In This Bulletin

The Department of Aging and Disability Services (DADS) continually strives to improve the usefulness of this bulletin for providers by making enhancements as needed. Providers can look forward to new additions, such as the “In This Corner” section and the “Bulletin Article Resources” table.

“In This Corner” will feature current topics and issues that require in-depth details to address. In this edition of the bulletin, “In This Corner” addresses the top three reasons why 3652 Client Assessment, Review, and Evaluation (CARE) forms reject and the most common reasons why 3652 CARE forms are pended. “In This Corner” provides tips for properly completing the 3652 CARE form and lists the advantages to requesting a Medicaid Eligibility Service Authorization Verification (MESAV) inquiry.

This bulletin also features an article titled “Most Frequently Asked Questions” (of this quarter) from providers to DADS and the Texas Medicaid & Healthcare Partnership (TMHP) staff members.

Standard information such as the glossary has been removed from the quarterly bulletin, but is available for providers’ everyday use on the website at www.tmhp.com, in the 2005 Long Term Care User Manual, and the February 2005 Long Term Care Bulletin.
What’s Coming Up?

2005 LTC User Manual to Be Mailed to Paper Submitters

In May 2005, the 2005 LTC User Manual for paper submitters will be mailed to providers who submit claims on the Form 1290. Providers who submit claims electronically can access the user manual on the TMHP website at www.tmhp.com.

Tentative Release of TDHconnect 3.0 Service Pack 6 Scheduled

TDHconnect 3.0 Service Pack 6 is tentatively scheduled for release in May 2005. Providers who use TDHconnect 3.0 are encouraged to download and install Service Pack 6 from the TMHP website at www.tmhp.com. In addition to resolving several existing issues, Service Pack 6 will also continue to support a dial-up connection.

Follow these steps to download the service pack:

1. Connect to TMHP through the Internet at www.tmhp.com.
2. Click the Find Software/Service Packs link in the I would like to… list on the right side of the homepage. The TMHP File Library webpage opens.
3. Scroll down to the File Library links.
4. Click the TDHconnect link. The TMHP File Library/TDHconnect webpage opens.
5. Scroll down to the File Library links.
6. Click the TDHconnect Updates link. The TMHP File Library/TDHconnect/Updates webpage opens.
7. Scroll down to locate the File Library links.
8. Select the most recent service pack, such as TDHconnect 3.0 Updates Service Pack 6.

For more information, or help with downloading or installing Service Pack 6, contact the Electronic Data Interchange (EDI) Help Desk at 1-800-626-4117, Option 3.

Adoption of National Provider Identifiers

As reported in the November 2004 LTC Bulletin, No. 20, the United States Department of Health and Human Services (HHS) published the National Provider Identifier (NPI) Final Rule in January 2004. This rule adopts the NPI as the standard, unique identifier for healthcare providers. All entities meeting the definition of healthcare provider as described in the 45 Code of Federal Regulations (CFR) 160.103 can apply for an NPI.

Long Term Care providers who meet the definition for healthcare providers are required to obtain and use NPIs in standard transactions by the compliance date of the rule, which is May 23, 2007. On this date, Texas Medicaid, other health plans, and healthcare clearinghouses must begin using NPIs to identify providers on standard electronic transactions. Healthcare providers and healthcare plans may also use NPIs on paper transactions.

To assist providers and healthcare plans in transitioning to the new identifier, providers were allowed to apply for the identifiers a full two years prior to the compliance date of May 23, 2005. However, providers should not use the NPI to bill Texas Medicaid until notified by the Texas Health and Human Services Commission (HHSC). Use of the new NPIs in lieu of currently accepted identifiers before HHSC’s system is modified to accept the new identifiers will result in delays in payment of claims.

Healthcare providers who are not considered “covered entities” may also apply for and be assigned an NPI if they file claims electronically. However, entities that do
not provide healthcare, such as transportation services, are not eligible to be assigned NPIs because they do not meet the definition of "healthcare provider" and are not subject to HIPAA regulations. There is no requirement for noncovered providers to obtain or use NPIs. Clearinghouses cannot require noncovered providers to obtain an NPI and must accommodate the providers’ existing identifiers to process their claims.

A specific healthcare provider should not have more than one NPI. Health plans may not require enumerated providers to obtain additional NPIs.

