**What’s New?**

**New DADS Provider Portal is Now Online**

People who contract to provide services to the Department of Aging and Disability Services (DADS) consumers will now find it easier to navigate the agency’s website with the launch of a new provider portal. The portal is available on the DADS website at www.dads.state.tx.us/providers.

According to Michael Jones, DADS communications manager, the idea behind reconfiguring the website was to create one-stop shopping for stakeholders. “By putting all the links for a particular provider type on one page, we are hoping it will make it easier for stakeholders to find the resources they need to do business with DADS,” Jones said.

On the homepage of the portal, providers can click on the name of the program for which they provide services to find all of their online resources, including handbooks, forms, communications, and claims. Organizations that are interested in becoming DADS providers can find enrollment information.

The new portal also allows providers and other interested persons to subscribe to some items, such as provider communications. Other subscription items will be added in the future.

**TDHconnect Replatforming**

Plans are underway to transition the TDHconnect software to a web-based application later this year. To submit claims through this web-based application, providers must have internet access through an internet service provider.

The Texas Medicaid & Healthcare Partnership (TMHP)

**What’s New?**

- New DADS Provider Portal is Now Online............ 1
- TDHconnect Replatforming............................. 1
- Third Party Biller Enrollment Delayed .............. 2
- It’s Not Too Soon to Prepare for FY08!............... 2

**In This Corner**

- Nursing Facilities/Hospice Providers—Who Do I Call?............................................................... 3

**Updates**

- Spring 2007 Workshops End June 20 .................. 4
- Quarterly HIPAA Crosswalk Updates ................ 5
- National Provider Identifier (NPI) Updates .......... 5
- New Integrated Care Management Program for Dallas and Tarrant Service Areas ......................... 6
- TILEs to RUGs Transition .................................. 6
- Top 3 Reasons Claims Are Denied .................... 7

**Reminders**

- How to Download and Install TDHconnect 3.0 Service Pack 8......................................................... 8
- Tips for Accessing and Downloading Information and Reports .................................................... 9
- ER&S Reports Useful for Tracking Billing Activity.. 9
- Verify Eligibility with a MESAV Inquiry ............. 10
- Providers Encouraged to Bill Electronically ........ 10

**Provider Resources**

- TMHP Provider Relations Representatives ........ 11
- TMHP LTC Contact Information ......................... 12
- DADS Contact Information .............................. 13
- Bulletin Article Resources .............................. 15
and DADS are committed to ensuring that providers are equipped to utilize this new application with minimal impact. The TMHP web portal will expedite the submission and retrieval of information because it processes information in real-time, which is similar to interactive claim submission through TDHconnect, for the following transactions:

- **Claim Submissions**
  - Professional
  - Institutional
  - Dental
  - Nurse Aide Training (NAT)
- Medicaid Eligibility Service Authorization Verifications (MESAVs)
- Claim Status Inquiries (CSI)
- Claim Adjustments
- Electronic Remittance and Status Reports (ER&S)

The new web-based portal application will be compatible with Internet Explorer 6.0 and Netscape.

TMHP will schedule workshops throughout Texas to help providers with this transition. Invitations will be mailed to providers after the workshops have been scheduled. For more information about the workshops, providers can also visit www.tmhp.com or call the TMHP Call Center/Help Desk at 1-800-626-4117.

**Third Party Biller Enrollment Delayed**

Third-party biller enrollment, which was scheduled to start February 11, 2007, has been delayed until further notice. The information about the enrollment of third-party billers who submit electronic claims on behalf of Medicaid providers enrolled with TMHP was originally published in the November 2006 *Long Term Care Provider Bulletin*, No. 28. TMHP recommends that providers notify their third-party billers of this delay. Details and updates to third-party biller enrollment will be published in future banner messages and bulletins and on the TMHP website at www.tmhp.com.

For more information, call the TMHP Call Center/Help Desk at 1-800-626-4117.

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**It’s Not Too Soon to Prepare for FY08!**

**Miscellaneous Claims**

The State of Texas fiscal year (FY) runs from September 1 through August 31. In the upcoming FY 2008, any claims submitted for FY05 (September 1, 2004, through August 31, 2005) that are received by TMHP on or after August 15, 2007, become Miscellaneous Claims and cannot be paid through the standard Claims Management System (CMS) payment process. A Miscellaneous Claim occurs when the service dates on a claim are older than two FYs before the current FY. Miscellaneous Claims for services that are less than four years old and/or those that total less than $25,000 owed to a single legal entity are paid on a first-come, first-served basis using funds that are appropriated during each legislative session. Any Miscellaneous Claim over $25,000 and/or for services more than four years old cannot be paid except as a special line item in the state budget. Please note that the legislature has appropriated zero funding for this purpose during the past two biennia (FY04-07).

If a provider submits a claim that has already become a Miscellaneous Claim, the claim is processed as a Transferred Status claim and appears on Remittance and Status (R&S) reports with a “T” status. The provider should not calculate T status claims in the Total Paid Amount on the R&S. T status claims must be submitted to the Texas Comptroller for Public Accounts for processing and payment, and are subject to the funding limitations described above. Provider Claims Services processes T status claims on a monthly basis. Assistance in filing an Application for Payment of Claim Against the State of Texas may be obtained by contacting Provider Claims Services at 1-512-490-4666, Option 3 (for nursing facilities, hospices, and Intermediate Care Facilities for the Mentally Retarded) and Option 4 (Community Care for the Aged and Disabled).

Providers should submit their claims in a timely manner to avoid significant delays in payment caused by Miscellaneous Claims. It is also useful to review R&S reports each week.

