LONG-TERM CARE (LTC) USER GUIDE

FOR NURSING FACILITY FORMS 3618/3619 AND MDS/LTCMI

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

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Contents

Learning Objectives

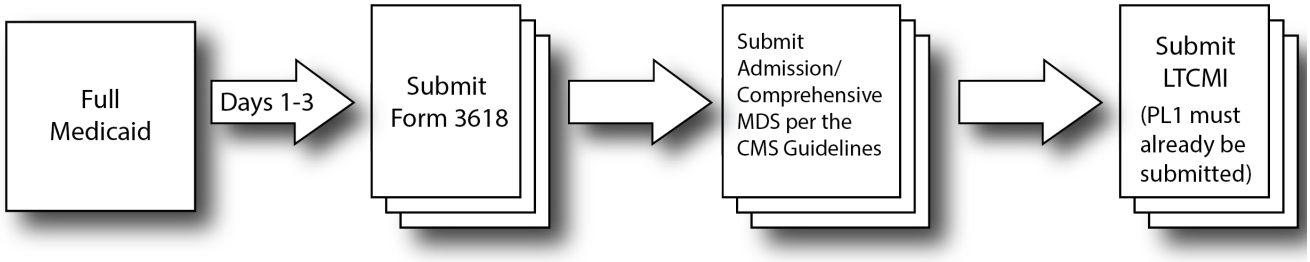
After reading this Long-Term Care (LTC) User Guide for Nursing Facility Forms 3618/3619 and Minimum Data Set/Long-Term Care Medicaid Information (MDS/LTCMI), you will be able to:

- Identify the forms and screenings to be submitted and their sequencing, including when and how to submit them.
- Understand the LTCMI section submission process.
- Understand and differentiate between MDS purpose codes (PCs) E and M.
- Understand the provider workflow process, which includes two sections: corrections and updates.
- Understand how to correct, modify, counteract, and inactivate forms or assessments, and the consequences of doing so.
- Identify form and assessment statuses and how to resolve issues.
- Recognize how to prevent Medicaid fraud, waste, and abuse.
- Understand that complying with the Health Insurance Portability and Accountability Act (HIPAA) is *your* responsibility.
- Seek legal representation when needed
- Consult the manuals or speak to your Texas Medicaid & Healthcare Partnership (TMHP) provider representative when you have questions.
- Identify additional resources for assistance.

Sequencing of Documents

The Preadmission Screening and Resident Review (PASRR) Level 1 (PL1) Screening Form must always be submitted prior to admission, regardless of payor source. Refer to the "Overview of PASRR Processes" section of the *Long-Term Care (LTC) User Guide for Preadmission Screening and Resident Review (PASRR)* for details.

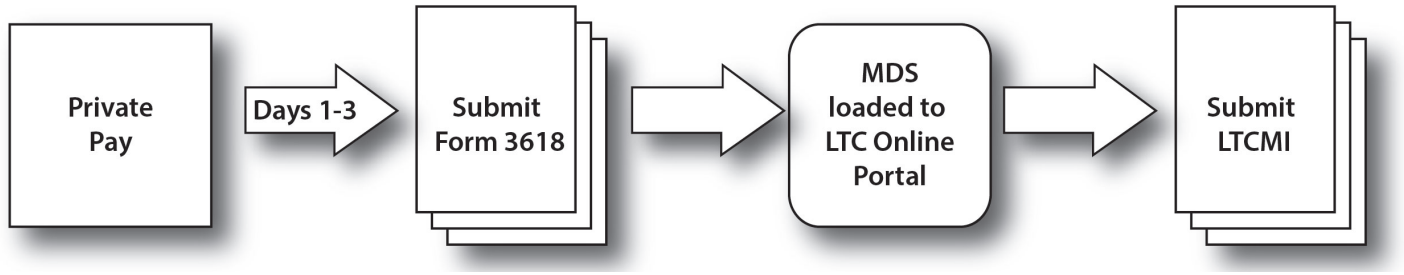
Admission as a Full Medicaid Recipient



This flow chart displays the admission process for a full Medicaid recipient.

- Nursing facilities (NFs) are required to initiate the Texas Health and Human Services Commission (HHSC) Medicaid Eligibility application process to ensure that validations of the client's Medicaid ID, Medicaid Eligibility, and applied income occur.
- A facility must submit a Form 3618 within 72 hours of admission for a client who has full Medicaid or is applying for Medicaid coverage.
- The Centers for Medicare & Medicaid Services (CMS) *Resident Assessment Instrument (RAI) User's Manual* requires completion of an admission or comprehensive MDS within 14 days of admission (MDS 3.0: A0310A=01). Submit the MDS to CMS in accordance with the *RAI User's Manual*.
- The Federal Claims Management Services guidelines allow providers up to 14 days to transmit MDS 3.0 assessments. Note that waiting will cause a delay in medical necessity (MN) determination and payment if the assessment is being used to establish Medicaid state payment.
- The MDS LTCMI on the LTC Online Portal (LTCOP) must be completed within the covering quarter of the MDS (PL1 must have already been submitted). MDS 3.0 = Z0500B + 91 days.
  Note: The above timeliness guidelines reflect the requirements of Texas Medicaid only. For Centers for Medicare & Medicaid Services (CMS) timeliness guidelines, refer to the *RAI User's Manual*.
- A quarterly assessment must be completed 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 for a private-pay client who is transitioning to full Medicaid. Submission should occur upon notification of application for Medicaid.

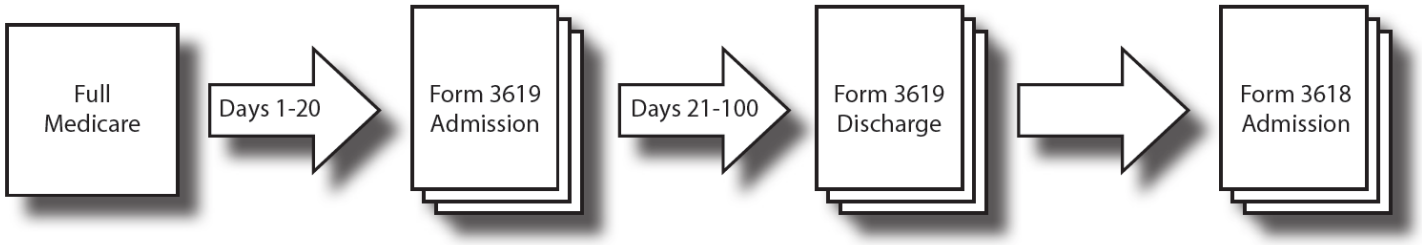
- A facility should submit a 3618 Admission indicating admission from private pay.
- After the 3618 has been submitted, any MDS assessment will be loaded onto the LTC Online Portal within 48 hours.
- The MDS LTCMI must be completed and submitted before TMHP can process the assessment.

If TMHP cannot retrieve the assessment from CMS because the client's Medicaid number or Social Security number (SSN) on the assessment does not match the number on the current Form 3618 Admission, the provider must submit an MDS modification to allow the LTC Online Portal to retrieve the assessment. Modifications should be submitted to CMS in accordance with the *RAI User's Manual*.

Note: If the last name on the assessment is not identical to the last name on the Medicaid identification card, there will be a conflict. Correct the assessment to match the Medicaid Identification card if the card is correct. If the name on the Medicaid identification card is incorrect, contact the appropriate Medicaid Eligibility worker to correct and match the names.

Full Medicare Transitioning to Medicaid

This flow chart displays the process of a client who is full Medicare and is transitioning to full Medicaid.