Until providers receive further direction from Texas Medicaid, healthcare providers and clearinghouses can do the following:

- Become informed about the NPI and its implementation.
- Identify processes and systems that are affected by provider identifiers.
- Develop implementation plans.
- Educate staff.

For additional information about the NPI implementation, including information about how to apply for an NPI, visit the Centers for Medicare & Medicaid Services (CMS) website at www.cms.hhs.gov/hipaa/hipaa2.

New Security Features Enhance TMHP Website

Effective May 26, 2005, TMHP will implement new security features on its website at www.tmhp.com. This enhancement is related to HIPAA, Section 164.308 (a) (2, 3) “Assigned Security Responsibility.” The guidelines in that section pertain to the provider’s responsibility of implementing appropriate electronic access to protected health information.

The new security enhancement allows a provider or a facility to assume control of user activity and access to protected data for a particular Texas Provider Identifier (TPI)/provider number(s) on the secure pages of the TMHP website. Providers and/or facilities are required to assign an administrator(s) for website privileges. Each administrator has the ability to create and/or delete a “User Name.” Additionally, permission levels may be limited to the following functions:

- Claim Status Inquiry (CSI)
- Eligibility Verification (EV)
- View R&S Reports
- Panel Reports

For example, the administrator may grant access to the Eligibility Verification but not the View R&S Reports section of the website.

An administrator is defined as an individual provider or a management-level employee for a provider/facility. Billing services and clearinghouses are required to obtain access to protected health information through the appropriate administrator of each TPI/provider number for which they are contracted to provide services.

Beginning May 26, 2005, all registered users of the TMHP website will begin to see special messaging regarding administrator enrollment at the top of each secure (password protected) page of the website. A two-week period ending on June 9, 2005, is being granted to allow providers the opportunity to assign new security access. After June 9, 2005, access to password-protected areas will be denied until an administrator is configured. Providers may still obtain Eligibility and Claim Status Inquiries through TDHconnect or through the TMHP Call Center/Help Desk at 1-800-626-4117, Option 1.

Only authorized individuals that wish to be an administrator for a particular TPI/provider number are required to select the administrator message option. Once the option is selected, the user is moved to an introduction page of the new security setup process. The system will identify the TPI/provider number(s) that is currently associated with the User Name. The user must accept the Terms and Conditions and validate their TPI/provider number(s).

Once the TPI/provider number is validated, the newly configured administrator account will be able to assign permissions to users that are associated with the TPI/provider number. An email notification is sent to each
The following are the most common reasons why 3652 CARE forms will not be listed on the Weekly Status Reports:

- The form is rejected and is not received by TMHP.
- The assessor/director of nurses (DON) license number on the form is not TILE-certified.
- The form includes an incorrect Vendor/Facility Site ID number.
- The form does not include all required information.

The following are the most common reasons why 3652 CARE forms are in a pending status:

- The form does not include all required information.
- The form does not include accurate documentation of the individual’s medical condition necessary to make a favorable medical necessity (MN) determination.
- Information on the form does not identify the need for licensed nurse care, such as no medications, or no diagnoses indicated.
- The form includes conflicting information, such as information listed in the Comments section conflicts with the information provided on Fields 50 through 99.

When a form is pending denial, additional medical information or clarification must be provided within a 21-day “hold” period. TMHP cannot make a valid MN determination without this additional information. Consequently the individual’s MN is denied. In most cases, the individual whose MN was denied will request a fair hearing.

The following gives statistics on fair hearing requests:

- Approximately 10 percent of all MN forms initially denied are approved prior to a fair hearing, when additional information is provided by the individual’s physician to appeal the MN determination.
- Approximately 60 percent of MN denials that go to fair hearings are reversed because additional medical information is provided by oral testimony at the fair hearing. This information could have been provided on the initial CARE form or during the 21-day “hold” period. Had this information been provided on the form, a fair hearing would not have been necessary.

**Reminder:** An accurate assessment of the individual’s condition is the key to MN approval.
Tips for Completing the 3652 CARE Form

1. When submitting a 3652 CARE form to TMHP to determine medical necessity, ensure the individual’s significant medical condition(s) and related treatment(s) are addressed. For example, if an individual has a diagnosis of Gastric Esophageal Reflux Disease (GERD) with treatment of Prevacid and a diagnosis of atherosclerotic cardiovascular (ASCVD) with the treatment of aspirin (ASA), use the second diagnosis and treatment. GERD is a medical diagnosis; however, not one that requires licensed nursing intervention on a regular basis unless the condition is unstable, such as GERD with esophageal varies. Use the Comment section to describe nursing intervention and any unstable medical conditions.