For further information on Miscellaneous Claims, refer to CMS Information Letter No. 2005-34, Miscellaneous Claims, available on the TMHP website at www.tmhp.com/LTC Programs/LTC Docs/LTC Information Letter 05-34.
In This Corner

Nursing Facilities/Hospice Providers—Who Do I Call?

While the TMHP Call Center/Help Desk is the LTC provider’s resource for general inquiries regarding claims rejections and denials, the DADS Provider Claims Services (PCS) Unit is the main resource for calls concerning:

- Service authorizations for nursing facility and hospice providers.
- Missing or incorrect information on CARE Form 3652A; Form 3618 Resident Transaction Notice; Form 3619 Medicare/SNF Patient Transaction Notice; Form 3071 Hospice Election/Cancellation/Discharge; and Form 3074 Physician Certification/Recertification of Terminal Illness.

Contacting the TMHP Call Center/Help Desk

Some reasons for contacting the TMHP Call Center/Help Desk are listed below. Additional reasons for contacting TMHP are listed in the Provider Resources section of each Long Term Care Provider Bulletin, including this issue.

- General Inquiries including how to submit claims, how to complete Long Term Care Claim Form 1290, claims status inquiries, how to process claim adjustments.
- How to download and read a Remittance and Status (R&S) Report.
- Technical issues on obtaining access and/or using TDHconnect and the LTC Online Portal.
- To speak to a nurse about CARE Forms 3652. Providers submitting paper CARE Forms 3652 should contact TMHP at 1-800-626-4117, Option 2, to speak with a nurse regarding medical necessity.
- Denied CARE Forms 3652. If medical necessity has been denied, providers should contact TMHP at 1-800-626-4117, Option 5, to request a Fair Hearing.

Researching/Accessing Reports

Before contacting PCS, you can access a MESAV and/or R&S to resolve most issues. It has been confirmed that most calls received by PCS can be resolved when accessing either a MESAV or R&S report. Even if this step does not resolve the issue, accessing a MESAV or R&S report will help expedite the call to TMHP or PCS. Reviewing the MESAV and/or R&S will clarify whether any records are missing, identify any gaps in services, etc., and confirm that you have specifically identified the issue that needs to be resolved.

In some cases, after reviewing the MESAV and/or R&S, it may not be appropriate to call TMHP or PCS; instead do the following:

- Contact the Medicaid Eligibility Worker if the claim rejected on an initial submission and the EOB F0155 (Unable to determine appropriate fund code for service billed, verify Medicaid eligibility) shows on the R&S or the Medicaid Eligibility segment does not show on the MESAV.
- Contact the Medicaid Eligibility Worker if the applied income record is missing or incorrect.
- Request a Claims Status Inquiry (CSI) by client number or contact TMHP if there is a gap in payment dates. The CSI will show what has been paid, denied, etc. for the requested period.
- If a claim denied/rejected and you have not been paid for a particular client and/or period, access a MESAV to determine whether there is missing information or check the EOB on the R&S report to find out the reason the claim denied. If there is no missing information on the MESAV and the EOB reflects you billed incorrectly, rebilling correctly will solve the problem. If there is missing client information on the MESAV, a call to PCS may be necessary.
- When accessing a MESAV, ensure that the MESAV includes the correct provider/contract number of the provider and that the timeframe that the information is being requested for is correct.

Contacting PCS

There are times when a call to PCS is necessary; for example:

- There is a gap in the client’s service authorization.
- The service authorization is pending and the MESAV indicates there is a TILE value.
The TILE value is missing and the eligibility segment is on the MESAV.

The service authorization is in pending status.

Form 3618 was submitted more than 10 days in the past and the form information is not on the MESAV.

Forms 3071 and 3074 were submitted more than 10 days in the past and the forms information is not on the MESAV.

The hospice provider has verified with the nursing facility that the appropriate forms have been submitted and it has been more than 10 days from the date the forms were submitted.

The service authorization begin date does not match the date payment should begin.

Medical necessity shows as approved on the LTC Online Portal but does not show on the MESAV.

In situations where you should call PCS, to expedite resolution of provider issues, agencies should have the following ready prior to calling PCS:

- Provider/contract/vendor number(s).
- Client name/number.
- A copy of the MESAV and/or R&S. Reviewing the MESAV and/or R&S will clarify whether any records are missing and confirm that you have specifically identified what needs to be resolved.
- If the issue has to do with a change of ownership, the old and new provider/contract/vendor number and effective dates of the change.

Often, you might have questions about forms submitted through the LTC Online Portal that may be solved by accessing the portal, for example:

- To find the status of a form submitted to TMHP. If a form cannot be located and a Document Locator Number (DLN) exists, the form could still be in process and not available for you or PCS to view. Try the portal again the next day.

- To provide additional medical information when the CARE Form 3652 is in Pending Status. Providers using the LTC Online Portal should enter missing medical information in the comment section of the CARE Form 3652. Providers submitting paper CARE Forms 3652 should call TMHP at 1-800-626-4116 (Option 2) to provide additional medical information.

Reminders

- Forms processed through the LTC Online Portal normally take up to 10 days to show up on a MESAV.
- When submitting requests for changes to PCS (either by phone or email) allow 10 business days for the change and/or response to be provided. Please do not submit duplicate requests because they create workload issues.

Updates

Spring 2007 Workshops End June 20

The LTC workshops have been updated with information on recent and upcoming changes. Both the Waiver Programs workshop and the newly combined Nursing Facility/Hospice workshop address forms that are now available through the LTC Online Portal.

