Long Term Care
Nursing Facility/Hospice
Workshop

Participant Guide
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The Long Term Care (LTC) Nursing Facility (NF)/Hospice workshop covers:

- The Medicaid team roles.
- The National Provider Information (NPI) requirements for form and assessment submissions.
- Basic portal features.
- How to create an administrator account.
- How to print assessments, and determine the status of those assessments.
- How to find and complete the LTC Medicaid Information (LTCMI).
- How to submit a Pre-Admission Screening and Resident Review (PASARR) and how to determine when PASARR is required.
- When and how to submit the LTCMI and forms 3618, 3619, 3071 and 3074.
- How to resolve submission and Medicaid processing errors.
- Understanding the various processing statuses including those requiring provider action.
- Understand and differentiate between the 3652-A Purpose Code E, the Minimum Data Set (MDS) Purpose Code E and Purpose Code M.
- How to correct, modify, or inactivate forms and assessments – and the consequences of doing so.
- How to identify and follow the Medical Necessity (MN) process including the fair hearing process.
- The Texas State University Resource Utilization Group (RUG) and Texas Index for Level of Effort (TILE) training requirements and web address.
- How to report Medicaid Waste, Abuse and Fraud.
- How to access additional resources.
Medicaid Team

The following groups and individuals make up the Medicaid Team. Together, they make it possible to deliver Medicaid services to Texans.

- **Centers for Medicare & Medicaid Services (CMS)** – Federal Agency that oversees the Medicaid Program on a Federal Level – Guidelines, Rules, and Regulations.

- **Texas Health and Human Services Commission (HHSC)** – oversees operations of the entire health and human services system in Texas. It operates the Medicaid acute care program, Children’s Health Insurance Program (CHIP), STAR+PLUS, and several other related programs. HHSC’s Office of Eligibility Services (OES) Medicaid for the Elderly and People with Disabilities (MEPD) workers determine eligibility for Medicaid.

- **Providers** – the crucial players in a quality healthcare program. The focus is on providing the best care possible while being reimbursed for allowed services rendered.

- **Recipients** – those served by Texas Medicaid Program.

- **Texas State Legislature** – The state legislature allocates budgetary dollars for Medicaid program.

- **Texas Medicaid & Healthcare Partnership (TMHP)** – contracted by the State as the claims administrator to process claims for providers under traditional Medicaid and Primary Care Case Management (PCCM). TMHP processes and approves claims for traditional LTC; TMHP does not pay LTC claims, this is done by the Office of the Texas Comptroller. Responsibilities also include:
  - Determination of Medical Necessity.
  - Provider education.
  - Provide timely processing of claims and represents the Department of Aging and Disability Services (DADS) at Fair Hearings.
  - Distribute yearly manuals, quarterly LTC bulletins, and Remittance and Status (R&S) reports.
  - Maintain the TMHP call center/help desk Monday through Friday, 7:00 a.m.- 7:00 p.m. Central Time.
  - Conduct training sessions for providers, which includes technical assistance on the TexMedConnect online application.

- **Texas Department of Aging and Disability Services (DADS)** – administers a comprehensive array of services for persons who are aging and for persons who have Intellectual and Development Disabilities (IDD). Additionally, DADS licenses and regulates providers of these services.
NPI Requirements

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the NPI as the standard unique identifier for health care providers and requires covered health care providers, clearinghouses, and health plans to use this identifier in HIPAA-covered transactions.

NPI is required on all claims submitted electronically, through third-party software, or through TexMedConnect. Paper-based submissions of the 1290 claim form also require a valid NPI. On the LTC Online Portal, NPI is used for security purposes, and links providers to their forms and assessments so that the only ones that are viewable are those associated with that NPI. Without an NPI, Nursing Facilities would not be able to locate their forms and assessments on the LTC Online Portal.

To obtain an NPI:

1. Go to https://nppes.cms.hhs.gov/NPPES.
2. Click the National Provider Identifier (NPI) link to apply for an NPI.
3. Click the Apply online for an NPI link, the following page will appear:
LTC Nursing Facility/Hospice Workshop Participant Guide

4. Click the “Begin Application Form” button, located at the bottom of this screen:

Step 2: Read the information below.
You must agree to the terms below when you submit your application:

I have read the contents of the application and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator immediately.

I authorize the NPI Enumerator to verify the information contained herein. I agree to keep the NPPES updated with any changes to data listed on this application form within 30 days of the effective date of the change.

I understand that the information provided in this application may be used by other agencies in accordance with privacy regulations.

I have read and understand the Privacy Act Statement.

I have read and understand the Penalties for Falsifying Information on the NPI Application / Update Form as stated in this application. I am aware that falsifying information will result in fines and/or imprisonment.

Penalties for Falsifying Information on the NPI / Update Form:
38 U.S.C. 1011 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 16 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Step 3: Begin online application.

5. Complete the NPI application instructions, clicking the “Next” button when finished with each section. Upon completion, you will receive your NPI.
To Inform DADS of Your NPI:

1. Go to www.dads.state.tx.us/providers/hipaa/forms.html.

2. Click the Contract NPI/API Association Form (MS Word) link and complete form.

3. Submit a copy of the NPPES NPI notification and a completed DADS Contract NPI/API Association Form by either of the following methods:
   - FAX: 1-512 438-3555
   - Postal Mail Service:
     Department of Aging and Disability Services
     P.O. Box 149030, MC W-535
     Austin, TX 78714-9030

It is important the NPI be on MDS submissions (section W1). NPI is required on claims, forms, and MDS assessment submissions using the following methods:

**Electronic**

- TexMedConnect
- LTC Online Portal
- Third Party Software Vendor

**Paper**

- 1290 Claim Form

**Note:** For more information you may refer to the DADS information letter found at www.dads.state.tx.us/providers/communications/2007/letters/IL2007-110.pdf.
The LTC Online Portal

Providers must use the LTC Online Portal to submit forms and assessments, with the exception of the 3071/3074 Hospice forms. These may also be mailed to:

Texas Medicaid & Healthcare Partnership
LTC Unit
P.O. Box 200765
Austin, TX 78720-0765.

Benefits of using the LTC Online Portal

- Web-based application.
- 24/7 system availability.
- TMHP provides LTC Online Portal technical support by phone at 1-800-626-4117, Option 3, from 7:00 a.m. - 7:00 p.m., Central Time, Monday through Friday - excluding holidays.
- Edits are in place to verify the validity of data entered.
- Provides error messages that must be resolved before submission.
- Providers have the capability to monitor the status of their forms and assessments by using Form Status Inquiry (FSI) or Current Activity.
- Allows providers to submit additional information through the LTC Online Portal.

LTC Online Portal Security

In order to utilize the LTC Online Portal, providers must request access to the LTC Online Portal. Your facility may already have an account. You may need to contact your facility’s administrator for user access. An administrator account is required for portal access, but it is strongly recommended to have multiple administrator accounts, in case one administrator is unavailable.

The administrator account is the primary user account for a provider/contract number.

This account has the ability to add/remove permissions (access to LTC Online Portal features) for other user accounts on the same provider/contract number.

A user account can be created by an administrator. User account permissions and limitations are set by the holder of an administrator account. This allows administrators to set the level of access according to employees’ positions.

If you already have either an administrator or user account, go to www.tmhp.com. Click the Access LTC Online Portal link to login to the LTC Online Portal.
If you do not have an account, you can create one by following the steps below. In order to do so, you will need to have:

- **Provider contract number** - assigned by DADS when the provider signs the contract to provide Medicaid services.
- **Vendor number** - four-digit number assigned by DADS when the provider signs the contract to submit forms through the LTC Online Portal.
- **Vendor password** - provider must call the Electronic Data Interchange (EDI) Help Desk at **1-888-863-3638** to obtain their vendor password. This password is formally known as the MicroECS password. Please note it may take 3-5 business days to receive the password, which is randomly generated by TMHP.

### How to Create LTC Online Portal Administrator Account

The administrator account is the primary user account. To create an administrator account, follow these steps:

1. Go to [www.tmhp.com](http://www.tmhp.com).
2. Click the **My Account** link in the blue navigational bar.
3. Click the **Activate my Account** link.
4. Click the **Create a Provider Administrator Account** link.
5. The following screen will appear. Follow the instructions listed at the top of the screen and click the **Create a provider/vendor administrator account** link.

6. Provider Type: Choose **NF/Waiver Programs** from the drop-down box.

   **Note:** The Provider Types listed below are the only two choices in the drop-down box that are applicable for this course.

   – Use **NF/Waiver Programs** to submit 3618, 3619, 3652-A Purpose Code E, Long Term Care Medical Information (LTCMI), and PASARR Screenings.

   – Use **Long Term Care** to access TexMedConnect (for submitting claims, accessing R&S reports, performing Medicaid Eligibility Service Authorization Verifications (MESAV), etc.) and to submit Hospice Forms 3071 and 3074.

   **Note:** If you already use TexMedConnect, you are required to create a NF/Waiver Programs account to submit those items listed.
7. Enter your provider number, vendor number, and vendor password, then click the “Next” button.

8. Check the “General Terms and Conditions” box at the bottom of the screen to indicate agreement.

9. Click the Create Provider Administrator link to create your User name and password.

   **Note:** User name and password is used for future logins to your account. Make a copy for your records.

---

**My Account**

**My Account** is used to perform various maintenance activities for your account, such as: setting up user accounts, changing passwords, and other administrative tasks.

To access **My Account**:

1. Go to [www.tmhp.com](http://www.tmhp.com)
2. Click the **My Account** link in the blue navigational bar at the top of the screen.
Login to the LTC Online Portal

Now that your User name has been created:

1. Go to [www.tmhp.com](http://www.tmhp.com).
2. Click the **Access LTC Online Portal** link.
3. Enter your User name and password. Click the “OK” button.
4. Upon login, Form Status Inquiry (FSI) will display by default:
Portal Basics

Blue Navigational Bar Links

All portal features based on your security level will be found in the blue navigational bar located at the top of the portal screen.

Options found in the blue navigational bar may include: Home, Submit Form, Form Status Inquiry, Current Activity, My Drafts, Printable Forms, or Help.

Home

When the blue navigational bar above is displayed, the Home link at the far left will take you to “My Account.” If you are already at the “My Account” page, the Home link will take you back to the www.tmhp.com home page.

Submit Form

This feature allows providers to submit forms and PASARR Screenings:
1. Login to the LTC Online Portal.

2. Click the Submit Form link located in the blue navigational bar.

3. Type of Form: Choose from the drop-down box.

4. If desired, enter additional information about an existing recipient. This will prepopulate the form or screening with the recipient’s demographical information (except gender).

5. Click the “Enter Form” button.

6. Enter all required information as indicated by the red dots.

   Note: Additional information about required fields (marked with a red dot) can be found in the “Other Basic Information” section.
7. From here you have two choices:
   a. Click the “Save as Draft” button, in the yellow Form Actions bar, to save the form or screening until ready to submit. The form or screening does not have to be complete to save the draft.
   
or
   a. Click the “Submit Form” button, located at the bottom of the screen, to submit the form or screening.

**Form Status Inquiry**

Form Status Inquiry (FSI) provides a query tool for monitoring the status of forms and assessments that have been submitted.

This allows providers to retrieve submissions in order to:

- Access forms and assessments to research and review statuses.
- Provide additional information to an assessment.
- Retrieve forms and assessments to make corrections or perform inactivations.

**Note:** FSI can retrieve information from the previous 3 years. The search is based on the TMHP Received Date. There is a 50-record line limit for search results, therefore you may need to narrow your search to retrieve specific records.

1. Click the **Form Status Inquiry** link in the blue navigational bar.

![Form Status Inquiry](image)

2. Type of Form: Choose from the drop-down box.

3. Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: “DLN,” “Last Name,” “First Name,” “SSN,” “Medicaid Number,” “Form Status,” and “To” and “From” Dates. As a basic search, you can locate all forms for a given time period. You can also search by a combination of elements within a date range. Dates are searched against the TMHP Received Date (date of successful submission).

4. Click the “Search” button, and the portal will return any matching submissions (records).
5. Click the View Detail link at the left of the DLN to display the details of the assessment.

![Form Status Inquiry](image)

7 record(s) returned.

<table>
<thead>
<tr>
<th>DLN</th>
<th>TMHP Received Date</th>
<th>SSN</th>
<th>Medicaid #</th>
<th>Medicare #</th>
<th>First Name</th>
<th>Last Name</th>
<th>Status</th>
<th>RUG</th>
<th>RN Signature Date</th>
<th>Purpose Code</th>
<th>Contract Number</th>
<th>Vendor Number</th>
<th>Reason for Assessment</th>
</tr>
</thead>
<tbody>
<tr>
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<td>4/2/2009</td>
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</tbody>
</table>

Descriptions of the column headings seen above are for results for Type of Forms, MDS and MDSQTR assessments:

- **View Detail**: The hyperlink used to open the document.
- **DLN**: The unique document locator number assigned to each successful submission.
- **TMHP Received Date**: The actual date the assessment was successfully submitted on the LTC Online Portal.
- **SSN (AA5a), Medicaid # (AA7), Medicare # (AA5b), First Name and Last Name (AA1)**: Information used to identify the individual associated with the submission.
- **Status**: The status of the assessment at the time of the search.
- **RUG**: The assigned RUG value.
- **RN Signature Date**: Date assessment was completed, as identified in field R2b.
- **Purpose Code**:
  - Purpose Code E - Missed Assessment.
  - Purpose Code M - Used when 3 month prior retro eligibility has been established.
- **Contract Number**: The nine-digit provider number.
- **Vendor Number**: The four-digit site identification number.
- **Reason for Assessment (AA8a)**:
  - 01: Admission assessment (required by day 14)
  - 02: Annual assessment
  - 03: Significant change in status assessment
  - 04: Significant correction of prior full assessment
  - 05: Quarterly review assessment
  - 10: Significant correction of prior quarterly assessment.
Current Activity

Providers have the ability to view form and assessment submissions or status changes within the last 14 calendar days. After 14 days, providers must utilize the FSI query tool to locate a form or assessment.

1. Click the Current Activity link in the blue navigational bar.

2. The results will display a summary of all form and assessment submissions or status changes within the last 14 calendar days.

3. Click the document locator number (DLN) link to display the details of the form or assessment.

My Drafts

This feature allows the user to access all drafts previously saved under the specific User name that was used to create the original draft.

Note: Only the user who created the original draft will be able to access the draft. Other users, including the administrator, will not have access to drafts saved under another’s User name.

To access a saved draft:

1. Login to the LTC Online Portal.

2. Click the My Drafts link in the blue navigational bar.

3. From here:
   a. Click the Open link to open the draft document to edit and submit.

   or

   a. Click the Remove link to permanently delete the document.

   Note: Once a draft has been removed it cannot be retrieved.
Printable Forms

This feature allows the providers to view and/or print a blank form or assessment:

1. Click the **Printable Forms** link in the blue navigational bar.

![Printable Forms](image1)

2. Choose a document by clicking the corresponding link. A new window and application called Adobe Reader will open displaying the blank document in PDF (Portable Document Format).

![Printable Form](image2)

3. Click the “Print” Icon.
   - To print the entire document:
     a. Printer: Choose printer name from drop-down box.
     b. Print Range: Click the “All” circle.
     c. Click the “OK” button.
   - To print certain pages instead of the entire document:
     a. Printer: Choose printer name from drop-down box.
     b. Print Range: Click the “Pages” circle.
c. Enter the pages to print. (example: 1-5 will print all pages 1 through 5; 1,3,7 will print only pages 1, 3 and 7.) This is useful for printing only the LTCMI, rather than the entire MDS assessment.

d. Click the “OK” button.

Help

The Help link at the far right in the blue navigational bar will display a Help page consisting of links to online guides to be used in conjunction with TMHP’s LTC Online Portal that will assist with questions you may have.
Yellow Form Actions Bar

Options found in the yellow Form Actions bar may include: Print, Use as template, Correct this form, Add Note, or Inactivate Form. Options will vary depending on your security, the type of document (e.g. PASARR Screening, MDS Assessment or Form 3618, 3619, 3652-A, 3071 or 3074), as well as document status. The yellow Form Actions bar is available when an individual document is being viewed in detail.

Print

This feature is applicable to all form and assessment types: 3071, 3074, 3652-A, 3618, 3619, Minimum Data Set (MDS), and PASARR Screening. Use the “Print” button to print completed documents.

Use as template

This feature is only available for Forms 3618, 3619, 3071, 3074, and PASARR Screenings. It allows a provider to complete a new form or screening by using the information in a completed form or screening as a template. Various fields will prepopulate; be sure to check for accuracy.

Once you have found and are displaying the form or screening utilizing FSI or Current Activity:

1. Click the “Use as template” button; the data in the document will be used to create a new document.

   **Note:** Not all fields will be copied over.

2. Enter data into remaining fields not prepopulated.

3. Click the “Print” button located in the yellow Form Actions bar to print the document in progress. (If you want a hard copy for your records). From here:

   a. Click the “Submit Form” button located at the bottom right of the screen, if ready to submit for processing.

   or

   b. Click the “Save as Draft” button located in the yellow Form Actions bar to save the document until ready to submit.
Correct this form

This feature is available for Forms 3618, 3619, 3071, 3074, and the LTCMI section of the MDS. PASARR Screenings and 3652-A Purpose Code E’s are not correctable. Use the “Correct this form” button to correct a previously submitted LTCMI or form. However, corrections are not allowed if a document is set to status “Form Inactivated” or “Invalid/Complete.”

Note: The steps to correct a form or an LTCMI are covered in the Corrections section.

Add Note

This feature is only available for Forms 3618, 3619, 3652-A Purpose Code E, PASARR Screenings, and MDS Assessments.

“Add Note” may be used to add additional pertinent information not captured upon original submission. Information is added to History of the document, not to the document itself (e.g. not added to S8. Comments). This information is not used in system processing.

“Add Note,” located in the yellow Form Actions bar, may be used to add additional Medical Necessity (MN) information not captured upon original submission or if the status is “Pending Denial (need more information).” If the status is “Pending Denial (need more information)” and a note is added, the document is set to status “Pending Review,” and the additional information will be reviewed by a TMHP nurse.

To add a note to a submitted document:

1. Locate the submission using FSI or Current Activity.
2. Click the “Add Note” button; a text box will open.
3. Enter additional information (up to 500 characters).
4. Click the “Save” button to save your note or “Cancel” button to erase your note, located under the text box.

Note: If unsure why an assessment or screening is set to status “Pending Denial (need more information),” please call the TMHP Help Desk (1-800-626-4117, Option 2) to speak with a nurse. If “Add Note” is chosen for any assessment or screening in “Pending Denial (need more information)” status, the assessment or screening will be reviewed again for medical necessity. If the nurse is unable to approve the assessment or screening with the additional information provided, the assessment or screening will be sent to the TMHP Medical Director for review and determination of medical necessity.

**Inactivate Form**

The “Inactivate Form” button is used when Forms 3618, 3619, 3071, 3074 and PASARR Screenings cannot be corrected and a new form or screening must be submitted. However, inactivations are not allowed if a document is set to status “Corrected.” Once inactivated, the form or screening will not be available for further processing, but it may be used as template. MDS assessments must be inactivated through the State MDS Database.

