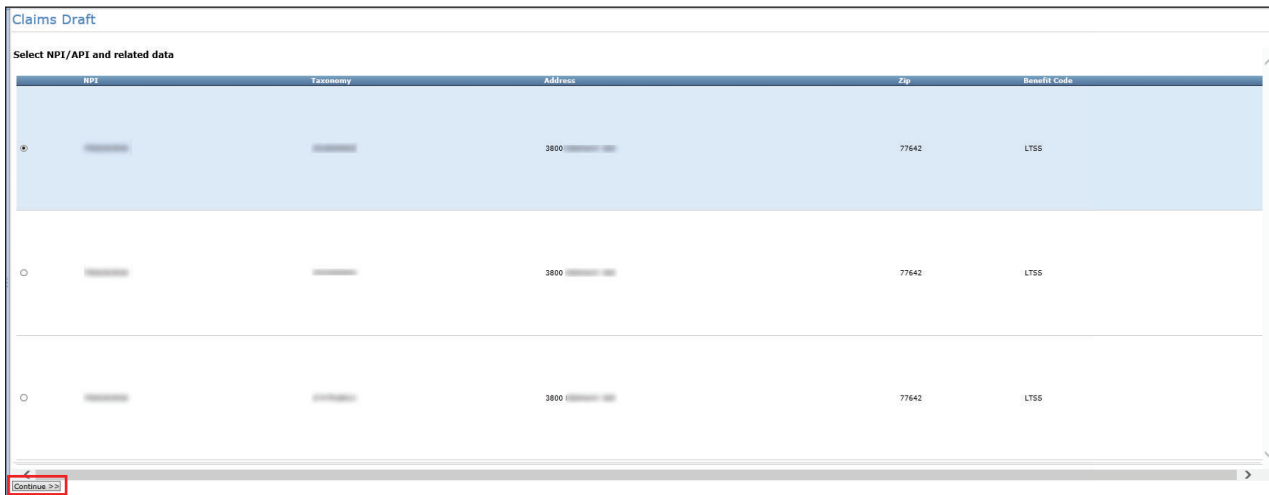
Viewing Draft Claims

A list of NPIs and APIs and related data appear in the Claims Draft screen. Once a draft is submitted, it is removed from the draft list. **Additionally, drafts are removed if they are not submitted within 45 days.** A maximum of 50 drafts can be created for each NPI or API number. Drafts are displayed by NPI or API. To view a list of draft claims:

- 1) Click **Draft** in the left navigation panel.



- 2) Select the NPI or API on the Claims Draft screen. Click **Continue**.



- 3) Click on a draft name to continue working on it. Drafts can be sorted by clicking column headers.



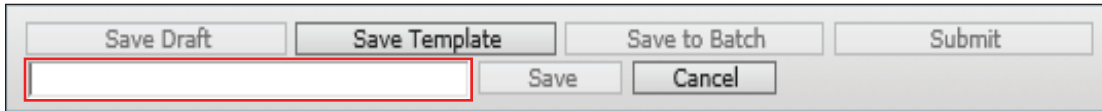
Saving Individual Claims as Templates

You can save individual claims as a template to save time submitting claims in the future. To save a claim as a template, follow these steps:

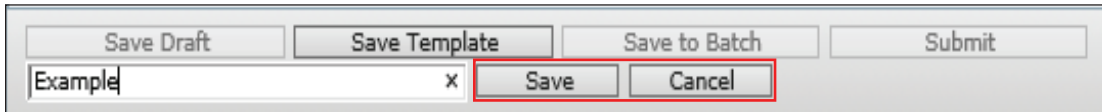
- 1) Click **Save Template**.



- 2) Enter a template name in the blank field that appears.



- 3) Click **Save** to save the template. Click **Cancel** to close the template name field.