- LTC Waiver Programs—This workshop now incorporates information about using the LTC Online Portal.
- Nursing Facility / Hospice—This workshop now incorporates information about using the LTC Online Portal for both Client Assessment, Review, and Evaluation (CARE) and Hospice forms.
- TDHconnect—A new web-based application will replace TDHconnect at a later date. TMHP does not plan further changes to TDHconnect at this time. All TDHconnect users should download and install Service Pack 8. Additional information will be available in future bulletins and on the NPI Announcements webpage of the TMHP website at www.tmhp.com/C13/NPI Announcements/default.aspx.
Waiver Programs Workshop

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Nursing Facility/Hospice Workshop

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Quarterly HIPAA Crosswalk Updates

The LTC Bill Code Crosswalk is updated quarterly on the first day of March, June, September, and December. There were no changes in March that affected LTC providers. Providers can access the LTC Bill Code Crosswalk on the TMHP website at www.tmhp.com and on the new DADS Provider Portal at www.dads.state.tx.us/providers/hipaa/index.html.

National Provider Identifier (NPI) Updates

NPI implementation is getting closer and to date approximately a third of all long term care (LTC) providers have submitted their NPIs to the Department of Aging and Disability Services (DADS).

Providers that have not applied for an NPI through the National Plan and Provider Enumeration System (NPPES) should do so as soon as possible. In general, the time it takes to receive an NPI is increasing, with delays of a few weeks being reported in some instances.

To avoid potential delays in payment processing, DADS suggests that providers obtain and submit their NPIs to DADS by June 1, 2007. LTC providers that deliver acute care services must also complete attestation with TMHP in addition to submitting their NPI to DADS.

Information about the acute care attestation process is available on the TMHP website at www.tmhp.com.

Information Letter 06-89—DADS NPI Collection Process, which was mailed to providers in October 2006, details how to submit an NPI to DADS. Information Letter 06-89 and a list of the top ten most frequently asked questions (FAQs) about the NPI and their answers are available on the new DADS Provider Portal at www.dads.state.tx.us/providers/hipaa/NPI_FAQs.pdf. Information Letter 06-89 and the FAQs can also be accessed on the TMHP website at www.tmhp.com.

Understanding the NPI Submission Process

NPIs are assigned to providers through NPPES; DADS does not assign NPIs. Providers must have the following information to complete the NPI application process:

- Legal business name
- Employer Identification Number (EIN)
- Other business name (former or doing business as [DBA])
- Mailing address
- Physical address
- Provider numbers (Medicare, Medicaid, DADS)

After the NPI is assigned, LTC providers should immediately forward to DADS the NPI notification they received from either NPPES or FOX Systems, Inc., along with the completed Contract NPI Association form. The form notifies DADS of the NPI that will be used in place of the provider’s contract number on claims. Providers should note the following when completing the form:

- The contract number (i.e., provider number) is the number currently sent on claims.
- The column labeled “Atypical” is reserved for use by DADS.
- Enter the NPI and a DBA name if one is available.
- The service group can be the service provided [e.g., meals, Home and Community Based Services (HCS), Community Based Alternatives (CBA), Medically Dependent Children’s Program (MDCP)], or the Service Group number (2, 3, 7, etc.).
**Dual Strategy Extension**

The “dual strategy” approach, which permits providers to use their contract number and new NPI, has been extended until July 30, 2007. On that date, the NPI will become the only provider identifier and the contract number will no longer be accepted.

**New Billing Referral Number**

DADS will institute the use of billing referral numbers to determine specific provider/client service authorizations with the implementation of NPI. Providers who use one NPI to identify multiple contract agreements with DADS will be required to submit the billing referral number on all electronic claims. The billing referral number will automatically be returned on a MESAV response.

**Additional NPI Information Sources**

Detailed information about the implementation of the NPI was published in the January 2007 *National Provider Identifier (NPI) Special Bulletin for Long Term Care (LTC) Providers*, No. 202, and will also be published in the Summer 2007 *National Provider Identifier (NPI) Special Bulletin for Long Term Care (LTC) Providers*, No. 205. Information is also available on the TMHP website at www.tmhp.com and on the DADS website at www.dads.state.tx.us/providers/hipaa/index.html.

**New Integrated Care Management Program for Dallas and Tarrant Service Areas**

As described in the February 2007 *Long Term Care Provider Bulletin*, No. 29, the HHSC Integrated Care Management (ICM) Program is a non-capitated, managed care system intended to integrate acute care and long term services and supports (LTSS) for the Supplemental Security Income (SSI), SSI-related, and eligible Medical Assistance Only (MAO) Medicaid clients in the Dallas and Tarrant service areas. The Dallas Service Area consists of Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties. The Tarrant Service Area consists of Denton, Hood, Johnson, Parker, Tarrant, and Wise counties. HHSC’s enrollment broker, MAXIMUS, will be responsible for enrolling eligible Medicaid recipients into the ICM Program.

The ICM contract was awarded to Evercare of Texas, LLC (Evercare) on March 12, 2007. As the ICM contractor, Evercare will assist HHSC in implementing the ICM Program by managing and coordinating acute care services and long term services and supports (LTSS) for eligible ICM members. Evercare will be responsible for administrative services related to utilization, care management, and service coordination, including the authorization and management of Medicaid services; however, Evercare will not be responsible for paying claims or setting rates. The original implementation date was July 1, 2007. HHSC will delay implementation until 90 days after obtaining federal approval. This will allow adequate time to ensure a successful launch of the ICM program.

LTSS providers should review the DADS website at www.dads.state.tx.us/providers/index.cfm for important information letters regarding ICM implementation activities, particularly those related to contracts and billing submission deadlines for the following services in the ICM service areas: Community Based Alternatives (CBA), Primary Home Care (PHC), and Day Activity and Health Services (DAHS).