Note: The Comment section is limited to 250 characters.

2. Attention should be placed on using words like “non-compliant.” Treatment can be a choice, and the individual has a right to refuse treatment. If the thought is that the individual is not making an informed or educated treatment decision, words like “poor judgment” should be used and the reason for the poor judgment stated.

3. When stating an individual is unable to self-medicate in the Comment section, indicate why the individual is unable to self-medicate. For example, “It is due to (d/t) a physical condition such as poor hand dexterity related to (r/t) neuropathy,” or “It is mental d/t cognitive loss r/t age or a disease process.”

4. Additional research may be necessary to capture an accurate overall picture of an individual’s care needs. For example, speak with the family or informal support to get a better picture of the individual’s condition and functional status. Check with the individual’s doctor to ensure the list of medical diagnoses and medications are complete.

5. Have the individual’s chart and other pertinent medical information available when calling the TMHP Call Center/Help Desk. For example, be prepared to answer questions about the individual’s licensed nursing needs and the reason the individual is unable to manage the condition(s) and treatment(s) themselves.

These issues are discussed in detail in the “3652 CARE Forms” article on page 4 of this bulletin.

Top Three Reasons Why Claims Deny

The following are the top three reasons (explanation of benefits [EOB] codes) why claims deny:

1. EOB F0077 — “Billing code not submitted or cannot be determined.” Claims deny with EOB F0077 when the Healthcare Common Procedure Coding System (HCPCS) code entered on the claim does not match what is on the individual’s service authorization. To resolve this EOB, verify and insure the accuracy of the following:

   • The provider number is correct and includes all nine digits.
   • The individual’s case/Medicaid number is correct.
   • The individual’s name is spelled correctly.
   • The individual’s level of service on the MESAV inquiry is for the code being billed.
   • The procedure codes billed are correct for the period billed. Refer to the most current LTC Bill Code Crosswalk for a listing of procedure codes.

2. EOB F0155 — “Unable to determine appropriate fund code for service billed, verify Medicaid eligibility.” Claims deny with EOB F0155 when the individual has lost eligibility, the wrong HCPCS code was entered on the claim, or the fund code entered on the individual’s service authorization was entered incorrectly. To resolve this EOB, verify that the individual is eligible for services during the period billed. Process a MESAV inquiry to verify eligibility, coverage code, category code, and program type code. (Click the Med Elig/Med Nec tab).

   • If eligibility or medical necessity for the dates entered in the MESAV inquiry have not been established, the Med Elig/Med Nec tab will be grayed out/disabled. Contact the caseworker to establish eligibility for the individual.
   • The coverage codes listed on the Med Elig/Med Nec tab are “W,” the individual has temporary medical necessity; “H,” the individual has permanent medical necessity; and “O,” the individual’s medical necessity was denied.
3. EOB F0138 — “A valid service authorization for this individual for this service on these dates is not available.” Claims deny with EOB F0138 when the information provided on the claim does not match the information on the individual’s service authorization. Some examples of this are when the individual’s case/Medicaid number does not match the number on the service authorization, the provider number is incorrect, the individual is not eligible for services for the dates of service on the claim, or the service authorization does not cover all dates of service being billed. To resolve this EOB verify and insure the accuracy of the following:

- The individual’s case/Medicaid number is correct.
- The provider number is correct and includes all nine digits.
- The individual is eligible for services for the entire period billed. If the provider is billing for even one day of service that is not covered by a service authorization, the entire claim will deny.

-- Process a MESAV inquiry and view the Service Authorization tab.
-- If eligibility for the dates entered in the MESAV inquiry have not been established, the Med Elig/Med Nec tab will be grayed out/disabled. Contact the caseworker to establish eligibility for the individual.

Providers Verify Eligibility With a Medicaid Eligibility Service Authorization Verification (MESAV) Inquiry

A MESAV inquiry allows providers to electronically obtain eligibility and service authorization information through TDHconnect software. DADS updates TMHP files each weekday so the most current MESAV information is available to providers daily.