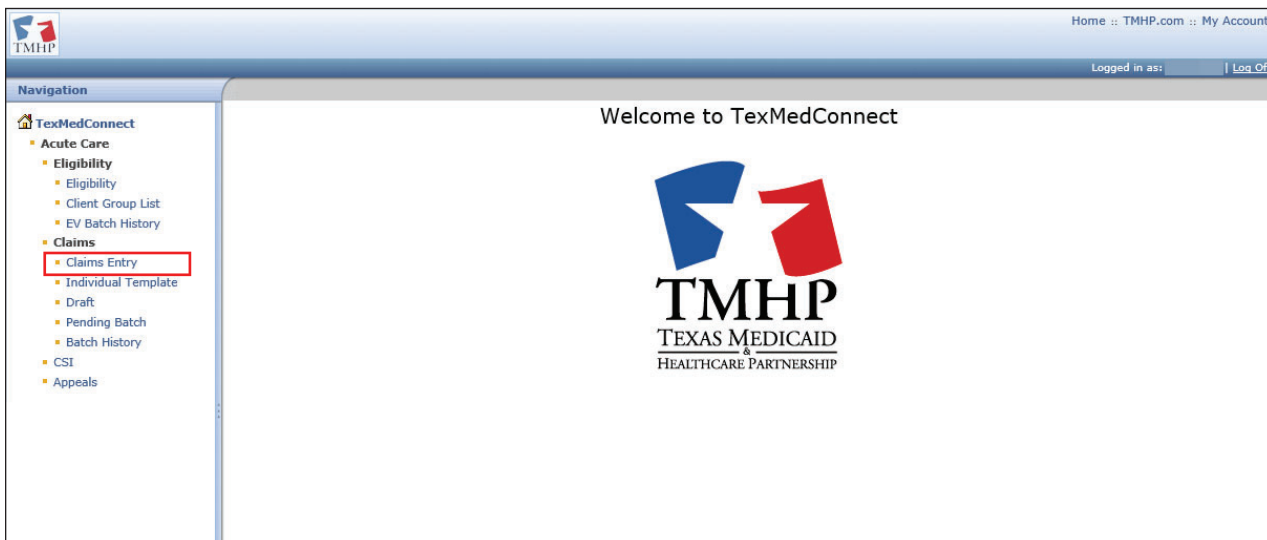


- 4) The claim is saved to the Individual Template screen for completion at a later time.

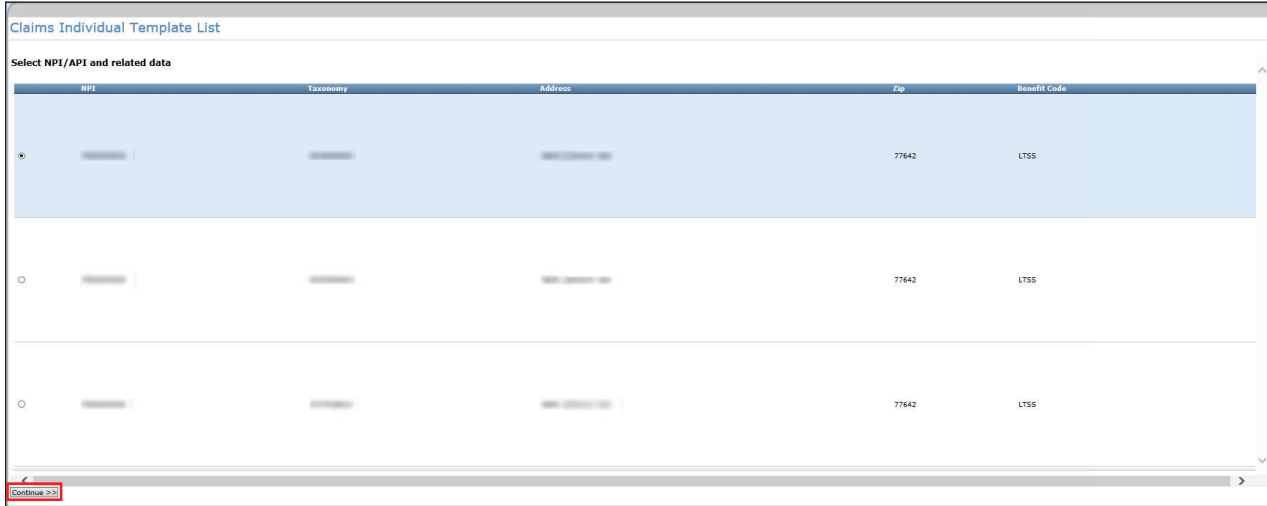
Viewing Individual Templates

A list of NPIs and APIs and related data appear in the Claims Individual Template List screen. Templates are displayed by NPI or API. **Templates do not disappear when used, but they are removed after 90 days of not being used.** A maximum of 1000 individual claim templates can be created for each NPI or API number. To view a list of individual templates:

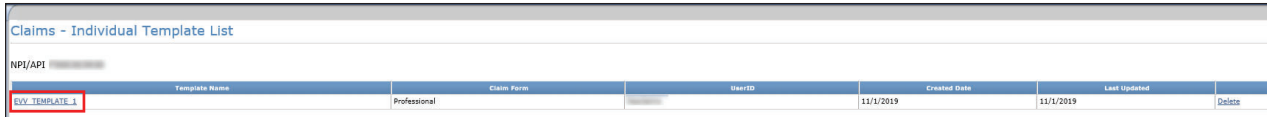
- 1) Click **Individual Template** in the left navigation panel.