Physicians and hospital representatives interested in receiving an Evercare ICM contract and credentialing application should contact an Evercare representative at 1-866-574-6088. Medicaid Long Term Service and Support (LTSS) providers interested in receiving an Evercare ICM contract and credentialing application should contact an Evercare representative at 1-972-866-1696. To address general questions about the LTSS components of the ICM project, please contact Lena Brown-Owens via email at lena.brownowens@dads.state.tx.us or via telephone at 1-512-438-5609. For online information about the ICM Program, please refer to www.hhsc.state.tx.us/contract/529060406/rfp_home.html.

**TILEs to RUGs Transition**

The TILEs to RUGs project is charged with managing the transition from the state case-mix system for payments, which is based on the Texas Index for Level of Effort (TILE) model, to the federal case-mix system, which is based on the Minimum Data Set Resource Utilization Group (MDS RUG-III) model. TILE has 11 different levels of classification, while RUG has 34 levels (groups).
This project is expected to meet two goals:

1. Convert from the TILEs reimbursement methodology to the RUGs reimbursement methodology using the Federal Minimum Data Set (MDS) specification version 2.0.

2. Convert from the use of the Client Assessment, Review, and Evaluation (CARE) Form 3652-A to the federal Resident Assessment Instruments (RAI) based on the MDS.

Replacing the CARE Form 3652-A will also eliminate use of Form 3618-Resident Transaction Notice and Form 3619-Medicare/SNF Patient Transaction Notice. The implementation date for RUGs is September 1, 2008.

Project Status Update

State project workgroups are currently documenting the required changes that involve the following areas:

- Business processes for the submission and use of MDS data from nursing facilities and community services programs for Medicaid state payment purposes;
- Information systems, including the TMHP LTC Online Portal, DADS Service Authorization Systems, and Texas Integrated Enrollment Redesign System (TIERS);
- Texas Administrative Code (TAC);
- Community services waivers;
- Texas State Medicaid Plan.

Training Strategy

Staff members are also identifying related training needs for nursing facility providers, community services providers, and state personnel. A combination of instructor-led classroom training and online web-based training will be made available as the project progresses into the training phase, which is projected to begin late in the summer of 2008.

Additional information will be provided as this project progresses.

Top 3 Reasons Claims Are Denied

The following are the top three reasons why claims are denied:

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 client’s service authorization. To resolve this issue verify and correct the following information:

- Is the individual’s Medicaid number correct?
- Is the name of the individual spelled correctly?
- Is the provider number correct and does it include all nine digits?
- Is the individual eligible? Request a Medicaid Eligibility Service Authorization Verification (MESAV) to confirm eligibility.
- Are the correct codes used? Use the most recent LTC Bill Code Crosswalk.

2. EOB F0155—“Unable to determine appropriate fund code for service billed, verify Medicaid eligibility.”

This means that the individual may have lost eligibility, that the wrong HCPCS code was entered on the claim, or that the fund code entered on the client’s service authorization may have been entered incorrectly. The following actions will resolve EOB F0155:

- Verify the individual’s Medicaid eligibility for the dates billed.
- Process a MESAV request to verify the Medicaid eligibility, coverage code, category code, and program type code (click the Med. Elig./Med Nec. tab):
  - When there is no Medicaid eligibility or medical necessity established for the individual for the dates entered in the MESAV request, the tab will be dim/disabled and cannot be chosen.
  - If the coverage code is:
    - W—The individual will have permanent medical necessity.
H—The individual currently has permanent medical necessity

O—The individual has been denied medical necessity.

Contact the caseworker to establish eligibility for the individual.

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 client may not be eligible for the services for the dates of service on the claim, or the service authorization does not cover all dates of service being billed. The following actions will resolve EOB F0138:

- Verify the individual’s case/Medicaid number.
- Verify the provider’s nine-digit provider number
- Confirm that the client was eligible for services for the dates of service on the claim:
  - Process a MESAV request and view the Service Authorization tab.
  - When there is no Medicaid eligibility for the individual for the dates entered on the MESAV request, the tab will be dim/disabled and cannot be chosen.
  - If billing for even one day of service that is not covered by a service authorization, the claim will deny.
- Contact your caseworker to establish a service authorization for the dates in question before re-submitting the claim.

Reminders

How to Download and Install TDHconnect 3.0 Service Pack 8

All TDHconnect users should download Service Pack 8 by July 30, 2007. TDHconnect 3.0 Service Pack 8 was released on May 28, 2006. TDHconnect was modified to accept the NPI for electronic LTC transactions. Providers who use TDHconnect 3.0 are encouraged to download and install Service Pack 8 from the TMHP website at www.tmhp.com.

TDHconnect users should download all previously requested responses, such as CSIs and MESAVs, before installing any service pack.

Download

Follow these steps to download the service pack:

2. Click the Find Publications/File Library link on the “I would like to…” list on the right side of the homepage. The TMHP File Library webpage opens.
3. Click the TDHconnect link. The TMHP File Library/TDHconnect webpage opens.
4. Click the TDHconnect Updates link. The TMHP File Library/TDHconnect/TDHconnect Updates webpage opens.
5. Click tdhsp8 to begin installation.

Installation

To install TDHconnect service packs, follow these steps:

1. Double-click the TDHconnect 3.0 Updates Service Pack 8.msi icon. This icon was added to the desktop during the file download.
2. A dialog opens with the following message: “This will install TDHconnect 3.0 Service Pack 8. Do you want to continue?” Click Yes to install the TDHconnect 3.0 Service Pack 8.
3. After the TDHconnect Service Update Installation Utility window opens and the TDHconnect 3.0 Service Pack wizard opens, several informational messages will open. Read each message and click Next to advance to the next screen.
4. A dialog box opens with the following message: “Do you wish to backup your databases?” This will overwrite databases that are in the Backup folder. Choose one of the following options:
   - Click Yes to backup your databases before installing any database updates (this is the recommended choice).
   - Click No to continue with the installation without making backups.