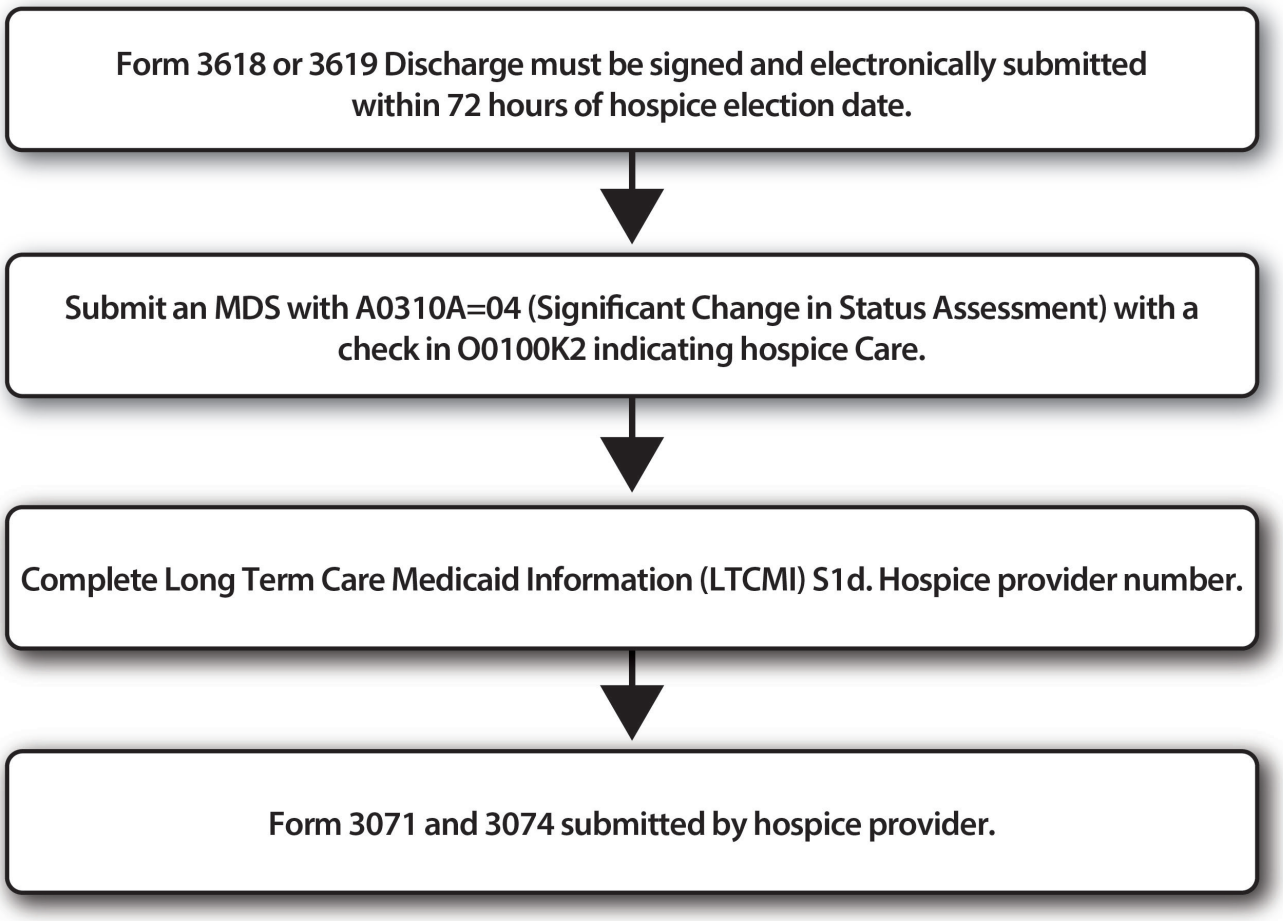


- Full Medicare reimburses for the first 20 days.
- The facility must submit a 3619 Admission within 72 hours of the start of day 21 for Medicare payment to begin Medicare coinsurance, which can last up to a maximum of 80 days. The entire Medicare stay cannot exceed 100 days.
- The facility must submit a 3619 Discharge on the 101st day of the Medicare stay or the day of discharge from Medicare coinsurance and a 3618 Admission on the same day to admit the client to full Medicaid.
- The 3619 Discharge and 3618 Admission changing to full Medicaid will be the same date unless the client left the facility.
- The facility may submit an LTCMI on an MDS assessment for a client who will be transitioning from Medicare to Medicaid. However, the LTCMI cannot be submitted prior to the 3619 Admission. The provider has two options for submitting the LTCMI; it can be done prior to the resident being discharged from Medicare or after the resident is considered full Medicaid.

Current Resident Admitted to Hospice

To admit a current resident to hospice care, the following steps must be performed:

- Submit a Form 3618 or 3619, as appropriate, to discharge the client to hospice care.
- CMS states that an SCSA should be submitted for a resident who is admitted to hospice. The MDS 3.0 LTCMI should include the hospice provider number and Hospice Care should be indicated in O0100K2.
- Enter the hospice provider on the LTCMI.
- The hospice provider submits Forms 3071 and 3074.



Current Hospice Residents

After an MDS SCSA is submitted, the NF should continue the MDS cycle for hospice clients. In addition to indicating Hospice Care on the assessment, the hospice provider number on the LTCMI is required to allow the hospice provider to view the assessments that are submitted with their provider numbers. The hospice provider number entered on the LTCMI will be validated and must contain a valid hospice provider number to be accepted in the LTC Online Portal.

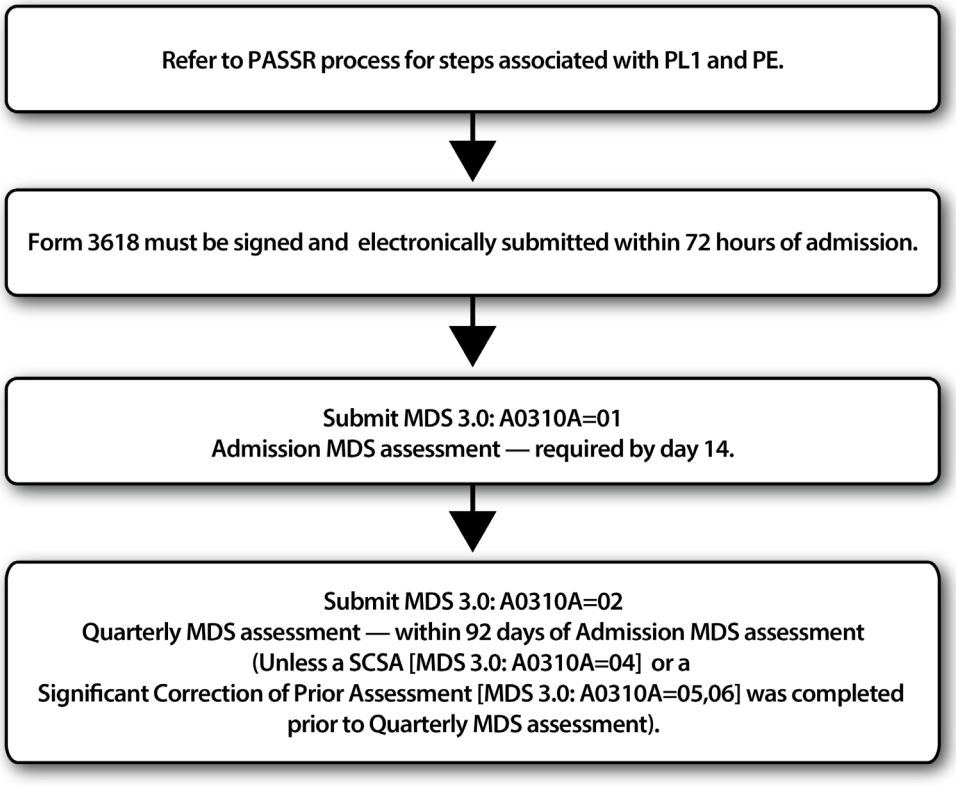
In the LTC Online Portal, hospice providers can view MDS assessments submitted on their behalf, based on the hospice provider number that is indicated in the LTCMI S1d (Hospice Provider Number S1d must be completed correctly to view those assessments).

Hospice nurses are not required to sign off on the assessment for the clients in hospice. Providers can print and sign their assessment prior to submission. The assessment should be signed by the NF's registered nurse (RN) MDS assessment coordinator.

Resident Returns (Prior Discharge – Return Not Anticipated)

If the resident returns, but the return was not anticipated, perform the following steps:

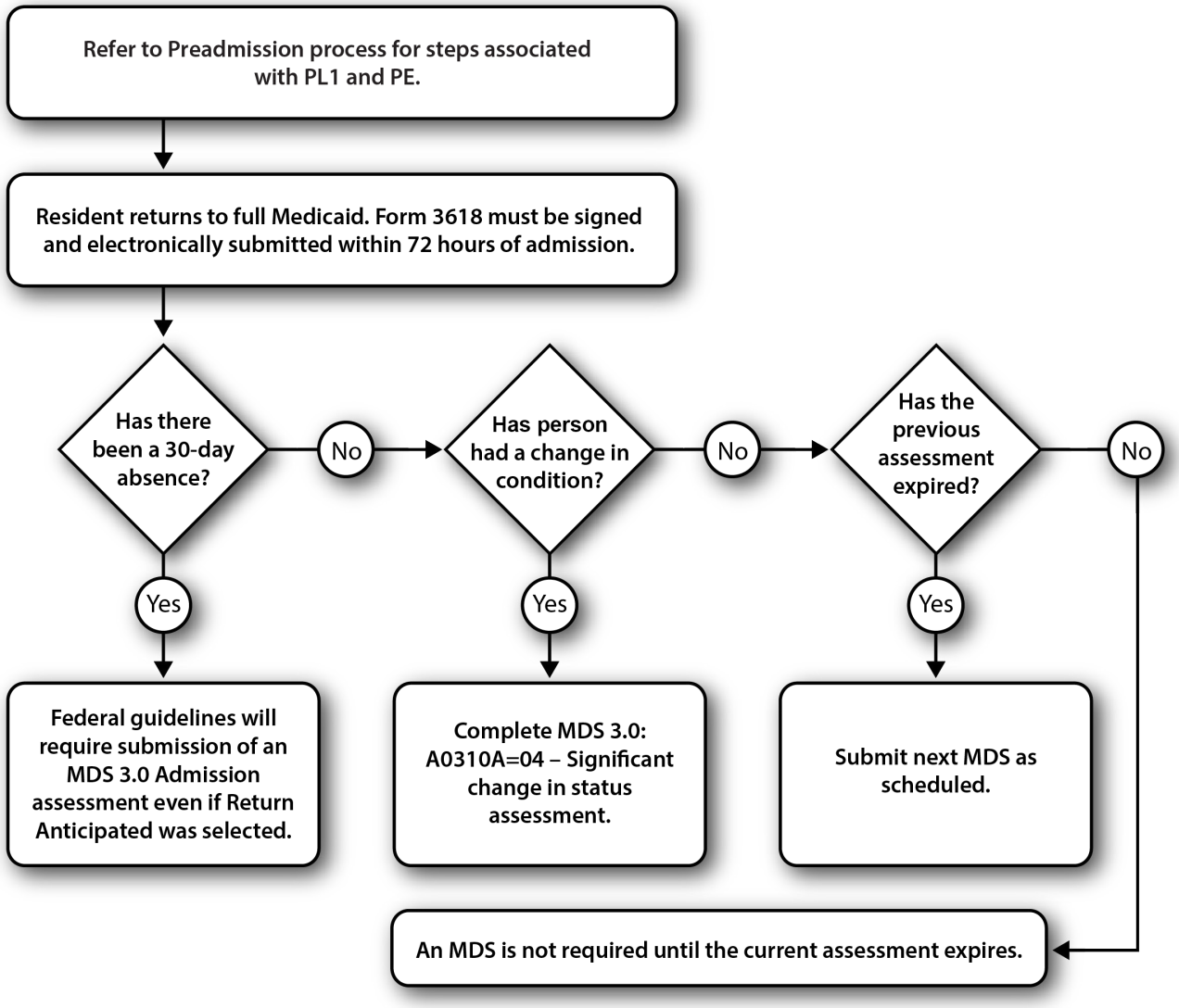
- Follow the PASRR process to start over with a new PL1 and a new PASRR Evaluation (PE), if needed.
- Submit a 3618 Admission within three days (admitting to full Medicaid).
- Complete an Admission MDS assessment within 14 days.
- Complete a quarterly assessment within 92 days of the Admission MDS unless an SCSA was already submitted.