- 2) Select the NPI or API on the Claims Individual Template List screen. Click **Continue**.



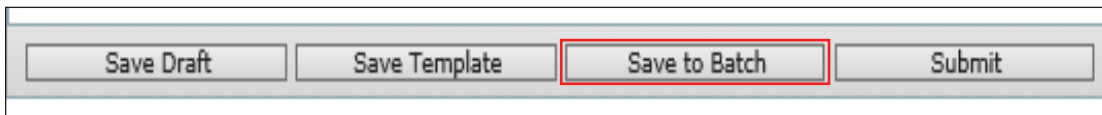
- 3) Click on a template name to continue working on a claim. Templates can be sorted by clicking column headers.



Saving as Batch

You can save a claim to batch, which creates a pending batch list that is maintained until you submit the batch. One batch can contain up to 250 claims. Claims from Draft, Templates, or claims currently being created can be saved to a pending batch. Pending batches not submitted after 45 days are deleted. To save a claim to batch, follow these steps:

- 1) Click **Save to Batch**.

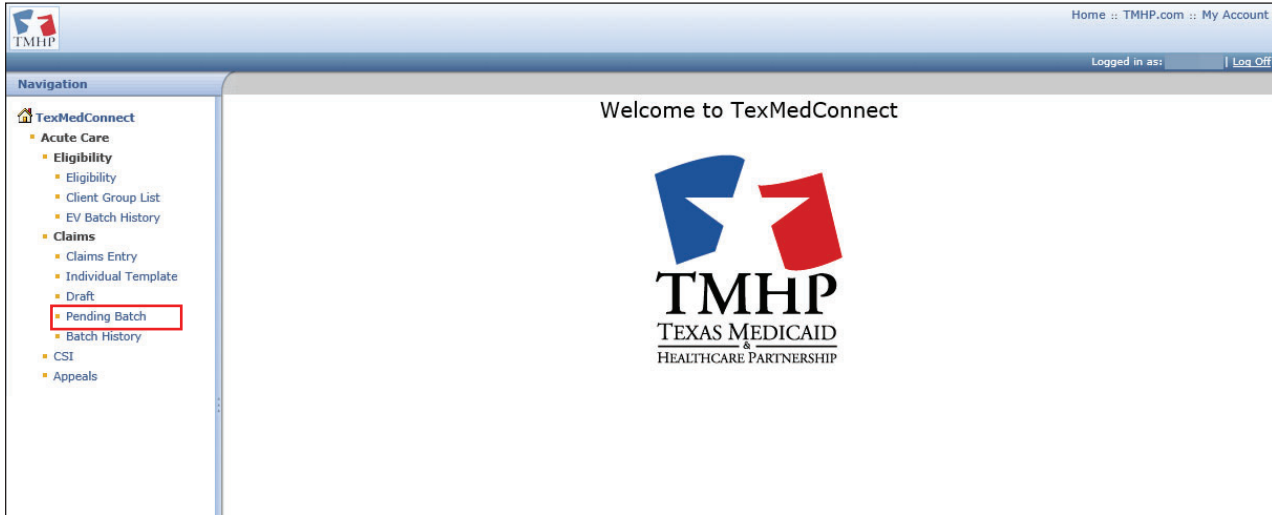


- 2) After you click **Save to Batch**, the system will take you back to the claims entry screen.