Note: The steps to inactivate an assessment will be covered in the Inactivations section.
Form Actions Available When Assessment is Set to Status
“Awaiting LTC Medicaid Information”

Save LTCMI

The “Save LTCMI” button allows providers to save the LTCMI section so that any previously entered LTCMI data is not lost. Once saved, the LTCMI section can be accessed by all users who have the same vendor/contract number access as the person who originally saved the information. Once an LTCMI is saved, the assessment will remain in “Awaiting LTC Medicaid Information” status until it is successfully submitted. It will not be saved to My Drafts. A message will appear at the top of the screen with a date and time indicating the LTCMI data has been saved. Once the “Save LTCMI” button is clicked, it will automatically unlock the assessment, allowing others to access it.

To save information entered onto an LTCMI, click the “Save LTCMI” button located in the Yellow Form Actions Bar.

- The LTCMI has been successfully saved but has not been submitted. 5/15/2009 3:03:38 PM

Populate LTCMI

The “Populate LTCMI” button allows providers to use a recipient’s previously submitted assessment to populate information on a new LTCMI. However, it will only populate information from an assessment with the same vendor/contract number, and it will only populate information if the previous LTCMI was submitted within the last six months. The following error will be displayed if there is not a previous assessment available:

- No previous LTCMI for this resident and contract number received within the last 6 months can be found to populate the LTCMI.

Two important reminders:

1. If information has been entered onto the LTCMI and saved prior to selecting the “Populate LTCMI” button, the “Populate LTCMI” button will not be available.

2. All information will populate into the current LTCMI except for fields S1e (Purpose Code), S1f (Missed Assessment Start Date), S1g (Missed Assessment End Date), and S10 (Comments).

To populate information on a new LTCMI, click the “Populate LTCMI” button located in the Yellow Form Actions Bar. Be sure to review the pre-populated information for accuracy, and add any new information if needed. Once the LTCMI is complete and accurate, the provider may choose to save the information by clicking the “Save LTCMI” button, or the assessment may be submitted to TMHP by clicking the “Submit Form” button.
Other Basic Information

Required Fields

Within the portal, red dots indicate required fields. Fields without the red dot are optional.

History

Every screening, form, and assessment will have a “history” of statuses. After opening a form or assessment, scroll to the bottom. History will display a list of every processing status that has been held by the form or assessment along with any appropriate details. Any notes added by the provider or any comments from TMHP or DADS will also be located in History.

<table>
<thead>
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UnLock Form

Upon opening, the document becomes automatically locked by the viewer and will remain locked for 20 minutes of no activity or until the viewer clicks the “UnLock Form” button. The “UnLock Form” button will unlock the document so that a different user can make changes. If a document is locked, others will not be able to make changes or add additional information. You may be asked to unlock a document if you are seeking assistance from TMHP, DADS or PASARR.

To unlock a document click the “UnLock Form” button located at the top right corner of the screen.

Error Messages

If required information is missing or information is invalid, error message(s) will display and you will not be able to move onto the next step until resolved. You may need to scroll up to see this section. You may also click the error message hyperlink to be directed automatically to the field(s) containing the error.

Entering Dates

To enter dates, you have the option to click on the calendar icon next to any of the date fields to activate the dynamic calendar. Choose the date desired. Or, you may enter in the date using the mm/dd/yyyy format.

Timeout

The LTC Online Portal will timeout after 20 minutes of no activity. To prevent this timeout from occurring when completing the “Section LTCMI” tab of an MDS Assessment, complete and submit within 20 minutes or click on a different tab (e.g. Section A) to reset the timer, then click the “Section LTCMI” tab to return to the LTCMI and complete.
Forms and Screenings To Be Submitted

Form 3618

The Purpose of Form 3618

Form 3618 is used when the recipient is under a “Full Medicaid payment” or “Medicaid pending” status (refer to flow chart in the Sequencing of Forms and Assessments section). A 3618 submission informs Medicaid Eligibility workers about transactions and status changes and provides DADS with information to initiate, close or adjust provider payments.

Form 3618 is to be submitted for admissions, discharges and death. The 3618 Form must be submitted on the LTC Online Portal. MDS Discharge Tracking Form and Re-entry Tracking Form are not extracted to the LTC Online Portal.

Providers should submit Form 3618 when the recipient is being classified as Full Medicaid. This can occur upon initial admission or can follow a Medicare stay, it can also follow a change in payor source from private pay. If the form is submitted for a change from private pay or Medicare to Medicaid this is the indicator for TMHP to extract the MDS for that recipient for Medicaid processing. An MDS is not required upon change to Medicaid if the cycle is already established. Once the Form 3618 has been submitted, the most recent MDS assessment will be extracted from the State MDS Database—a data repository where the MDS assessments are stored by the State of Texas—and will appear on the LTC Online Portal with the status of “Awaiting LTC Medicaid Information.” The recipient must reside in a valid Medicaid contracted bed. If form 3618 is submitted, it is assumed that the recipient is in a contracted bed.

The facility administrator must sign Form 3618 prior to submission. In order for a Medicaid recipient to begin Full Medicaid Provider Payment the following must apply:

- The recipient must have Medicaid Eligibility. Form 3618 will not process until the recipient has been determined to be eligible.
- Form 3618 must be in processed/complete status for services to be authorized.
- MDS RUG is authorized (note: The MDS should have been submitted to the State MDS Database whether Medicare, Medicaid or private pay status. MDS submission to the State MDS Database is not dependant upon the payor source.)
- The form must be signed and submitted by the facility administrator within 72 hours of the recipient’s Admission to or Discharge from the Medicaid Vendor System to be considered timely.

A facility administrator may authorize a person to sign the form in his/her absence. The authorization must be in writing and on file at the facility. The administrator date signed and attestation check box is still required for the 3618 and 3619 forms.
If the facility is temporarily without an Administrator, a signature is still required. Note in the comment section of the 3618 form that the facility is without an Administrator at this time, and enter “999999” in field 13 for the State Board License No.

**Note:** Nursing facilities are reminded that Form 3618's should not be submitted after a recipient is classified as Hospice in the facility. If the recipient is classified as Hospice upon admission, Form 3618's should not be submitted. Hospice providers should only submit Forms 3071/3074. If the recipient is Medicare for a non-related condition and classified as SNF (Skilled Nursing Facility) by the Hospice provider, Form 3619's are appropriate. Nursing facilities should inactivate any Forms 3618/3619 rejected to the Provider Action Required workflow submitted by facilities in error for full Hospice recipients.

Instructions for completing the 3618 can be found at the following link:
http://www.dads.state.tx.us/forms/3618/index.htm

**Repercussions of Submitting Form 3618 Late**

- Payment to the facility will be delayed.
- Personal needs allowance for Supplemental Security Income (SSI) clients will be delayed.
- Can delay the Medicaid Eligibility certification for a client applying for Medicaid.
- Failure to submit the 3618 can restrict the recipient to only having a reduced number of prescriptions.
- The facility can be written up for not following their contract.

**How to Submit Form 3618**

1. Login to the LTC Online Portal.
2. Click **Submit Form** link located in the blue navigational bar.
3. Type of Form: Choose **3618: Resident Transaction Notice** from the drop-down box.
4. Click the “Enter Form” Button.
5. Enter all required information as indicated by the red dots.

**Note:** The discharge type (Return Anticipated or Return Not Anticipated) has an effect on the client’s MDS RUG cycle. “Return not Anticipated” ends the facility’s current RUG records. This should match the MDS Tracking Form.

6. From here you have two choices:
   a. Click the “Submit Form” button to submit the form.
   
   or
   
   b. Click the “Save as Draft” button to store the form for future use, but not submit it. The form does not have to be complete to save the draft.

**Note:** If the form is successfully submitted a Document Locator Number (DLN) will be assigned and the portal will show “Your form was submitted successfully.” If there are errors they will be displayed in a box at the top of the screen. These errors will need to be resolved before the form will be successfully submitted. Once all errors are resolved, click the “Submit Form” button again to submit the form.
**Note:** A form 3618, admitting the recipient to Full Medicaid or a Form 3619 (Medicare Co-insurance), must be submitted prior to submission of the MDS LTCMI (to be discussed later).

### Form 3619

#### Purpose of Form 3619

Form 3619 is for recipients who fall under the Medicare Co-insurance category. It provides information to Medicaid for the Elderly and People with Disabilities (MEPD) worker about the status of a Medicare Co-insurance applicant or individual. Form 3619 provides DADS with information to initiate, close, or adjust Medicare Skilled Co-insurance payments. The dates of qualifying stay are tracked by DADS. Traditional Medicare will pay for up to 100 days stay in a skilled nursing facility. After the first 20 days, the facility must look to private pay, a third party insurance, or Medicaid to pay for the deductible portion of the remaining days.

Occasionally, Medicare/Medicaid eligible recipients may be discharged and readmitted under the same Medicare authorization. These recipients are eligible for 100 days of skilled nursing care per spell of illness and may use their days in several short-term stays or in one long stay.

Form 3619 provides information about the status of a Medicaid applicant or recipient. Form 3619 establishes the 20
When Medicaid provides the rest of the payment this is called Medicare Co-insurance. In order for Medicare Co-insurance to begin, the recipient must meet the following:

- Medicaid financial eligibility.
- Have an Admission Notice 3619 on file.
- Have qualifying stay of 20 days of full Medicare coverage (not the three-day acute care hospitalization stay).

The Dates of Qualifying Stay fields allow for two separate time frames. However, the dates may be broken up into multiple stays but will need to total 20 days. If the dates entered on the form equal less than 20 days, the provider must add comments to the form explaining the reason for this. Once the comments are added, the form may be submitted.

Instructions for completing the 3619 can be found at the following link:
http://www.dads.state.tx.us/handbooks/instr/3000/F3619/

**Repercussions of Submitting Form 3619 Late**

- Payment will be delayed.
- The facility can be written up for not following their contract.
- Not doing timely 3619 discharges on a regular basis could be interpreted as fraud.
How to Submit Form 3619

1. Login to the LTC Online Portal.
2. Click the **Submit Form** link located in the blue navigational bar.
3. Type of Form: Choose **3619: Medicare/SNF patient Transaction Notice** from the drop-down box.
4. Enter all required information as indicated by the red dots.
5. From here you have two choices:
   a. Click the “Submit Form” button to submit the form.
   or
   b. Click the “Save as Draft” button to store the form for future use, but not submit it. The form does not have to be complete to save the draft.

**Note:** If the form is successfully submitted a DLN will be assigned and the portal will show “Your form was submitted successfully.” If there are errors they will be displayed in a box at the top of the screen. These errors will need to be resolved before the form will be successfully submitted. Once all errors are resolved, click the “Submit form” button again to submit the form.

Submit Form 3619 for:

- Medicare Co-insurance Admission.
- Medicare Co-insurance Discharge.

Form 3619 Discharge is needed if the co-insurance is no longer due the nursing facility; (i.e., the client discharged from the nursing facility, Medicare benefits are exhausted/denied, or the client is deceased.)

In addition, type the following information in the comments section of form 3619:

- Medicare Replacement
- Name of the insurance carrier
• Number of co-insurance payment days allowed under the Medicare replacement policy
• Daily co-payment amount
Hospice Form 3071-Election/Cancellation Notice

This form is used to notify DADS of a Medicaid hospice recipient’s voluntary election or cancellation of the Texas hospice program, or to update changes in the Medicaid hospice recipient’s location and status.

Each Form 3071 should be completed either as an election, an update, or a cancellation. Complete an update transaction to document if the contract numbers change, or if the recipient changes recipient location from/to community or nursing home. If the form is intended to elect a recipient to the hospice program, check the ELECT box and include only the FROM Date. If the form is intended to terminate a recipient from the hospice program, check the CANCEL box and include only the TO Date. If the form will update information already provided on an existing election document, check the UPDATE box, include only the FROM Date, and complete the appropriate fields.

• The hospice staff must complete Form 3071.
• The provider must maintain an original Form 3071 on file for reproduction. Submission of the form is outlined under How to Submit Form 3071, below. An original can be obtained by submitting a written request to Medicaid Hospice Program, Department of Aging and Disability Services, Provider Forms, P.O. Box 149030, Mail Code E205, Austin, Texas 78714-9030. This form is also located on line at: http://www.tmhp.com/LTC%20Programs/default.aspx
• If a person is discharged from hospice for any reason and the person re-elects hospice, regardless of the amount of time, a new election and a new physician certification form must be completed.

Note: The effective date of Form 3071 is the hospice election date or the recipient signature date, whichever occurs last. See the Helpful Telephone Numbers section for contact information on Hospice claims, policy and contracting.

For Hospice forms, policy questions should be directed to the state according to policy. TMHP only addresses technical questions related to using the LTC Online Portal for hospice form submission.

Note: Nursing facilities are reminded that Form 3618’s should not be submitted after a recipient is classified as Hospice in the facility. If the recipient is classified as Hospice upon admission, Form 3618’s should not be submitted. Hospice providers should only submit Forms 3071/3074. If the recipient is Medicare for a non-related condition and classified as SNF (Skilled Nursing Facility) by the Hospice provider, Form 3619’s are appropriate. Nursing facilities should inactivate any Forms 3618/3619 rejected to the Provider Action Required workflow submitted by facilities in error for full Hospice recipients.

Instructions for completing the 3071 can be found at the following link: http://www.dads.state.tx.us/handbooks/instr/3000/F3071/

How to Submit Form 3071

1. Login to the LTC Online Portal.
2. Click the Submit Form link located in the blue navigational bar.
3. Type of Form: Choose 3071: Recipient Election/Cancellation/Discharge Notice from the drop-down box.
4. Enter all required information as indicated by the red dots.
5. From here:
   a. Click the “Submit Form” button to submit the form.
   or
   b. Click the “Save as Draft” button to store the form for future use, but not submit it. The form does not have to be complete to save the draft.
### LTC Nursing Facility/Hospice Workshop Participant Guide

#### LTC Online Portal Submission

**Form 3071—LTC Online Portal Screen**

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### 3071 Recipient Election/Cancellation/Discharge Notice

**Provider Information**

**TEST PROVIDER CM2**

PO BOX 148039
AUSTIN, TX 787140000

**Recipient Information**

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**Transaction Information**

**Form Type**

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**Setting**

Yes

**Medicare Part A**

Yes

**All Terminal Diagnoses - List All Terminal Illnesses**

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**Comments**


### Hospice Information

**Hospice Name**

TEST PROVIDER CM2

**Contract Number**

000009600

**Hospice Phone Number**


**Address**

PO BOX 148039

**City**

AUSTIN

**State**

TX

**Zip**

787140000

### Physician Information

**Physician First Name**


**Physician Last Name**


**State License No.**


**Date of Orders**


### Signatures

**Hospital First Name**


**Hospital Rep Last Name**


**Date Signed**


**Is Signature on File?**

Yes

**Client Date Signed**


**Is Client Signature on File?**

Yes

[Submit Form]
Hospice Form 3074- Medicaid/Medicare Physician Certification of Terminal Illness

This form is used to certify that the recipient has a diagnosis of six months or less to live if the illness runs its normal course, and to complete enrollment for the Medicaid hospice program. This form may also be used for Medicare physician certification.

The provider must maintain an original Form 3074 on file for reproduction. An original can be obtained by submitting a written request to Medicaid Hospice Program, Department of Aging and Disability Services, Provider Forms, P.O. Box 149030, Mail Code E205, Austin, Texas 78714-9030. This form is also located online at:
http://www.tmhp.com/LTC%20Programs/default.aspx or on the TMHP LTC Online Portal under Printable Forms feature.

The physician completes the form when an individual elects hospice and every six months (recertification) thereafter. Physician certification statements are valid for six months and must be renewed with a new certification statement. A hospice recipient’s terminal condition can be verified within two days of the hospice election date as evidenced by verbal verification by the hospice staff. The physician is allowed to sign and date the certification/recertification within the six-month terminal illness time frame the physician is certifying if a verbal verification is obtained. If no verbal is obtained, the physician’s signature must be obtained within two days of the Election.

Note: Recertification forms must be signed no earlier than 30 calendar days before the recertification date or anytime during the six-month recertification period.

• If a person is discharged off of hospice for any reason and the person re-elects hospice, regardless of the amount of time, a new election and new physician certification form must be completed.
  Note: All eligibility forms must be successfully submitted prior to receipt of payment.

• If the initial certification statement is signed by the physician after the six-month time frame, the effective date will be the date the document was signed by the physician. Medicaid payment will not be made prior to that date.

• The two day verbal verification period does not apply to recertification. The recertification statements must be signed and dated by the physician prior to the expiration date of the recertification period.

• Medicaid payment will not be made for any period where a gap exists in the certification periods. This form must be completed in order for the individual to receive Medicaid hospice services and for the provider to be paid for those services.

For hospice forms, policy questions should be directed to the DADS Hospice Policy (Medicaid) numbers on page 102 of this participant guide (Helpful Telephone Numbers). TMHP only addresses technical questions related to using the LTC Online Portal for hospice form submission.

Instructions for completing the 3074 can be found at the following link:
http://www.dads.state.tx.us/handbooks/instr/3000/F3074/

How to Submit Form 3074

1. Login to the LTC Online Portal.

2. Click the Submit Form link located in the blue navigational bar.

3. Type of Form: Choose 3074: Physician Certification of Terminal Illness from the drop-down box.

4. Enter all required information as indicated by the red dots.
5. From here you have two choices:

   a. Click the “Submit Form” button to submit the form.

   or

   b. Click the “Save as Draft” button to store the form for future use, but not submit it. The form does not have to be complete to save the draft.
PASARR (Pre-Admission Screening and Resident Review)

PASARR is a federal mandate that requires the State of Texas to screen all persons suspected of having Mental Illness (MI), or Intellectual or Developmental Disabilities (IDD), before they are admitted into a certified nursing facility. PASARR is used to determine medical necessity, and to determine if the recipient could benefit from specialized services (i.e. occupational therapy, physical therapy, speech therapy or workshop/day programming).

MI and IDD indicators are located on the LTCMI section of the PASARR Screening S2a thru S2c. At least one of the fields in S2a thru S2c must be Y. Per the PASARR regulations, if a recipient has only diagnoses of MI or IDD, and there are NO medical conditions for which a nurse is required, the recipient does not meet the criteria of medical necessity for admission into facility.

Entering PASARR

PASARR Screenings are submitted directly on the LTC Online Portal by the provider and assigned a Document Locator Number (DLN). The PASARR Screening is reviewed for Medical Necessity Determination. The provider can login to the LTC Online Portal and access the PASARR Screening through FSI or Current Activity for status information.

The PASARR Screening is based on the Quarterly MDS with additional state specific information in the LTCMI section. When a PASARR Screening is submitted via the LTC Online Portal, the system will check to see if there is an existing PASARR on file. If a PASARR has not previously been submitted, the PASARR will go through the standard Medical Necessity (MN) admission assessment determination process. If PASARR Screening is found and MN approved, with a message in history indicating PASARR found, the PASARR will not be reviewed for MN. A PASARR Screening is required prior to submission of an MDS Admission (AA8a=01) if the assessment indicates Mental Illness, or Intellectual or Developmental Disabilities. The Nursing Facility has the responsibility to complete and submit the PASARR Screening. If admitting physician is unknown at the time of screening, the facility’s Medical Director may be entered onto the PASARR Screening. The Medical Director’s name and license number is required.