MESAV inquiries provide valuable information about each individual participating in the LTC Program. It allows providers to check services, units, eligibility, medical necessity, applied income/co-payment, and level of service in the Service Authorization System (SAS), as well as the effective dates for those authorizations.

Authorized providers can access information about a specific individual for a specific date range by requesting a MESAV inquiry. Information may be requested for dates spanning up to three months. The information returned may expand beyond the three-month range. Information that providers receive is based on the individual’s eligibility information available at TMHP. The Claims Management System maintains confidentiality by returning information only to the provider authorized to perform requested services for that individual.

Providers should verify an individual’s eligibility before submitting a claim by generating a MESAV inquiry, and also ensure the dates of service being billed fall within the effective dates of the service authorization. As indicated previously, one of the most common reasons that claims deny is due to dates of service not authorized during the service authorization period. If the EOB states the individual is not authorized for services received, the MESAV inquiry should be checked to verify that the correct dates and services are on file at TMHP. Eligibility can expire or could be on hold.

Providers submitting paper claims on a Form 1290 can verify an individual’s eligibility by contacting the TMHP Call Center/Help Desk at 1-800-626-4117, Option 1.

Electronic Remittance and Status Reports (ER&S) Useful for Tracking Billing Activity

ER&S reports are valuable tools to use in tracking billing activities. Providers are encouraged to download and generate ER&S reports weekly because each report is only available for a 30-day time period. When generating a report, use dates beginning on Friday through the following Monday.
ER&S reports are divided into the following three separate sections:

- The “Nonpending” section contains HIPAA-compliant information based on the national procedure or revenue code submitted on the claim. It also lists any adjustments made to the total provider payment. Providers will receive one ER&S report per warrant issued for the reporting period.

- The “Claim Activity” section provides information about all finalized claims and claims still pending processing and/or payment. Finalized claims that make it through the claims payment process are either approved to pay or denied. This section contains information such as the derived local billing code, units paid, billed amount, paid amount, and so forth. Providers will receive only one “Claim Activity” section per reporting period. The “Claim Activity” section may correspond to multiple Nonpending sections if more than one warrant was received that week.

- The “Financial Summary” section provides warrant and warrant amounts for the reporting period.

To accurately assess claim activity for the report period, all three sections must be used. The Nonpending and the Claim Activity sections outline which claims were processed, the national code billed, the local bill code derived, and the payment amount for the services based on the derived bill code.

This is the only way to determine if the system derived the correct bill code for payment. The number of warrants issued, and indirectly the number of Nonpending sections to look for, are provided in the Financial Summary section.

**Most Frequently Asked Questions During This Quarter Answered**

**Question:** When submitting an adjustment for a previous over bill, I received an EOB F0250 — “Late Billing — Must be filed within 12 months from the end of the service month.” What is the process to correct the over billing and allow reimbursement to the state?

**Answer:** Contact the CMS coordinator assigned to the provider’s region. The coordinator will request that the claim be overridden to allow reimbursement to the state.

**Question:** A caseworker end dated an individual’s service authorization in error for the period of January 1, 2001, through December 31, 2001. This resulted in a retroactive adjustment and reimbursement for all claims previously paid by the state. Claims are listed on the R&S report with a negative “T” (miscellaneous) status. Since these claims are now considered to be miscellaneous, how can I receive reimbursement?

**Answer:** Contact the caseworker that made the change to the service authorization and ask that the authorization be reinstated. Once the service authorization has been reinstated, claims must be resubmitted to place the claims back into a positive “T” status. Although the claims show up on the R&S report with a negative status, the amount was never deducted from the provider’s warrant. The negative amount should not be deducted from the total paid. The deduction is made only on paper. Once the claims are balanced/finalized, they will appear one last time in the “NonPending” section of the R&S report.

**Question:** What happens if the Vendor/Facility Site ID number is not included in the 3652 CARE form?

**Answer:** The form is not processed and filed because TMHP does not have any identifying information other than the Vendor/Facility Site ID number to identify an agency. This 3652 CARE form will not appear on the Weekly Status Report because TMHP could not determine which agency submitted the form. The vendor/facility must resubmit the form and include the Vendor/Facility Site ID number.