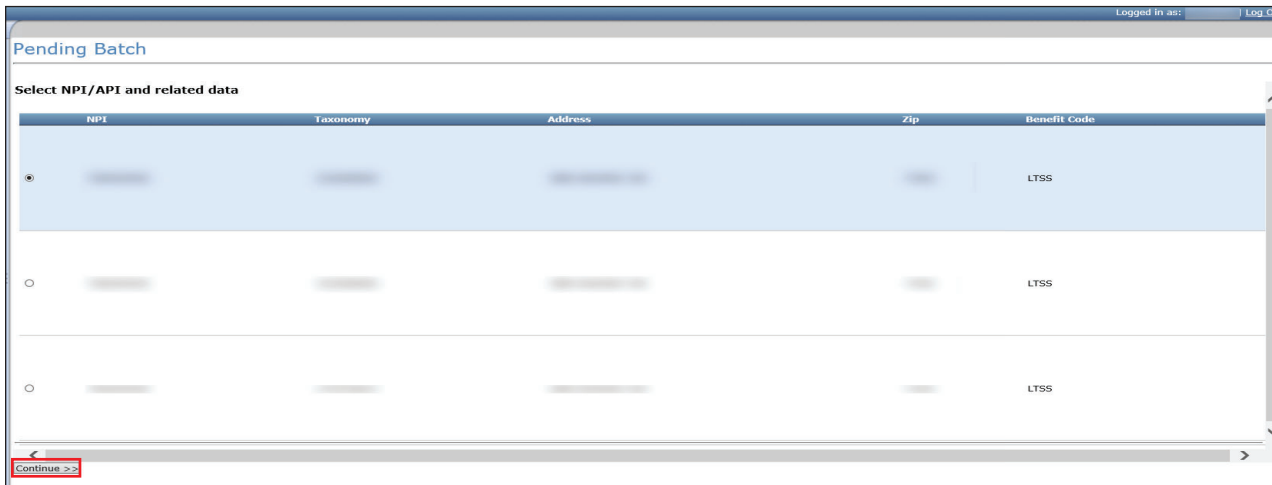
Pending Batch

The pending batch list displays claims that are ready to be submitted. To submit a batch of pending claims, follow these steps:

- 1) Click **Pending Batch** in the left navigation panel.



- 2) Select the NPI or API in the Select NPI/API and related data list, then click **Continue**.



- 3) Click **View** to view pending claim detail. Click **Edit** to make changes to the pending claim. Click **Delete** to delete the pending claim.

Click **Submit Batch** when all pending claims displayed are ready to be submitted. All claims in the batch will be submitted, even if they were created by other users under the same NPI.

Pending Batch - List of Claims

NPI/API [Redacted]

| Client # | Account No | Last Name | First Name | Start Date Of Service | Billed Amt | Claim Form | User ID | View | Edit | Delete |
|------------|------------|------------|------------|-----------------------|------------|--------------|------------|------|------|--------|
| [Redacted] | [Redacted] | [Redacted] | [Redacted] | 12/03/2019 | \$5,336.00 | Professional | [Redacted] | View | Edit | Delete |
| [Redacted] | [Redacted] | [Redacted] | [Redacted] | 12/10/2019 | \$5,336.00 | Professional | [Redacted] | View | Edit | Delete |
| [Redacted] | [Redacted] | [Redacted] | [Redacted] | 12/11/2019 | \$5,336.00 | Professional | [Redacted] | View | Edit | Delete |
| [Redacted] | [Redacted] | [Redacted] | [Redacted] | 12/12/2019 | \$5,336.00 | Professional | [Redacted] | View | Edit | Delete |

Total Billed Amount: \$ 21344.00

Submit Batch

- 4) A confirmation appears when the batch is submitted.

Pending Batch - List of Claims

NPI/API [Redacted]

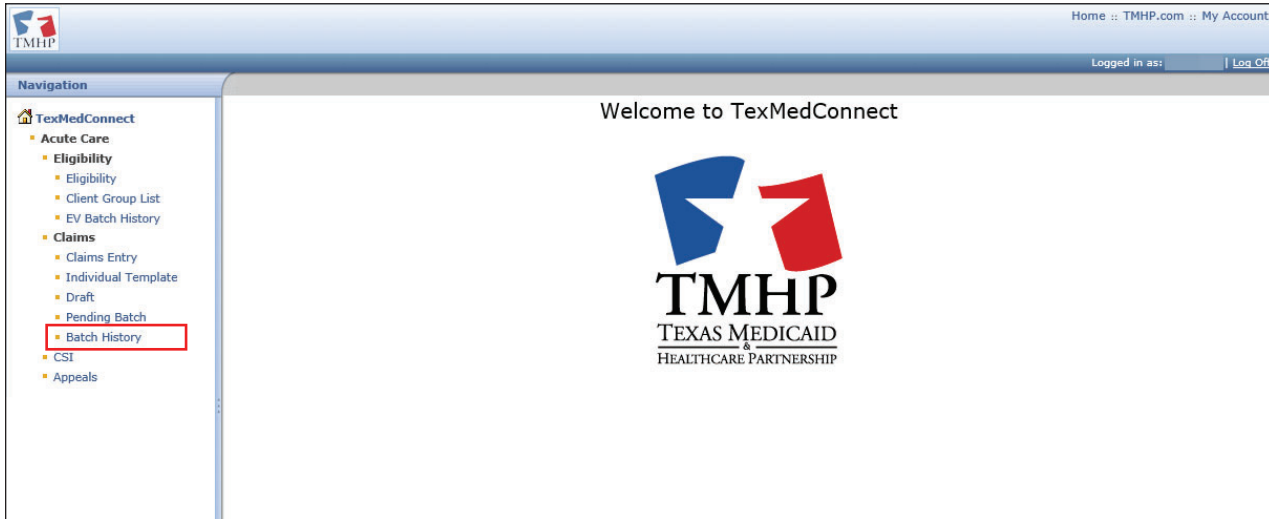
The pending batch was successfully submitted. 4 claims have been submitted in this batch. The status and details for this batch can be viewed in the Batch History Screen.