Resident Returns (Prior Discharge – Return Anticipated)

If the resident returns, but the return was anticipated, perform the following steps:

- Follow the PASRR process to start over using a new PL1 and a new PE, if needed.
- Submit a 3618 within 72 hours of admission.
- If the client returns after a 30-day absence, an MDS 3.0 Admission assessment is required, even if the discharge indicated Return Anticipated.
- If the client was admitted to another NF, an admission assessment is required.
- If there has been a change in condition, submit an SCSA.
- If the previous MDS assessment is less than 92 days old, has not expired, and the client has not had a change in condition, then no additional assessment is required.
- If the previous MDS assessment has expired, complete the next scheduled assessment per the federal guidelines.



Forms to be Submitted

Form 3618 – Resident Transaction Notice

Form 3618 is used when the client is in a Full Medicaid or Medicaid Pending status (refer to the flow chart in the "Sequencing of Documents" section of this user guide). A 3618 submission informs Medicaid Eligibility workers about transactions and status changes and provides HHSC with information to initiate or close service authorizations or adjust provider payments.

Form 3618 should be submitted for admissions, discharges, and death. Form 3618 must be submitted on the LTC Online Portal. The client must reside in a valid, Medicaid-contracted bed. If Form 3618 is submitted, it is assumed that the client is in a contracted bed. MDS Discharge Tracking and Re-Entry Tracking forms (3.0: A0310F) are not used by Texas Medicaid.

Providers submit Form 3618 when the client is being classified as full Medicaid. This can occur upon initial admission or after 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, Medicare, or hospice to Medicaid, TMHP will retrieve MDS Assessments for that client for Medicaid processing. Providers are not required to submit a new MDS to CMS upon change to Medicaid if the cycle is already established. After Form 3618 has been submitted, the most recent MDS assessment that meets the necessary criteria will be loaded onto the LTC Online Portal and set to status Awaiting LTC Medicaid Information.

For a Medicaid recipient to begin full Medicaid provider payment, the following must apply:

- The client must have Medicaid financial eligibility. Form 3618 will not be processed until the client is determined to be eligible.
- The MN must be approved on the MDS and Patient-Driven Payment Model for long-term care (PDPM LTC) calculated.
- Medicaid Eligibility Service Authorization Verification (MESAV) must be updated to reflect the processing of Form 3618 and the MDS PDPM LTC.

Note: The MDS must be submitted to CMS in accordance with the *RAI User's Manual* whether the client is under Medicare, Medicaid, or private pay status. MDS submissions to CMS are not dependent upon the payor source.

Form 3618 must be signed and submitted by the facility administrator within 72 hours of the client'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 their absence. The authorization must be in writing and on file at the facility. The administrator date signed checkbox is required for Forms 3618 and 3619.

If the facility is temporarily without an administrator, a signature is still required. Note in the comment section of Form 3618 that the facility is without an administrator at this time, and enter 999999 in field 13 for the State Board License No.

Note: NFs are reminded that a Form 3618 Discharge must be submitted after a client is classified as Hospice and continues to reside in the facility. If the client is classified as Hospice upon admission, Form 3618 should not be

submitted. Hospice providers should submit only Forms 3071 and 3074. If the client is under Medicare for a non-related condition and classified as skilled nursing facility (SNF) by the Hospice provider, Form 3619 is appropriate. NFs should inactivate any Forms 3618 and 3619 rejected by the Provider Action Required Workflow and submitted in error for full Hospice clients.

Repercussions of Submitting Form 3618 Late

If Form 3618 is submitted late, then the following may apply:

- Payment to the facility will be delayed or denied.
- Personal needs allowance for people receiving Supplemental Security Income (SSI) will be delayed.
- The Medicaid eligibility certification for a client applying for Medicaid may be delayed.
- Failure to submit Form 3618 can restrict the client to a limited number of prescriptions.
- The facility may be subject to sanctions (such as vendor hold) as a result of contractual noncompliance.

How to Submit Form 3618

To submit Form 3618, complete the following steps:

1) Log in to the LTC Online Portal.

2) Click **Submit Form** located in the blue navigational bar.

3) Type of Form: Choose **3618: Resident Transaction Notice** from the drop-down menu.

4) Click **Enter Form**.

5) Enter all required information as indicated by the red dots:

    - Enter at least one of the following numbers: Medicaid Recipient No., Social Security No., or Medicare or RR Retirement Claim No.
    - For a hospital admission, enter the hospital admission date in the field provided between **Location** and **Date of Above Transaction.**
    - For a private pay admission, enter the physical admission date in the field next to **Private Pay**.
    - **Deceased** indicates that the client was pronounced dead in the facility.
    - **Location** indicates where the client is admitting from or discharging to.
    - **Date of Above Transaction** will be the actual admission or discharge date.
      Note: Validation is performed on the Medicaid/SSN/Medicare number and the last name of the client. The last name must match exactly what is shown on the Medicaid card. If the Medicaid/SSN/Medicare number and last name do not match, processing will not occur, and the form will be set to status ID Invalid. Validations are against the Medicaid Eligibility file. Compare the client's Medicaid card or the MESAV

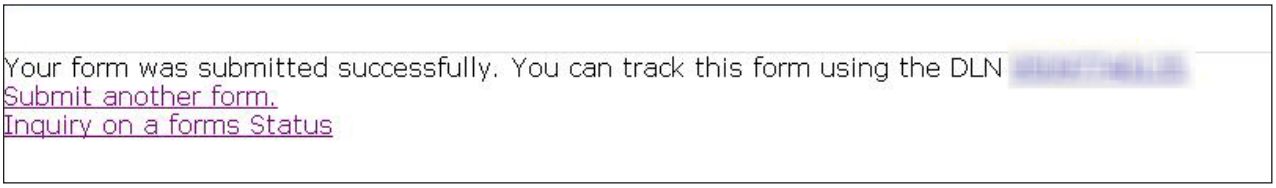
with the entry being made. If the Medicaid card is incorrect, contact the Medicaid Eligibility worker. The corrected information must be submitted. After the form is submitted, only corrections to the First Name or Medicare ID Number fields are allowed. The Last Name, SSN, and Medicaid ID Number fields cannot be corrected. Incorrect entries require inactivation and a new submission. Also note that the discharge type Return Anticipated or Return Not Anticipated affects the client's MDS cycle. Discharge type Return not Anticipated ends the client's current PDPM LTC records. This should match the MDS Tracking Form.

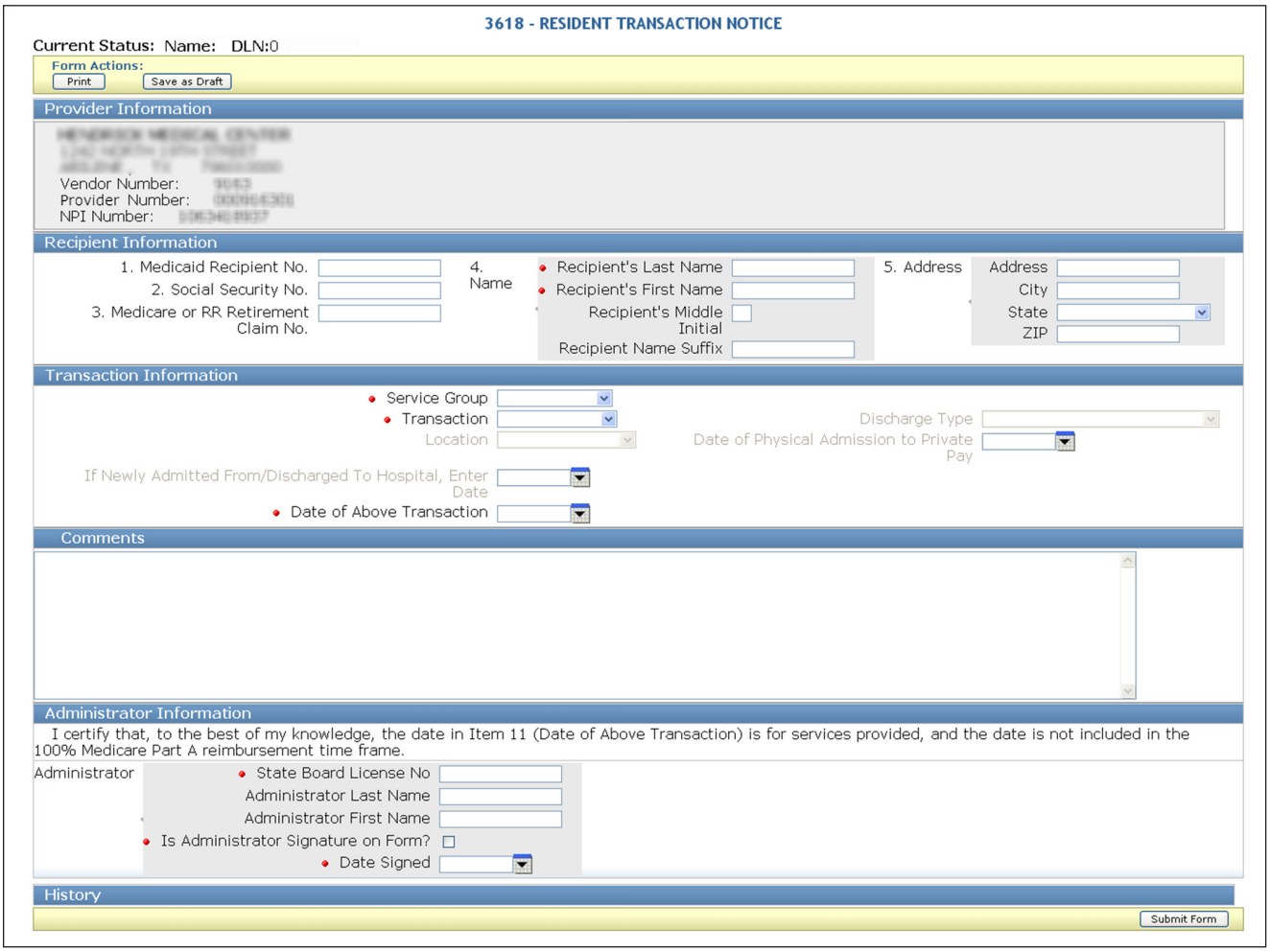
6) From here, you have two choices:

   a) Click **Submit Form** to submit the form.

   b) Click **Save as Draft** 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 submitted, a Document Locator Number (DLN) will be assigned, and the LTC Online Portal will confirm that your form was submitted successfully. If there are errors, they will be displayed in a box at the top of the screen. You must resolve these errors before you can submit the form. After all errors are resolved, click **Submit Form**.





Note: A Form 3618 admitting the client to full Medicaid or a Form 3619 (Medicare coinsurance) must be submitted prior to submission of the MDS LTCMI.

Form 3619 – Medicare/SNF Patient Transaction Notice

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

Occasionally, Medicare or Medicaid-eligible clients may be discharged and readmitted under the same Medicare authorization. These clients are eligible for up to 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 establishes the 20 qualifying days of full Medicare coverage. A Form 3619 Admission must be completed on the 21st day to begin Medicare coinsurance. Before submission of a Form 3619 Admission, the client must have already spent 20 days of full Medicare coverage in a skilled nursing bed, though the stay does not have to be in

the same facility. The administrator must sign and submit the form within 72 hours of the client's admission to or discharge from Medicare coinsurance to be considered timely. In hospitals acting as temporary Texas Medicaid nursing homes, the person responsible, such as the director of nurses (DON), may sign as the administrator; the 72-hour deadline will still apply.

Facility administrators may authorize a person to sign the form in their absence. The authorization must be in writing and on file at the facility. The administrator date signed checkbox is required for Forms 3618 and 3619. If the facility is temporarily without an administrator, a signature is still required. Note in the comment section of Form 3619 that the facility is without an administrator at this time, and enter 999999 for the State Board License No.

When Medicaid provides the rest of the payment, it is called Medicare coinsurance. For Medicare coinsurance to begin, the client must meet the following requirements:

- The client is financially eligible for Medicaid.
- The client has an Admission Form 3619 on file.
- The client has a 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 timeframes. The dates may be broken up into multiple stays, but must 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. After the comments are added, the form may be submitted. If additional sets of dates are needed to document the qualifying stay, the provider must enter a comment that additional forms are being submitted for the form to be accepted into the LTC Online Portal with less than 20 days. A second Form 3619 must be completed using the same date of above transaction to supply the additional set(s) of dates. This form will also require a comment because it will not document a full 20 days of qualifying stay.

If the client has a Medicare replacement (also known as Medicare Advantage plan or Medicare health maintenance organization [HMO]), the full coverage requirement may vary. Include the following information in the Comments section of the Form 3619:

- Medicare replacement
- Name of the insurance carrier
- Number of coinsurance payment days allowed
- Daily coinsurance payment amount

Repercussions of Submitting Form 3619 Late

If Form 3619 is submitted late, then the following may apply:

- Payment to the facility may be delayed or denied.
- The facility may be subject to sanctions (such as vendor hold) as the result of contractual noncompliance.

How to Submit Form 3619

To submit Form 3619, complete the following steps:

1) Log in to the LTC Online Portal.

2) Click **Submit Form** located in the blue navigational bar.

3) Type of Form: Choose **3619: Medicare/SNF Patient Transaction Notice** from the drop-down menu.

4) Click **Enter Form**.

5) Enter all required information as indicated by the red dots.

    a) Enter at least one of the following: Medicaid Recipient No., Social Security No., or Medicare or RR Retirement Claim No.

    b) Indicate either an admission or discharge transaction. Medicaid does not pay for the date of death of people who have Medicare coinsurance.

    c) Location indicates where the client is being admitted from or discharged to.

    d) Date of Above transaction will be the actual admission or discharge date.

    e) Enter the qualifying stay dates equal to 20 days. If full Medicare is more than two time periods, use multiple forms with the same Date of Above Transaction to submit the 20 days of full coverage.

Note: Validation is performed on the Medicaid/SSN/Medicare number and the last name of the client. The last name must match exactly what is shown on the Medicaid card. If the Medicaid/SSN/Medicare number and last name do not match, processing will not occur, and the form will be set to status ID Invalid. Validations are against the Medicaid Eligibility file. Compare the client's Medicaid card or the MESAV with the entry being made. If the Medicaid card is incorrect, contact the Medicaid Eligibility worker. The corrected information must be submitted. As noted previously, after the form is submitted, no corrections to the Last Name, SSN, or Medicaid ID Number fields are allowed. Incorrect entries require inactivation and a new submission.

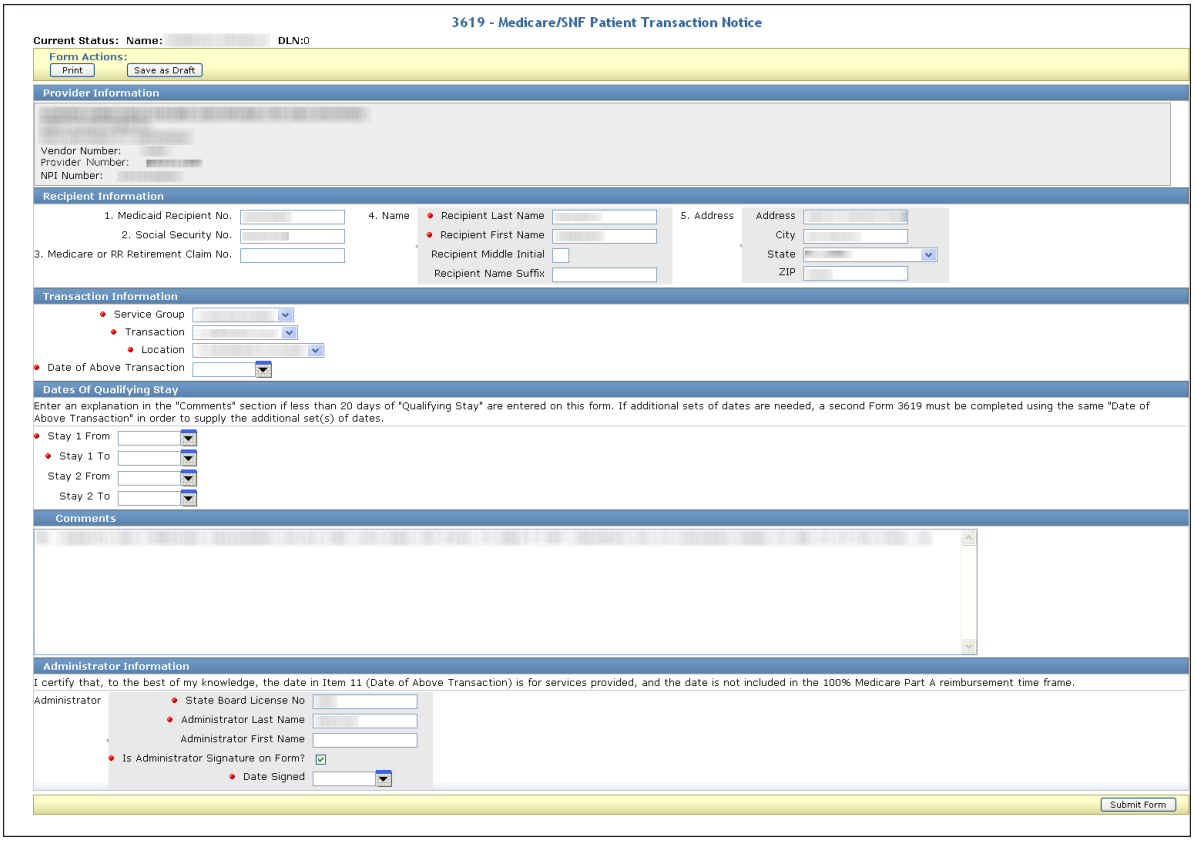
6) From here, you have two choices:

    a) Click **Submit Form** to submit the form.

    b) Click **Save as Draft** 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 submitted, a DLN will be assigned, and the LTC Online Portal will show that your form was submitted successfully. If there are submission errors, they will be displayed in a box at the top of the screen. These errors must be resolved before the form can be successfully submitted. After all errors are resolved, click **Submit Form**.