**Question:** The instructions to Field 008, Vendor No, of the 3652 CARE form indicate to enter the four-digit site identification number. Is this number the same as the provider/contract number?

**Answer:** No. The vendor number is the four-digit number assigned by DADS to Nursing Facilities, CBA providers, and other providers who use the 3652 CARE form. The provider/contract number is the seven- or nine-digit number assigned to a provider upon entering into a contract with DADS.
Reminders

New Bulletin Article Resource Table Introduced

A Bulletin Article Resource Table has been added to this bulletin. It includes a list of previously published articles, sequenced in order of the bulletin edition in which they appear, starting with November 2004. Refer to page 15 to view this new resource. ■

Tips Given for Accessing and Downloading Information and Reports

The following are suggestions for accessing and downloading information and reports:

- For help while using TDHconnect to complete, download, or retrieve files, press the F1 key to access the electronic help option.
- View the latest NEWS (banner pages) weekly on the TMHP website at www.tmhp.com/LTC Programs. Contact TMHP at 1-800-626-4117, Option 3, for assistance. ■

Providers are Encouraged to Bill Electronically

TDHconnect is a software designed for electronic submission of claims. It is recommended that all providers submit claims electronically. The advantages of using TDHconnect are:

- TDHconnect is free of charge.
- Providers can receive payment within five to seven days.
- The billing cycle is more closely related to business needs.
- Time delays due to mailing are avoided.

Providers can contact the TMHP Call Center/Help Desk at 1-800-626-4117, Option 3, to obtain TDHconnect software. ■

Following LTC Claim Form 1290 Guidelines Expedites Claims Processing

Providers should use the following guidelines when billing LTC Claim Form 1290 paper claims:

- Print legibly.
- Do not write in cursive.
- If data is typed, use a font large enough to distinguish between characters.
- Complete all required fields.
- Use the most current LTC Bill Code Crosswalk.
- Review the form for accuracy before submitting.
- Sign each form.
  - An original signature is required on each form.
  - Copied or stamped signatures are not accepted.

Mail Form 1290 to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Long Term Care, MC-B02
PO Box 200105
Austin, TX 78720-0105

Delivery to TMHP could take five business days. Allow ten business days for the claim to appear in the system. Send overnight mail to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Long Term Care, MC-B02
12357-B Riata Trace Parkway
Austin, TX 78727

Allow three days for the overnighted claim to appear in the system. When contacting TMHP to check the status on a claim, the overnighted mail tracking number must be provided. ■

Form 1290

Mail Form 1290 to the following address:

Texas Medicaid & Healthcare Partnership
Attention: Long Term Care, MC-B02
PO Box 200105
Austin, TX 78720-0105
Most Frequently Used Reports

Processed 3652 CARE Forms Shown in Medical Necessity Weekly Status Report

The Medical Necessity Weekly Status report contains all the 3652 CARE forms that have been successfully processed by TMHP for the previous week. Providers receive the report in the same manner that forms are submitted. If forms are transmitted electronically, the report is sent electronically. If forms are submitted by mail, the report is mailed to the provider.

If a form was mailed or submitted electronically and it does not appear on the Medical Necessity Weekly Status Report, contact the Technical Support Help Desk at 1-800-626-4117, Option 3. When contacting the Technical Support Help Desk, providers must have transmission information available (the transmission number, date of transmission, number of forms sent, etc.).

For additional information, contact the TMHP Call Center/Help Desk at 1-800-626-4117, Option 1.

Error and Suspense Reports
Available for Medicaid-Certified Nursing Facility Providers

Nursing facility (NF) providers can electronically access the Nursing Home Form Suspense and Error Report. This report contains transaction notices, Forms 3618 and 3619, and 3652 CARE forms, which have suspended or received errors in the system and cannot be processed for payment. For more information, refer to the DADS secured webpage at http://txnfsr.dhs.state.tx.us/NFSRWeb/app/home.

Provider Resources

Helpful Information Found on Frequently Accessed LTC Websites

The following websites contain information that is helpful to providers:

- LTC Program information is available on the TMHP-LTC webpage at www.tmhp.com/LTC Programs.
- The DADS website address is www.dads.state.tx.us. On this website, providers can:
  A. Access mental retardation services information.
  C. Access information for nursing facilities and therapy providers at www.dads.state.tx.us/business/ltc-policy/index.cfm under Communications.
  E. Access LTC messages and alerts.