Total Billed Amount: \$.00

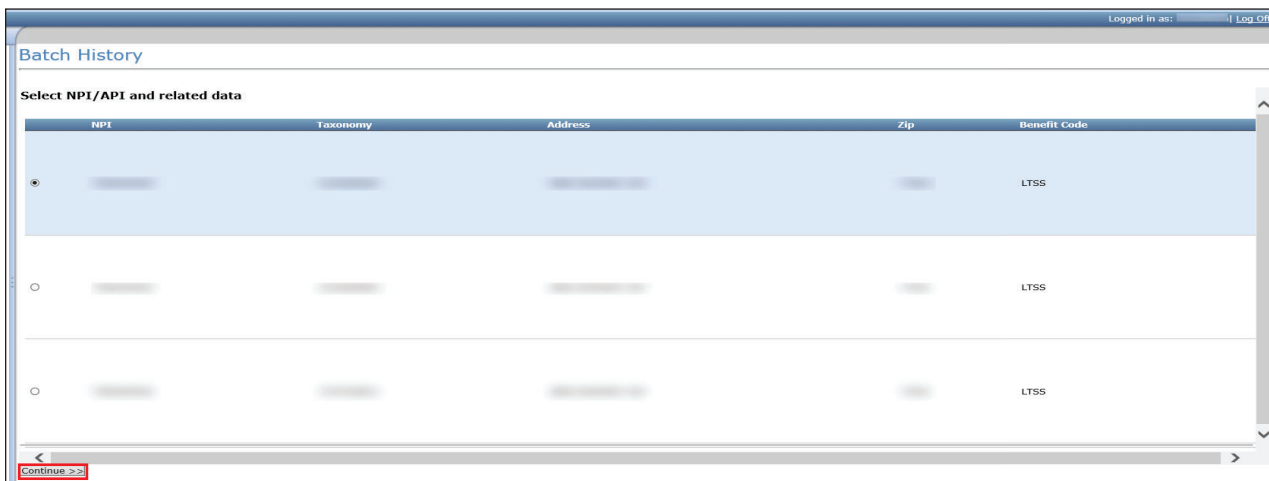
Batch History

You can view the history of previously submitted claim batches for the previous 120 days. Batches that are more than 120 days old are automatically deleted from the history. To view a batch history, follow these steps:

- 1) Click **Batch History** in the left navigation panel.



- 2) Select the NPI or API in the Select NPI/API and related data list, then click **Continue**.



3) A Batch History list appears. Batch IDs are assigned a **Submitted** status or a **Processed** status.

A **Submitted** status indicates the user has submitted the batch, but it has not been forwarded to the payer. A **Processed** status indicates the batch has been processed by the system and forwarded to the payer. A **Submitted** status will change to a **Processed** status within 24 hours. Contact the EDI Help Desk a 888-863-3638, Option 4, if the batch remains in a **Submitted** status for over 24 hours.

Click a **Batch ID** in **Processed** status to view the list of claims in that batch.

Batch History

NPI/API [Redacted]

| Batch ID | Status | Claim Count | Total Billed Amount | Transmission Date | Submitted By |
|------------|-----------|-------------|---------------------|------------------------|--------------|
| [Redacted] | Submitted | 1 | \$5,336.00 | 12/26/2019 03:57:18 PM | [Redacted] |
| [Redacted] | Submitted | 2 | \$9,336.00 | 01/13/2020 12:20:30 PM | [Redacted] |
| [Redacted] | Submitted | 1 | \$200.00 | 01/13/2020 01:12:53 PM | [Redacted] |
| [Redacted] | Processed | 1 | \$495.00 | 01/13/2020 01:23:00 PM | [Redacted] |
| [Redacted] | Submitted | 4 | \$21,344.00 | 01/15/2020 09:24:16 AM | [Redacted] |

4) A list of claims for the Batch ID appears. Claims are in a **Forwarded**, **Accepted**, or **Rejected** status. **Forwarded** claims have been sent to the payer, but have not been accepted or rejected. **Accepted** claims have been accepted by the payer. **Rejected** claims have been rejected by the payer.