5. Installation of the TDHconnect 3.0 Service Pack is complete. To view the Read Me file, check the View Read Me check box, and click Finish. The Read Me document opens.

6. Read the document, close it, uncheck the View Read Me check box, and click Finish.

7. When prompted to restart the computer, select “Yes, I want to restart my computer now,” and then click Finish.

The next time TDHconnect is opened, the version of the service pack is listed along with the name TDHconnect 3.8.0. For more information, or help with downloading or installing service packs, contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-800-626-4117, Option 3.

**Tips for Accessing and Downloading Information and Reports**

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

- To get help while using TDHconnect to complete, download, or retrieve files, press the F1 key to access the Help menu.
- Visit the News section of the TMHP website at www.tmhp.com/LTC Programs for the latest weekly postings.

**ER&S Reports Useful for Tracking Billing Activity**

Electronic Remittance and Status (ER&S) reports are valuable tools for tracking billing activities. A successful business typically has good accounting practices, such as the reconciliation of ER&S reports. Agencies that do not reconcile their ER&S reports may be billing incorrectly, which can result in audits and penalties. It is the provider’s responsibility to ensure that all billing is accurate and that any problems or issues associated with the claim are resolved within the 12-month filing limitation. If the repayment of invalid or inappropriate recoupments is not resolved within 12 months, they are subject to the 12-month filing limitation.

Invalid or inappropriate recoupments should be reported immediately by contacting Provider Claims Services at 1-512-490-4666, Option 3.

Providers are encouraged to download and generate their ER&S reports weekly, because each report is only available for 30 days. Use dates that begin on a Friday through the following Monday to generate a report.

ER&S reports are divided into three sections:

The Non-Pending section contains HIPAA-compliance information that is based on the national procedure or revenue codes 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 or payment. Finalized claims that make it through the claims payment process are either approved to pay or denied. The section includes the derived local billing code, units paid, billed amount, paid amount, and other details. Providers will receive only one Claim Activity section per reporting period. If more than one warrant is received in a particular week, the Claim Activity section may correspond to multiple Non-Pending sections.

The Non-Pending and 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 whether the system derived the correct bill code for payment.

The Financial Summary section provides warrant information and warrant amounts for the reporting period.

To accurately assess claim activity for the reporting period, all three sections must be used.

The number of warrants issued and, indirectly, the number of Non-Pending sections to look for are provided in the Financial Summary section.
Reminders

Verify Eligibility with a MESAV Inquiry

A Medicaid Eligibility Service Authorization Verification (MESAV) inquiry enables 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 always available.

MESAV inquiries provide valuable information about each individual enrolled in LTC programs. The inquiries enable providers to check services, units, eligibility, medical necessity, applied income/copayment, level of service in the Service Authorization System (SAS), and 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 extend beyond the three-month range. Information that providers receive is based on the individual’s eligibility information available through 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 with a MESAV inquiry before submitting a claim, making certain that the billed dates of service fall within the effective dates of the service authorization. One of the most common reasons claims are denied is that the dates of service are not within the service authorization period. If the EOB states the individual is not authorized for services received, submit a MESAV inquiry to verify that the correct dates and services are on file with TMHP. Eligibility may have expired or 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.

Providers Encouraged to Bill Electronically

It’s fast. No more waiting by the mailbox or phone inquiries; know what’s happening to claims in less than 24 hours and get paid for approved claims within a week. TDHconnect users can submit individual requests interactively and receive a response immediately.

It’s free. All electronic services offered by TMHP are free, as well as the TDHconnect software and its technical support, upgrades, and training. TDHconnect users can access our website directly, without having to pay for an internet connection.

It’s easy. TMHP offers free workshops for TDHconnect, billing, and many other topics, as well as a large library of reference materials and manuals on www.tmhp.com.

It’s safe. TMHP EDI services use virtual private networking (VPN) and secure socket layer (SSL) connections, just like the U.S. government, banks, and other financial institutions, for maximum security.

It’s accurate. TDHconnect and many other software programs have features that let providers know when they’ve made a mistake, which means fewer rejected and denied claims. Rejected claims are returned with messages that explain what’s wrong, so the claim can be corrected and resubmitted right away.

It’s there when it’s needed. Electronic services are available day and night—from home, the office, or anywhere in the world.

It makes record keeping and research easy. Not only can software be used to send and receive claims, it can retrieve the Remittance and Status (R&S) report electronically, perform claim status inquiries, and archive claims. TDHconnect can generate and print reports on everything it sends, receives, and archives.

Contact the TMHP Call Center/Help Desk at 1-800-626-4117, Option 3, to order TDHconnect software.
Provider Resources

TMHP Provider Relations Representatives

TMHP provider relations representatives offer a variety of services designed to inform and educate the provider community about TDHconnect and claims filing procedures. Provider relations representatives assist providers through telephone contact, on-site visits, and scheduled workshops.

The map to the right and the following table indicate TMHP provider relations representatives and the areas they serve. Additional information, including a regional listing by county and workshop information, is available on TMHP website at www.tmhp.com/Providers/default.aspx. Click on the Regional Support link, and then choose the applicable region.