Visit the DADS website at www.dads.state.tx.us for additional information to assist providers with claims filing and individual services and benefits.
Dates and Locations Given for TMHP Provider Workshops

TDHconnect Workshops
TMHP conducts TDHconnect 3.0 workshops in select cities every quarter. The following are dates and locations for the 2005 LTC workshops:

- June 2005 in Austin, Harlingen, Lubbock, and El Paso
- August 2005 in San Angelo, Abilene, and Corpus Christi
- October 2005 in Tyler, Beaumont, and Weslaco

These workshops are designed to educate LTC providers about claims submission, MESAV inquiries, claim status inquiries, ER&S reports, and much more.

3652 CARE Form, and 3618 and 3619 Form Completion Training—Nursing Facilities and CBA Providers
TMHP conducts forms completion workshops in select cities every quarter. The following are dates and locations for the 2005 LTC workshops:

- June 2005 in Austin, Harlingen, Lubbock, and El Paso
- August 2005 in San Angelo, Abilene, and Corpus Christi
- October 2005 in Tyler, Beaumont, and Weslaco

These workshops are designed to educate LTC providers about medical necessity, processes for submitting a 3652 CARE form, the importance of downloading and using the Weekly Status Report, and much more.

Workshop information is posted on the TMHP website at www.tmhp.com when schedules are finalized. Providers will be mailed an invitation for the June 2005 workshops and a postcard to remind providers to register for the August and October 2005 workshops. Providers should register at least ten days before the preferred workshop date. Providers can register online at the TMHP website, by faxing the completed registration form to 1-512-302-5068, or by mailing the registration form to:

TMHP
Attn: Provider Relations
PO Box 204270
Austin, TX 78720-4270

Providers do not receive a confirmation for registration. For a copy of the Workshop Registration Form, go to page 17 of this bulletin or to the TMHP website at www.tmhp.com/C18/Workshops/Workshop Forms/Workshop Registration Form.pdf.
TMHP Provider Relations Representatives by Territory

TMHP provider relations representatives offer a variety of services designed to inform and educate the provider community about TDHconnect and claims filing procedures. They assist providers through telephone contact, onsite visits, and scheduled workshops. The table below indicates the representative serving each area.

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<th>Territory</th>
<th>Regional Area</th>
<th>Provider Representative</th>
<th>Telephone Number</th>
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<tr>
<td>1</td>
<td>Amarillo and Lubbock</td>
<td>Elizabeth Ramirez</td>
<td>1-512-506-6217</td>
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<td>2</td>
<td>Abilene, Midland, Odessa, and San Angelo</td>
<td>Diane Molina</td>
<td>1-512-506-3423</td>
</tr>
<tr>
<td>3</td>
<td>El Paso</td>
<td>Isaac Romero</td>
<td>1-512-506-3530</td>
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<tr>
<td>4</td>
<td>Del Rio, Kerrville, and North San Antonio</td>
<td>Sue Lamb</td>
<td>1-512-506-3422</td>
</tr>
<tr>
<td>5</td>
<td>Brownsville, Falfurrias, and Laredo</td>
<td>Cynthia Gonzales</td>
<td>1-512-506-7991</td>
</tr>
<tr>
<td>6</td>
<td>Corpus Christi and South San Antonio</td>
<td>Will McGowan</td>
<td>1-512-506-3554</td>
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<td>7</td>
<td>Galveston, Harris County, and Wharton</td>
<td>Rachelle Moore</td>
<td>1-512-506-3447</td>
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<tr>
<td>8</td>
<td>Harris County</td>
<td>Linda Dickson</td>
<td>1-512-506-3446</td>
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<td>9</td>
<td>Conroe and Harris County</td>
<td>Linda Wood</td>
<td>1-512-506-7682</td>
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<td>10</td>
<td>Beaumont and Lufkin</td>
<td>Gene Allred</td>
<td>1-512-506-3425</td>
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<td>11</td>
<td>Dallas, Tyler, and Waxahachie</td>
<td>Sandra Peterson</td>
<td>1-512-506-3552</td>
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<td>12</td>
<td>Dallas and Texarkana</td>
<td>Olga Fletcher</td>
<td>1-512-506-3578</td>
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<tr>
<td>13</td>
<td>Eastland, Fort Worth, and Wichita Falls</td>
<td>Rita Martinez</td>
<td>1-512-506-7990</td>
</tr>
<tr>
<td>14</td>
<td>Austin, Bryan, College Station, Marble Falls, and Waco</td>
<td>Andrea Daniell</td>
<td>1-512-506-7600</td>
</tr>
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**TMHP LTC Contact Information**

The TMHP Call Center/Help Desk operates Monday through Friday, 7 a.m. to 7 p.m., Central Time (excluding holidays).