Important: Validation is performed on the Medicaid/SSN/Medicare number and the last name of the client. The last name must match exactly what is shown on the Medicaid card. If the Medicaid/SSN/Medicare number and last name do not match, processing will not occur, and the form will be set to status ID Invalid. Validations are against the Medicaid Eligibility file. Compare the client's Medicaid card or the MESAV with the entry being made. If the Medicaid card is incorrect, contact the Medicaid Eligibility worker. The corrected information must be submitted. As noted previously, after the form is submitted, no corrections to the Last Name, SSN, or Medicaid ID Number fields are allowed. Incorrect entries require inactivation and a new submission.



Submit Form 3619 for:

- Medicare Coinsurance Admission.
- Medicare Coinsurance Discharge.

Form 3619 Discharge is needed if the coinsurance is no longer due to the NF (e.g., the client has been discharged from the NF, Medicare benefits are exhausted or 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 coinsurance payment days that are allowed under the Medicare replacement policy
- Daily copayment amount

Forms 3618 and 3619 Submission Validation Rules and Edits

Based on information entered in certain fields and on the sequence in which the form is being submitted, validation, or front-end edits will occur and may result in an error. The form will not be accepted until all errors are resolved. The system messages will be displayed at the top of the LTC Online Portal submission page. If you do not receive the DLN number-assigned page after clicking the **Submit Form** button, there are errors that must be resolved. These errors will be displayed at the top of the page, and you may need to scroll to the top of the page to see them.

An example of a validation or front-end edit occurs when the Date of Above Transaction is more than one year old or more than or equal to five years old. A front-end edit may also require the provider to enter additional information, depending upon the message received.

Sequencing 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 submission of a 3619 and vice versa.
- Transactions must alternate between admission and discharge.
- The Date of Above Transaction should be chronological unless you are submitting a retroactive form.
- Retroactive forms should be submitted in pairs creating or filling a gap of time.

Forms set to 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, and AI Check Inactive.

The errors will be displayed at the time of a 3618 or 3619 form submission. Errors can vary for each form, so 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 LTC Online Portal at the time of submission.

2) **System Message Clarification**. This provides further clarification of the LTC Online Portal error message, including a basic example of the situation.

3) **System Message Resolution**. This provides assistance with resolving the error.

When a form is missing, providers must submit the missing form in order for it 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 a draft. Submit the missing form, and then retrieve the draft and submit to complete both transactions.
- If the submission displays a message stating 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 after the edit has been resolved.

The submission of the missing form and the form causing an error can occur on the same day. The missing form must be submitted before the form causing an error is submitted.

3618 Edit Descriptions

System Message (Displayed at Time of Submission)	System Message Clarification	System Message Resolution (Assistance for Resolving Error)
Last form submitted was an admission. Please supply discharge form prior to this admission.	Rejection of New Admission for missing Previous Discharge. New admission follows an admission for **same contract**; e.g., 11-12-2022 admission (no discharge) 12-16-2022 admission submitted.	Submit a discharge prior to this admission. Attempting to submit two 3618 admissions in a row, missing a 3618 discharge. Submit the missing discharge and then submit the 3618 admission. **Scenarios:** 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/20/22. 3618 admit submitted for person A, provider A, transaction date = 10/21/22. Submission is not allowed without a prior discharge. 3618 admit exists in Corrected status for person A, provider A, transaction date = 10/20/22. 3618 admit submitted for person A, provider A, transaction date = 10/21/22. Submit allowed (previous admit in Corrected status so not considered).

System Message (Displayed at Time of Submission)	System Message Clarification	System Message Resolution (Assistance for Resolving Error)
Last form submitted was a discharge. Please supply admission form prior to this new discharge.	Rejection of New Discharge for missing Previous Admission. New discharge follows a discharge for *same contract;* e.g., 11-1-2022 discharge (no admission). 12-1-2022 discharge submitted.	Submit an admission prior to this discharge. Attempting to submit two 3618 discharges in a row, missing a 3618 admission. Submit the missing admission and then submit the 3618 discharge. **Scenarios:** 3618 discharge exists in Processed/ Complete status for person A, provider A, transaction date = 10/19/22. 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/19/22. 3618 admit submitted for person A, provider A, transaction date = 10/21/22. Submission is allowed because of multiple matching date of above transaction on prior form. 3618 admit exists in ME Check Inactive status for person A, provider A, transaction date = 10/20/22. 3618 admit submitted for person A, provider A, transaction date = 10/21/22. Submit allowed (previous admit in ME Check Inactive status so not considered).

System Message (Displayed at Time of Submission)	System Message Clarification	System Message Resolution (Assistance for Resolving Error)
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.	Rejection of New Admission for Same Date of Above Transaction. New admission has same Date of Above Transaction as an admission already received, e.g., 11-1-2022 admission, 11-1-2022 admission.	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. One provider is in error. Contact the other provider. **Scenarios:** 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/1/22. 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/21/22. 3618 admit submitted for person A, provider A, transaction date = 10/1/22. Submit *not* allowed because date already in Processed/Complete. 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/1/22. 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/21/22. 3618 admit submitted for person A, provider B, transaction date = 10/1/22. Submit *not* allowed because date already in Processed/Complete for another provider.

System Message (Displayed at Time of Submission)	System Message Clarification	System Message Resolution (Assistance for Resolving Error)
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.	Rejection of New Discharge for Same Date of Above Transaction. New discharge has same Date of Above Transaction as a discharge already received, e.g., 11-1-2022 discharge, 11-1-2022 discharge.	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 the other provider.
Date of Above Transaction is over one year old, do you want to continue?	When submitting a form that is between one and five years old, providers will receive this warning message. The provider will have an option to select **OK** or **Cancel** before the form will continue to be processed.	If a provider submits a Date of Above Transaction that is equal to or more than five years old, the form will not be accepted onto the LTC Online Portal. Additionally, forms with a future date in the Date of Above Transaction field will not be accepted onto the LTC Online Portal.

System Message (Displayed at Time of Submission)	System Message Clarification	System Message Resolution (Assistance for Resolving Error)
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.	Rejection of 3618 Discharge following a 3619 admission. 3618 discharge received following a 3619 regardless of contract.	Submit either a 3619 discharge or 3618 admission (as appropriate) prior to this 3618 Discharge. **Scenarios:** 3619 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/20/22. 3618 admit submitted for person A, provider A, transaction date = 10/21/22. Submit not allowed. 3619 discharge exists in Processed/Complete status for person A, provider A, transaction date = 10/20/22. 3618 discharge submitted for person A, provider A, transaction date = 10/21/22. Submit not allowed. 3619 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/19/22. 3619 discharge exists in Processed/Complete status for person A, provider A, transaction date = 10/19/22. 3618 discharge submitted for person A, provider A, transaction date = 10/21/22. Submit not allowed.

3619 Edit Descriptions

System Message (Displayed at Time of Submission)	System Message Clarification	System Message Resolution (Assistance for Resolving Error)
Last form submitted was an admission. Please supply discharge form prior to this new admission.	Rejection of New Admission for missing Previous Discharge. New admission follows an admission for the *same contract*; e.g., 11-1-2022 admission (no discharge) 12-1-2022 admission submitted.	Submit a discharge form prior to this admission. Attempting to submit two 3619 admissions in a row, missing a 3619 discharge. Submit the missing discharge and then submit the 3619 admission.
Last form submitted was a discharge. Please supply admission form prior to this new discharge.	Rejection of New Discharge for missing Previous Admission. New discharge follows a discharge for *same contract* e.g., 11-1-2022 discharge (no admission). 12-1-2022 discharge submitted.	Submit an admission form prior to this discharge. Attempting to submit two 3619 discharges in a row, missing a 3619 admission. Submit the missing admission and then submit the 3619 discharge.
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.	Rejection of New Admission for Same Date of Above Transaction. New admission has same Date of Above Transaction as an admission already received, e.g., 11-1-2022 admission, 11-1-2022 admission.	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 the other provider.
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.	Rejection of New Discharge for Same Date of Above Transaction. New discharge has same Date of Above Transaction as a discharge already received, e.g., 11-1-2022 discharge, 11-1-2022 discharge.	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 the other provider.

System Message (Displayed at Time of Submission)	System Message Clarification	System Message Resolution (Assistance for Resolving Error)
Previous form was a 3618. A 3618 discharge or 3619 admission (as appropriate) must be submitted before a 3619 discharge can be submitted.	Rejection of 3619 Discharge following a 3618 admission. 3619 discharge received following a 3618 (regardless of contract on form).	Submit either a 3618 discharge or 3619 admission (as appropriate) prior to this 3619 discharge.
Date of Above Transaction is over one year old, do you want to continue?	When submitting a form that is between one and five years old, providers will receive this warning message. The provider will have an option to select **OK** or **Cancel** before the form will continue to process.	If a provider submits a Date of Above Transaction that is equal to or more than five years old, the form will not be accepted onto the LTC Online Portal. Additionally, forms with a future date in the Date of Above Transaction field will not be accepted onto the LTC Online Portal.
Please provide a reason in the comments field why the Dates of Qualifying Stay for this client do not equal 20.	The Dates of Qualifying Stay must add up to exactly 20 non-duplicative days. If the Dates of Qualifying Stay do not equal 20 days, a comment is required in the Comments field.	Correct the Dates of Qualifying Stay to equal 20 days. If the dates do not equal 20 days because additional space is needed, add a comment to the form indicating that additional forms are being submitted to capture the full 20 days. If the person has a Medicare replacement policy, indicate the following information in the comments: • Medicare replacement • Name of the insurance carrier • Number of copay days allowed • Daily copay amount

MDS Assessments

The LTC 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- or Medicaid-certified LTC facility. The MDS contains items that measure physical, psychological, and psychosocial functioning. The items in the MDS give a multidimensional view of the client's functional capacities and help staff to identify health problems.