<table>
<thead>
<tr>
<th>Territory</th>
<th>Regional Area</th>
<th>Provider Representative</th>
<th>Telephone Number</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Amarillo, Childress, and Lubbock</td>
<td>Elizabeth Ramirez</td>
<td>1-512-506-6217</td>
</tr>
<tr>
<td>2</td>
<td>Midland, Odessa, and San Angelo</td>
<td>Mindy Wiggins</td>
<td>1-512-506-3423</td>
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<tr>
<td>3</td>
<td>Alpine, El Paso, and Van Horn</td>
<td>Isaac Romero</td>
<td>1-512-506-3530</td>
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<tr>
<td>4</td>
<td>Del Rio, Eagle Pass, and Laredo</td>
<td>Candice Myers</td>
<td>1-512-506-7271</td>
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<td>5</td>
<td>Brownsville, Harlingen, and McAllen</td>
<td>Cynthia Gonzales</td>
<td>1-512-506-7991</td>
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<tr>
<td>6</td>
<td>Abilene and Wichita Falls</td>
<td>Matthew Cogburn</td>
<td>1-512-506-7095</td>
</tr>
<tr>
<td>7</td>
<td>Brady, Brownwood, Hospitals in Travis County, Round Rock, and Waco</td>
<td>Andrea Daniell</td>
<td>1-512-506-7600</td>
</tr>
<tr>
<td>8</td>
<td>Austin, Bryan, College Station, and Wharton</td>
<td>Will McGowan</td>
<td>1-512-506-3526</td>
</tr>
<tr>
<td>9</td>
<td>San Antonio and Kerrville</td>
<td>Mary Poole</td>
<td>1-512-506-3422</td>
</tr>
<tr>
<td>10</td>
<td>San Antonio, Corpus Christi, and Victoria</td>
<td>Jill Ray</td>
<td>1-512-506-3554</td>
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<tr>
<td>11</td>
<td>Cleburne, Denton, and Fort Worth</td>
<td>Rita Martinez</td>
<td>1-512-506-7990</td>
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<tr>
<td>12</td>
<td>Dallas, Corsicana, and Groesbeck</td>
<td>Sandra Peterson</td>
<td>1-512-506-3552</td>
</tr>
<tr>
<td>13</td>
<td>Dallas and Whitesboro</td>
<td>Olga Fletcher</td>
<td>1-512-506-3578</td>
</tr>
<tr>
<td>14</td>
<td>Tyler, Texarkana, and Paris</td>
<td>Trilby Foster</td>
<td>1-512-506-7053</td>
</tr>
<tr>
<td>15</td>
<td>Beaumont and Lufkin</td>
<td>Gene Allred</td>
<td>1-512-506-3425</td>
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<tr>
<td>16</td>
<td>Houston and Conroe</td>
<td>Linda Wood</td>
<td>1-512-506-7682</td>
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<td>17</td>
<td>Houston and Katy</td>
<td>Rachelle Moore</td>
<td>1-512-506-3447</td>
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<tr>
<td>18</td>
<td>Galveston and Matagorda</td>
<td>John Miller</td>
<td>1-512-506-3586</td>
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<tr>
<td>19</td>
<td>Houston</td>
<td>Stephen Hirschfelder</td>
<td>1-512-506-3446</td>
</tr>
</tbody>
</table>
TMHP LTC Contact Information

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

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

Providers should have their four-digit Vendor/Facility or Site ID number available for calls about Forms 3618, 3619, and the CARE Form 3652-A.

Providers must have a Medicaid or Social Security number and a medical chart or documentation for inquiries about a specific individual.

For questions, providers should call the TMHP Call Center/Help Desk at the following telephone numbers:
- Austin local telephone number at 1-512-335-4729
- Toll-free telephone number (outside Austin) at 1-800-626-4117 or 1-800-727-5436

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<table>
<thead>
<tr>
<th>For questions about…</th>
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</tr>
</thead>
<tbody>
<tr>
<td>General inquiries</td>
<td>Option 1: Customer service/general inquiry</td>
</tr>
<tr>
<td>Using TDHconnect</td>
<td></td>
</tr>
<tr>
<td>Completing Claim Form 1290</td>
<td></td>
</tr>
<tr>
<td>Claim adjustments</td>
<td></td>
</tr>
<tr>
<td>Claim status inquiries</td>
<td></td>
</tr>
<tr>
<td>Claim history</td>
<td></td>
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<tr>
<td>Claim rejection and denials</td>
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<tr>
<td>Understanding R&amp;S reports</td>
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<td>CARE Form 3652-A</td>
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</tr>
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<td>Forms 3618 or 3619</td>
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<td>Forms 3071 and 3074</td>
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<td>Texas Index for Level of Effort (TILE) levels</td>
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<td>Medical necessity</td>
<td>Option 2: To speak with a nurse</td>
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<tr>
<td>TDHconnect—Technical issues, obtaining access, user IDs, and passwords</td>
<td>Option 3: Technical support</td>
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<td>Modem and telecommunication issues</td>
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<tr>
<td>Processing provider agreements</td>
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<tr>
<td>Verifying that system screens are functioning</td>
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<td>Electronic transmission of CARE Form 3652-A</td>
<td>Option 3: Technical support</td>
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<td>Electronic transmission of Forms 3618 and 3619</td>
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<td>Electronic transmission of Forms 3071 and 3074</td>
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<td>Forms Status Inquiry</td>
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<td>American National Standards Institute (ANSI) ASC X12 specifications, testing, and transmission</td>
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<td>Getting EDI assistance from software developers</td>
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<td>EDI and connectivity</td>
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<td>LTC Online Portal</td>
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<td>Electronic transmission of Forms 3071 and 3074</td>
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<td>Technical issues</td>
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<tr>
<td>Transmitting forms</td>
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<td>Interpreting Quality Indicator (QI) Reports</td>
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<td>Current Activity Report (formerly Weekly Status Report)</td>
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<td>MDS submission problems</td>
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<td>New messages (banner) in audio format for paper submitters</td>
<td>Option 4: Headlines/topics for paper submitters</td>
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<td>Individual appeals</td>
<td>Option 5: Request fair hearing</td>
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<td>Individual fair hearing requests</td>
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<td>Replay for menu options</td>
<td>Option 6: Replay options</td>
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## DADS Contact Information