When calling the TMHP Call Center/Help Desk, providers are prompted to enter their nine-digit LTC provider/contract number using the telephone keypad. If calling from a rotary telephone, remain on the line for assistance.

Providers calling about Forms 3618, 3619, and the 3652 CARE form need to enter their nine-digit LTC provider/contract number using a telephone keypad.

Additionally, providers should have their four-digit Vendor/Facility Site ID number available.

When inquiring about a specific individual, providers must have the Medicaid and/or Social Security number available along with the individual’s file or documentation.

When the nine-digit LTC provider/contract number is entered on the telephone keypad, the TMHP Call Center/Help Desk system automatically populates the TMHP representative’s screen with that provider’s specific information, such as name and telephone number. TMHP call center representatives can instantly view a provider’s contact history, complete with prior communication dates, discussion topics, and any notes made by representatives the provider has spoken to previously. These enhancements enable the representative to research and respond to inquiries more effectively.

For questions to TMHP, providers should call the TMHP Call Center/Help Desk at the following telephone numbers:

- Austin local telephone number: 1-512-335-4729
- Toll-free telephone number (outside Austin): 1-800-626-4117
- Toll-free telephone number (outside Austin): 1-800-727-5436

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<td>General Inquiry</td>
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<td>• Completing claim Form 1290</td>
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<td>• Modem and telecommunication issues</td>
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<td>• ANSI ASC X12 specifications, testing, and transmission</td>
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<td>• Verifying that system screens are functioning</td>
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<td>• Getting assistance from software developers with electronic data interchange (EDI)</td>
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Choose…

Option 3: Technical support

- Electronic transmission of 3652 CARE forms
- Electronic transmission of Forms 3618 and 3619
- Weekly Status Reports
- MDS submission problems
- Technical issues
- EDI and connectivity
- CARE form software (CFS) installation
- Transmitting forms
- Interpreting Quality Indicator (QI) Reports

Option 4: Headlines/topics for paper submitters

- New messages (banner) in audio format for paper submitters

Option 5: Request fair hearing

- Individual appeals
- Individual fair hearing requests
- Appeal and denial processes and guidelines

Option 6: Replay options

- Replay for menu options

DADS Contact Information—Claims Management

If you have questions about…

Medicaid eligibility and name changes

Medicaid Eligibility (ME) Worker or Claims Management: 1-512-490-4666 Fax: 1-512-490-4668 Website: http://ausmis31.dsh.state.tx.us/cmsmail

Obtaining a copy of LTC Claim Form 1290

Website: www.dads.state.tx.us/business/communitycare/infoletters/index.cfm under Community Care Information Letters or Contract Manager

Status of warrant/claim after it has been transmitted to Accounting (fiscal) by TMHP.

Accounting: 1-512-438-3989 (When calling Accounting, provide the DLN number assigned by TMHP.) Comptroller’s Website: https://ecpa.cpa.state.tx.us Choose the State Vendor Payment Information, Online Service link.

Cost report information (days paid and services paid)

Submit a batch claim status inquiry (CSI) using TDHconnect.

How to sign up for or obtain direct deposit/electronic funds transfer

Accounting: 1-512-438-3189 or 1-512-438-4684

How to prepare a cost report (forms and instructions)

HHSC: 1-512-491-1175 Website: www.hhsc.state.tx.us/medicaid/programs/medicaid/2012/index.html

Texas State University TILE training

Online course: 1-512-245-3150 Correspondence course and general information: 1-512-245-2507 Website: www.txstate.edu/continuinged/
If you have questions about... | Contact...
---|---
Contract enrollment | Provider Services (CCAD): 1-512-438-3875  
Institutional Service: 1-512-438-2546  
Hospice Services: 1-512-438-2546  
MR Services: 1-512-438-3544

