1. **What assistance is available if providers have additional questions regarding claims billing using TexMedConnect?**

A: Contact the TMHP Long Term Care Help Desk at 1-800-626-4117, Option 1, for additional assistance with TexMedConnect.

2. **Can a managed care organization (MCO) refuse to accept a claim? If that happens, how will the provider know?**

A: Yes, the MCO can reject claims. Providers can verify whether a forwarded claim has been Rejected or Accepted by the MCO by viewing the status in Batch History in TexMedConnect. The provider must contact the MCO as to why it was rejected.

3. **What is “Informational Pricing?”**

A: Informational pricing is the fee-for-service (FFS) amount Texas Medicaid & Healthcare Partnership (TMHP) would have paid.

4. **How does the provider know if the forwarded claim was accepted by the MCO?**

A: The provider will receive a 277CAU or 999 (Health Care Claims Acknowledgement) response when submitting an EDI transaction informing them whether the claim was accepted or rejected. TexMedConnect submitters can do a MCO claim status inquiry (CSI) or Batch History search to see if the status was updated from ‘forwarded’ to ‘accepted/rejected.’

5. **What is an ETN?**

A: An ETN is a 28-character EDI Transaction Number providers can use to track the status of the forwarded claim.

6. **How can a provider adjust a claim paid by the MCO?**

A: Providers must adjust the claim with the MCO which paid the claim; therefore, adjustments must be submitted through the MCO claims portal.
7. **Can providers still use TexMedConnect to adjust claims?**

A: Providers can still use TexMedConnect to adjust FFS claims. To adjust a forwarded claim for managed care, providers will need to follow the MCO’s adjustment procedures.

8. **Will the MCO that accepts forwarded claims call the provider to notify them that they have accepted the claim?**

A: The provider will receive a 277CAU or 999 (Health Care Claims Acknowledgement) response when submitting an EDI transaction informing them whether the claim was accepted or rejected. TexMedConnect submitters can do a MCO claim status inquiry (CSI) or Batch History search to see if the status was updated from ‘forwarded’ to ‘accepted/rejected.’

9. **On the admit date, should the initial admit or the most recent admit date (readmission) be used?**

A: Use the most recent admit date.

10. **Under “Attending Provider,” should the Nursing Facility National Provider Identifier (NPI) or the attending physician NPI be entered?**

A: The NF should enter the NPI of whoever is providing the care, which could be the Nursing Facility.

11. **Under “Attending Provider,” it doesn’t allow entry of the Nursing Facility NPI and name. Do I need to call TMHP for technical support?**

A: Yes, call the Long Term Care Help Desk at 1-800-626-4117, Option 1.

12. **Will the Medicaid Eligibility and Service Authorization Verification (MESAV) indicate the resident’s contracted MCO?**

A: Yes, the MCO is listed in the Managed Care section of the MESAV.

13. **Can the MESAV indicate whether the claim has been paid or not paid?**

A: For FFS individuals, the MESAV will continue to track utilized units; for managed care individuals, the MESAV will not track utilized units. When conducting a Claim Status Inquiry (CSI) for a FFS claim, nothing will change. If conducting a CSI for a managed care individual, providers will see the ETN or batch history. The status of forwarded claims will change from ‘forwarded’ to ‘accepted’ or ‘rejected’ once processed by the MCO.
14. **Is a Ventilator considered an add-on?**

A: Ventilator services are considered an add-on service when billing an MCO as stated in the [Long Term Care Information Letter 14-68](#). However, the service authorization is still issued by DADS based upon the MDS submittal.

15. **Will it take the MCO 30 days to pay on a Ventilator or Trach?**

A: MCOs have up to 30 days to pay a clean claim for add-on services.

16. **How do providers submit claims for individuals in residence who are pending Medicaid approval, billing for retro days, corrections for past periods, etc.?**

A: The Medicaid eligibility process does not change as a result of the transition to managed care. Providers should continue to bill FFS until the MESAV indicates a managed care segment.

17. **Do claim payments to the Nursing Facility come from the MCO, or from TMHP?**

A: Payments will come directly from the MCO; Nursing Facilities are encouraged to sign up for Electronic Funds Transfer with the MCO.

18. **Is there an estimated turnaround time for payments from the MCO?**

A: The MCO is required to pay a clean claim for Medicaid Daily Care and Medicare Co-insurance within 10 days. The MCO has up to 30 days to pay for add-on services.

19. **Will there be a delay in payments from the MCOs if the provider submits a claim through TMHP?**

A: The TMHP system has been configured to post forwarded claims hourly.