Note: The PASARR must be submitted and approved by TMHP prior to the Admission assessment being completed by the NF and submitted to TMHP.

TMHP generates PASARR approval and denial letters to the recipient and physician. Detailed instructions for the PASARR Screening can be found online at http://www.dads.state.tx.us/providers/pasarr/index.html.

How to Submit a PASARR Screening

1. Login to the LTC Online Portal.
2. Click the Submit Form link located in the blue navigational bar.
3. Type of Form: Choose PASARR: PASARR Screening from the drop-down box.
4. Click the “Enter Form” button.
5. Enter all required information as indicated by the red dots. Click on all section tabs and enter the information requested. All tabs must be completed.
6. Click the “Print” button located in the Form Actions bar to print the screening in progress.
7. Click the “Submit Form” button.
Note: If the screening is successfully submitted a DLN will be assigned and the portal will show “Your form was submitted successfully.” If there are errors they will be displayed in a box at the top of the screen. These errors will need to be resolved before the screening will be successfully submitted. Once all errors are resolved, click the “Submit form” button again to submit the form.

If an MDS Admission (AA8a=01) assessment is currently in a status of “PASARR not found invalid form” awaiting this successful PASARR submission, call TMHP at 1-800-626-4117 Option 1 or 2 for further assistance.
Sequencing of Forms and Assessments

Admission as a Full Medicaid Recipient

This flow chart displays the process of a recipient who is admitted as a Full Medicaid recipient.

- Nursing Facilities are required to initiate the HHSC Medicaid Eligibility application process to ensure validations occur with the Medicaid ID, Medicaid Eligibility and the Applied Income.
- PASARR Screening (if applicable)
- A facility must submit a 3618 for a recipient that has full Medicaid or is applying for Medicaid coverage within 72 hours of admission.
- Federal CMS Resident Assessment Instrument (RAI) User’s Manual requires completion of an admission/comprehensive MDS within 1-14 days of admission (AA8a= 01). Submit the MDS to the State MDS Database.
- Federal CMS guidelines allow providers up to 31 days to transmit assessments to the State MDS Database. Please note waiting will cause a delay in Medical Necessity determination and payment, if the assessment is being used to establish Medicaid State payment.
- Complete the MDS LTCMI on the LTC Online Portal within the covering quarter of the MDS (R2b + 91 days).
- Complete a Quarterly Assessment within 92 days of the Admission MDS unless a Significant Change in Status Assessment (SCSA) was completed prior to this.
Recipient Transitioning to Full Medicaid

This flow chart displays the process of a private pay recipient that is transitioning to Full Medicaid. Submission should occur upon notification of application for Medicaid. Submission should occur upon notification of application for Medicaid.

- Facility should submit a 3618 admission indicating admission from private pay.
- Once the 3618 has been submitted, the LTC Online Portal will extract the MDS Assessment.
- Please remember that the MDS LTCMI must be completed and submitted before TMHP can process the assessment.

If TMHP is unable to extract the assessment from the State MDS Database because the recipient’s Medicaid number or SSN is different on the assessment, the provider will have to submit an MDS modification to allow the LTC Online Portal to extract the assessment. Modifications will be discussed later in the participant guide.

**Note:** If the name on the assessment does not exactly match the Medicaid identification card, there will be a conflict. Contact the appropriate Medicaid Eligibility worker to make name corrections so that there is an exact match.

Full Medicare Transitioning to Medicaid

This flow chart displays the process of a recipient that is Full Medicare and transitioning to Full Medicaid.

- Full Medicare reimburses for the first 20 days.
- The facility must submit a 3619 Admission on day 21 (within 72 hours) of Medicare payment to begin Medicare Co-insurance up to a maximum of 100 days.
- The facility must submit a 3619 Discharge on the 101st day or the day of discharge from Medicare Co-insurance and a 3618 Admission on the same day to admit the recipient to Full Medicaid.
- 3619 discharge and 3618 admission changing to Full Medicaid will be the same date unless the recipient physically went out of the facility.
- The facility may submit an LTCMI on an MDS assessment for a resident that will be transitioning from Medicare to Medicaid. However, the LTCMI should not be submitted prior to the 3619 admission. The provider has the option to submit the LTCMI either prior to the resident discharging off of Medicare or waiting until the resident is considered Full Medicaid.
Current Resident Admitted to Hospice

- Submit a 3618 or 3619, as appropriate, discharging the recipient to Hospice Care.
- Submit a Significant Change in Status Assessment (SCSA) for a current recipient admitted to hospice if the recipient meets the federal criteria for an SCSA (only if the recipient qualifies physically for a SCSA). Admitting to Hospice alone does not require a new assessment; however, CMS recommends that an SCSA be submitted to facilitate coordination between the Nursing Facility and Hospice.
  - Indicate Hospice Care in P1a.o.
  - Hospice contract number must be entered on the LTCMI.
- Hospice provider submits 3071 and 3074 form.

Form 3618 Discharge must be signed and electronically submitted within 72 hours of hospice election date.

If a significant change in status has not occurred, continue with the current MDS schedule.

If a significant change in status has occurred, submit MDS AA8a=03 (Significant Change in Status Assessment) with a check in Section P1a.o indicating hospice care.

Complete Long Term Care Medicaid Information (LTCMI) S1d. Hospice contract number.

Current Hospice Residents

Nursing Facilities should use the current MDS cycle for hospice recipients. If a significant change has occurred, then a SCSA should be completed including the hospice provider number in LTCMI, and P1a.o. indicated. Section P Field 1a.o. “Hospice Care” should be indicated on the next MDS due, and the Hospice contract number on the LTCMI will be required to allow the hospice provider to view assessments submitted with their contract numbers.

Hospice providers can view (on the LTC Online Portal) MDS Assessments submitted on their behalf – based on the hospice contract number that is indicated in the LTCMI S1d. (Hospice Contract Number. S1d must be completed correctly in order to view those assessments.)

Hospice nurses are not required to sign-off on the assessment for the hospice recipients. Providers can print and sign their assessment prior to submitting. The assessment should be signed by the MDS RN Assessment Coordinator.
Resident Returns (Prior Discharge - Return Not Anticipated)

- Submit a 3618 Admit by day three (admitting to full Medicaid).
- Complete an Admission MDS Assessment by day 14.
- Complete a Quarterly Assessment within 92 days of the Admission MDS unless a Significant Change in Status Assessment (SCSA) was completed prior to this.

Form 3618 must be signed and electronically submitted within 72 hours of admission.

Submit AA8a=01
Admission MDS assessment — required by day 14

Submit AA8a=05
Quarterly MDS assessment — within 92 days of Admission MDS assessment
(Unless a SCSA [AA8a=03] was completed prior to Quarterly MDS assessment)
Resident Returns (Prior Discharge - Return Anticipated)

- Submit a 3618 by day three.
- If the previous MDS Assessment is less than 92 days old—has not expired—and the recipient has not had a change in condition, no additional assessment is required.
- If the previous MDS Assessment has expired, complete the next scheduled assessment OR if there has been a change in condition, submit a SCSA.

Resident returns to full Medicaid. Form 3618 must be signed and electronically submitted within 72 hours of admission.

Has previous assessment expired?

Has resident had a change in condition?

Complete AA8a=03 – Significant change in status assessment.

An MDS is not required until the current assessment expires.

Submit next MDS as scheduled.
The Long Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all recipients in a Medicare and/or Medicaid-certified long-term care facility. The MDS contains items that measure physical, psychological and psychosocial functioning. The items in the MDS give a multidimensional view of the recipient’s functional capacities and helps staff to identify health problems.

Assessments submitted to the State MDS Database and used for Medicaid payment include:

- Admission assessment (required by day 14)
  
  **Note:** Texas will use Date of Entry, AB1, for the effective date of an admission assessment. The system is programmed to use AB1 or Date RN Assessment Coordinator signed as complete, R2b, minus 30 days, whichever is later. If there are more than 30 days between the AB1 and R2b, the additional days have to be processed manually by DADS Provider Claims Services (PCS).

- Annual assessment
- Quarterly review assessment
- Significant change in status assessment
- Significant correction to prior full assessment
- Significant correction to prior quarterly assessment
- Inactivation
- Modification

Assessments are extracted by TMHP to the LTC Online Portal in “Awaiting LTC Medicaid Information” status for completion of the LTCMI and the determination of medical necessity after the successful submission of the LTCMI. MDS Swing Bed assessments are submitted on the State MDS Database, however they are not extracted by TMHP. To submit a swing bed assessment for MN determination, submit the quarterly assessment to the State MDS Database and complete the LTCMI with service group =10. MDS Discharge Tracking and Re-Entry Tracking forms are used by CMS but are not extracted to the LTC Online Portal. The 3618 and 3619 are used by the State for Medicaid processing of recipient movement.

If the recipient expires on the day the MDS Quarterly is due and there is no level of service for the date of death, the MDS must be submitted in order to receive payment for the date of death.

To receive a RUG payment when a resident expires prior to completion of an admission assessment, the admission assessment must be completed and submitted to the State MDS Database with the information that is available. If the State MDS Database cannot calculate a RUG because the admission assessment is incomplete or has errors, the State MDS Database will still assign a RUG value of BCI which is the default rate. If the admission assessment meets medical necessity and the resident has Medicaid eligibility for the days of services, payment can be made for the RUG value calculated by the State MDS Database.
Submission and Extraction of MDS Assessment

Providers should use their current method for submission to the State MDS Database, either through RAVEN or another third party software package. Validate the acceptance of the MDS Assessment to the State MDS Database using the validation report process from Federal CMS.

TMHP extracts assessments from the State MDS Database which meet all of the following extraction criteria:

- AA7 Medicaid Number contains “+” or a 9 digit numeric value.
- AA8a Reason for Assessment = 01, 02, 03, 04, 05 or 10.
- W1 National Provider ID should be entered in order for Nursing Facilities to locate assessments “Awaiting LTC Medicaid Information.”

The assessment is placed onto the LTC Online Portal and assigned a DLN and set to status “Awaiting LTC Medicaid Information.”

Providers must login to the LTC Online Portal and use Form Status Inquiry (FSI) or Current Activity to find the submitted MDS Assessment in “Awaiting LTC Medicaid Information” status. Complete the LTCMI and submit.

Note: An MDS assessment is not immediately accessible when submitted. It may be approximately an hour before the MDS assessment is on the LTC Online Portal for data entry in “Awaiting LTC Medicaid Information” status.

The MDS assessment must include a completed LTCMI and be accepted by the LTC Online Portal to begin the MN determination process. Periodically review the status of the MDS Assessment for MN and Medicaid Processing using Form Status Inquiry (FSI) or Current Activity.

Note: Providers should follow the federal RAI User’s Manual for submission of an assessment every 92 days. If the provider follows the federal guidelines for submission, there will not be a lapse in coverage. DADS includes 31 days for submission as part of the expiration date of each MDS for subsequent processing. However, if the provider does not submit an assessment every 92 days, the assessments will be out of compliance with the federal RAI guidelines.

MDS Dually Coded Assessments

Dually coded assessments will be extracted and placed on the LTC Online Portal if the extraction criteria above is present. If the assessment is processed successfully for Medicare, but fails due to the Medicaid ID/Recipient name, the provider should first try to modify the name on the MDS by submitting a modification ensuring the name on the assessment matches that of the Medicaid card. If the assessment continues to fail processing due to the recipient’s name, the provider should inactivate the MDS assessment, correct the spelling of the name and resubmit the assessment. The reason for assessment, AA8a and AA8b should remain the same.

Note: Providers should only submit an inactivation on dually coded assessments after attempting to submit a modification. An inactivation will affect Medicare, as well as Medicaid payment. (Modifications and Inactivations will be discussed later.)

Requirements for a Rehab RUG

There are two requirements for documentation of Nursing Facility Restorative Nursing Care:

1. According to 40 TAC 19.1006, The facility must have a program of restorative nursing care that is an integral part of nursing service and is directed toward helping each resident to achieve and maintain an optimal level of self-care and independence, as defined by the Comprehensive Assessment and Comprehensive Care Plan. Nursing personnel must be trained in restorative nursing and must provide restorative services daily for residents who require them. Nursing personnel must routinely record these services in the resident’s clinical record.
2. According to the RAI manual, the recipient must require Rehabilitative/Restorative Care that include nursing interventions that assist or promote the recipient’s ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item P1b. In addition, to be included in this section, rehabilitation or restorative care must meet all of the following criteria:

- Measurable objectives and interventions must be documented in the care plan and in clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- This category does not include groups with four or more residents per supervising helper or caregiver.

The MDS assessment needs to be coded according to the conditions of the resident. If the resident’s MDS assessment generates a rehab RUG and the coding for the assessment is documented, then this is acceptable.

**Long Term Care Medicaid Information (LTCMI)**

LTCMI is the replacement for the Federal MDS Section S and contains state specific items for Medicaid payment. Providers must access the LTC Online Portal and retrieve their MDS Assessments to successfully complete the LTCMI. Providers should complete the LTCMI section as soon as possible in order to submit the MDS Assessment into TMHP’s MN workflow for review.

**Submission of LTCMI**

To enter the LTCMI, the provider must login to the LTC Online Portal and access their assessments in “Awaiting LTC Medicaid Information” through the FSI or Current Activity. The LTCMI must be completed with all required data and be successfully submitted. The assessment is then available for medical necessity determination by TMHP.

**Finding Assessments Through Form Status Inquiry**

1. Click the **Form Status Inquiry** link in the blue navigational bar.

2. Type of Form: Choose MDS or MDSQTR from the drop-down box.
3. Form Status: Choose **Awaiting LTC Medicaid Information** from the drop-down box.

4. Click the “Search” button.

5. Click the **View Detail** link to display the details of the assessment.

**If You Cannot Locate Your MDS on Current Activity or Via Form Status Inquiry**

Be sure to verify all of the following:

- The MDS was accepted (not rejected) by the state database via your validation report.
- A valid Medicaid number or + was entered in field AA7.
- Field AA7 does NOT contain an ‘N.’
- Field AA8a had a response of 01, 02, 03, 04, 05 or 10.
- Field AA8a does NOT contain 00.
- Name on MDS is exactly the same as the recipient’s Medicaid ID card.
- NPI entered in Section W1 matches the Vendor/Contract information on the MESAV for that client.

**How to Submit Long Term Care Medicaid Information (LTCMI)**

Once you have found and opened the assessment in “Awaiting LTC Medicaid Information” status using FSI or Current Activity:

1. Click the “Section LTCMI” tab.

2. Enter data into remaining fields not prepopulated. At this time, the provider will have the option to manually enter information or use the “Populate LTCMI” button. Also, the “Save LTCMI” button will be available to save any entered data prior to submission.
**Note:** To ensure that the LTCMI can be submitted once completed, check for the “Submit Form” button at the bottom of the screen. If the assessment is being used (locked) by another user, the “Submit Form” button will not be available (displayed). Additionally, a message will display in the upper right of the screen “This form is being viewed by another user and cannot be changed.”

3. Click the “Print” button located in the yellow Form Actions bar to print the LTCMI in progress.
   a. Printer: Choose printer name from drop-down box.
   b. Print Range: Click the “Pages” circle.
   c. Enter the pages to print. Pages for the LTCMI for the MDS Comprehensive are 10-11. Pages for the LTCMI for the MDS Quarterly are 6-7.
   d. Click the “OK” button.

4. Click the “Submit Form” button located at the bottom right of the screen, if ready to submit for processing.
   a. Successful submission will display the DLN and a message “Your form was submitted successfully.”
   b. Unsuccessful submission will result in error messages being displayed at the top of the page (you will need to scroll to the top of the page to see the errors).
Circumstances for LTCMI Submission

Nursing Facilities are directed to complete the LTCMI when seeking full Medicaid reimbursement (when a recipient is moving to full Medicaid or continuation of Medicaid payment). The LTCMI is not required for Medicare recipients or co-insurance. If the provider expects that the MDS will be used for Medicaid within the quarter it covers (R2b + 91 days), it is recommended that the LTCMI be completed to begin the MN process.

Note: DADS recommends completing the LTCMI if the client could possibly become Full Medicaid during the 92 days the assessment represents. If the client admitted with Medicare and the Admission assessment’s LTCMI is completed, it would be in place for the admission to Medicaid for the remainder of the 92 days (e.g., 60 days). (The LTCMI cannot be submitted until an admission, either 3618/3619, has been submitted.) If the provider chose not to do the Admission assessment LTCMI, an MDS Quarterly would have to have an R2b date matching the admission date to Medicaid to insure full RUG payment.
LTCMI Fields
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- **S1. Claims Processing Information.**
  - S1a. DADS Vendor/Site ID Number.
    This field is auto populated based on the NPI number in field W1. This field is not correctable.
  - S1b. Contract/Provider Number.
    This field is auto populated based on the NPI number in field W1. This field is not correctable.
  - S1c. Service Group.
    Required field.
    Enter the number that corresponds to the appropriate response:
    1. Nursing Facility.
    10. Swing Beds.
    This field is not correctable once successfully submitted.
  - S1d. Hospice Contract Number.
    Required field, if P1a.o. Hospice Care is checked.
    Enter the Medicaid hospice provider contract number assigned by DADS. This allows hospice providers to view assessments submitted on their behalf.
    Therefore this number must be accurate.
  - S1e. Purpose Code.
    Enter the value that corresponds to the appropriate response:
    E. Recovery of Lost Payment.
    M. 3 month prior eligibility MN.
  - S1f. Missed Assessment Start Date (The first date the facility was not paid).
    This would be the first missed assessment date (Check MESAV for gaps).
    Required field if S1e. Purpose Code = E or M.
    Enter the date in mm/dd/yyyy format of the missed assessment start date.
  - S1g. Missed Assessment End Date (The last date the facility was not paid).
    This would be the last missed assessment date (Check MESAV for gaps).
    Required field if S1e. Purpose Code = E or M.
    Enter the date in mm/dd/yyyy format of the missed assessment end date.
    These dates are used to locate a gap of time. If a gap is not found within the range provided, the assessment will not be processed. If gap is for one day, submit a 2-day E and it will be reduced to actual gap.

- **S2. PASARR Information.**
  - S2a. To your knowledge, does the recipient have a condition of mental illness?
    Required field.
    Enter the most appropriate response: Y = YES or N = NO.
  - S2b. To your knowledge, does the recipient have a related condition (Developmental Disabilities)?
    Required field.
    Enter the most appropriate response: Y = YES or N = NO.
  - S2c. To your knowledge, does the recipient have mental retardation (Intellectual Disabilities)?
    Required field.
    Enter the most appropriate response: Y = YES or N = NO.
    **ENTRY TIP:** If one value from S2a - S2c is a ‘Y’, then a PASARR Screening must be on file. If a PASARR
is not on file, **STOP**. Submit PASARR Screening and wait for MN approval of that PASARR Screening prior to submitting LTCMI.

- **S2d.** Is the recipient a danger to himself / herself?
  Required field.
  Enter the most appropriate response: **Y** = YES or **N** = NO.
  If unknown, then reply with **N** = NO.

- **S2e.** Is the recipient a danger to others?
  Required field.
  Enter the most appropriate response: **Y** = YES or **N** = NO.
  If unknown, then reply with **N** = NO.

