Effective February 1, 2015, Long Term Care Institutional Claims Submitted Via TexMedConnect Will Require Additional Information

Information posted January 20, 2015

Beginning February 1, 2015, long term care institutional claims submitted via TexMedConnect will require the additional information listed below. Updates to institutional claim templates will also be required to accommodate these changes. Providers are responsible for notifying third-party submitters regarding these changes.

All institutional claim transactions submitted to TMHP via TexMedConnect on or after February 1, 2015, will reject until all required information has been provided.

Changes to Existing TexMedConnect Fields

- Attending Provider NPI/API (All institutional claims):

The NPI or API of the Attending Provider, or entity providing care/service, is required for all institutional claims submissions. All Medicaid-contracted providers are required to have an NPI or API in order to submit claims.

- Place of Service (All institutional claims):

Place of Service, also known as Facility Type, indicates where the individual is receiving services. You should select the Place of Service which most accurately describes the location/facility in which services were rendered. 21-SNF Inpatient (Including Medicare Part A), 22-SNF Inpatient (Medicare Part B), and 86-Residential Facility (Medicaid Only) have been added to the available options in the drop-down box. Providers will no longer see 25-Skilled Nursing Level I, 27-Skilled Nursing Level III, or 33-Home Health Outpatient in the Place of Service drop-down box.

- Principal Diagnosis Code/Admitting Diagnosis Code (Conditionally required):

Under the heading of Diagnosis, field 1 is intended for the individual’s Principle Diagnosis Code and is always required. Field 2 will appear, when required, and is intended for the Admitting Diagnosis Code. The Principle Diagnosis and the Admitting Diagnosis may be the same.

New TexMedConnect Fields

- Patient Discharge Status (All institutional claims):

Patient Discharge Status identifies the location of the individual at the end of the billing cycle. There are several options to choose from in the drop-down box. The most common status selected will be 30 Still Patient. This indicates the individual continues to receive services and subsequent claims will be submitted. There are instances in which 30 Still Patient is not appropriate. For example: Any claim on which you indicate the individual has discharged or a claim which contains the last billable date of a stay (either date prior to discharge or date of death) will not have a Patient Discharge Status of 30 Still Patient. When you are submitting a claim which contains the last billable date of a stay, you should select the appropriate Discharge or Expired status from the drop-down box.
• Claim Frequency (All institutional claims):

The code selected for the Claim Frequency drop-down box should indicate the position of the claim within the billing sequence. Four options are available:
1 Admit Through Discharge Claim (Claim dates include both the Admission and Discharge dates of a stay)
2 Interim – First Claim (Claim includes Admit Date and indicates continuing service)
3 Interim – Continuing Claim (Claim indicates continuing service)
4 Interim – Last Claim (Claim indicates last billable date is included)

NOTE: If you have selected Claim Frequency 1 Admit Through Discharge Claim or 4 Interim – Last Claim, Patient Discharge Status 30 Still Patient must not be used.

• Admit Date (When required):

When required, the Admit Date drop-down calendar will be enabled. You should select the date of the admission which corresponds with the dates being submitted on the claim. Most often, this will be the most recent date of admission into the facility or program.

Additional Changes for Nursing Facilities (NFs)

• Taxonomy (NF institutional claims only):

This field is required on all claims submitted to TexMedConnect for Nursing Facility services. The Healthcare Provider Taxonomy Code is associated with the National Provider Identifier (NPI) of the billing entity on the claim. Taxonomy codes further define the type, classification, and/or specialization of the health-care provider. The drop-down box options include 314000000X defined as Skilled NFs, 313M00000X defined as Other NFs and a field for other types of taxonomy. More information related to Taxonomy may be found at www.cms.gov.

• Revenue Code for Medicare Skilled to distinguish this service from NF Daily Care use Revenue Code 0101 for dates of service on or after February 1, 2015.

• Revenue Code for NF Daily Care Claims continue to use 0100.

• Additional modifiers are required for the following add-on services (effective February 1, 2015):
  o Ventilator
  o Occupational Therapy
  o Speech Therapy
  o Physical Therapy

See the Long Term Care Bill Code Crosswalk at: www.dads.state.tx.us/providers/hipaa/billcodes/LTCBillCodeCrosswalk.pdf.

For further details on the upcoming changes to NF claims, see the Department of Aging and Disability Services (DADS) Information Letter 14-68, Nursing Facility Changes to the Medicaid Claims Submission Process – Revised, Information Letter 14-82, Upcoming Updates to Institutional Claim Submission for TexMedConnect and Electronic Data Interchange.
Transactions, and Information Letter 14-83, Upcoming Updates to Institutional Claim Submission for TexMedConnect and Electronic Data Interchange Transactions.

For questions about how to submit claims using TexMedConnect, contact the LTC Help Desk at 1-800-626-4117, Option 1.