<table>
<thead>
<tr>
<th>If you have questions about...</th>
<th>Contact...</th>
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| **12-month claims payment rule** | Provider Services (Community Care for Aged and Disabled Programs (CCAD))—Contract Manager  
Institutional Services (NFs)—Provider Claims Services: 1-512-490-4666, Option 1  
MR Services—Provider Claims Services: 1-512-490-4666, Option 1 |
| **Contract enrollment** | Provider Services (CCAD): 1-512-438-3875  
Institutional Services: 1-512-438-2546  
Hospice Services: 1-512-438-3875  
MR Services: 1-512-438-3544 |
| **Cost report information (days paid and services paid)** | Use TDHconnect to submit a batch of CSIs. |
| **Rate Analysis Contacts** | Website: www.hhsc.state.tx.us/medicaid/programs/rad/index.html  
Click the Long Term Care link and then select the appropriate program. |
| **How to prepare a cost report (forms and instructions)/approved rates posted** | Website: www.hhsc.state.tx.us/medicaid/programs/rad/index.html |
| **How to sign up for or obtain direct deposit/electronic funds transfer** | Accounting: 1-512-438-4310, 1-512-438-5595, or 1-512-438-4684 |
| **Medicaid eligibility and name changes** | Medicaid Eligibility (ME) Worker  
Integrated Eligibility and Enrollment (IEE) Call Center at telephone number 211  
Website: www.hhs.state.tx.us/consolidation/IE/IE.shtml |
| **Obtaining a copy of LTC Claim Form 1290** | Contract Manager or  
Website: www.dads.state.tx.us/business/communitycare/infoletters/index.cfm under Community Care Information Letters |
| **Deductions and provider-on-hold questions** | Provider Services (CCAD)—Contract Manager  
Institutional Services (NFs)—Provider Claims Services: 1-512-490-4666, option 3  
Website: http://ausmis31.dhs.state.tx.us/cmsmail  
MR Services: 1-512-438-3544 |
| **Status of warrant/claim after it has been transmitted to Accounting (fiscal) by TMHP** | Accounting: 1-512-438-3989  
When calling Accounting, provide the document locator number [DLN] number assigned by TMHP.  
Comptroller's website: https://ecpa.cpa.state.tx.us  
Choose the State-to-Vendor-Payment Info-Online-Search link. |
| **Texas State University Texas Index Level of Effort (TILE) training** | The Office of Continuing Education:  
Online course: 1-512-245-7118 or 1-512-245-2507 (correspondence course and general information)  
Website: www.txstate.edu/continuinged |
| **TILE Calculator** | HHSC website located at www.hhsc.state.tx.us/medicaid/programs/rad/nf |
| **Third Party Resources (TPR)/TORT** | Provider Claims Services: 1-512-490-4666, option 4  
Website: http://ausmis31.dhs.state.tx.us/cmsmail |
<table>
<thead>
<tr>
<th>If you have questions about…</th>
<th>Contact…</th>
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<tbody>
<tr>
<td>Community Care for the Aged and Disabled Programs (CCAD), Community-Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DB-MD), Medically Dependent Children Program (MDCP), Consolidated Waiver Program (CWP), Home and Community Based Services (HCS), Texas Home Living Waiver (TxHmL), and Hospice Programs</td>
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<tr>
<td>CLASS Program</td>
<td>Program Consultant</td>
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<tr>
<td>CLASS Interest Line</td>
<td>1-877-438-5658</td>
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<td>DB-MD Program</td>
<td>1-512-438-2622</td>
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<td>DB-MD Interest Line</td>
<td>1-877-438-5658</td>
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<td>CBA/CCAD financial or functional eligibility criteria</td>
<td>Caseworker or Case Manager</td>
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<td>CBA/CCAD Program policies/procedures</td>
<td>Contract Manager</td>
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<td>Hospice policy questions</td>
<td>1-512-438-2756</td>
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<tr>
<td>Hospice Program service authorization issues</td>
<td>Provider Claims Services: 1-512-490-4666, option 1</td>
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<td>Medically Dependent Children Program (MDCP)</td>
<td>1-512-438-5391</td>
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<tr>
<td>HCS and TxHmL billing, policy, payment reviews</td>
<td>Billing: Gaynell Bray 1-512-438-3612</td>
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<td>Prior approval AA/MHM/Dental: Sean Ivie 1-512-438-3598</td>
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<td>Intermediate Care Facility for the Mentally Retarded (ICF-MR)</td>
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<td>Nursing Facility Program</td>
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<tr>
<td>Cost report payments/quality assurance fee (QAF)</td>
<td>1-512-491-1739</td>
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<td>Health and Human Services Commission Network (HHSCN) connection problems</td>
<td>1-512-438-4720</td>
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<td>ICF-MR/durable medical equipment (DME), DME authorizations, Home and Community-Based Services (HCS), Texas Home Living Waiver (TxHmL), home modifications, adaptive aids, and dental services approvals</td>
<td>1-512-490-4642 or 1-512-490-4651</td>
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<td>Email: <a href="mailto:HSCAuths@dads.state.tx.us">HSCAuths@dads.state.tx.us</a></td>
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<td>ICF-MR/Residential Care (RC) individual movements/service authorization questions</td>
<td>Provider Claims Services: 1-512-490-4666, option 1</td>
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<td>Fax: 1-512-490-4669</td>
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<td>Website: <a href="http://ausmis31.dhs.state.tx.us/cmsmail">http://ausmis31.dhs.state.tx.us/cmsmail</a></td>
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<td>Client Assessment Registration System (CARE) Help Desk</td>
<td>1-512-438-4720</td>
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<tr>
<td>Program enrollment for utilization review (UR)/usual, customary utilization control (UC), Purpose codes, and MRC Assessment Form, level of service, level of need, level of care, and ICAP</td>
<td>1-512-438-5055</td>
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<td></td>
<td>Fax: 1-512-438-4249</td>
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<tr>
<td>Provider contracts and vendor holds for ICF-MR</td>
<td>1-512-438-3544</td>
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<tr>
<td>Provider systems access for ICF-MR CARE forms</td>
<td>ICF/MR: 1-512-438-3554</td>
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<td>HCS: 1-512-438-5428</td>
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<td>CARE Form 3652-A and Forms 3618 and 3619 missing/incorrect information</td>
<td>Provider Claims Services: 1-512-490-4666, Option 1</td>
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<td>Rehabilitation specialized/emergency dental authorizations</td>
<td>1-800-792-1109</td>
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<td></td>
<td>Fax: 512/490-4620</td>
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<tr>
<td>Service authorizations for Nursing Facilities</td>
<td>Provider Claims Services: 1-512-490-4666, Option 1</td>
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<td>Fax: 1-512-490-4669</td>
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</tr>
</tbody>
</table>
**Bulletin Article Resources**