Assessments that providers may submit to CMS and for Medicaid payment include:

- Admission assessment (required by day 14).
- Quarterly review assessment.
- Annual assessment.
- Significant change in status assessment.
- Significant correction to prior comprehensive assessment.
- Significant correction to prior quarterly assessment.
- Inactivation.
- Modification.

MDS 3.0 assessments that are accepted by CMS are retrieved by TMHP nightly, loaded onto the LTC Online Portal, and set to status Awaiting LTC Medicaid Information. After the LTCMI has been successfully completed and submitted on the LTC Online Portal, the MN determination process will begin.

MDS 3.0 admission assessments are effective based on the Entry Date entered into field A1600. System processing will start the level record based on either the entry date or the completion date (Z0500B) minus 30 days, whichever is later.

Note: Field A1600 will remain the designated effective date of the assessment. To qualify for PDPM LTC, the system will verify that both the A1600 (Entry Date) and A2300 (Assessment Reference Date) are on or after September 1, 2025. If both dates meet this requirement, PDPM LTC will be applied. If either date does *not* meet the criteria, the system will default to RUG classification instead.

Note: If the begin date of the level record needs to be adjusted because the timeframe between the entry date and the completion date is over 30 days, you must call HHSC LTC Provider Claims Services (PCS) at 512-438-2200, option 1.

All other assessment types will be effective based on the completion date (Z0500B).

All assessments without a PC are valid for up to 92 days from the completion date. Expiration dates on the MESAV also include a 31-day grace period for the next submission.

An MDS 3.0 admission assessment is valid in three situations:

1) For a first physical admission into a NF, an admission assessment is valid. Regardless of whether the person is private pay, Medicare, or Medicaid, the provider should complete an Admission assessment for a first physical Omnibus Budget Reconciliation Act (OBRA) admission within 14 calendar days of admission to the NF. For Texas Medicaid, if a resident is active in a NF and discharges to another NF for even one day, then returns to the original NF, the readmission to the original NF is considered a first physical admission. When another provider is introduced, the prior NF's MDS cycle for the client ends and must be restarted if the client returns to the original NF. Discharging to the client's home, to Hospice, to another Medicaid service (community services), or to the hospital is not discharging to another NF.

2) If the resident discharges from a NF and the Form 3618 discharge type indicates Return Not Anticipated, a new admission assessment is required if the person readmits to the NF. Remember that the Form 3618 is expected to match the MDS discharge tracking form also submitted for this client. The MDS discharge tracking form would indicate Discharge – Return Not Anticipated. Although CMS rules allow the use of the Reason for Assessment on the discharge tracking form for any client whose first physical admission to the NF is less than 14 days, a provider should *not* use this reason for the assessment if the client's stay is being paid for by Texas Medicaid. This is because if the provider does not complete an OBRA admission assessment, even if the client is in the provider's building for only one day, the provider will not have an MDS assessment for billing purposes. If the Form 3618 or MDS tracking form discharge type is marked incorrectly, the discharge type can be corrected.

3) If the resident is physically discharged from the facility for over 30 days, regardless of the reason or location, CMS requires an admission assessment. For example, if the discharge to the hospital was marked Return Anticipated, and the client is in the hospital over 30 days, a new MDS 3.0 admission assessment is due. The Entry Date should be the new admission to the facility after the discharge that was over 30 days. If the Entry Date is a date prior to the discharge, a modification will be required to adjust the date so the assessment is valid for the dates after readmission.

Validating the Appropriateness of an Admission Assessment

If the Entry Date of an MDS assessment overlaps with an established MDS for the same NF, the coding of the admission assessment is most likely in error.

One of the considerations in validating an admission assessment is the relationship between the Entry Date and the completion dates. An admission assessment should be completed within 14 days of the Entry Date. CMS and HHSC will accept the assessment if the timeframe is longer, but the provider must validate whether an admission assessment is the appropriate type of assessment to submit. If the Entry Date is two years prior to the completion date, this assessment probably should not be an admission assessment.

If the admission assessment is needed because the resident had a Form 3618 discharge indicating Return Not Anticipated, the Entry Date should be the new readmission date, not an admission prior to the discharge. If the provider already submitted the assessment with the Entry Date prior to the discharge date, a modification must be transmitted to the state MDS database to adjust the Entry Date to a readmission date following the discharge.

Swing bed providers are required to submit MDS 3.0 assessments A0200 Type of Provider coded as 2. Swing Bed. MDS 3.0 assessments for swing bed providers include assessments listed in items A0310B, A0310C, A0310D, and A0310F. These assessments are submitted to CMS; however, they are not retrieved by TMHP. Swing bed providers must complete the appropriate MDS 3.0 OBRA-required Comprehensive or Quarterly assessments listed in item A0310A in accordance with the MDS 3.0 *RAI User's Manual* if services provided are eligible for Medicaid reimbursement. OBRA-required assessments listed in A0310A that meet TMHP guidelines are retrieved by TMHP, and the associated LTCMI will have field S1c (Service Group) autofilled to equal ten based on the vendor or provider number that was provided upon login.

MDS Discharge Tracking and Re-Entry Tracking forms (3.0: A0310F) are used by CMS but are not retrieved and loaded onto the LTC Online Portal. Forms 3618 and 3619 are used by the state for Medicaid processing of recipient movement.

If the resident dies on the day that the MDS Quarterly is due and there is no level of service for the date of death, the MDS Quarterly must be submitted to receive payment for the date of death.

To receive a PDPM LTC payment when a resident expires prior to completion of an admission assessment, the admission assessment must be completed and submitted to CMS with the information that is available. If the LTCOP cannot calculate the PDPM LTC because the admission assessment is incomplete or has errors, the system will assign a PDPM LTC value of Z01, which is the default rate. If the admission assessment meets MN and the resident has Medicaid eligibility for the days of services, payment can be made for the calculated PDPM LTC value.

Submission and Retrieval of MDS Assessment

Providers should use their current method for submission to CMS, either through the Resident Assessment Validation and Entry System (jRAVEN) or another third-party software package. Validate the acceptance of the MDS 3.0 assessment using the validation report process from CMS.

TMHP receives assessments nightly. Only assessments that meet the following criteria will be loaded onto the LTC Online Portal:

- Reason for Assessment:
  - Admission assessment: A0310A=01
  - Quarterly review assessment: A0310A=02
  - Annual assessment: A0310A=03
  - Significant change in status assessment: A0310A=04
  - Significant correction to prior comprehensive assessment: A0310A=05
  - Significant correction to prior quarterly assessment: A0310A=06
- National Provider ID (MDS 3.0: A0100A) should be entered to locate assessments set to status Awaiting LTC Medicaid Information.
- Medicaid Number (MDS 3.0: A0700) contains + or a nine-digit numeric value.

Note: After being accepted by CMS, it may be up to 48 business hours before the MDS 3.0 assessment is accessible on the LTC Online Portal for data entry in an Awaiting LTC Medicaid Information status.

Note: The effective date of quarterly review assessments with a date after the 30-day submission period can be adjusted by contacting HHSC PCS directly to make the adjustment.

Assessments loaded onto the LTC Online Portal are assigned a DLN and set to status Awaiting LTC Medicaid Information.

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

The MDS assessment must be accepted by the LTC Online Portal and have an LTCMI completed to begin the MN determination process. Periodically review the status of the MDS assessment for MN and Medicaid processing using FSI or Current Activity.

When an MDS assessment is set to status PE MN Denied but the MN determination on the PE has been overturned, the NF can change the status of the MDS assessment. For more information, see the "MDS Set to Status PE MN Denied" section of this user guide.

Note: Providers should follow the federal MDS 3.0 *RAI User's Manual* for submission of an assessment. If the provider follows the federal guidelines for submission and completes the LTCMI on the LTC Online Portal, there will not be a lapse in Texas Medicaid coverage.

MDS Dually Coded Assessments

Dually coded assessments will be retrieved and loaded onto the LTC Online Portal nightly if the retrieval criteria above are met. If the assessment fails due to the Medicaid ID/Recipient name, the provider should refer to chapter 5 in the MDS 3.0 *RAI User's Manual* for further instructions and guidelines for submitting modifications to key resident-identifying information fields.

Dually coded assessments can be submitted as multiple combinations. If the client has been established with level of service (RUG or PDPM LTC) for the facility, then discharges to the hospital and returns to Medicare, the assessment can be dually coded for the appropriate Medicaid assessment due and the appropriate Medicare assessment due. An assessment for an established person admitting to Medicare can be coded as a Medicaid Quarterly and a Medicare five-day assessment. If an assessment is coded for a Medicaid Admission assessment and a Medicare five-day assessment, and the client has a current NF level of service already established, the Medicaid admission assessment will not be used unless the client was out over 30 days or discharged as Return Not Anticipated. If the level of service is required for Medicaid, it will require inactivating the assessment at CMS and resubmitting with a different Medicaid reason for the assessment.