- **S2f.** Has the recipient had a previous PASARR assessment?
  Optional field.
  Enter the most appropriate response:
  
  - **Y** = YES
  - **N** = NO
  - **U** = Unknown

- **S2g.** Date of previous PASARR assessment.
  Optional field.
  Date of Previous PASARR Screening could also be a 3652-A Purpose Code P. If so, please enter the date of the 3652-A form if known.
  Enter the R2b date (RN Assessment Coordinator signed as complete) in mm/dd/yyyy format of the previous PASARR Screening, if known.

- **S3. Physician’s Evaluation & Recommendation.**
  - **S3a.** Do you have plans for the eventual discharge of this patient?
    Required, if Initial Assessment, SCSA, or Recovery of Lost Payment (Purpose Code E).
    Enter the most appropriate response:
    
    - **Y** = YES or **N** = NO.

  - **S3b.** Rehabilitative Potential.
    Enter the most appropriate response:
    
    - **1** = Good
    - **2** = Fair
    - **3** = Minimal

  - **S3c.** I certify that this individual requires nursing facility services or alternative based community services under supervision of an MD/DO.
    Required, if Initial Assessment, SCSA, or Recovery of Lost Payment (Purpose Code E).
    Enter the most appropriate response:
    
    - **Y** = YES or **N** = NO.

  - **S3d.** MD/DO Last Name.
    Required field.
    Enter the last name of the MD/DO.

  - **S3e.** MD/DO License #.
Required field, if S3f. MD/DO Military Spec Code # is not populated.
Enter the license number of the MD/DO.
This number is validated against the Texas Medical Board file.
Physicians are not required to complete the RUG training.
– S3e1. MD/DO License State.
  Required field, if S3f. MD/DO Military Spec Code # is not populated.
Enter the license state of the MD/DO.
– S3f. MD/DO Military Spec Code #.
  Required field, if S3e. MD/DO License # is not populated.
Enter the Military Spec Code number of the MD/DO.

• S4. Licenses.
  – S4a. RN Coordinator Last Name.
    Required field.
Enter the last name of the RN Coordinator.
  – S4b. RN Coordinator License #.
    Required field.
Enter the license number of the RN Coordinator.
This number is validated against the Texas Board of Nursing (TBN) or Compact License as applicable. This number is validated to ensure RUG training requirements have been met. The license numbers supplied at S4b must be RUG trained as offered by Texas State University. The assessment will not be accepted on the LTC Online Portal if the license # is not indicated as having completed the RUG training. The RUG training is online (web-based training) as offered by Texas State University. The training is valid for 2 years. The name entered in S4a should match the name in section R2a.

  Note: An error will occur if the license number does not pass validation. The assessment will not be considered “successfully submitted” until all errors are resolved.
  – S4b1. RN Coordinator License State.
Enter the license state of the RN Coordinator.

• S5. Primary Diagnosis & Associated Medications.
Enter a valid ICD-9 code for the recipient’s primary diagnosis. Use your best clinical judgment.
  – S5a1. Primary Diagnosis ICD-9 Description.
To populate the ICD-9 description, click the magnifying glass icon.

• S6. Therapeutic Interventions.
  – S6a. Tracheostomy Care.
This field is only required if P1aj. Tracheostomy Care is indicated on the MDS.
Enter the number corresponding to the appropriate response.
  1 = Less than once a week
  2 = 1 to 6 times a week
  3 = once a day
  4 = twice a day
  5 = 3 – 11 times a day
6 = every 2 hours
7 = 24 hour continuous

**ENTRY TIP**: A non-zero reply requires P1aj. Tracheostomy Care on the MDS to be checked. The Provider must submit an MDS Modification if P1aj. field is not checked and S6a is to be claimed for the add-on rate.

- **S6b. Ventilator / Respirator**
  
  This field is only required if P1al. Ventilator/Respirator is indicated on the MDS.

  Enter the number corresponding to the appropriate response. Do not include BIPAP/CPAP time.
  
  1 = Less than once a week
  2 = 1 to 6 times a week
  3 = once a day
  4 = twice a day
  5 = 3 – 11 times a day
  6 = 6 – 23 hours
  7 = 24 hour continuous

- **S7. For DADS Use Only**
  
  This section is reserved for DADS.

- **S8. Recipient Address.** (Please assure accuracy of the recipient’s address as this is the address used in any correspondence letters mailed to the recipient.)
  
  - S8a. Recipient Address.
    
    Enter the street address of the recipient.
  
  - S8b. City.
    
    Enter the city of the recipient.
  
  - S8c. State.
    
    Enter the state of the recipient.
  
  - S8d. ZIP Code.
    
    Enter the zip code of the recipient.

- **S9. Medications.**
  
  This field is optional but important for TMHP RNs to make an MN determination. Completing this field will expedite your assessment through the MN process.
  
  - S9 (1.) Medication Name and Dose Ordered. Free form text.
  
  - S9 (2.) RA (Route of Administration). Select from the list of options.
  
  - S9 (3.) Freq (Frequency). Select from the list of options.
  
  - S9 (4.) PRN-n (number of doses) as necessary - number of times in last 30 days.
    
    Enter the number of times in the last 30 days, if frequency was identified as PRN (as necessary).

  Section O of the MDS Assessment reflects the number of medications and section S9 allows for more detailed information to be submitted. (I.e. name of medications).

- **S10 Comments.**
  
  Optional up to 500 characters if needed. Include pertinent medical information and history, ability to understand medications and side effects and change in condition.

  Communicate anything of significance that has not been captured on the assessment instrument.
A Purpose E should be used for a missed assessment.

According to 40 TAC §19.2413:

(3) Missed MDS assessment—An MDS assessment that is received by the state Medicaid claims administrator outside the time period that the MDS assessment covers.

(g) Missed MDS assessments. When the state Medicaid claims administrator receives a missed MDS assessment, DADS pays the nursing facility a default RUG rate for the entire period of the missed MDS assessment if the recipient meets financial eligibility for Medicaid, except as provided in paragraph (2) of this TAC subsection.

Note: An On-Time MDS assessment is an MDS assessment that is submitted in accordance with the federal MDS submission schedule and the state Medicaid claims administrator within 31 days of the completion date. A Late MDS assessment is an assessment with an R2b date after the 31-day submission period, but within the 92 days the assessment represents.

If a new client is admitted to the facility and the admission assessment is submitted more than 91 days after R2b of that admission assessment, the admission assessment will have to be submitted as a PC E. Payment for this gap will be made at the PC E default rate. MDS Purpose Code E is used to recover missed assessment time frames. Originally a missed assessment time period occurred when the TILE was allowed to expire prior to establishing a RUG. Currently it occurs when a MDS is not submitted within the anticipated quarter time frame. The anticipated quarter is the 92-day anticipated MDS assessment quarter following the 92-day span of the current MDS assessment. A missed assessment can also occur if the admission assessment is not submitted within 92 days of the form’s assessment date. Purpose Code E can only be submitted on the Admission Assessment, Annual Assessment or Quarterly Review Assessment. The PC E must be submitted within 365 days from the last uncovered day.
NF/Hospice Provider Tips for When to Submit an MDS PC E

The following provides information to help Nursing Facility/Hospice providers determine when to submit an MDS PC E. PC E can only be submitted on an MDS Admission, Annual or Quarterly Assessment.

There typically are three situations when MDS PC E should be submitted:

1. **TILEs to RUGs Conversion Gap.** A PC E must be used to fill the gap if the TILE was allowed to expire prior to the date when the RUG was started during the conversion from the TILEs to RUGs. Depending on how long it took to establish the RUG, this gap could be from one to 92 days. When a TILEs to RUGs conversion gap occurs, payment for the gap period (ranging to no more than 92 days) will be paid at the PC E default rate. To fill the gap, submit an Admission, Annual or MDS Quarterly Assessment including the LTCMI by completing:
   - the S1e field on the LTCMI completed as the PC E;
   - the Missed Assessment Start Date (S1f); and
   - the Missed Assessment End Date (S1g).

2. **RUG Gap.** Once the recipient has been established as a RUG recipient, a PC E will be needed if the next MDS assessment submission completely misses the anticipated assessment quarter. Each R2b establishes a 92-day period (R2b + 91 days), so the next assessment should be completed and submitted within the 92-day anticipated MDS assessment quarter following the 92-day span of the current MDS assessment.
   - The RUG of the current assessment will expire 31 days after the covering quarter (R2b + 91 days) unless the next MDS assessment has been successfully completed. DADS cannot pay for services on days when a RUG has expired.
   - The next MDS assessment will not be considered missed if it has an R2b date within the anticipated MDS assessment quarter and the LTCMI is completed on the LTC Online Portal within 91 days of the new MDS assessment R2b date.
   - If the new MDS assessment is submitted after the expiration of the RUG on file but within the anticipated quarter the gap following the 31 days and prior to the new R2b date will automatically be filled with the new calculated RUG.
   - If the new MDS is not submitted within the anticipated quarter or the LTCMI is not completed within 91 days of the R2b date, a gap will be created following the 31 days until the R2b date of the new assessment. Payment for this gap will be made at the PC E default rate. To fill the gap, submit an Admission, Annual, or Quarterly MDS Assessment including the LTCMI by completing:
     - the S1e field on the LTCMI completed as the PC E;
     - the Missed Assessment Start Date (S1f); and
     - the Missed Assessment End Date (S1g).

3. **Missed MDS.** If an LTCMI is submitted more than 91 days after the R2b date of the assessment, the assessment will have to be submitted as a PC E. Payment for this gap will be made at the PC E default rate. Submit the assessment, including the LTCMI, by completing:
   - the S1e field on the LTCMI completed as the PC E;
   - the Missed Assessment Start Date (S1f); and
   - the Missed Assessment End Date (S1g).
MDS Purpose Code M

The Purpose Code M is used when Prior Medicaid Eligibility has been established. Prior eligibility can begin up to three months prior to certification of Medicaid. Purpose Code M can only be submitted on the Admission Assessment, Annual Assessment or Quarterly Review Assessment.

Missed Assessment Start and End Dates are used by the provider to identify the Prior Medicaid period. The MESAV must reflect a Medicaid coverage type of “P” (prior eligibility).

LTCMI section should include:
- S1e = M (Purpose Code)
- S1f = Missed Assessment Start Date (This is the prior eligibility start date)
- S1g = Missed Assessment End Date

The correction of an existing LTCMI Purpose Code to an E or M invalidates the original time frame. If the LTCMI is changed to indicate a PC E or PC M and the assessment had been part of the recipient’s cycle, the original time frame is voided (e.g. set to status “Corrected”) and only the PC E or PC M dates will be covered.

More information on Purpose Code E and M can be found at:

The information below is an excerpt from the Information Letter (referenced above).

What is a Purpose Code M and how do you complete a Purpose Code M?

Purpose Code M – an MDS submitted if three months prior to application is granted after the client is certified for Medicaid. When there is an application for Medicaid the client’s financial eligibility is considered and reviewed based on the month of application. If the client is determined to be Medicaid eligible, the worker does a consideration on the three months prior to the application to determine if the client may have been financially eligible at an earlier date. The Purpose Code M was designed to allow the provider to submit a MDS Purpose Code M to cover those 3 months so the payment could be made at a RUG value rather than the default PCE rate. The retroactive Medicaid is shown on the MESAV as a TP 14 Coverage Code P or TP 11/ TP 12 which are retroactive TP13 SSI coverage.

To fill a period approved by the financial worker for dates prior to the application the provider has two options:

1. Submit an off-cycle MDS quarterly assessment including the Long Term Care Medicaid Information (LTCMI) by completing
   - The S1e field on the LTCMI completed as the PC M
   - The start date of the approved prior period (S1f); and
   - The end date of the approved prior period (S1g)

2. Modify an earlier MDS that has not been used for the Medicaid cycle and complete the LTCMI as a PC M by completing
   - The S1e field on the LTCMI completed as the PC M
   - The start date of the approved prior period (S1f); and
   - The end date of the approved prior period (S1g)
Medical Necessity and the MN Determination Process

TMHP is responsible for reviewing submitted assessments to determine Medical Necessity.

Definition of Medical Necessity

“Medical Necessity is the determination that a recipient requires the services of licensed nurses in an institutional setting to carry out the physician’s planned regimen for total care. A recipient’s need for custodial care in a 24-hour institutional setting does not constitute a medical need. A group of health care professionals employed or contracted by the Medicaid claims administrator contracted with HHSC makes individual determinations of medical necessity regarding nursing facility care. These health care professionals consist of physicians and registered nurses.” 40 TAC 19.101 #73

“A recipient may establish permanent medical necessity status after completion date of any MDS assessment is approved for medical necessity no less than 184 calendar days after the recipient’s admission to the Texas Medicaid Nursing Facility Program.” 40 TAC 19.2403(e)

The Difference Between Licensed Nurse Needs and Custodial Care

Custodial care is identified as care given by nurses’ aides or lay caregivers that provides safety and/or assistance with activities of daily living such as: bathing, toileting, eating, dressing and ambulation/mobility.

Licensed nurse needs are defined as skills provided by licensed nursing personnel to assess, plan, supervise, and provide treatment on a regular basis. These include, but are not limited to: observation; promotion and maintenance of health; prevention of illness and disability; management of health care during acute and chronic phases of illness; guidance and counseling of individuals and families; and referral to physicians, other health care providers, and community resources, when appropriate.
General Qualifications for Medical Necessity Determinations

According to 40 TAC 19.2401, medical necessity is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. This section contains the general qualifications for a medical necessity determination. To verify that medical necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this section.

(1) The individual must demonstrate a medical condition that:
   a. is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and
   b. requires licensed nurses’ supervision, assessment, planning, and intervention that are available only in an institution.

(2) The individual must require medical or nursing services that:
   a. are ordered by the physician;
   b. are dependent upon the individual’s documented medical conditions;
   c. require the skills of a registered or licensed vocational nurse;
   d. are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and
   e. are required on a regular basis.

Note: Medical necessity is not the only prerequisite to qualify for Medicaid eligibility.
1. Medical necessity determinations are made on PASARR Screenings and MDS assessments. This flowchart above provides a high level overview of the process used for determination of medical necessity. Providers can utilize the LTC Online Portal to check the status of MN determination.

2. Submissions are reviewed by the TMHP nurse for medical necessity determination within 3 business days of successful submission of the LTCMI.

   In order to expedite processing, TMHP automatically checks submitted assessments, with a Medicaid Number, to determine if the recipient already has Permanent MN (PMN). If the recipient has PMN, the assessment is automatically approved. The assessment history will state “Client has permanent MN.”

   For recipients who do not have PMN, TMHP systems automatically review specific criteria on the assessments. If the criteria are appropriately met, the assessment is automatically approved. If not, the provider will see “The Form has failed Auto MN Approval” displayed in the history. The assessment will then be sent to a nurse for manual MN review. The status will show “Pending Review” on the FSI search results; however, the last message showing in the history will be “The Form has failed Auto MN Approval.”

3. Once reviewed, the submission is either approved (meeting medical necessity) or placed in a “Pending Denial (need more information)” status for up to 21 days. FSI or Current Activity can be used to view the status of MN determination whether approved, denied, or pending denial (need more information) status.
4. The Director of Nurses (DON) or other licensed nurse within the facility must either add additional information clarifying nursing/medical needs through the "Add Note" feature or by calling TMHP and speaking with a TMHP nurse.

5. If the TMHP nurse determines that medical necessity has been met, the assessment is approved.

6. If the TMHP nurse still cannot determine any licensed nursing need, after additional information has been provided, the assessment is sent to the TMHP physician for a medical necessity determination.

7. If the TMHP physician determines that medical necessity has been met, the assessment is approved.

8. If medical necessity is denied by the TMHP physician, notification of denied medical necessity is sent to:
   - The recipient in a letter via mail.
   - The physician of record in a letter via mail.

9. The recipient's physician may submit additional information within 14 calendar days of the date on the denial letter by faxing additional medical information to the TMHP LTC department (40 TAC 19.2407). Or, the DON or other licensed nurse within the facility may provide additional information by calling and speaking with a TMHP nurse. The recipient's assessment and the additional (or new) medical information are then returned to the TMHP physician for a second medical necessity determination.
   - If the TMHP physician determines that medical necessity has been met, the assessment is approved.
   - If the TMHP physician determines that medical necessity has not been met, the denial will be upheld.

10. The recipient may initiate the appeal process when notified by TMHP that medical necessity was denied by the TMHP physician. If a hearing is requested, additional information may be submitted at any time by the provider or by the individual's physician either via a phone call to the TMHP nurses or via fax.

11. If the Nursing Facility or recipient's physician does not provide additional information clarifying nursing/medical needs within 21 days of “Pending Denial (need more information),” the assessment is sent to the TMHP physician for review, and the steps 6-10 will apply.

Note: The nursing facility is responsible for checking the status of their submitted forms and assessments using FSI or Current Activity and supplying additional information, if needed.
Request for Fair Hearing

A fair hearing is an informal, orderly, and readily available proceeding held before an impartial health and human services enterprise hearing officer. At the hearing, a recipient/applicant (appellant), or their representative, including legal counsel, may present the case as he wishes to show that any action, inaction, or agency policy affecting the case should be reviewed.

The recipient, the recipient's responsible party, or in the case of no responsible party, the director of nurses or the nursing facility administrator may request a fair hearing on behalf of the recipient within 90 days from the effective date of the decision or from the notice of adverse action date, whichever is later by calling TMHP at 1-800-626-4117 and choosing option 5. When a resident receives a letter denying medical necessity and giving the resident the right to request a fair hearing, the resident must request a fair hearing within 10 days of the date of the letter for Medicaid payment to continue until the fair hearing decision. Medicaid payment will only continue if the resident was already receiving services. If the resident requests a fair hearing later than 10 days of the date of the letter, Medicaid payment will not be made for days past day 10. The resident can request a fair hearing up to 90 days after the date of the letter.

Form 4803, Acknowledgement and Notice of Fair Hearing, serves as a notice of the fair hearing. It is sent to the appellant to acknowledge the receipt of a request for a hearing and to set a time, date, and place for the hearing. Form 4803 will be sent to all known parties and required witnesses at least 10 calendar days in advance of the hearing.

The fair hearing is held at a reasonable place and time. They are normally scheduled in the order in which requests are received and are held via teleconference.

Appellants may present their own case, or bring a friend, relative, or attorney to present their case. DADS/Health and Human Services enterprise does not pay attorney fees. Appellants may request additional time to prepare for their case by contacting the hearing officer.

Appellants may request an interpreter at no cost. However, appellants must notify the hearing officer at least two days before the hearing if they are going to require an interpreter.

Before and during the hearing, appellants and their representatives have the right to examine the documents, records, and evidence that DADS will use. To see medical evidence before the hearing, the appellant must make a written request to the hearing officer. The appellant may bring witnesses and present facts and details about the case. The appellant may also question or disagree with any testimony or evidence that is presented by the department.

Appellants have the right to know all the information the hearing officer examines in making his decision. The laws and policies which apply to the appellant's case and the reasons for DADS' action will be explained.

The hearing officer will issue a final written order. The decision by the hearing officer is DADS' final administrative decision. If the appellant believes the hearing officer did not follow applicable policy and procedures, the appellant can submit a request for administrative review within 30 days of the date of the decision. The appellant submits the request for administrative review to the Hearing Officer, who will forward the request to the appropriate legal office for review.