5) Clicking the **Status** link will take you to additional details on the MCO CSI Search Details screen.

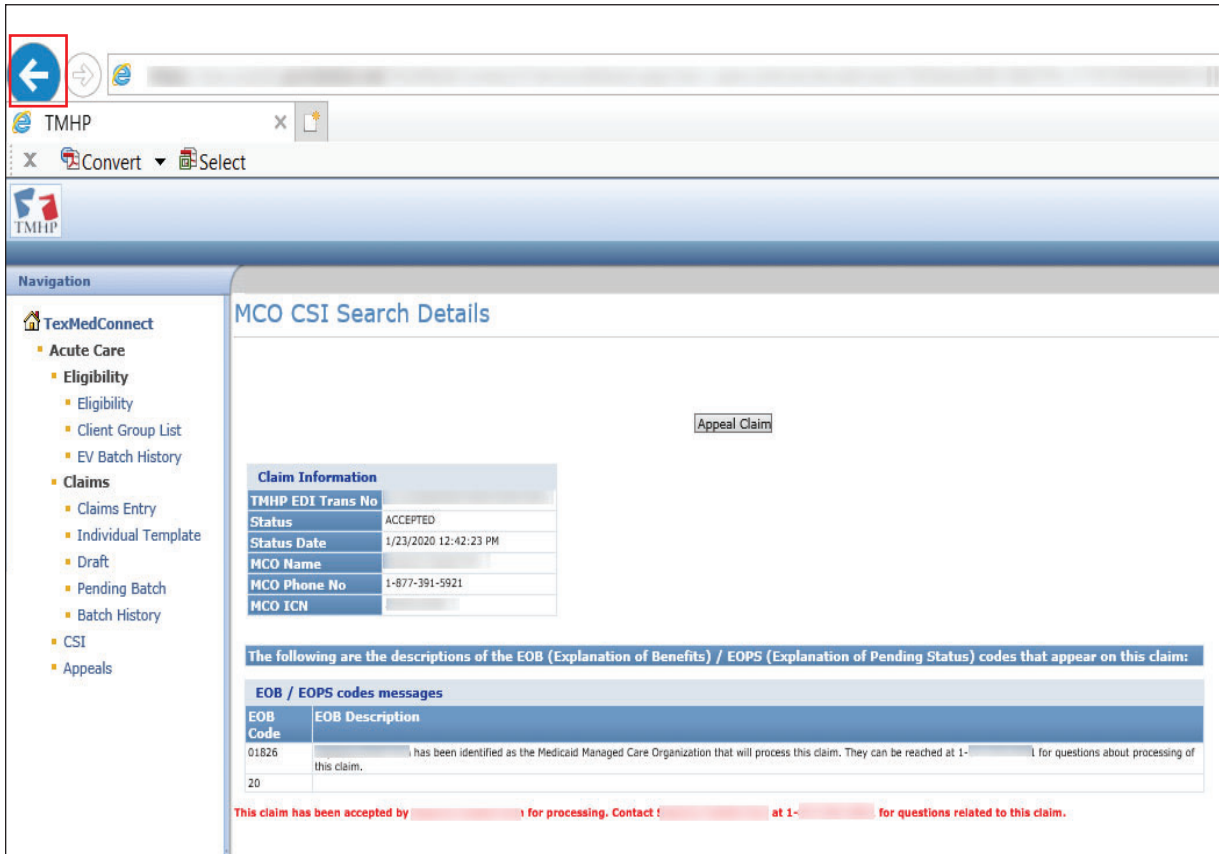
Batch History - List of Claims - [Redacted]

| Status | Client # | Account No | Payer Name | Last Name | First Name | Start Date Of Service | Billed Amt | Claim Form | User ID |
|-----------|------------|------------|------------|------------|------------|-----------------------|------------|--------------|------------|
| Forwarded | [Redacted] | 12341234 | [Redacted] | [Redacted] | [Redacted] | 01/03/2020 | \$495.00 | Professional | [Redacted] |

Total Billed Amount: \$ 495.00
BatchID: [Redacted]

Go Back

- 6) The MCO CSI Search Details screen appears. Use the internet browser back button to return to the previous screen.



- 7) Click **Go Back** to return to the list of claims.