20. **How will the process of claims adjustments and clean up billing due to changes in Resource Utilization Group (RUG) be handled going forward?**

A: Claims must be adjusted with the entity which paid the claim. Claims paid by TMHP must be adjusted by TMHP, and claims paid by the MCO must be adjusted by the MCO. Clean up billing must be made with the payer of the claim.

21. **Will clean up billing for dates of service prior to March 1, 2105, be done through TMHP?**

A: Any claims for dates of service prior to March 1, 2015, should be submitted to TMHP; these claims will remain fee-for-service claims.
22. Are claims sent through TMHP as clean claims also accepted through the MCO as a clean claim?

A: Claims submitted to TMHP for managed care members will not be fully evaluated for 'clean claim' criteria before being forwarded to the associated MCO since they are not being adjudicated by TMHP. Therefore, edits may be applied at the associated MCO to determine if the claim is clean for adjudication and payment. Edits used at TMHP for clean claim criteria have been incorporated into the MCO process.

23. Will a claim for a customized power wheelchair submitted through TexMedConnect be forwarded to the MCO?

A: If the individual receiving the customized power wheelchair is enrolled in an MCO, the claim will be forwarded to the appropriate MCO in the same manner as any add on service. If the individual is FFS, the claim will process through TMHP.

24. Who pays the claim for customized power wheelchairs that have already been approved and MESAV funded before March 1, 2015?

A: For customized power wheelchairs, payment is contingent on delivery date. All payments for individuals enrolled in Managed Care after March 1, 2015, will be from the MCO.

25. If an MCO's Portal is not ready to provide Remittance Advice or R&S Reports, will TMHP provide those?

A: TMHP will be unable to provide R&S Reports from the MCOs. All MCOs are set up to provide R&S Reports to providers. TMHP will continue to provide R&S Reports for FFS claims.

26. Will the R&S Reports be available on just the MCOs' websites?

A: Contact the specific MCO to determine R&S Report frequency and availability.

27. Where will the 277CAU Report be located?

A: The 277CAU Report will be in the same location where providers receive R&S Reports or 277CA's.

28. Can providers still download an R&S/835 from TMHP?

A: Yes, for FFS claims. Contact the MCO for R&S download options and instructions.
29. If a provider usually submits claims on a weekly basis, can they continue to do so?

A: Yes, billing frequencies through either the MCO or TMHP can remain the same.

30. Does an individual need to reapply for Nursing Facility benefits, or is it okay to start billing the MCO once admitted?

A: If the individual is Medicaid eligible, and MESAV shows a managed care segment, the provider can bill immediately.

31. Is a provider required to submit claims directly to an MCO, or can they continue to submit to TMHP for forwarding?

A: Providers may submit claims directly to the MCO, or they can submit claims to TMHP for forwarding to the MCO. However, providers will not be able to track the MCOs processing of claims submitted through TMHP via TexMedConnect. Claims processing of forwarded claims must be tracked with the MCO.

32. Once an individual is approved for Medicaid, can a Nursing Facility submit claims and get paid for room and board, even if the individual has not chosen an MCO?

A: Provider should check MESAV to verify Medicaid eligibility and managed care enrollment. Whenever MESAV does not indicate a STAR+PLUS managed care plan for a resident, the NF should continue billing FFS as they do today.

33. Will other insurance have to be added to each individual claim to satisfy cost avoidance, or will MCOs auto populate?

A: Refer to the Long Term Care Information Letter 15-10 for specific instructions. The other insurance paid amount must be submitted on the claim and the denials must be kept in the medical record.

34. At what point during the Medicaid application process will the client be assigned or allowed to choose the MCO?

A: After the resident has been determined Medicaid eligible for Nursing Facility services, the resident will receive a STAR+PLUS enrollment packet and have 15 days to select a managed care plan. Providers should check MESAV to verify Medicaid eligibility and managed care enrollment. Whenever MESAV does not indicate a STAR+PLUS managed care plan for a resident, the NF should continue billing FFS as they do today.
35. If a resident in a Skilled Nursing Facility is awaiting the finalization of the MCO of choice, but is already approved Medicaid, will the facility be paid Out Of Network?

A: The facility can bill FFS until the choice enrollment is complete. Nursing Facilities should check MESAV regularly. Provider should check MESAV to verify Medicaid eligibility and managed care enrollment. Whenever MESAV does not indicate a STAR+PLUS managed care plan for a resident, the NF should continue billing FFS as they do today.

36. If a new admission has not chosen an MCO, does the individual need to apply for Nursing Facility benefits?

A: Follow the normal process for someone non-Medicaid eligible who is being admitted to the facility. If the individual is Medicaid eligible but has not yet selected an MCO, claims should be submitted to TMHP as FFS. Provider should check MESAV to verify Medicaid eligibility and managed care enrollment. Whenever MESAV does not indicate a STAR+PLUS managed care plan for a resident, the Nursing Facility should continue billing FFS as they do today.