12-month claims payment rule | Provider Services (CCAD)—Contract Manager  
Institutional Services (NFs)—Claims Management: 1-512-490-4666  
MR Services—Claims Management: 1-512-490-4666

Provider-on-hold questions | Provider Services (CCAD)—Contract Manager  
Institutional Services (NFs)—Claims Management: 1-512-490-4636  
MR Services: 1-512-438-3544

Third Party Resources (TPR)/TORT | Claims Management: 1-512-490-4635

Community Care for the Aged and Disabled Programs (CCAD),  
Community-Based Alternatives (CBA),  
Community Living Assistance and Support Services (CLASS,  
Deaf and Blind with Multiple Disabilities (DB/MD),  
Medically Dependent Children Program (MDCP),  
Consolidated Waiver, and Hospice Programs

Service authorizations | Caseworker or Case Manager
Policies/procedures and Financial or functional eligibility criteria | Caseworker or Case Manager
Program policies/procedures | Contract Manager
CLASS Program | Program Consultant
DB/MD Program | 1-512-438-2622
Hospice policy questions | 1-512-438-3169
MDCP | 1-512-438-5391

Intermediate Care Facility for Persons with Mental Retardation (ICF-MR)

MHMR Client Assessment Registration System (CARE) Help Desk | 1-512-438-4720
Provider systems access for CARE forms | 1-512-438-5037
TPR issues | 1-512-490-4635
Health and Human Services Commission Network (HHSCN) connection problems | 1-512-438-4720
Provider contracts, eligibility, and vendor holds | 1-512-438-3544
ICF/MR/RC billing questions and Individual movements/service authorization | Claims Management: 1-512-490-4666  
Fax: 1-512-490-4668  
Website: http://ausmis31.dhs.state.tx.us/cmsmail
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<td>ICF/MR/durable medical equipment (DME), Home Community-Based Services (HCS), Texas Home Living Waiver (TxHml), and (home modifications, adaptive aids, and dental services)</td>
<td>1-512-438-3597</td>
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<td>Program enrollment for UR/UC, Purpose codes, and MR/RC Assessment Form, level of service, level of need, level of care, and ICAP</td>
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<td>Cost report payments/quality fee (QAF)</td>
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<td>Hospice, Nursing Facilities, Swing Beds, or Rehabilitation Specialized Services</td>
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| Service authorizations | Claims Management: 1-512-490-4666  
Fax: 1-512-490-4668  
Website: http://ausmis31.dhs.state.tx.us/cmsmail |
| 3652 CARE form and Forms 3618 and 3619 missing/incorrect information | Claims Management: 1-512-490-4666  
Fax: 1-512-490-4668  
Website: http://ausmis31.dhs.state.tx.us/cmsmail |
| Deductions  
Provider-on-hold questions  
Audits | Claims Management: 1-512-490-4666  
Fax: 1-512-490-4636  
Website: http://ausmis31.dhs.state.tx.us/cmsmail |
| Hospice—Authorization Forms 3071/3074 issues | Claims Management: 1-512-490-4666  
Fax: 1-512-490-4668  
Website: http://ausmis31.dhs.state.tx.us/cmsmail |
| Rehabilitation specialized services | 1-800-792-1109 |
| HCS, TxHml billing, policy, payment reviews | 1-512-438-3612 |

**Bulletin Article Resources**

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Seating and materials are limited. Please RSVP at least 10 days prior to your preferred workshop date by logging on to the TMHP website at www.tmhp.com, or completing the form below and faxing it to 1-512-302-5068. Or mail to:

TMHP  
Attn: Provider Relations  
PO Box 204270  
Austin, TX 78720-4270

Select a Workshop:

☐ Community-Based Alternatives 3652 CARE Form  ☐ Nursing Facility 3618, 3619, and 3652 CARE Form

☐ TDHconnect 3.0

Please Print:

Workshop City  Workshop Date

Provider Name  Vendor/Site ID Number

Contact Name  (______)  Daytime Telephone Number

Number of Attendees  Email Address  
(Please provide an email address in case TMHP needs to contact you.)

Individuals with disabilities who require auxiliary aids or services should call TMHP at 1-512-506-7810 for assistance with these arrangements.
ATTENTION: BUSINESS OFFICE