The appellant may have to pay back any overpayments DADS made to the appellant because the appellant did not supply correct and complete information or was overpaid while waiting for the hearing decision.
Forms and assessments process through several validations after receiving a Medical Necessity determination and before reaching a status of “SAS Request Pending.” The following will outline the various statuses.

1. **Medicaid ID Pending** validation results in either:
   - **ID Confirmed** – if confirmed it continues to next validation.
   - **ID Invalid** – If the form or assessment is in this status, the provider must verify Medicaid number, SSN, Medicare number and the first four digits of the last name for accuracy. They must match what is on the resident’s Medicaid card (if they have one). However, the last name cannot contain spaces or special characters (e.g. hyphen).
     - If this information is accurate, the provider may contact TMHP to have the form restarted.
     - If different, the incorrect information will need to be corrected and the form or assessment resubmitted.
   - **Med ID Check Inactive** – In this status, the Medicaid ID validation was attempted nightly for up to six months and either failed or the request was cancelled.
     - If the resident is certified for Medicaid after six months, the form or assessment can be reactivated by the provider by clicking on the “Reactivate Form” button.

2. **Pending Medicaid Eligibility** validation will result in either:
   - **Medicaid Eligibility Confirmed** – if confirmed it continues to next validation.
   - **Pending Medicaid Eligibility** – In this status, validation attempts will occur nightly until eligibility is found, the request is cancelled, or until six months has expired, whichever comes first.
     - If Medicaid Eligibility has already been established, the provider may contact TMHP to have form or assessment restarted.
     - After Medicaid Eligibility has been established the provider must allow 14 days for the systems to interface. AFTER two weeks the provider may call TMHP to have the form or assessment restarted.
   - **ME Check Inactive** - In this status, the Medicaid Eligibility validation was attempted nightly for up to six months and either failed or the request was cancelled.
     - If the resident is certified for Medicaid after six months, the form or assessment can be reactivated by the provider by clicking on the “Reactivate Form” button.
3. **Pending Applied Income** validation will result in either:

- **Applied Income Confirmed** – the form or assessment will process to “SAS Request Pending.”
- **Pending Applied Income** - In this status, validation attempts will occur nightly until applied income is found, the request is cancelled, or until six months has expired, whichever comes first.
  - If Applied Income has already been established, the provider may contact TMHP to have form or assessment restarted.
  - After Applied Income has been established, the provider must allow 14 days for the systems to interface. AFTER two weeks the provider may call TMHP to have the form or assessment restarted.
- **AI Check Inactive** - In this status, the Applied Income validation was attempted nightly for up to six months and either failed or the request was cancelled.
  - If the Applied Income is determined after six months, the form or assessment can be reactivated by the provider by clicking on the “Reactivate Form” button.

**Note:** The six month time frame is a cumulative time period, meaning the form or assessment has a TOTAL of six months to pass through all three validations, NOT six months to pass each validation.

**Note:** Detailed diagrams illustrating the Medicaid Eligibility Verification Workflows can be found in Appendix A and B of this guide.

The example below shows an assessment that flows successfully:

<table>
<thead>
<tr>
<th>History</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awaiting LTC Medicaid Information</td>
<td>4/3/2009 12:00:35 PM</td>
</tr>
<tr>
<td>Form Submitted</td>
<td>4/7/2009 8:42:18 AM</td>
</tr>
<tr>
<td>Approved</td>
<td>4/7/2009 8:42:27 AM</td>
</tr>
<tr>
<td>Medicaid ID Pending</td>
<td>4/7/2009 8:42:30 AM</td>
</tr>
<tr>
<td>ID Confirmed</td>
<td>4/7/2009 8:42:31 AM</td>
</tr>
<tr>
<td>Pending Medicaid Eligibility</td>
<td>4/7/2009 8:42:31 AM</td>
</tr>
<tr>
<td>Medicaid Eligibility Confirmed</td>
<td>4/7/2009 8:42:34 AM</td>
</tr>
<tr>
<td>Pending Applied Income</td>
<td>4/7/2009 8:42:34 AM</td>
</tr>
<tr>
<td>Applied Income Confirmed</td>
<td>4/7/2009 8:42:35 AM</td>
</tr>
<tr>
<td>SAS Request Pending</td>
<td>4/7/2009 8:42:37 AM</td>
</tr>
</tbody>
</table>

The example below shows a status of ID Invalid, indicating the assessment failed Medicaid ID validation:

<table>
<thead>
<tr>
<th>ID Invalid</th>
<th>Changed by System on 9/19/2008 3:12:06 PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>0/19/2008 3:12:06 PM</td>
<td>TMHP : Medicaid ID deemed invalid by DADS</td>
</tr>
</tbody>
</table>
Provider Workflow Process

Provider Workflow allows providers to independently manage their forms and assessments when errors in the systems processing occur. The system sends the form and assessment information to DADS and updates the MESAV. The functionality of Provider Workflow allows providers to directly manage their rejections which occurred during the nightly processing. The benefit to this process is shorter time in resolution.

Provider Workflow in summary:

• Form and assessment has not been successfully processed.
• Error occurred during the nightly batch processing.
• Rejection error message can be found within the form and assessment history.
• Ownership for resolution belongs to the provider.
• Form and assessment status is “Provider Action Required.”

The provider workflow is the responsibility of the provider to monitor and manage. Forms and assessments end up in the provider workflow as a result of the systems processing discovering an error while attempting to process the form or assessment. System processing errors are found within the history of the form or assessment and the status is set to “Provider Action Required.” Once a form or assessment status is “Provider Action Required”, the form or assessment will require provider action before processing on that particular form or assessment continues.

Type of Forms being sent to the Provider Workflow include: 3618, 3619, MDS and MDSQTR.

If a batch error occurs, the error will display in the history of the form or assessment. The form or assessment status will be “Provider Action Required.”

Finding Forms and Assessments with “Provider Action Required” Status

To find the items in your provider workflow (i.e. those items with system processing errors to be resolved by the provider):

1. Click the Form Status Inquiry link in the blue navigational bar.
2. Type of form: Choose Type of Form (e.g. 3618) from the drop-down box.

Note: 3618, 3619, MDS and MDSQTR “Type of Form” in the drop-down box could result in a status of “Provider Action Required.” Therefore each of these “Type of Form” options must be reviewed individually. This example will continue with choosing the 3618. Providers will need to review all the other applicable Type of Forms as well.
3. Enter the “From Date” and “To Date” range in the fields allocated.

4. Form Status: Choose **Provider Action Required** from the drop-down box.

5. Click the “Search” button found on the bottom right of the screen to submit the Inquiry.

6. Those 3618 forms with a status of **Provider Action Required** will display.

*Note: For confidentiality purposes, the form details (i.e. Medicaid #, etc.) have been hidden in this document.*
7. Click the **View Detail** link to open the form.

8. Scroll to the bottom of the page to view History.

9. Find “**Provider Action Required**” status on the far left. It should be the last line in history.

10. Find the rejection message in the white line just below the “**Provider Action Required**”.

11. Perform the necessary research to resolve the error. See the Provider Workflow rejection messages later in this document for more information.
12. Depending on the provider research, providers have one of three options to move the form or assessment out of the provider workflow. There are situations where the Provider Action is to contact Provider Claims Services.

- **“Correct this form.”** “Correct this form” allows provider to submit a correction. The original form or assessment with a status of “Provider Action Required” will be given a status of “Corrected” and will have a parent DLN to the new/child form. The new form or assessment replaces the original form or assessment.
- **“Inactivate Form.”** “Inactivate Form” will inactivate the form. Forms will change to a status of “Form Inactivated” and cannot be corrected or re-submitted. An example of when this “Inactivate Form” button would be used is when the provider research indicates the form being submitted is a duplicate.
- **“Resubmit Form.”** “Resubmit Form” will change the form or assessment status to “SAS Request Pending.” The form or assessment will process during the nightly batch processing. Check the status of the form or assessment within 2-4 days to determine if the form or assessment processed successfully. Status will be “Processed/Complete” if successfully processed.

13. If the provider chooses, “Correct this form,” a parent/child DLN relationship will be created.
14. If the provider chooses “Inactivate Form,” the provider will receive the following confirmation window.

   – Click the “OK” button to inactivate and the form or assessment status will be set to status “Form Inactivated.”
   – Click the “Cancel” button to cancel the Inactivation request keeping the form or assessment status as “Provider Action Required.”

15. If the provider has chosen “Resubmit Form,” the following screen will appear allowing the provider to add any comments.

   There is an option to select “2-System” or “1-ProviderFacing.”

   – **2-System**: will allow comments entered by the provider to be seen only by internal state staff. The comments will not be able to be seen by the provider.
   – **1-ProviderFacing**: will allow comments entered to be seen by both state staff and the provider.

   In either case, the comments will be seen in the History section of the form or assessment.
The provider may choose to enter comments. Entering comments is optional.

Click the “Cancel” button to cancel the request keeping the form or assessment in the status of “Provider Action Required”

or

Click the “Change Status” button; form or assessment is then set to status “SAS Request Pending.”

16. Once one of the actions have been completed—“Correct this form,” “Inactivate form” or “Resubmit Form”—the status of the form or assessment will no longer be “Provider Action Required” status. Processing will continue based upon action chosen.

17. Provider should repeat all the steps for each particular “Type of Form” until there are no more results found. Our example was using 3618.

Note: Don't forget, there are 4 “Type of Forms” that can end up in the Provider Workflow: 3618, 3619, MDS and MDSQTR. Once one type is completed with “No Results Found,” continue with the next “Type of Form” repeating all the steps to clear those with a status of “Provider Action Required.”

Using Current Activity

An alternate method for working forms or assessments recently set to status “Provider Action Required” is to use Current Activity.

Current Activity will show all forms and assessments that have changed status in the last 14 days. Once the form or assessment has been in status of “Provider Action Required” over two weeks, it must be located using Form Status Inquiry.

Once a form or assessment is being considered for “Provider Action Required,” you may want to perform a recipient search to see if the recipient has any other forms or assessments are in status of “Provider Action Required.”

Current Activity is in the blue navigational bar next to Form Status Inquiry.
General Instructions

- Review the effective date on the form or assessment to ensure it is correct. For 3618s and 3619s, the effective date is the Date of Above Transaction. For admission MDS assessments, the effective date is the AB1 Date. For all other MDS assessments, the effective date is the R2b Date.
  - If the effective date is incorrect, take the appropriate action to correct the form or assessment.
    - 3618/3619: Correct the form on the Portal and submit.
    - MDS: Correct the assessment and submit the modified MDS to the Federal CMS database, then complete the LTCMI on the Portal.
  - If the effective date is correct, continue on to the next General Instruction.
- If a 3618/3619 form that needs to be resubmitted is in Submitted to Manual Workflow status, click on “Correct this form,” add a comment (example: resubmit), then click on “Submit Form.”

Provider Workflow Rejection Messages

Below are the rejection messages providers will receive as a result of an error occurring during the nightly batch processing. The messages are in order of message number.

The table contains 3 columns:

1. **Provider Message.** This is the system message that will be displayed in form and assessment history.

2. **Associated with Forms.** What form and assessment can receive this message. Some messages only apply to certain types of assessments. When only specific types are affected, they are shown. Otherwise, MDS would indicate all types.
   a. AA8a = 01. Admission Assessment
   b. AA8a = 02. Annual Assessment
   c. AA8a = 03. Significant Change in Status Assessment
   d. AA8a = 04. Significant Correction of Prior Full Assessment
   e. AA8a = 05. Quarterly Assessment
   f. AA8a = 10. Significant Correction of Prior Quarterly Assessment

3. **Suggested Action.** The messages and suggested action button is written assuming that the rejected form or assessment is correct in Form Type, Date of Above Transaction and Effective Date. First verify that the rejected form is a valid submission. If the Form Type or Date of Above Transaction date is incorrect, submit an inactivation of that form and submit the correct type or transaction. If the Date of Above Transaction is incorrect, submit a correction for the correct date and resolve any missing form issues. If the MDS Reason for Assessment is incorrect or the MDS is invalid, submit an inactivation through the State MDS Database. If the AB1 date submitted is incorrect, modify it through the State MDS Database.
<table>
<thead>
<tr>
<th>Reject Message Description</th>
<th>Associated with Forms or Assessments</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NF-0001</strong>: The request cannot be processed because the client’s Applied Income is not available to SAS. Contact the client’s Eligibility Worker to update the client’s Applied Income. Once the Applied Income has been updated, this request can be resubmitted to SAS.</td>
<td>MDS</td>
<td>1. Pull a MESA for the client covering the date requested on the assessment. Note: If the client does not already have Service Authorizations for your contract, this information will not be available on the MESA. 2. If the MESA does not show an Applied Income for the dates of the assessment, contact the client’s HHSC Eligibility Worker to update the Applied Income records. 3. Once the Applied Income has been updated, submit the rejected assessment. If the client is already established in your facility, you may monitor the MESA for updated Applied Income. 4. If the MESA does show an Applied Income for the dates of the assessment, resubmit the rejected assessment.</td>
</tr>
<tr>
<td><strong>NF-0002</strong>: The request cannot be processed because there is no gap in the Level records for this client, for the requested PC E timeframe.</td>
<td>MDS (AA8a=01, 02, 05)</td>
<td>1. Pull a MESA for the PC E dates requested on this assessment and verify the dates shown in the Level section of the client’s MESA. 2. If the Level coverage dates on file are valid, a PC E is not needed. Inactivate the assessment on the Federal CMS database. 3. If the expected gap is not reflected on the Level record, contact Provider Claims Services (512-438-2200 option 1) for assistance. 4. If the PC E dates are wrong, correct the PC E dates on the LTCMI and submit.</td>
</tr>
<tr>
<td><strong>NF-0003</strong>: The request cannot be processed because the resident does not have retroactive Medicaid eligibility. Please contact the local Eligibility Worker.</td>
<td>MDS (AA8a=01, 02, 05)</td>
<td>Once Prior eligibility is available, resubmit assessment. If Prior Eligibility does not apply to the period requested, change the Purpose Code to PC E if needed.</td>
</tr>
<tr>
<td><strong>NF-0004</strong>: The request cannot be processed because the client does not have a corresponding Nursing Facility admission (missing 3618/3619). Please verify that the admission 3618/3619 has been processed.</td>
<td>MDS</td>
<td>1. Review the facility’s records to determine whether the client is considered Medicare or Medicaid and what the admission date is for your facility. 2. Review the LTC Online Portal to determine the status of the admission (3618/3619). Locate the associated admission.  • If the 3618/3619 is not in a completed status, determine why the form rejected.  ^ Correct the current 3618/3619 admission, or Inactivate and resubmit a new 3618/3619 admission.  • If the 3618/3619 is in a completed status, compare the processed/complete date to the rejection date of the MDS. If the admission was processed after the MDS rejected, use “submit to SAS” to resubmit the MDS to the system.  • If the processed/complete date on the admission is prior to the MDS rejection, contact DADS Provider Claims Services (PCS) at 512/438-2200 Option 1.</td>
</tr>
<tr>
<td><strong>NF-0008</strong>: The request cannot be processed because an assessment with the same effective date has already been processed. Please continue to submit assessments based on the resident’s MDS assessment schedule.</td>
<td>MDS (AA8a=05)</td>
<td>1. Verify if the Assessment date on the rejected assessment is correct. If not submit a modification to the State database to correct. 2. If Assessment date is correct, determine which assessment is appropriate for the assessment date and inactivate the other MDS. 3. If the processed assessment is inactivated, the new assessment can be resubmitted once the inactivation is processed. If the rejected assessment is inactivated, no further actions are needed.</td>
</tr>
</tbody>
</table>
## Reject Message Description