37. For new Medicaid admissions after March 1, 2015, who have not selected an MCO, to which entity should the claims be submitted?

A: Nothing changes. If the individual has not chosen an MCO and is fee-for-service, claims can be submitted to TMHP. Once the individual has selected an MCO, the MCO is billed. Providers should check MESAV to verify Medicaid eligibility and managed care enrollment. Whenever MESAV does not indicate a STAR+PLUS managed care plan for a resident, the Nursing Facility should continue billing FFS as they do today.

38. Are two diagnosis codes required now?

A: TexMedConnect will determine if one or two diagnosis codes are required based on the values entered in the Place of Service and Frequency values.

39. Do providers need to report Bed Hold days for Medicaid residents even if they are not reimbursed for them?

A: There is no change to reporting Bed Hold days as a result of managed care.
40. If an individual is discharged to the hospital for two days, in the claims frequency section are providers supposed to use the admit to discharge? Once the individual is returned are providers supposed to use first claim?

A: Claim Frequency ‘1 Admit Through Discharge’ should only be used if the claim contains both the first and last billable dates of a stay. A claim containing the admission date of an ongoing stay should have a Frequency of ‘2 – First Claim’ and a claim which contains the last billable date of a stay but not the admission date should have a frequency of ‘4 – Last Claim.’ Additional information may be found in the TexMedConnect FAQ located here.

41. If a provider has an individual who is enrolled with an MCO the provider is not contracted with, should the provider call MAXIMUS to switch MCOs?

A: A resident may choose any MCO plan in that service delivery area regardless of whether the Nursing Facility is contracted with them. The provider is not permitted to switch MCOs on behalf of a resident. If the resident desires to switch, which they may do at any time, they or their authorized representative can call MAXIMUS at 1-800-964-2777. If a resident chooses an MCO plan that the Nursing Facility is not contracted with, the Nursing Facility will be reimbursed as an out-of-network provider. For additional information, see Department of Aging and Disability Services (DADS) Article: Claims Forwarding, Dental Billing, and Other Changes Related to the Nursing Facility Transition to Managed Care or Long Term Care Information Letter 15-06.

42. Do lines still need to be split for Level of Care (LOC) changes?

A: Yes, there is no change to the current process.

43. What should a Skilled Nursing Facility use for Place of Service if submitting a claim for regular long term care Medicaid services?

A: Providers should select the Place of Service which most accurately describes the location/facility in which services were rendered.

44. How often will claims be forwarded to the MCO?

A: The TMHP system has been configured to forward claims to the MCOs hourly.

45. Will the MCO’s automatically adjust claim for applied income changes, Rug changes etc.?

A: MCOs will perform the same types of adjustments which are handled today including changes to applied income.
46. If a provider submits a claim through TMHP, what is the timeframe for payment?

A: If the claim is fee-for-service, then it will follow the current five to seven business days. The MCO will adjudicate clean claims for Nursing Facility unit rates and Medicare coinsurance no later than 10 calendar days after submission to the MCO or the Health and Human Services Commission’s designated portal, whichever occurs first. The MCO will adjudicate clean claims for Nursing Facility add-on services no later than 30 days after the claim is received by the MCO or its designee.

47. Do providers use the same Place of Service code and rev code for Medicare Co-insurance as they do regular Medicaid?

A: Place of Service, also known as Facility Type, indicates where the individual is receiving services. Providers 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 dropdown box. The revenue code for Service Code 3, commonly referred to as Co-insurance, was updated based on the dates of service being billed. For dates of service on or before January 31, 2015, providers should use revenue code 0100 and for dates of service on or after February 1, 2015, providers should use revenue code 0101.

48. Are the ten days to process a clean claim Business days or Calendar days?

A: See the response to question number 46.

49. What are the revenue codes for Medicare Co-insurance and Daily Care?

A: For Co-insurance claims being billed with dates of service on February 1, 2015, or later the revenue code is 0101. Daily care has not changed and is still 0100 regardless of date of service being billed; Co-insurance claims being billed for dates of service January 31, 2015, or earlier will also remain 0100.

50. What is the 277CAU?

A: The 277CAU is an unsolicited claim acknowledgement response that will be generated when the MCO provides a response for the forwarded claim. The 277CAU is generated only when the claim is submitted through EDI.
51. **What if the MCO is not yet listed on the MESAV?**

A: If there is not an MCO plan code listed on the MESAV, continue to bill fee-for-service to TMHP.