Claim Status Inquiry (CSI)

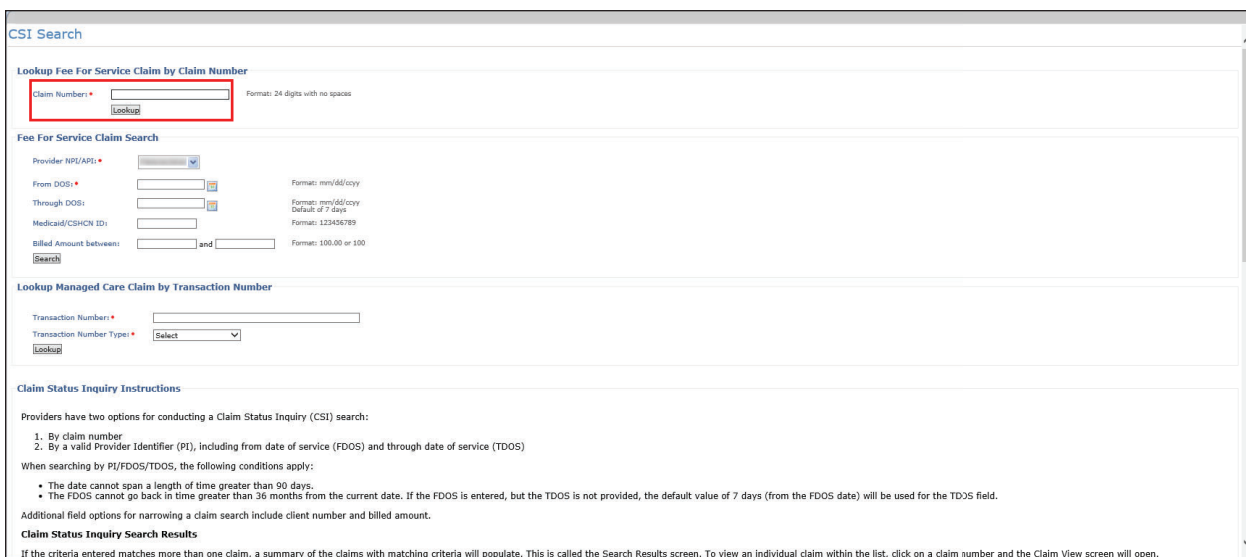
CSI allows you to determine the status of processed claims. The search can be performed using a claim number or a combination of other fields. A summary of claims within the past three years that matches the search criteria appears, and claim detail can be accessed. A maximum of 250 results are returned. To perform a CSI search:

- 1) Click **CSI** in the left navigation panel.



- 2) Enter a claim number. Click **Lookup**. If you do not know the claim number, enter other claim information and click **Search**.

It is important to note that a date range cannot be longer than 30 days, and the From date of service (DOS) field cannot have a date more than 36 months prior to today's date.



- 3) CSI search details appear if a match is found. If the search does not locate the desired claim, narrow the search criteria to produce a more specific match.

MCO CSI Search Details

Appeal Claim

| Claim Information | |
|-------------------|----------------------|
| TMHP EDI Trans No | L119* |
| Status | ACCEPTED |
| Status Date | 11/7/2019 4:35:17 PM |
| MCO Name | Superior Health Plan |
| MCO Phone No | 1-877-391-5921 |
| MCO ICN | |

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

| EOB / EOPS codes messages | |
|---------------------------|--|
| EOB Code | EOB Description |
| 01826 | Superior Health Plan has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at 1-877-391-5921 for questions about processing of this claim. |