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 to submit the MDS assessment into TMHP's workflow for review within the anticipated quarter timeframe. The anticipated quarter is within 92 days of the date the RN assessment coordinator signed the MDS assessment as complete (Z0500B). This is known as the 92-day timeliness rule.

Submission of LTCMI

To enter the LTCMI, the provider must log in to the LTC Online Portal and access their assessments set to status Awaiting LTC Medicaid Information using FSI or Current Activity. The LTCMI must be completed with all required data and successfully submitted on the LTC Online Portal.

Note: The LTC Online Portal allows a 60-day grace period for submission of the LTCMI for change of ownership (CHOW) and new owners. Facilities have 60 days from the day the first MDS LTCMI is submitted on the LTC Online Portal with the new provider number to submit any additional MDS assessments in Awaiting LTC Medicaid Information status, whether within the 92-day submission window or not, without requiring a PC E.

LTCMI Rejections

The LTCMI may be rejected for a variety of issues. If an LTCMI has been rejected, it may be due to one of the issues listed in this section.

If a PL1 Screening Form has not been submitted prior to the submission of the LTCMI, and no PL1 is found on the LTC Online Portal for this client, the LTCMI will not be accepted on the LTC Online Portal. Attempting to submit the LTCMI without a PL1 Screening Form will result in an error message stating "PASRR Screening (PL1) not found. A PL1 is required before an MDS LTCMI can be submitted; you may save the LTCMI and submit after PL1 is submitted."

If a PL1 has been submitted with an assessment date that is prior to the assessment date of the LTCMI being submitted, and the Vendor/Provider numbers in Section D of the PL1 do not match the MDS LTCMI Vendor/Provider numbers of the NF, the LTCMI will not be accepted on the LTC Online Portal. Attempting to submit the LTCMI without a matching PL1 will result in an error message stating "PASRR Screening (PL1) not found for this Nursing Facility. A PL1 is required before MDS LTCMI can be submitted; you may save the LTCMI and submit after PL1 is submitted."

For preadmission PASRR positive persons with an active PL1, the LTC Online Portal will not accept the LTCMI without an associated PE. Attempting to submit the LTCMI without a PE will result in an error message stating "PE not found. A PE is required before MDS LTCMI can be submitted. Contact your local authority (LA) to perform the PE; you may save the LTCMI and submit after the PE is submitted."

In addition, when a PE is required for the admission process, an MDS LTCMI cannot be submitted prior to MN determination on the PE. The initial MDS assessment will inherit the MN determination from the PE if the MDS assessment effective date is within 30 days (plus or minus) of the PE assessment date. Attempting to submit the LTCMI prior to MN determination will result in an error message stating "MDS LTCMI cannot be submitted prior to MN determination on the PE; you may save the LTCMI and submit after MN on PE is complete."

If the LTCMI is rejected because the latest interdisciplinary team (IDT) meeting on the latest PASRR Comprehensive Service Plan (PCSP) submitted for the client that is associated with the NF was not submitted on the LTC Online Portal within the last year, the NF can save the LTCMI and resubmit it after the IDT meeting is submitted. The error message will read "An Interdisciplinary Team (IDT) meeting submission is not found on the LTC Online Portal, or it was found but the IDT meeting date is more than one year ago. An IDT meeting submission is required before the MDS LTCMI can be submitted. You may save the LTCMI and submit it again after the IDT meeting is submitted on the PCSP form."

The LTC Online Portal will not reject the MDS LTCMI for missing an IDT meeting submission under the following circumstances:

- The PL1 is inactive (the client has been transferred, is deceased, or has been discharged).
- A positive PE for this client at this NF was not found on the LTC Online Portal.
- The client is in the Hospice Program (Service Group 8) as of the current date or the MDS Assessment Effective Date. Indication of Hospice will be checked in the MDS (Section O and LTCMI) and the Claims Management System.
- The NF has undergone a CHOW, and the system finds that the IDT (with the IDT meeting date within the past year) was submitted on the pre-CHOW PCSP form.

Providers have the ability to save the LTCMI and attempt resubmission after the PL1 Screening Form, PE, or IDT meeting have been submitted on the LTC Online Portal.

Finding Assessments Using Form Status Inquiry

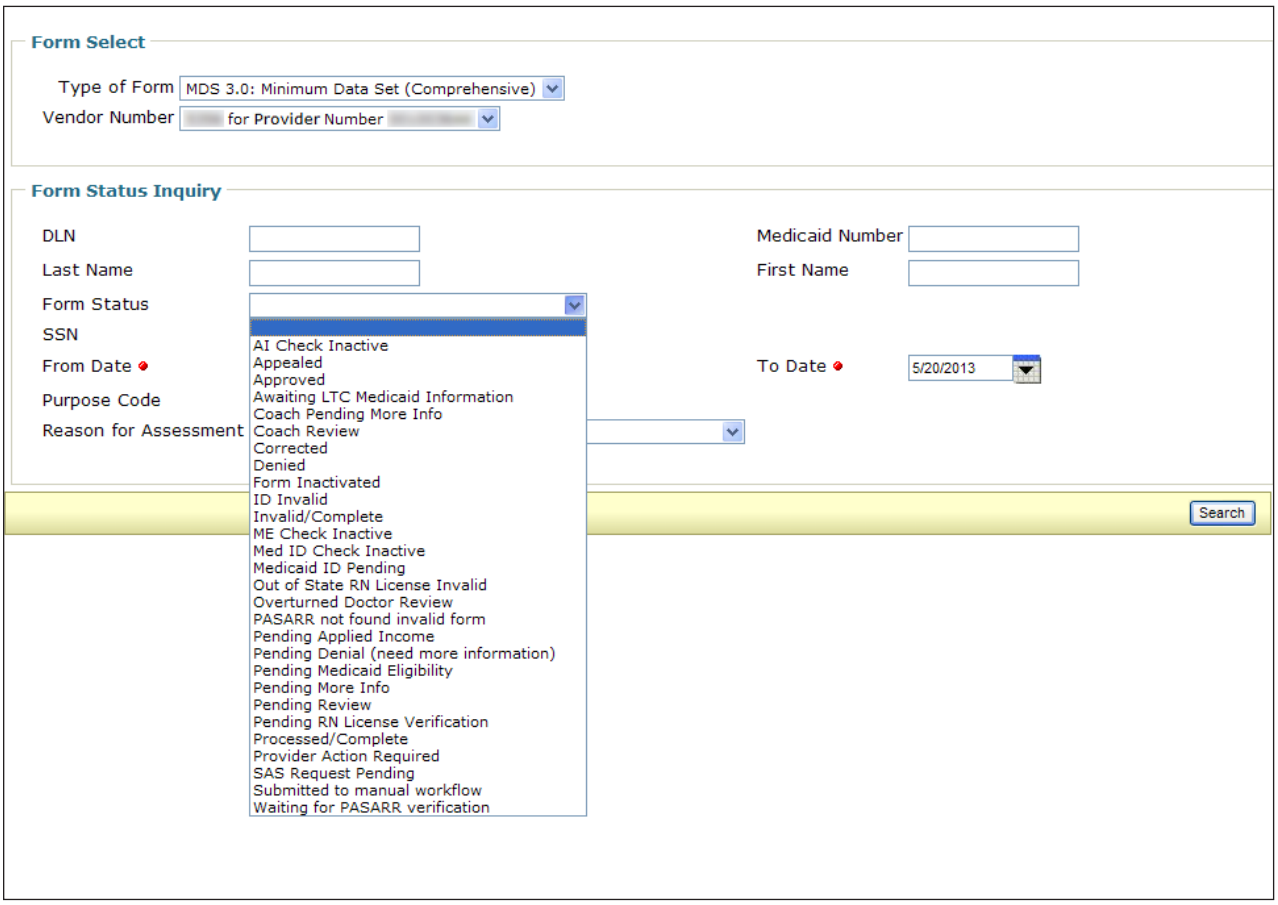
Complete the following steps to find assessments from the Form Status Inquiry:

1) Choose **Form Status Inquiry** from the drop-down menu located in the blue navigational bar.

2) Type of Form: Choose one of the following options from the drop-down menu:

    - MDS 3.0: Minimum Data Set (Comprehensive)

- MDSQTR 3.0: Minimum Data Set (Quarterly)
  Note: The following is an example of an MDS 3.0 Comprehensive assessment.



3) Form Status: Choose **Awaiting LTC Medicaid Information** from the drop-down menu.

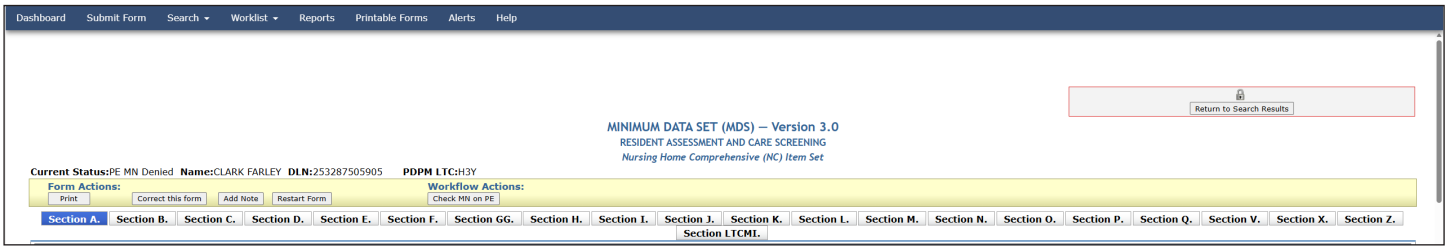
4) Enter a date range for the period for which you are searching. The system default for the search is within the past month; however, the date range must include the period in which the assessment was submitted.
   Note: It may take up to 48 business hours after submission to CMS before the MDS 3.0 assessment is accessible on the LTC Online Portal for data entry in Awaiting LTC Medicaid Information status.