<table>
<thead>
<tr>
<th>Provider Message (displayed in History)</th>
<th>Associated with Forms or Assessments</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| NF-0010: The request cannot be processed because an assessment with the same effective date has already been processed and is not a Quarterly. Please continue to submit assessments based on the resident’s MDS assessment schedule. | MDS (AA8a=10) | 1. Verify if the Assessment date on the rejected assessment is correct. If not submit a modification to the State database to correct.  
2. If Assessment date is correct, determine which assessment is appropriate for the assessment date and inactivate the other MDS. If the processed assessment is inactivated, the new assessment can be resubmitted once the inactivation is processed. If the rejected assessment is inactivated, no further actions are needed. |
| NF-0011: The request cannot be processed because you have reached the limit of Swing Bed days for this resident for a 12 month period. Please submit an admission if the resident becomes eligible to receive additional Swing Bed services. | 3618 | Medicaid Swing Bed services are limited to 30 days per stay. Verify dates, if incorrect submit correction. |
| NF-0012: The request cannot be processed because SAS records indicate the client is currently in Hospice. If the client is no longer enrolled in the Hospice program, please contact the Hospice provider and request that they discharge the client from the program. Once the Hospice discharge is processed, resubmit your request. If the client is a Hospice recipient, inactivate your request. | 3618, 3619 | 1. Review the facility’s records to determine if the client is Hospice.  
2. If the client is Hospice, Inactivate the Nursing Facility form. Note: Form 3618/3619s should not be submitted on Hospice clients.  
3. If the client has requested to terminate the Hospice program, contact the Hospice provider and request that the provider submit a discharge Form 3071.  
4. If the Form 3071 has already been submitted, allow 10 days for processing before resubmitting the admission to SAS. Note: If the form rejects again, the Hospice provider needs to follow up with Provider Claims Services.  
5. If the Form 3071 has not yet been submitted, allow the time requested by the Hospice provider for processing of the Hospice discharge before resubmitting to SAS. |
| NF-0013: The admission cannot be processed because the client is already admitted into a facility. If a discharge prior to this admission is rejected, the rejected discharge must be processed first. This admission can then be resubmitted to SAS. If this is the initial admission into your facility, please contact the prior provider and request that they submit the missing discharge. | 3618 | 1. If this is the initial admission into your facility, please contact the previous provider and request that they submit a discharge on the client.  
2. If not, pull a MESAV for the client to determine the begin date of the current Service Authorization.  
3. Based on the Service Authorization begin date and the effective date of the rejected admission, submit the discharge that falls between these dates.  
4. Once the previous discharge has a status of SAS Request Pending, resubmit the rejected admission. |
<p>| NF-0014: The request cannot be processed because an earlier admission has already been processed. If a discharge prior to this admission is missing, please resubmit once the matching discharge is submitted. | 3618 | Click the “Resubmit Form” button once the prior discharge has been processed. |</p>
<table>
<thead>
<tr>
<th>Reject Message Description</th>
<th>Associated with Forms or Assessments</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>NF-0015: The request cannot be processed because an earlier admission from another provider has already been processed. Please contact the prior provider to have a discharge submitted. Please resubmit once the missing discharge is submitted.</td>
<td>3618</td>
<td>Click the “Resubmit Form” button once the prior facility’s discharge has been submitted processed.</td>
</tr>
<tr>
<td>NF-0016: The request cannot be processed because an earlier admission has already been processed. If a discharge prior to this admission is missing, please resubmit once the missing discharge is submitted. If this is the initial admission to your facility, please contact the prior provider to have a discharge submitted.</td>
<td>3618</td>
<td>Click the “Resubmit Form” button once the prior discharge has been processed</td>
</tr>
</tbody>
</table>
| NF-0017: This admission cannot be processed because a later admission is already on file. This admission occurs in the past and must be one of a pair, which will create a separate Service Authorization. If the discharge following this admission is missing or rejected, both forms must be submitted to SAS on the same day. | 3618, 3619 | 1. Review the facility’s records to determine which discharge follows this admission.  
2. Pull a MESAV and review the Service Authorizations to see if a gap exists for the period that will be created by the admission and discharge pair.  
   a. If a gap exists, resubmit the admission to SAS, then submit or re-submit the following discharge. Both forms must be submitted on the same day. The system will process both forms as a pair.  
   b. If a gap does not exist, review the facility’s records to determine if a discharge prior to the rejected admission is reflected on the client’s MESAV.  
      • If the discharge is not reflected on the client’s MESAV, submit the missing or rejected discharge, followed by the admission and discharge pair.  
      If the discharge is reflected on the client’s MESAV, contact Provider Claims Services for assistance. |
| NF-0018: The request cannot be processed because the client does not have a corresponding Nursing Facility admission (missing 3618). Please verify that the admission 3618 has been processed. | MDS | 1. Review the facility’s records to determine which admission is prior to this discharge.  
2. Pull a Medicaid Eligibility Service Authorization Verification (MESAV) and review the Service Authorizations to determine if the prior admission has processed and authorized services. If the MDS for the admission has not processed you will not have services authorized.  
3. Review the LTC Online Portal to see the status of the prior Form 3618 admission. If it is rejected, take the necessary actions to process the admission. If the client admitted from another provider and the client has been admitted into your facility over 14 days, please contact the prior facility. If resolution cannot be reached, please call PCS.  
4. Once the admission has been processed, click “submit to SAS” on the discharge with the NF-0018 error  
5. If the discharge with the NF-0018 is reflected on the client’s MESAV, contact PCS for assistance. |
<table>
<thead>
<tr>
<th>Reject Message Description</th>
<th>Provider Message (displayed in History)</th>
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</thead>
</table>
| NF-0019:                   | This discharge cannot be processed because the client is not admitted into this facility. If an admission prior to this discharge is rejected, the rejected admission must be processed first. This discharge can then be resubmitted to SAS. | 3618 | • Review the facility records to identify the admission prior to this discharge.  
• If the prior admission form was rejected, correct the form and submit. The admission must be processed before the discharge can process.  
If the prior admission form is missing, submit the missing form on the Portal. |
| NF-0020:                   | The request cannot be processed because a later discharge has already been processed. If an admission after this discharge is missing, please resubmit with the submission of the matching admission. | 3618 | This discharge is part of a retroactive pair. It must be submitted the same day as the admission following it. If the form is not part of a pair, it should be a correcting discharge, not a new discharge. Inactivate this form and correct transaction date of the later discharge. |
| NF-0021:                   | The request cannot be processed because a later admission to another provider has already been processed. If an admission prior to this discharge is missing, please resubmit with the submission of the matching admission. | 3618, 3619 | This discharge is part of a retroactive pair. It must be submitted the same day as the admission before it. If the form is not part of a pair, it should be a correcting discharge, not a new discharge. Inactivate this form and correct transaction date of the earlier discharge. |
| NF-0022:                   | The request cannot be processed because the client does not have a corresponding Nursing Facility admission (missing 3618). Please verify that the admission 3618 has been processed. | 3618 | 1. Review the facility’s records to determine which admission is prior to this discharge.  
2. Pull a MESAV and review the Service Authorizations to determine if the prior admission has processed and authorized services. If the MDS for the admission has not processed you will not have services authorized. A review of the LTC Online Portal can also determine the status of the admission.  
3. Review the Service Authorizations to see if a gap exists for the period that will be created by the admission and discharge pair. This could be a time frame between existing authorizations or following the last discharge on file.  
4. If the transaction dates are after the last end date authorized, submit the admission followed by the discharge.  
5. If transactions dates are prior to the most recent begin date, the admission and discharge must be submitted as a retroactive pair.  
• If a gap exists between authorizations, submit or resubmit the prior admission to SAS, then resubmit the rejected discharge. Both forms must be submitted on the same day. The system will process both forms as a pair.  
• If a gap does not exist, review the facility’s records to determine if a discharge prior to the rejected admission is needed on the client’s MESAV. Also determine if an admission is needed between the rejected discharge and the end date already on file.  
• If the discharge is needed on the client’s MESAV, submit the missing or rejected discharge, followed by the admission. You must also submit both the discharge and the later admission as a pair on the same day.  
6. If the discharge with the NF-0022 is reflected on the client’s MESAV, contact PCS for assistance. |
<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>NF-0023: The admission cannot be processed because the client is already admitted into a facility. If a discharge prior to this admission is rejected, the rejected discharge must be processed first. This admission can then be resubmitted to SAS. If this is the initial admission into your facility, please contact the prior provider and request that they submit the missing discharge.</td>
<td>3619</td>
<td>1. If this is the initial admission into your facility, please contact the previous provider and request that they submit a discharge on the client. 2. If this is not the initial admission into your facility, pull a MESAV for the client to determine the begin date of the current Service Authorization. 3. Based on the Service Authorization begin date and the effective date of the rejected admission, submit the discharge that falls between these dates. Once the previous discharge has a status of SAS Request Pending, resubmit the rejected admission.</td>
</tr>
<tr>
<td>NF-0024: The request cannot be processed because an earlier admission has already been processed. If a discharge prior to this admission is missing, please resubmit once the matching discharge is submitted.</td>
<td>3619</td>
<td>Click the “Resubmit Form” button once the prior discharge has be processed.</td>
</tr>
<tr>
<td>NF-0025: The request cannot be processed because an earlier admission from another provider has already been processed. Please contact the prior provider to have a discharge submitted. Please resubmit once the missing discharge is submitted.</td>
<td>3619</td>
<td>Click the “Resubmit Form” button once the prior facility’s discharge has been processed.</td>
</tr>
<tr>
<td>NF-0026: The request cannot be processed because an earlier admission has already been processed. If a discharge prior to this admission is missing, please resubmit once the missing discharge is submitted. If this is the initial admission into your facility, please contact the prior provider about submitting a discharge.</td>
<td>3619</td>
<td>Click the “Resubmit Form” button and submit the earlier admission - retroactive forms must be submitted in pairs.</td>
</tr>
<tr>
<td>NF-0028: The request cannot be processed because the Qualifying Stay days, plus any Full Medicare days already documented, add up to more than the 20 days allowed for this Spell of Illness.</td>
<td>3619</td>
<td>For each Medicare Spell of Illness, 20 days of Full Medicare coverage is required, between one or more providers. 1. Check the Dates of Qualifying Stay From and To Dates on the form. The number of days on the form, plus any Full Medicare days already documented for that Spell of Illness, cannot exceed 20 days. 2. If the Dates of Qualifying Stay on the form are wrong, correct the form and submit. 3. If the Dates of Qualifying Stay on the form are correct, contact Provider Claims Services to request manual processing. <strong>Note:</strong> If this is not traditional Medicare, please document this in the comment section and call 512-438-2200 option 3 or Fax the Medicare Replacement’s EOB with a copy of the 3619 to 512-438-3400.</td>
</tr>
<tr>
<td>Reject Message Description</td>
<td>Associated with Forms or Assessments</td>
<td>Suggested Action</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| **NF-0029:** The days of Qualifying Stay have been recorded. However, the request for Medicare Part A Co-Insurance cannot be processed because the Qualifying Stay days, plus any Full Medicare days already documented, are less than the 20 days required for this Spell of Illness. | 3619 | For each Medicare Spell of Illness, 20 days of Full Medicare coverage is required, between one or more providers.  
1. Check the Dates of Qualifying Stay From and To Dates on the form. The dates entered must add up to the 20 day requirement, or an additional form must document the remainder of the 20 days of Qualifying Stay.  
2. If the Dates of Qualifying Stay on the form are wrong, correct the form and submit.  
3. If the Dates of Qualifying Stay on the form are correct, submit another form to document the remaining days of Qualifying Stay, once that information becomes available.  
**Note:** If this is not traditional Medicare, please document this in the comment section and call 512-438-2200 option 3 or Fax the Medicare Replacement's EOB with a copy of the 3619 to 512-438-3400. |
<p>| <strong>NF-0030:</strong> The request cannot be processed because it has not been more than 60 consecutive days since the resident was discharged from Medicare (cannot begin a new spell of illness). Please review Medicare remittance to determine when Medicare Co-Insurance is due. Submit a new Form 3619 based the resident’s Medicare remittance. | 3619 | Validate the dates of the spell of illness to see if this admission is part of the prior stay or if it begins a new stay of illness. Submit corrections needed of any earlier 3619’s and resubmit this admission accordingly. |</p>
<table>
<thead>
<tr>
<th>Reject Message Description</th>
<th>Associated with Forms or Assessments</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| **NF-0032**: The request cannot be processed because the client does not have a corresponding Nursing Facility admission (missing 3619). Please verify that the admission 3619 has been processed. | 3619 | 1. Review the facility records to identify the Medicare Co-Insurance admission date prior to this discharge.  
2. Pull a MESAV and review the Service Authorizations to determine if the Form 3619 admission has processed and authorized services.  
3. If Medicare Co-Insurance is authorized, compare the end date of the service authorization to the rejected discharge date. If the rejected discharge date is later than the service authorization end date by more than one day, the discharge is exceeding the 80-day limit of Medicare Co-Insurance. An earlier discharge and readmission may be needed prior to the rejected discharge to allow for additional days before reaching 80-day limit.  
4. If Medicare Co-Insurance is not authorized, use the LTC Online Portal to determine the status of the Form 3619 admission.  
• If the 3619 is not in a completed status, determine why the form rejected.  
5. Correct the 3619 admission, or Inactivate and resubmit a new 3619 admission.  
• If the 3619 is in a completed status, compare the processed/complete date to the rejection date of the Form 3619 discharge. If the admission was processed after the Form 3619 rejected, use “submit to SAS” to resubmit the Form 3619 to the system.  
• If the processed/complete date on the admission is prior to the Form 3619 rejection, see bullet 3.  
6. If the Admission and Discharge transaction dates are prior to the most current Service Authorization begin date, the admission and discharge are a retroactive Pair  
• Review the Service Authorizations to see if a gap exists for the period that will be created by the admission and discharge pair. Submit or resubmit the prior admission to SAS, then resubmit the rejected discharge. Both forms must be submitted on the same day. The system will process both forms as a pair.  
• If a gap does not exist, review the facility’s records to determine if a discharge prior to the rejected admission is needed on the client’s MESAV. Also determine if an admission is needed between the rejected discharge and the end date already on file.  
• If the discharge is needed on the client’s MESAV, submit the missing or rejected discharge, followed by the admission. You must also submit the discharge and later admission as a pair and on the same day.  
7. If the discharge with the NF-0032 is reflected on the client’s MESAV, contact PCS for assistance. |
<p>| <strong>NF-0033</strong>: The request cannot be processed because a later discharge has already been processed. If an admission after this discharge is missing, please resubmit with the submission of the matching admission. | 3619 | This discharge is part of a retroactive pair. It must be submitted the same day as the admission before it. If the form is not part of a pair, it should be a correcting discharge, not a new discharge. Inactivate this form and correct transaction date of the earlier discharge. |</p>
<table>
<thead>
<tr>
<th>Reject Message Description</th>
<th>Associated with Forms or Assessments</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| **NF-0048**: The request cannot be processed because more than one assessment was submitted on the same day with the same assessment effective date. | MDS                                 | 1. Validate the R2b Dates on the MDSs submitted. If an entry error for the assessment date has occurred on one MDS, submit a modification to the Federal CMS database for that assessment.  
2. If the MDS with the correct date rejected, use “submit to SAS” to reprocess the form after the modification of the incorrect date has processed.  
3. If one of the assessments was submitted in error, inactivate the mistaken assessment.  
4. If the correct form rejected, use “submit to SAS” to reprocess the form after the inactivation has processed. |
| **GN-9101**: The request cannot be processed because of the resident’s Financial Eligibility or Income. Please contact the local Eligibility Worker. | 3618, 3619, MDS                      | Click the “Resubmit form” button after MESAV reflects the appropriate coverage by the eligibility worker.                                                                                                           |
| **GN-9102**: The request cannot be processed because of the resident’s Financial Eligibility or Income. Please contact the local Eligibility Worker. | 3618, 3619, MDS                      | Click the “Resubmit form” button after MESAV reflects the appropriate coverage by the eligibility worker.                                                                                                           |
| **GN-9103**: The request cannot be processed because the client’s Applied Income is not available to SAS. Contact the client’s Eligibility Worker to update the client’s Applied Income. Once the Applied Income has been updated, this request can be resubmitted to SAS. | 3618, 3619, MDS                      | 1. Pull a MESAV for the client covering the date requested on the form or assessment. Note: If the client does not already have Service Authorizations for your contract, this information will not be available on the MESAV.  
2. If the MESAV does not show an Applied Income for the dates of the form or assessment, contact the client’s HHSC Eligibility Worker to update the Applied Income records.  
3. Once the Applied Income has been updated, resubmit the rejected form or assessment. If the client is already established in your facility, you may monitor the MESAV for updated Applied Income.  
4. If the MESAV does show an Applied Income for the dates of the form or assessment, resubmit the rejected form sitting in the Provider Action Required Workflow. |
| **GN-9104**: The request cannot be processed because of the resident’s Financial Eligibility or Income. Please contact the local Eligibility Worker. | 3618, 3619, MDS                      | Click the “Resubmit form” button after MESAV reflects the appropriate coverage by the eligibility worker.                                                                                                           |
| **GN-9105**: The request cannot be processed because of the resident’s Financial Eligibility or Income. Please contact the local Eligibility Worker. | 3618, 3619, MDS                      | Click the “Resubmit form” button after MESAV reflects the appropriate coverage by the eligibility worker.                                                                                                           |
| **GN-9106**: The request cannot be processed because of the resident’s Financial Eligibility or Income. Please contact the local Eligibility Worker. | 3618, 3619, MDS                      | Click the “Resubmit form” button after MESAV reflects the appropriate coverage by the eligibility worker.                                                                                                           |
Corrections can be made to certain fields on LTCMI, Forms 3618, 3619, 3071 and 3074. Corrections cannot be performed on PASARR Screenings or 3652-A Purpose Code E’s.

**LTCMI Corrections**

Corrections to only the LTCMI data can be submitted directly on the LTC Online Portal. Once you have found the assessment in the FSI or Current Activity.

**Note:** If no purpose code is identified in field S1e. (Purpose Code), it may be corrected to reflect either an E or M. A Purpose Code (PC) M may be corrected to a PC E. However, a PC E is unable to be corrected to a PC M. Once an assessment is classified as a PC E, field S1e. is not correctable.

1. Login to the LTC Online Portal.
2. Click the **FSI** or **Current Activity** link.
3. Search for Assessment in any status using the recipient’s SSN, Medicaid recipient number, and/or First and Last Name.
4. Click the **View Detail** link.
5. Click the “Correct this form” button.

![Minimum Data Set (MDS) — Version 2.0](image)
6. Click the “Section LTCMI” tab and complete only the fields needing correction.

7. Click the “Submit Form” button.

8. The original assessment (parent) is set to status “Corrected” and the new assessment (child) DLN is assigned, creating a parent/child DLN relationship. The new child assessment replaces the parent assessment.

Note: Corrections are processed overnight. Providers must wait until the following day to see changes.
3618 and 3619 Corrections

NF Providers must submit 3618 and 3619 Form corrections directly on the LTC Online Portal.

Correctable Fields on 3618 and 3619

- Administrator Signature Date
- Administrator License Number
- Comment Section
- Date of Above Transaction
- Discharge Type
- Location
- Recipient Address
- Recipient First Name
- Recipient Middle Name
- Dates of Qualifying Stay

If a non-correctable field is filled incorrectly inactivate and resubmit the form.

TMHP places the original form in a corrected status and gives the new form a DLN creating a Parent/Child DLN relationship.

Correction to 3618 or 3619:

1. Login to the LTC Online Portal.
2. Click the Form Status Inquiry link in the blue navigational bar.
3. Search for 3618 or 3619 using the recipient’s SSN, Medicaid recipient number, First and Last Name, and/or DLN.
4. Click the View Detail link.
5. Click the “Correct this form” button.
6. Complete only the fields needing correction.

7. Click the “Submit Form” button.

Note: If the form is successfully submitted a DLN will be assigned and the portal will show “Your form was submitted successfully.” If there are errors they will be displayed in a box at the top of the screen. These errors will need to be resolved before the form will be successfully submitted. Once all errors are resolved, click the “Submit form” button again to submit the form.

8. Click the DLN link displayed in the “Your form was submitted successfully” message to return to the form.

9. Click the “Print” button in the Form Actions bar to print the completed form.
3071 and 3074 Corrections:

NF Providers must submit 3071 and 3074 Form corrections directly on the LTC Online Portal.

**Correction to 3071 and 3074:**

1. Login to the LTC Online Portal.
2. Click the **Form Status Inquiry** link in the blue navigational bar.
3. Search for 3071 or 3074 using the recipient’s SSN, Medicaid recipient number, First and Last Name, and/or DLN.
4. Click the **View Detail** link.
5. Click the “Correct this form” button.
6. Complete only the fields needing correction.
7. Click the “Submit Form” button.

**Note:** If the form is successfully submitted a DLN will be assigned and the portal will show “Your form was submitted successfully.” If there are errors they will be displayed in a box at the top of the screen. These errors will need to be resolved before the form will be successfully submitted. Once all errors are resolved, click the “Submit form” button again to submit the form.

8. Click the **DLN** link displayed in the “Your form was submitted successfully” message to return to the form.
9. Click the “Print” button in the Form Actions bar to print the completed form.
Modifications

Nursing Facility providers submit all MDS Correction requests to the State MDS Database. Corrections that are classified as a Modification are extracted by TMHP for processing. In field AT3 select the reason for modification. TMHP places the original assessment in a status of “Corrected” and gives the new assessment a DLN creating a Parent/Child DLN relationship set to status “Awaiting LTC Medicaid Information.” The LTCMI must be completed and submitted at this time. The MN will then be determined.

Note: Providers are allowed to submit modifications to an on-time MDS without requiring a Purpose Code for up to one year. For Modifications to an MDS assessment that did not originally meet the timelines rules, a Purpose Code E will be required upon submission of the LTCMI.


Providers must access the LTC Online Portal to retrieve the new assessment, complete the LTCMI, and submit.
Inactivations

MDS Assessment

For MDS Inactivations, NF Providers complete the MDS Correction Request Form ensuring field AT4 (reason for inactivation) was completed prior to submitting it to the State MDS Database. TMHP will extract all successfully submitted MDS Inactivation Requests from the State MDS Database for processing. When the inactivation is placed on the TMHP portal, TMHP will automatically inactivate the associated LTCMI and the assessment status will be set to “Form Inactivated.” LTCMI inactivations are not permitted on the LTC Online Portal. If the assessment had a previous status of “Processed/Complete,” which means it was already been processed by SAS, the assessment status will be set to “Submitted to manual workflow.” Inactivations set to “Submitted to manual workflow” will be manually inactivated and the assessment status will be set to “Invalid/Complete.” Any MDS assessment status set to “Form Inactivated” or “Invalid/Complete” cannot be corrected or resubmitted.