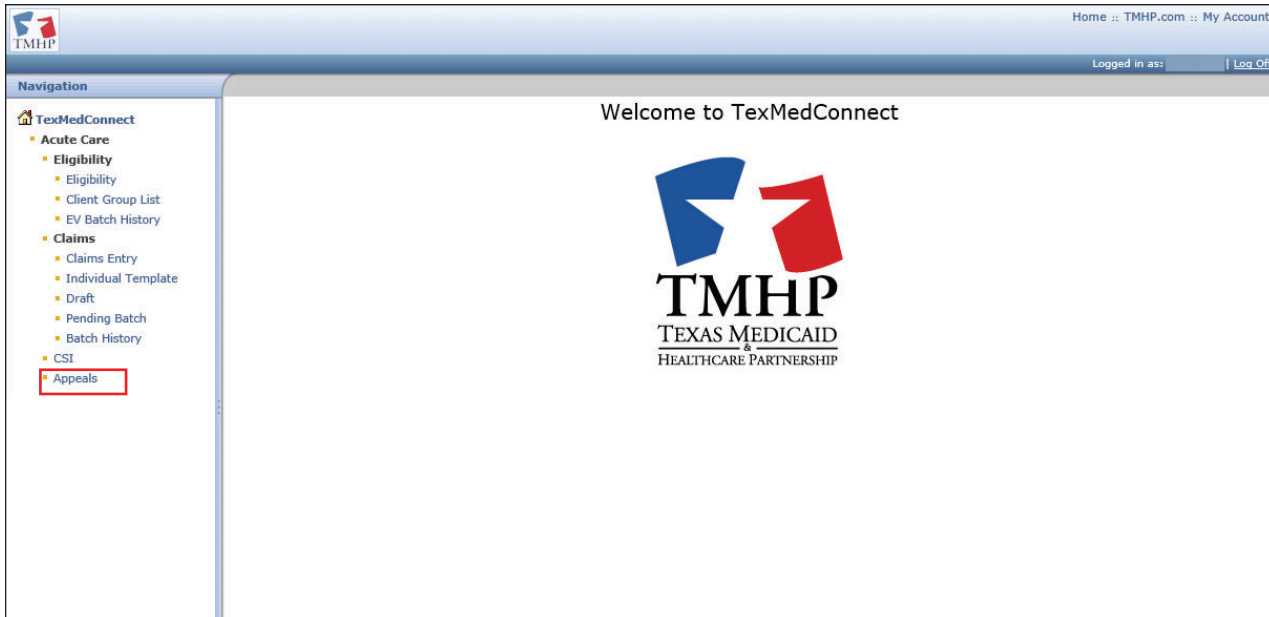
This claim has been accepted by Superior Health Plan for processing. Contact Superior Health Plan at 1-877-391-5921 for questions related to this claim.

Claims Appeals

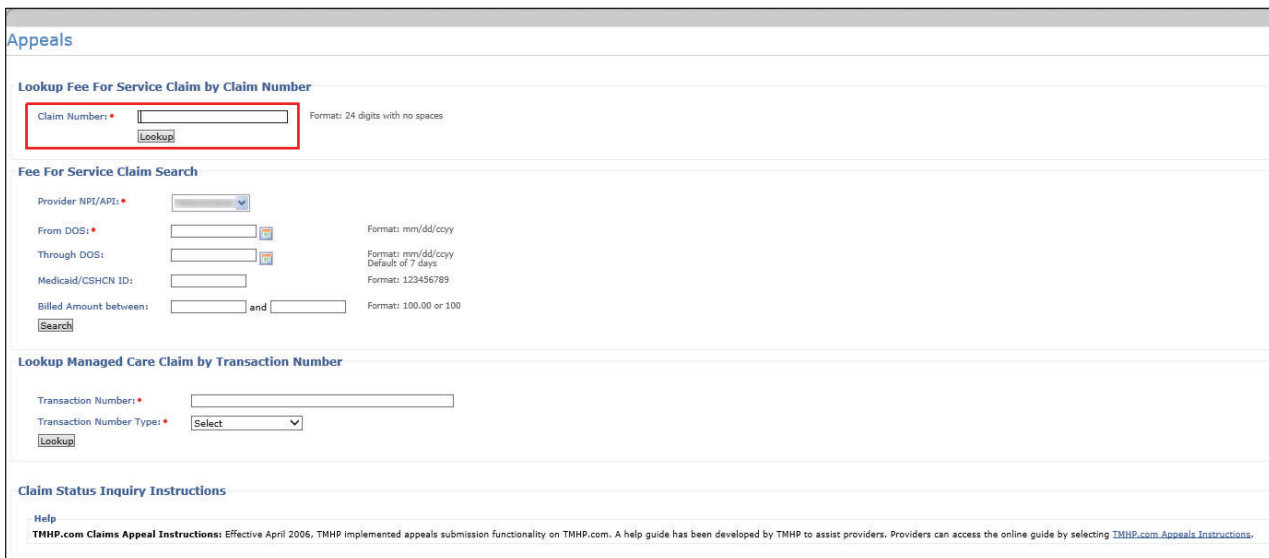
Institutional outpatient claims with a finalized status, such as *Denied* or *Paid*, must be appealed directly with the MCO using the existing appeal process.

Professional claims with a finalized status, such as *Denied* or *Paid*, can be appealed directly from TexMedConnect. You can only appeal finalized claims. **NOTE:** Your MCO may refer to “Appeals” as “Corrections,” “Adjustments,” or “Updates.” To appeal a claim, follow these steps:

- 1) Click **Appeals** in the left navigation panel.



- 2) Enter the claim number. Click **Lookup**. If you do not know the claim number, enter other claim information and click **Search**.



3) CSI search details appear if a match is found. Click **Appeal Claim** to begin the appeal process.

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