The Bulletin Article Resource table includes a list of previously published articles in the order of the bulletin edition in which they appeared, starting with May 2006. Providers may use this table as a resource for referencing previously published articles.

<table>
<thead>
<tr>
<th>Article Name</th>
<th>LTC Bulletin</th>
<th>Page #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where to Find the LTC Glossary of Terms</td>
<td>May 2006, No. 26</td>
<td>2</td>
</tr>
<tr>
<td>How to Apply for an NPI</td>
<td>May 2006, No. 26</td>
<td>6</td>
</tr>
<tr>
<td>Tips for Completing the 3652-A CARE Form</td>
<td>May 2006, No. 26</td>
<td>8</td>
</tr>
<tr>
<td>Release of TDHconnect 3.0 Service Pack 8</td>
<td>May 2006, No. 26</td>
<td>9</td>
</tr>
<tr>
<td>New Address for Submission of Purpose Codes U</td>
<td>August 2006, No. 27</td>
<td>2</td>
</tr>
<tr>
<td>Learn about the Loss of Eligibility Report</td>
<td>August 2006, No. 27</td>
<td>2</td>
</tr>
<tr>
<td>The CFS will be replaced by the LTC Online Portal</td>
<td>August 2006, No. 27</td>
<td>2</td>
</tr>
<tr>
<td>Answers to This Quarters Most Frequently Asked Questions</td>
<td>August 2006, No. 27</td>
<td>7</td>
</tr>
<tr>
<td>• Rate Changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Billing Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Claims Status Inquiry (CSI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC Online Portal Implementation</td>
<td>November 2006, No. 28</td>
<td>1</td>
</tr>
<tr>
<td>STAR+PLUS Program Expansion</td>
<td>November 2006, No. 28</td>
<td>2</td>
</tr>
<tr>
<td>Top Three Reasons Why Claims are Denied</td>
<td>November 2006, No. 28</td>
<td>3</td>
</tr>
<tr>
<td>New TILES to RUGS Project</td>
<td>November 2006, No. 28</td>
<td>4</td>
</tr>
<tr>
<td>National Provider Identifier (NPI) Update</td>
<td>November 2006, No. 28</td>
<td>4</td>
</tr>
<tr>
<td>Third-Party Biller Enrollment</td>
<td>November 2006, No. 28</td>
<td>6</td>
</tr>
<tr>
<td>Nursing Facility Services Provided to STAR+PLUS Clients Will be Billed</td>
<td>November 2006, No. 28</td>
<td>6</td>
</tr>
<tr>
<td>Through TMHP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIPAA Crosswalk Available Online</td>
<td>February 2007, No. 29</td>
<td>2</td>
</tr>
<tr>
<td>STAR+PLUS Nursing Facility Services Provided to STAR+PLUS Clients should be</td>
<td>February 2007, No. 29</td>
<td>3</td>
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<tr>
<td>billed through TMHP</td>
<td></td>
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<tr>
<td>STAR+PLUS Program Expansion</td>
<td>February 2007, No. 29</td>
<td>3</td>
</tr>
<tr>
<td>New Integrated Care Management (ICM) – Dallas and Tarrant Service Areas</td>
<td>February 2007, No. 29</td>
<td>3</td>
</tr>
<tr>
<td>Claim Statistics Recap</td>
<td>February 2007, No. 29</td>
<td>5</td>
</tr>
<tr>
<td>Mandatory Claim Submission Changes for Third-Party Billers</td>
<td>February 2007, No. 29</td>
<td>5</td>
</tr>
<tr>
<td>National Provider Identifier (NPI) Update</td>
<td>February 2007, No. 29</td>
<td>6</td>
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<tr>
<td>TILES to RUGS Transition</td>
<td>February 2007, No. 29</td>
<td>8</td>
</tr>
</tbody>
</table>
ATTENTION: BUSINESS OFFICE