PASARR Screening, Form 3618, and Form 3619

PASARR Screenings, 3618 and 3619 inactivations must be submitted directly on the LTC Online Portal after being located by a search through FSI or Current Activity. Once the inactivation is submitted and accepted, the form or PASARR Screening is set to status “Form Inactivated” and is unavailable for any further action.

Inactivations

1. Login to the LTC Online Portal.
2. Click the FSI or Current Activity link in the blue navigational bar.
3. If using FSI, you may search for a PASARR Screening, 3618, or 3619 using SSN, Medicaid Number, or DLN.
4. Click the View Detail link.
5. Click the “Inactivate Form” button.

6. Click the “OK” button when the pop-up window asks “Are you sure you want to Inactivate this form?”

7. Click the Add Note button, and select or type the reason for the inactivation.

Note: An inactivated form or screening is given a status of ‘Form Inactivated’ and can not be reactivated, corrected or re-submitted. Once the form or screening is inactivated it is removed from all workflows. Providers can use the inactivated form or screening as a template.

Providers can retrieve the status of their MDS Assessment by accessing FSI or Current Activity on the LTC Online Portal. The following are statuses that a provider may see, and their definition:

- **AI Check Inactive**: Applied Income validation attempted nightly for up to 6 months and failed or the request was canceled.
- **Appealed Doctor Review**: Provider has appealed the MN determination and provided more information for consideration. Assessment is now awaiting TMHP Doctor Review.
- **Appealed Pending Fair Hearing**: Fair Hearing has been requested.
- **Approved/MN Approved**: MN approved.
- **Awaiting LTC Medicaid Information**: MDS has been extracted from the Federal CMS database. If LTCMI is submitted, assessment will be processed by DADS.
- **Coach Pending More Info**: Provider Claims Services is reviewing.
- **Coach Review**: Provider Claims Services is reviewing.
- **Corrected**: Forms are moved into a corrected status when the form is corrected by another form. View the history to find the original DLN. No further actions allowed on form or assessment with a status of corrected.
- **Denied**: View the history for detailed status and information about the denial of Medical Necessity.
- **Form Inactivated**: Assessment/form has been inactivated. No further actions allowed on the form or assessment.
- **ID Invalid**: Medicaid ID validation failed. Cannot be processed until Medicaid ID is corrected. Contact Medicaid Eligibility Worker to verify recipient’s name, social security number and Medicaid ID. A new form or assessment must be submitted with correct information.
- **Invalid/Complete**: DADS processing deemed this form or assessment invalid. See history for details.
- **Invalid Form Sequence**: Only applies for Forms 3618 and 3619. Form 3618/3619 sequence is invalid. For example - 3618 needs to be submitted before the MDS can be accepted.
- **ME Check Inactive**: Medicaid Eligibility validation attempted nightly for up to 6 months and failed or the request was canceled.
- **Med ID Check Inactive**: Medicaid ID validation attempted nightly for up to 6 months and failed or the request was canceled.
- **Medicaid ID Pending**: Medicaid ID validation is pending. Validation attempts occur nightly until deemed valid, invalid or until 6 months has expired, whichever comes first. Contact the Medicaid Eligibility Worker to verify recipient’s name, social security number and Medicaid ID. This status will also apply to private pay residents whose assessments are successfully, but unnecessarily, submitted via LTC Online Portal. The assessment will suspend for 6 months and then close if the resident never applies for Medicaid.
- **Out of State RN License Invalid**: The state issuing the compact license has indicated the compact RN license is invalid.
• **Overtuned Doctor Review:** Assessment was denied medical necessity, then provider supplied more information. Assessment is pending.

• **PASARR not found invalid form:** PASARR Screening is required however a PASARR Screening is not on the TMHP LTC Online Portal. Submit a PASARR Screening.

• **Pending Applied Income:** Applied Income validation is pending. Validation attempts occur nightly until applied income is found, request canceled, or until 6 months has expired, whichever comes first.

• **Pending Denial (need more information):** TMHP nurse did not find the assessment to qualify for Medical Necessity. Provider has 21 days to submit additional information for consideration.

• **Pending Doctor Review:** MN determination is pending TMHP Doctor Review.

• **Pending LTCMI:** MDS has been extracted from the Federal CMS database. If LTCMI is submitted, assessment will be processed by DADS.

• **Pending Medicaid Eligibility:** Medicaid Eligibility validation is pending. Validation attempts occur nightly until eligibility is found, the request is canceled, or until 6 months has expired, whichever comes first.

• **Pending More Info:** DADS needs more information from provider. See history for further details on information required.

• **Pending Nurse Review:** MN determination is pending TMHP Nurse Review because the assessment was not approved through the automated MN determination process.

• **Pending PASARR Verification:** MDS admission assessment indicates a PASARR Screening is required. PASARR Screening is required however a PASARR Screening is not on the TMHP LTC Online Portal. Submit a PASARR Screening.

• **Pending RN License Verification:** RN License number is pending verification from the Texas Board of Nursing or the licensing state from which the compact license was issued.

• **Processed/Complete:** Form or assessment has been processed and complete. Please check MESAV.

• **Provider Action Required:** Form or assessment needs to be reviewed by Provider due to the form or assessment being Rejected by SAS. Refer to form or assessment history for specific error message.

• **SAS Request Pending:** Form or assessment has passed all validations (Medicaid ID, Medicaid Eligibility, Applied Income, etc) and will be sent from TMHP to DADS for processing. Please allow 2 – 4 business days for the next status change.

• **Submitted to manual workflow:** Form or assessment needs to be reviewed by Provider Claims Services due to the form or assessment being Rejected by SAS. Refer to form or assessment history for additional information.
3618 and 3619 Submission
Validation Rules and Edits

Any one of the situations in the following tables will result in a sequencing validation error at the time of form submission. The form will not be accepted until all errors are resolved. The system messages will display at the top of the portal submission page. If you do not receive the DLN number assigned page after clicking the “Submit Form” button, there are errors that need to be resolved. The errors will be displayed at the top of the page therefore you will need to scroll to the top of the page to see the errors.

Validation edits are based on three levels: Form Type, Transaction and Date of Above Transaction

- Form type – admission 3618 must be discharged with a 3618 before submitting a 3619 and the reverse.
- Transactions must alternate between admission and discharge.
- Date of above transaction should be chronological unless submitting a form effective retroactive.
- Retroactive forms should be submitted in pairs creating or filling a gap of time.

Forms with the following statuses are excluded from consideration in meeting form sequencing requirements: Corrected, Invalid/Complete, Invalid Form Sequence, ID invalid, Form Inactivated, Med ID Check Inactive, ME Check Inactive, or AI Check Inactive.

The errors will display at the time of a 3618 or 3619 form submission. There are different errors dependent upon the form type, therefore, the error messages below have been categorized by form type.

1. **System Message.** This is the specific error message that will be displayed in the portal at time of submission.

2. **System Message Clarification.** Further clarification of the portal error message including basic example of the situation.

3. **System Message Resolution.** Assistance with resolving the error.

For those situations where a form is missing, providers will need to submit the missing form in order for the erroring form to pass validations.

The provider has two options regarding the submissions:

- If a submission displays a message that a form is missing, the provider can save the form as draft. Submit the missing form and then retrieve the draft and submit to complete both transactions.
- If the submission displays that a form is missing, that form can be adjusted to submit the missing form and then, using “use as template”, the original form can be submitted now that the edit has been resolved.

The submission of the missing form and the erroring form can occur the same day. The missing form will need to be submitted and then the erroring form. Providers do not need to wait for the missing form to process overnight.
# Form 3618 Resident Transaction Notice Edits

<table>
<thead>
<tr>
<th>Edit Description</th>
<th>System Message Clarification</th>
<th>System Message Resolution (assistance for resolving error)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last form submitted was an admission. Please supply discharge form prior to this admission.</td>
<td>Rejection of New Admission for missing Previous Discharge&lt;br&gt;New admission follows an admission for same contract i.e. 11-12-2008 admission (no discharge)&lt;br&gt;12-16-2008 admission submitted</td>
<td>Submit a discharge prior to this admission&lt;br&gt;Attempting to submit two 3618 admissions in a row, missing a 3618 discharge. Submit the missing discharge then submit the 3618 admission.&lt;br&gt;Scenarios:&lt;br&gt;3618 admit exists in Processed/Complete status for client A, provider A, transaction date = 10/20/08.&lt;br&gt;3618 admit submitted for client A, provider A, transaction date = 10/21/08. Submission is not allowed without a prior discharge&lt;br&gt;3618 admit exists in Corrected status for client A, provider A, transaction date = 10/20/08.&lt;br&gt;3618 admit submitted for client A, provider A, transaction date = 10/21/08. Submit allowed. (Previous admit in corrected status so not considered)&lt;br&gt;3618 admit exists in ME Check Inactive status for client A, provider A, transaction date = 10/20/08.&lt;br&gt;3618 admit submitted for client A, provider A, transaction date = 10/21/08. Submit allowed. (Previous admit in ME Check Inactive status so not considered)&lt;br&gt;3618 discharge exists in Processed/Complete status for client A, provider A, transaction date = 10/19/08.&lt;br&gt;3618 admit exists in Processed/Complete status for client A, provider A, transaction date = 10/19/08.&lt;br&gt;3618 admit submitted for client A, provider A, transaction date = 10/21/08. Submission is allowed because of multiple matching date of above transaction on prior form.</td>
</tr>
<tr>
<td>Last form submitted was a discharge. Please supply admission form prior to this new discharge.</td>
<td>Rejection of New Discharge for missing Previous Admission&lt;br&gt;New discharge follows a discharge for same contract i.e. 11-1-2008 discharge (no admission)&lt;br&gt;12-1-2008 discharge submitted</td>
<td>Submit an admission prior to this discharge.&lt;br&gt;Attempting to submit two 3618 discharges in a row, missing a 3618 admission. Submit the missing admission then submit the 3618 discharge.</td>
</tr>
<tr>
<td>System Message (displayed at time of submission)</td>
<td>System Message Clarification</td>
<td>System Message Resolution (assistance for resolving error)</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>Same contract: An admission has already been received for the Date of Above Transaction. OR Different contract: An admission from another provider has already been received for the Date of Above Transaction</td>
<td>Rejection of New Admission for Same Date of Above Transaction New admission has same Date of Above Transaction as an admission already received i.e. 11-1-2008 admission 11-1-2008 admission</td>
<td>Same contract: Possibly attempting to submit a duplicate form. OR Different contract: A different provider has previously submitted an admission for the same Date of Above Transaction date. One provider is in error. Contact other provider.</td>
</tr>
<tr>
<td>Same contract: A discharge has already been received for the Date of Above Transaction OR Different contract: A discharge from another provider has already been received for the Date of Above Transaction</td>
<td>Rejection of New Discharge for Same Date of Above Transaction New discharge has same Date of Above Transaction as a discharge already received i.e. 11-1-2008 discharge 11-1-2008 discharge</td>
<td>Same contract: Possibly attempting to submit a duplicate form. OR Different contract: A different provider has previously submitted a discharge for the same Date of Above Transaction date. One provider is in error. Contact other provider.</td>
</tr>
<tr>
<td>System Message (displayed at time of submission)</td>
<td>System Message Clarification</td>
<td>System Message Resolution (assistance for resolving error)</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Previous form was a 3619. A 3619 discharge or 3618 admission (as appropriate) must be submitted before a 3618 discharge can be submitted. Applicable for same or different contract.</td>
<td>Rejection of 3618 Discharge following a 3619. 3618 discharge received following a 3619 regardless of contract.</td>
<td>Submit either a 3619 discharge or 3618 admission (as appropriate) prior to this 3618 Discharge. <strong>Scenarios:</strong> 3619 admit exists in Processed/Complete status for client A, provider A, transaction date = 10/20/08. 3618 discharge submitted for client A, provider A, transaction date = 10/21/08. Submit not allowed. 3619 discharge exists in Processed/Complete status for client A, provider A, transaction date = 10/20/08. 3618 discharge submitted for client A, provider A, transaction date = 10/21/08. Submit not allowed. 3619 admit exists in Processed/Complete status for client A, provider A, transaction date = 10/19/08. 3619 discharge exists in Processed/Complete status for client A, provider A, transaction date = 10/19/08. 3618 discharge submitted for client A, provider A, transaction date = 10/21/08. Submit not allowed.</td>
</tr>
<tr>
<td>Edit Description</td>
<td>System Message Clarification</td>
<td>System Message Resolution (assistance for resolving error)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Last form submitted was an admission. Please supply discharge form prior to this</td>
<td>Rejection of New Admission for missing Previous Discharge</td>
<td>Submit a discharge form prior to this admission.</td>
</tr>
<tr>
<td>new admission.</td>
<td>New admission follows an admission for same contract i.e. 11-1-2008 admission (no discharge)</td>
<td>Attempting to submit two 3619 admissions in a row, missing a 3619 discharge. Submit the missing discharge then submit the 3619 admission.</td>
</tr>
<tr>
<td></td>
<td>12-1-2008 admission submitted</td>
<td></td>
</tr>
<tr>
<td>Last form submitted was a discharge...Please supply admission form prior to this</td>
<td>Rejection of New Discharge for missing Previous Admission</td>
<td>Submit an admission form prior to this discharge.</td>
</tr>
<tr>
<td>new discharge.</td>
<td>New discharge follows a discharge for same contract i.e. 11-1-2008 discharge (no admission)</td>
<td>Attempting to submit two 3619 discharges in a row, missing a 3619 admission. Submit the missing admission then submit the 3619 discharge.</td>
</tr>
<tr>
<td>Same contract: An admission has already been received for the Date of Above</td>
<td>Rejection of New Admission for Same Date of Above Transaction</td>
<td>Same contract: Possibly attempting to submit a duplicate form.</td>
</tr>
<tr>
<td>Transaction OR Different contract: An admission from another provider has already</td>
<td>New admission has same Date of Above Transaction as an admission already received i.e. 11-1-2008 admission</td>
<td>OR</td>
</tr>
<tr>
<td>been received for the Date of Above Transaction</td>
<td>11-1-2008 admission</td>
<td>Different contract: A different provider has previously submitted an admission for the same Date of Above Transaction date. One provider is in error. Contact other provider.</td>
</tr>
<tr>
<td>Same contract: A discharge has already been received for the Date of Above</td>
<td>Rejection of New Discharge for Same Date of Above Transaction</td>
<td>Same contract: Possibly attempting to submit a duplicate form.</td>
</tr>
<tr>
<td>Transaction OR Different contract: A discharge from another provider has already</td>
<td>New discharge has same Date of Above Transaction as a discharge already received i.e. 11-1-2008 discharge</td>
<td>OR</td>
</tr>
<tr>
<td>been received for the Date of Above Transaction</td>
<td>11-1-2008 discharge</td>
<td>Different contract: A different provider has previously submitted a discharge for the same Date of Above Transaction date. One provider is in error. Contact other provider.</td>
</tr>
<tr>
<td>Previous form was a 3618. A 3618 discharge or 3619 admission (as appropriate)</td>
<td>Rejection of 3619 Discharge following a 3618</td>
<td>Submit either a 3618 discharge or 3619 admission (as appropriate) prior to this 3619 Discharge.</td>
</tr>
<tr>
<td>must be submitted before a 3619 discharge can be submitted</td>
<td>3619 discharge received following a 3618 (regardless of contract on form)</td>
<td></td>
</tr>
</tbody>
</table>
RUG Training Requirements

Resource Utilization Group (RUG) training is intended for long-term care nurses. RUG training is designed to provide providers the requirements for completing RUG fields in assessments for Texas Medicaid payment.

Texas State University, in cooperation with the HHSC Office of Inspector General (OIG) has made this training available through the Office of Continuing Education's online course program.

To register for the RUG training, or for more information visit: www.txstate.edu/continuinged/programs/Online-Programs/RUG-Training.html

RUG training is valid for two years, then it must be renewed by completing the online RUG training via Texas State University.

Resource Utilization Groups (RUG) training is required for Registered Nurses (RNs) who sign assessments as complete.

RUG training can take 2-7 working days (M-F, 8-5) to process and report completions of RUG training to TMHP, depending on current volume of enrollments and completions.

RUG Worksheet and Definitions

The link to the RUG worksheet and definition for each RUG classification can be found at:

- www.cms.hhs.gov/MDS20SWSpecs/12_RUG-IIIVersion5.asp
- https://www.qtso.com/edu.html
Non-Emergency Ambulance

If you need to transport a Medicaid client by ambulance for a doctor appointment or other nonemergency reason, here are some important things to know:

Prior Authorization Requirements

According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled nursing facility, or other health-care provider is required to obtain authorization from Medicaid before an ambulance is used to transport a client in circumstances not involving an emergency.

The HRC states that an ambulance provider who is denied payment for nonemergency ambulance transport may be entitled to payment from the nursing facility, health-care provider, or other responsible party that requested the service if payment under the Medical Assistance Program is denied because of lack of prior authorization and the provider submits a copy of the bill for which payment was denied.

Ambulance provider may file a complaint with DADS Complaint Hotline at 1-800-458-9858. The complaint will be referred to DADS Regulatory Services department for review. Should DADS Regulatory Services confirm that the nursing facility failed to properly obtain prior authorization and then subsequently failed to properly reimburse the ambulance provider, the nursing facility will be cited for non-compliance with §19.2320 and a plan of correction will be necessitated. (Nursing facilities can also reference DADS Information Letter 06-83 for additional information.)

To avoid liability for requested nonemergency ambulance transports, be sure to follow Medicaid's requirements for prior authorization.

Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid. TMHP responds to nonemergency transport prior authorization requests within 48 hours of receipt of the request. Physician Medical Necessity Certification requests for 180 day authorizations are worked within 24 hours of receipt. It is recommended that all requests for a prior authorization number (PAN) be submitted in sufficient time to allow TMHP to issue the PAN before the date of the requested transport. If the client's medical condition is not appropriate for transport by ambulance, nonemergency ambulance services are not a benefit and the ambulance provider will not be paid by TMHP. Prior authorization is a condition for reimbursement for the ambulance provider but is not a guarantee of payment. The client and ambulance provider must meet all of the Medicaid requirements, such as client eligibility and claim filing deadlines.

These prior authorization requirements also apply to Medicaid clients who are enrolled in the Medicaid Primary Care Case Management (PCCM) Program. Services for Medicaid clients enrolled in one of the Medicaid Managed Care Health Maintenance Organization (HMO) plans must comply with prior authorization requirements of the managed care plan.

The TMHP Ambulance Unit reviews the prior authorization requests to determine whether the client's medical condition is appropriate for transport by ambulance. Incomplete information may cause the request to be denied.
The following information assists TMHP in determining the appropriateness of the transport:

- An explanation of the client’s physical condition that establishes the medical necessity for transport. The explanation must clearly state the client’s conditions requiring transport by ambulance.
- The necessary equipment, treatment, or personnel used during the transport.
- The origination and destination points of the client’s transport.