52. **Will payments through R&S Reports remain the same or will providers be paid by each individual MCO?**

A: Providers will receive payment and R&S Reports from each individual MCO to which claims have been forwarded. Providers will need to contact each MCO to ascertain R&S Report frequency. There are no changes to payment and the R&S Reports for fee-for-service claims.

53. **Is there a function to import 837 files from an accounting system to submit claims?**

A: If providers are currently using a third-party software vendor, the process will remain the same.

54. **When will the MESAVs be updated to show which MCO the resident will be using?**

A: For the residents currently in a Nursing Facility, the MESAV searches performed today will reflect the MCO effective March 1, 2015. For residents newly eligible for Medicaid, the MCO plan code will reflect in MESAV 15 to 45 days after Medicaid eligible. MESAV started showing enrollment segments for Nursing Facility residents in managed care as of February 18, 2015. If MESAV does not show a resident enrolled in managed care, it could be due to a loss of Medicaid eligibility or a lag in the alignment of the eligibility system. Be sure to query the MESAV for dates that span the March 1, 2015, effective date for the transition.

55. **What is the ICN Number?**

A: ICN is the acronym for Internal Control Number. An ICN is assigned when a claim is accepted by either TexMedConnect or EDI.

56. **Is the NPI Attending Provider the medical director of the facility using their physician NPI number?**

A: It can be. The NPI or API of the Attending Provider is required for all institutional claims submissions. All Medicaid contracted providers are required to have an NPI or API in order to submit claims. It is acceptable and appropriate for the billing provider NPI to be entered as the Attending Provider NPI.
57. Should providers batch claims by MCO, or can they continue to batch as they have been, and TMHP will know where to route the claims?

A: TexMedConnect users will still be able to send one batch. TexMedConnect will parse and send files to the corresponding MCOs.

58. Can providers submit claims for Assisted Living Facilities through TMHP?

A: Waiver services claims, such as Assisted Living, must be submitted directly to the MCO.

59. Can family members call Maximus to change the MCO if the resident is incapable of doing it themselves?

A: There are certain individuals who can change the MCO for a resident, such as a Legally Authorized Representative (LAR). Providers can call Maximus at 1-800-964-2777 to determine who is authorized to change the MCO.

60. Is prior authorization for nonemergency ambulance transport obtained from TMHP or the MCO?

A: For individuals enrolled in managed care, the MCO is responsible for the prior authorizations.

61. Does the Nursing Facility obtain approval for dental durable medical equipment (DME) from TMHP or the MCO?

A: Dental DME is an incurred medical expense and approvals will continue to go through Medicaid for the Elderly and People with Disabilities. Examples of dental DME include dentures and/or partial plates.

62. Is it possible to upload claims (such as an 837 billing file), or do claims have to be entered manually?

A: The EDI transaction process has not changed, and claims submitted via a file will be forwarded to the appropriate MCO by TMHP.

63. Where on the claim do providers put the MCO information?

A: When using TexMedConnect, TMHP will determine to which MCO to forward the claim.
64. If a provider submits a clean claim, and TMHP is unable to forward the claim to the MCO on the same day due to unforeseen system issues, does the MCO still have 10 days to pay the claim from the submission date?

A: The MCO will adjudicate clean claims for Nursing Facility unit rates and Medicare Co-insurance no later than 10 calendar days after submission to the MCO or HHSC’s designated portal, whichever occurs first. The state and TMHP will work with the MCO to ensure claims are received as quickly as possible.

65. Are some residents remaining on FFS, or are all transitioning to MCOs?

A: The majority of residents will transition to managed care; however, a select few will remain FFS based upon other factors, such as age. Also, there will continue to be a small portion of residents in FFS because enrollment in managed care is prospective -- it is not retroactive. Until a resident selects a STAR+PLUS health plan and is enrolled in that plan, providers will bill Medicaid FFS for those residents. Provider should check MESAV to verify Medicaid eligibility and managed care enrollment. Whenever MESAV does not indicate a STAR+PLUS managed care plan for a resident, the NF should continue billing FFS as they do today. For more information about this question, you may visit the HHSC Managed Care website: http://www.hhsc.state.tx.us/medicaid/managed-caremmc/starplus-expansion/

66. Where can providers find the Health Care Common Procedure Coding System (HCPCS) or Current Procedural Technology (CPT) codes that are relevant to long term care?

A: The HCPCS/CPT/REV codes can be located on the DADS LTC Bill Code Crosswalk, which can be found on the DADS website at www.dads.state.tx.us/providers/hipaa/billcodes/index.html.

67. A claim submitted to TMHP is showing as ‘forwarded,’ but nothing is showing on the MCO’s portal. What is the time limit for claim acceptance?

A: Each MCO has a different process for retrieving and processing forwarded claims. Contact the individual MCO for their claim processing timeframe.