**Nonemergency Prior Authorization Process**

Medicaid-enrolled nursing facilities or other providers may request prior authorization using one of the following methods:

- The client’s physician, nursing facility, Intermediate Care Facility for the Mentally Retarded (ICF-MR), health-care provider, or other responsible party completes the online prior authorization request on the TMHP website at [www.tmhp.com](http://www.tmhp.com).
- Providers may fax a copy of the Ambulance Fax Cover Sheet and the Physician’s Medical Necessity Certification for Nonemergency Ambulance Transports (Texas Medicaid Program) to the TMHP Ambulance Unit at 1-512-514-4205. The completed forms and any supporting documentation must be sent with the request before the client is transported to the medical appointment. These forms are available on the TMHP website at [www.tmhp.com](http://www.tmhp.com). Documentation requirements for a request are outlined in the “Supporting Documentation” section below.
- To request prior authorization, providers may call TMHP at 1-800-540-0694, 24 hours a day, 7 days a week. Between the hours of 7 p.m. and 7 a.m., Central Time, Monday through Friday, and all hours on weekends and holidays, prior authorization requests must be for nonrecurring, nonemergency transports initiated by the transferring facility. These requests must be submitted at least two hours prior to the scheduled transport. A request may be submitted up to 60 days before the date on which the nonemergency transport will occur.

Refer to: “Prior Authorization Requests Through the TMHP Website” in the *Texas Medicaid Provider Procedures Manual*. The manual contains additional information, including mandatory documentation requirements and retention.

TMHP reviews all of the documentation it receives. An online prior authorization request submitted on the TMHP website at [www.tmhp.com](http://www.tmhp.com) receives an online approval or denial. The provider is also notified by fax or mail if the request is modified or denied. The client is notified by mail if the authorization request is modified or denied. Reasons for denial include documentation that does not meet the criteria of a medical condition that is appropriate for transport by ambulance, the client is not eligible for the dates of services requested, or the request is submitted after the transport has been provided. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. After TMHP approves a request, the requesting nursing facility or other requesting provider contacts the ambulance provider and provides the PAN and the dates of service that were approved.

Requesting providers are not required to fax medical documentation to TMHP; however, in certain circumstances TMHP may request supporting documentation. Incomplete online or faxed request forms are not considered a valid authorization request and are returned as a denial.
Prior Authorization Types and Definitions

Short-Term
Short-term prior authorization requests are made for a client whose medical condition is such that use of an ambulance is the only appropriate means of transport. The authorization period for a short-term request is from 0 to 60 days. If the client already has a valid short-term or long-term PAN, the PAN may be used for the ambulance transport.

Long-Term
A 180-day prior authorization is issued to a client and is granted within 24 hours of the time received, excluding weekends and holidays, for the authorization of nonemergency ambulance services. The request will be effective for a period of 180 days from the date of issuance. Authorizations for 180-day periods will only be issued if the client meets medical necessity.

Nonemergency Prior Authorization and Retroactive Eligibility
If a client’s Medicaid eligibility is pending, a PAN must still be requested before a nonemergency transport. This request will be initially denied due to Medicaid eligibility. When Medicaid eligibility is established, the requestor has 95 days from the date that the eligibility was added to TMHP’s files to contact the TMHP Ambulance Unit and request that the authorization be reconsidered. Once the authorization is approved, the requesting nursing facility or other requesting provider contacts the ambulance provider and supplies the PAN and the dates of service that were approved. The ambulance provider can then submit its claim to TMHP.

Supporting Documentation
Supporting documentation is required to be maintained by both the ambulance provider and the requesting provider including a nursing facility, physician, health-care provider, or other responsible party.

An ambulance provider is required to maintain documentation that represents the recipient’s medical condition(s) and other clinical information to substantiate medical necessity and the level of service and mode of transportation requested. This supporting documentation is limited to documents developed or maintained by the ambulance provider.

Nursing facilities, physicians, health-care providers, or other responsible parties are required to maintain physician orders related to requests for prior authorization of nonemergency and out-of-state ambulance services. These providers must also maintain documentation of medical necessity for the ambulance transport.

Appeals
A denial of a prior authorization request may be appealed. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406.
HIPAA Guidelines and Provider Responsibilities

Providers must comply with the Health Insurance Portability and Accountability Act (HIPAA). It is YOUR responsibility to comply with HIPAA, to seek legal representation when needed, and to consult the manuals/speak to representatives when you have questions.

Medicaid Waste, Abuse and Fraud

What is Medicaid Fraud?

“An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.”

How to Report Waste, Abuse and Fraud

Reports may be made through the following website: https://oig.hhsc.state.tx.us. This website also gives instructions on how to submit a report, as well as, how to submit additional documentation that cannot be transmitted over the Internet. The website also provides information on the types of waste, abuse and fraud to report to OIG.

If you are not sure if an action is waste, abuse or fraud of the Medicaid Program, report it to OIG and let the investigators decide. If you are uncomfortable about submitting a report online, there is a phone number for Recipient Fraud and Abuse reporting 1-800-436-6184.
Major Points to Remember

- MDS cycle is based on the physical admission of the recipient regardless of the payor source.
- Assessments are due at a minimum of every 92 days.
- Hospice recipients do not require separate assessments for payment. A SCSA is not required unless a significant change in their physical condition has occurred. However CMS is recommending the submission of a SCSA to reflect the change in care as a Hospice client.
- Permanent MN is established based on the begin date (R2B) of the first assessment after the 184th day of assessments with Medicaid eligibility.
- Form 3619 tracks the Full coverage days also. The system must have record of the 20 days of Qualifying Stay before Medicare Co-insurance can be authorized. (Exception is non-traditional Medicare.)

Helpful Hints

- LTC Online Portal has 24/7 availability to submit and track forms and assessments.
- Ensure all MDS Assessment submissions include an accurate Medicaid ID to assist with eligibility validation.
- A current Admission 3618 or 3619 form must be available on the portal with TMHP to complete the MDS LTCMI.
- Submit a 3618/3619 Admission on the LTC Online Portal prior to completing the LTCMI. The portal validates an active admission is in the portal to allow the provider to complete the MDS LTCMI information on an assessment.
- MDS submissions are extracted and made available on the LTC Online Portal.
- The extraction criteria contains a “+” or a 9 digit numeric in the Medicaid Number field and AA8a = 01, 02, 03, 04, 05 or 10 and a valid NPI which is entered at W1.
- Providers should wait at least an hour prior to search FSI or Current Activity for up to 24 hours newly submitted MDS Assessments as they are not real-time extracts.
- All RN and MD/DO licenses are validated against the Texas Board license files for successful submission.
- All RN licenses are validated against the Texas State University RUG Training database for successful submission.
- Form corrections require an overnight wait.
Reminders

- Access your Forms and Assessments via the Form Status Inquiry or Current Activity.
- Print and sign forms and assessments prior to submission.
- Submit additional information via the LTC Online Portal when the assessment is set to status “Pending Denial (need more information)” or call TMHP.
- Use the TMHP website at: www.tmhp.com/LTC%20Programs

Types of Calls to Refer to TMHP

Call TMHP at 1-800-626-4117, Option 1, about the following:

- Nursing Facility forms completion – including Pre-Admission Screening and Resident Review (PASARR) screening.
- Rejection codes on the forms.
- Management of the “Provider Action Required” status.
- If the Medicaid, Social Security, or Medicare number and the name match the client’s Medicaid ID card and the form is set to status “ID Invalid,” call TMHP to have the form restarted through the system.

Types of Calls to Refer to PCS

Call PCS at 1-512-438-2200, Option 1, about the following:

- Denials or pending denials of clients who have established prior permanent Medical necessity, after verifying AA7, Medicaid Number, contains a nine digit numeric rather than “+” or “N.”
- If the previous nursing facility has not processed discharge Forms 3618/3619 within 10 business days of admission to your facility.
Helpful Telephone Numbers

Texas Medicaid & Healthcare Partnership (TMHP)
General Customer Service ............................................................................................................. 1-800-925-9126
Long Term Care (LTC) Department ......................................................................................... 1-800-727-5436 / 1-800-626-4117
    General Inquiries, MDS not in portal, LTCMI questions ......................................................... Press 1
    Medical Necessity .................................................................................................................. Press 2
    Technical Support ................................................................................................................ Press 3
    Audio Message for Paper Submissions .................................................................................... Press 4
    Fair Hearing .......................................................................................................................... Press 5
LTC Department (fax) ................................................................................................................. 1-512-514-4223
Medicaid Hotline ...................................................................................................................... 1-800-252-8263

Department of Aging and Disability Services (DADS) .............................................................. 1-512-438-3011
Provider Claims ...................................................................................................................... 1-512-438-2200
    Nursing Facility and Hospice .............................................................................................. Press 1
    Using PCS Website Email ................................................................................................. Press 2
    Deductions and Holds ..................................................................................................... Press 3
    Third Party Recovery ......................................................................................................... Press 4
    Home Community Services .............................................................................................. Press 5
    TX Home Living ................................................................................................................. Press 5
    Rehabilitative and Specialized Services ............................................................................. Press 6
Community Services Contracts Unit Support ........................................................................ 1-512-438-2080
Community Services Contracts Voice Mail ........................................................................ 1-512-438-3550
Consumer Rights & Services Hotline ................................................................................... 1-800-458-9858
    Complaint for LTC Facility/Agency .................................................................................. Press 2
    Information About a Facility .............................................................................................. Press 4
    Provider Self-Reported Incidents ....................................................................................... Press 5
    Survey Documents/DADS literature .................................................................................. Press 6
Criminal History Checks ......................................................................................................... 1-512-438-2363
Facility Licensure/Certification ............................................................................................. 1-512-438-2630
Hospice Policy (Medicaid) ....................................................................................................... 1-512-438-3519
Institutional Services Contracting .......................................................................................... 1-512-438-2546
Medication Aide Program ....................................................................................................... 1-512-231-5800
Nurse Aide Registry ................................................................................................................ 1-800-452-3934
Nurse Aide Training ................................................................................................................ 1-512-231-5800
Nursing Facility Administrator Program ............................................................................. 1-512-231-5800
Nursing Facility Dental/Rehab Services .................................................................................. 1-800-792-1109
Nursing Facility Policy .......................................................................................................... 1-512-438-3161
PASARR Screening Policy Questions .................................................................................... 1-512-438-5233
Regulatory Services .......................................................................................................... 1-512-438-2625
Health and Human Services (HHSC)

HHSC Ombudsman Office Medicaid Benefits: 1-877-787-8999
Medicaid Fraud: 1-800-436-6184

Resource Utilization Groups (RUGs) Information


Purpose Code U Questions: 1-512-491-2025
Texas State University RUG Training Information: 1-512-245-7118
Texas State University Training Online Course Questions: 1-512-245-7118
Vendor Drug: 1-800-252-8263
Informational Websites

Texas Medicaid & Healthcare Partnership (TMHP): [www.tmhp.com](http://www.tmhp.com)
- HIPAA information: [www.tmhp.com/hipaa](http://www.tmhp.com/hipaa)
- Long Term Care Division: [www.tmhp.com/LTC%20Programs](http://www.tmhp.com/LTC%20Programs)
- Nursing Facility Long Term Care Medicaid Information (LTCMI) and Pre-Admission Screening and Resident Review (PASARR) information is also available at: [www.tmhp.com/LTC%20Programs](http://www.tmhp.com/LTC%20Programs)

*Note: Instructions for providers on how to access clarification notices posted on LTC TMHP website: [www.tmhp.com/LTC%20Programs/default.aspx](http://www.tmhp.com/LTC%20Programs/default.aspx)*

Texas Department of Aging and Disability Services (DADS): [www.dads.state.tx.us](http://www.dads.state.tx.us)
All DADS provider information can be found at [www.dads.state.tx.us/providers/index.cfm](http://www.dads.state.tx.us/providers/index.cfm). Please choose your particular provider type for available online resources:
- Assisted Living: [www.dads.state.tx.us/providers/alf/index.cfm](http://www.dads.state.tx.us/providers/alf/index.cfm)
- Nursing Facility: [www.dads.state.tx.us/providers/nf/index.cfm](http://www.dads.state.tx.us/providers/nf/index.cfm)
- Nursing Facility MDS Coordinator Support Site: [http://qmweb.dads.state.tx.us/mdsweb/#overview](http://qmweb.dads.state.tx.us/mdsweb/#overview)
- PASARR: [www.dads.state.tx.us/providers/pasarr/index.html](http://www.dads.state.tx.us/providers/pasarr/index.html)
- Provider Claims Services: [https://hhsportal.hhs.state.tx.us/wps/portal](https://hhsportal.hhs.state.tx.us/wps/portal)
- Provider Letters: [www.dads.state.tx.us/providers/communications/letters.cfm](http://www.dads.state.tx.us/providers/communications/letters.cfm)
See the page for your particular provider type at [www.dads.state.tx.us/providers/index.cfm](http://www.dads.state.tx.us/providers/index.cfm)

Health and Human Services Commission (HHSC): [www.hhsc.state.tx.us](http://www.hhsc.state.tx.us)
- HHSC Regions: [www.hhsc.state.tx.us/research/dssi/brt/1M0.pdf](http://www.hhsc.state.tx.us/research/dssi/brt/1M0.pdf)
- Vendor Drug Program: [www.hhsc.state.tx.us/hcf/vdp/vdpstart.html](http://www.hhsc.state.tx.us/hcf/vdp/vdpstart.html)

Other
- Centers for Medicare & Medicaid Services: [www.cms.gov](http://www.cms.gov)
- Department of State Health Services: [www.dshs.state.tx.us](http://www.dshs.state.tx.us)
- National Provider Identifier (NPI):
  - To obtain: [https://nppes.cms.hhs.gov/NPPES](https://nppes.cms.hhs.gov/NPPES)
  - Inform DADS: [www.dads.state.tx.us/providers/hipaa/forms.html](http://www.dads.state.tx.us/providers/hipaa/forms.html)
- Texas Administrative Code: [www.sos.state.tx.us/tac/index.html](http://www.sos.state.tx.us/tac/index.html)
- Texas State RUG Training: [www.txstate.edu/continuinged/programs/Online-Programs/RUG-Training.html](http://www.txstate.edu/continuinged/programs/Online-Programs/RUG-Training.html)
Minimum Data Set (MDS) Quick Reference Guide

MDS Phone Numbers

AT&T Global Dialer Helpdesk ................................................................. 1-800-905-2069
MDS Automation/Report Questions ......................................................... 1-512-438-2396
MDS Clinical Questions/Training ............................................................. 1-210-619-8010
MDS/RAP/Care Plan Training ................................................................. 1-512-458-1257 / 1-512-467-2242
CASPER QM/QI Clinical Questions ......................................................... 1-210-619-8010
CASPER QM/QI Report Questions ......................................................... 1-512-438-2396
RAVEN Helpdesk .................................................................................. 1-800-339-9313
Swing Bed Automation/Technical ......................................................... 1-800-339-9313
Swing Bed Clinical MDS ........................................................................ 1-210-619-8010

MDS Informational Websites

QIES Technical Support Office (QTSO): www.qtso.com
- For AT&T Global Dialer, see: AT&T Global Dialer Requirements
- For RAVEN Download, see: RAVEN
- For validation report messages and descriptions, see: MDS

MDS Software Specifications: www.cms.hhs.gov/MDS20SWSpecs
MDS/RAP/Care Planning Training: www.tahsa.org
MDS/RAP/Care Planning Training: www.txhca.org
RAVEN: www.cms.hhs.gov/MinimumDataSets20/07_RAVENSoftware.asp
State MDS Policy: www.dads.state.tx.us/providers/mds/index.cfm
State MDS Clinical Web Page/The MDS Mentor: http://qmweb.dads.state.tx.us/MDSWeb/
Nursing Facility MDS Coordinator Support Site: http://qmweb.dads.state.tx.us/mdsweb/#ovr
Definitions of Terms

- **AA8a.** Reason for Assessment.
- **AB1.** Date of Entry.
- **CMS:** Centers for Medicare & Medicaid Services.
- **EDI:** Electronic Data Interchange.
- **Late Assessment:** An assessment received on day 123 is considered late. The previous RUG for that recipient has expired as of day 123.
- **LTCMI:** Long Term Care Medicaid Information. Is the replacement for the Federal MDS Section S and contains items for Medicaid state payment. Once your MDS Assessments have been transmitted to the State MDS Database, TMHP will extract all assessments and assign a DLN. The assessment will be placed in a “Awaiting LTC Medicaid Information” status.
- **MDS:** Minimum Data Set.
- **Missed Assessment:** Missed assessment is an assessment not submitted within the Anticipated Quarter or within 92 days of the dates that the assessment covers. The Anticipated Quarter is defined as the 92-day anticipated MDS assessment quarter following the 92-day span of the current MDS assessment.
- **Pre-Admission Screening and Resident Review (PASARR):** Is based on a revised MDS quarterly with additional state specific information. The screening must be submitted to TMHP via the LTC Online Portal for all recipients with mental illness (MI), intellectual disabilities (ID), or developmental disabilities (DD) prior to admission.
- **R2b.:** Date RN Assessment Coordinator signed as complete.
- **RAI:** Resident Assessment Instrument - includes instructions as to how to complete the MDS assessment.
- **Resident Assessment Validation and Entry (RAVEN):** Free MDS data entry software that offers users the ability to enter and transmit assessments to the State MDS Database. The Centers for Medicare & Medicaid Services (CMS) provides this free MDS data entry software. Provides can download the free software at the Federal CMS website indicated on the slide.
- **RUG:** Resource Utilization Groups.
- **State MDS Database:** A repository where MDS assessments are stored for the State of Texas.
Medicaid Eligibility Verification – Resident with Medicaid Eligibility

*Does not apply to PASARR*

- **ID Invalid**
  - ID Invalid
  - **Request/Validate Medicaid ID**
    - ID Confirmed
    - **Assessment Reviewed for Medical Necessity (MN)**
      - MN Approved
      - **ID Pending**
      - **Medicaid ID Pending**
      - **Medicaid ID Check Inactive**
    - **Provider Reactivates**

- **SAS Request Pending**
  - AI Confirmed
  - **Request/Validate Applied Income Check**
    - Pending AI
    - **Pending AI**
    - **AI Check Inactive**
    - **Provider Reactivates**

- **Resident may not have correct NF coverage. If no, new application needs to be filed.**

NF confirms SSN/Medicaid/Medicare #s and first four letters of last name match. If yes, contact TMHP to restart form. If no, NF submits correction.

If resident is ME certified after 6 months, NF can reactivate assessment by clicking on the “Reactivate Form” button.
Medicaid Eligibility Verification – Resident with Pending Medicaid Eligibility

Assessment Reviewed for Medical Necessity (MN)

- ID Invalid
  - ID Invalid
  - Request/Validate Medicaid ID

- ID Confirmed
  - Request/Validate Medicaid Eligibility (ME)
    - ME Confirmed
      - ME Check Inactive*

- Medicaid ID Pending
  - Medicaid ID Check Inactive*

If more than 45 days from the application date, contact ME worker

Non-TIERS: If no AI, contact ME worker
TIERS: If no AI, contact PCS. If in SAS but not MESAV, contact TMHP to restart form.
(Note: If resident does not have correct NF coverage, AI will not be available, new application needs to be filed).

If resident is ME certified after 6 months, NF can reactivate assessment by clicking on the "Reactivate Form" button.

** If resident is ME certified after 6 months, NF can reactivate assessment by clicking on the "Reactivate Form" button.