5) Click **Search** and the search results will display.

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

PDPM LTC Value

The Patient-Driven Payment Model Long-term Care (PDPM LTC) is used by MDS 3.0 to classify relative direct care resource requirements for people in an NF and to determine the rate of payment for NF daily care, hospice room, and boarding fees. After a client's assessment is open, the PDPM LTC value can be found next to the DLN at the top of the page.



If You Cannot Locate Your MDS Using FSI or Current Activity

After confirming the requested date range, verify the following:

- MDS was accepted (not rejected) by CMS in your validation report.
- A valid Medicaid number or + was entered in field A0700.
- A0700 does not contain an N.
- A0310A has a response of 01, 02, 03, 04, 05, or 06.
- A0310A does not contain a 99.
- The name on the MDS is exactly the same as on the client's Medicaid ID card.
- The NPI entered in field A0100A matches the vendor or provider information on the MESAV for that client.

Using FSI to Identify People with Specific PASRR Conditions

NFs can use FSI to identify people with specific PASRR conditions. This can assist NFs in identifying the number of clients in the facility who are Intellectual or Developmental Disability (IDD) only, Mental Illness (MI) only, IDD and MI, or PASRR negative.

The LTC Online Portal will:

- Derive and store the PASRR condition of clients in an NF, as indicated by the latest active PE for the client at the time of the most recent MDS LTCMI submission. (An active PE is one that is not set to status Pending Form Completion or Form Inactivated.)
- Export the client-based search results to Microsoft Excel™.
- Search for clients in the facility based on their PASRR condition by selecting an option from the drop-down menu in the FSI.
- Display a list of clients when searching by a PASRR condition listed in the PASRR Eligibility Type drop-down menu of the FSI.

To use FSI this way, you must select **MDS 3.0: Minimum Data Set (Comprehensive)** or **MDSQTR 3.0: Minimum Data Set (Quarterly)** from the FSI Type of Form drop-down menu.

1) Click **Search** on the blue navigational bar.

2) Choose **Form Status Inquiry** from the drop-down menu.

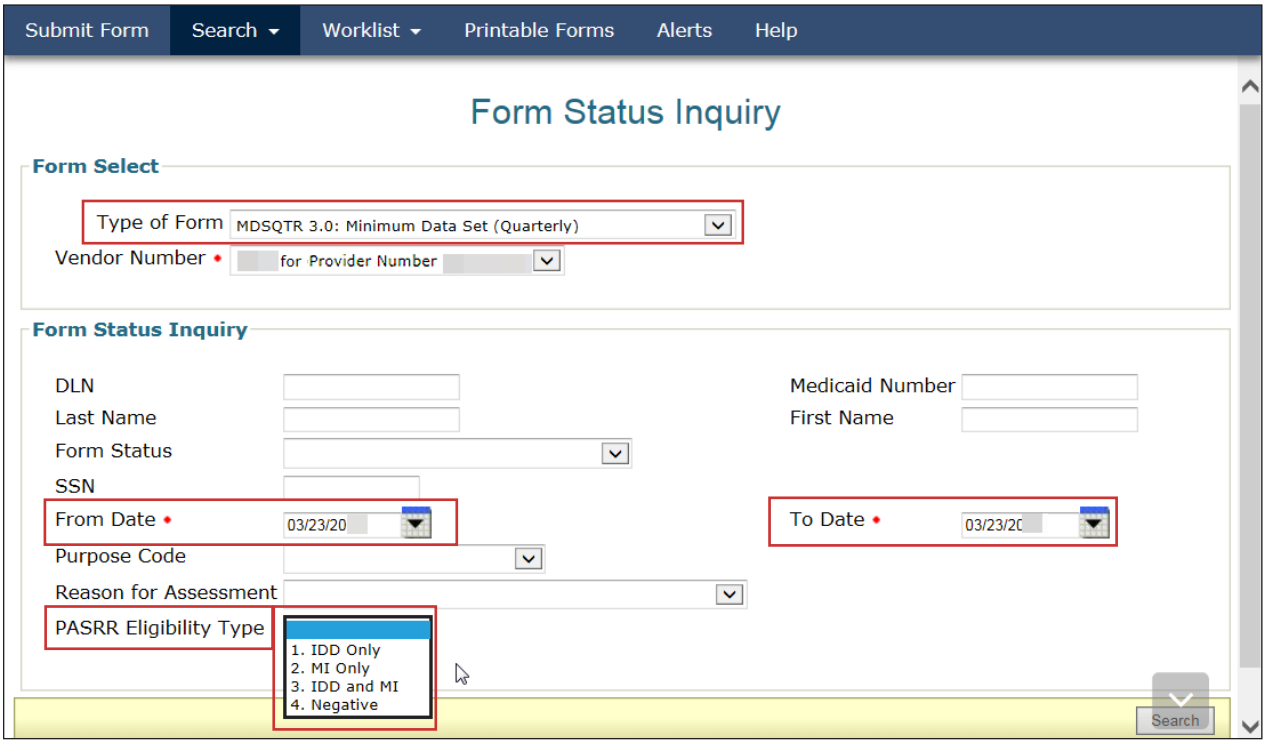
3) Type of Form: Choose one of the following options from the drop-down menu:

   - **MDS 3.0: Minimum Data Set (Comprehensive)**
   - **MDSQTR 3.0: Minimum Data Set (Quarterly)**

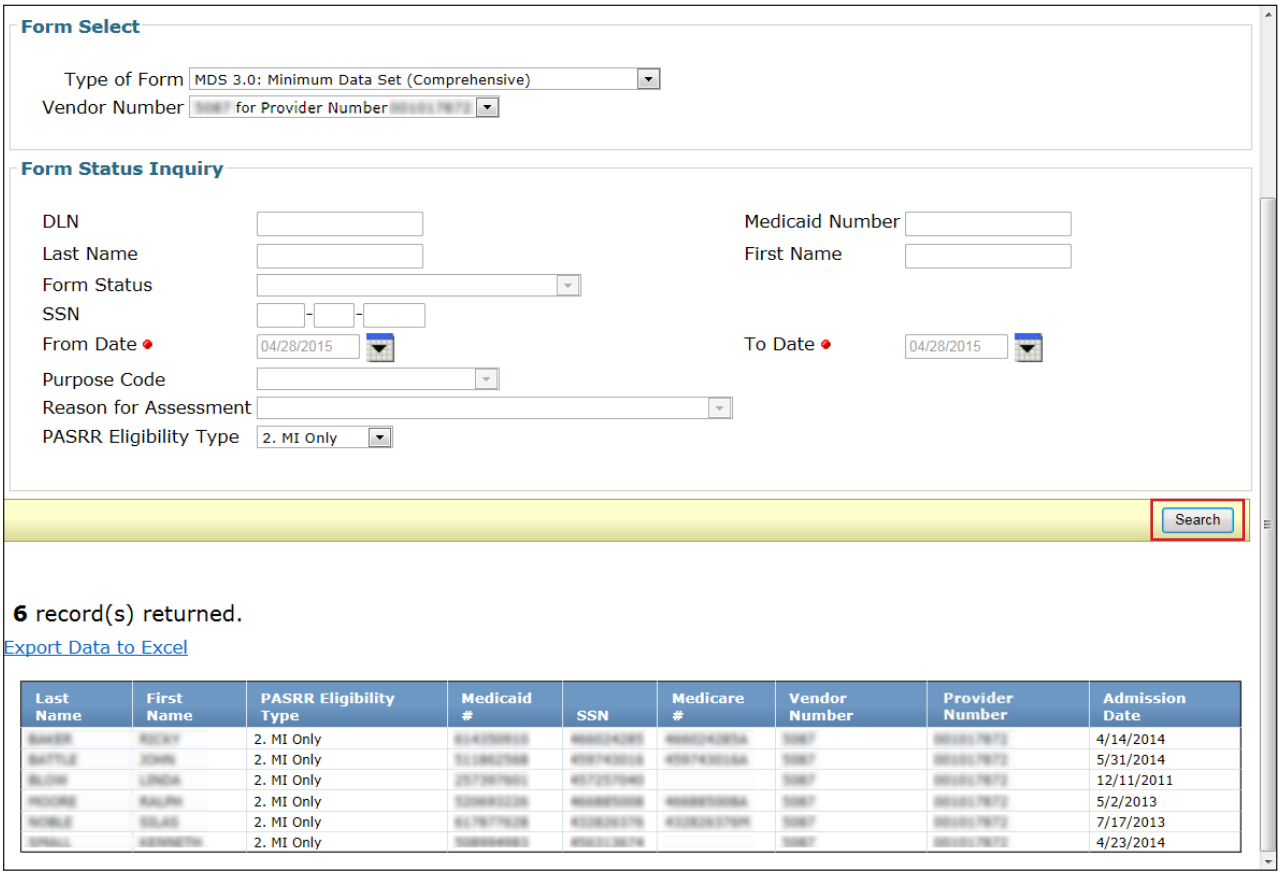
4) Vendor Number: Choose the submitter Vendor Number/Provider Number from the drop-down menu.

5) Choose one of the following from the PASRR Eligibility Type drop-down menu:

   - **IDD Only**
   - **MI Only**
   - **IDD and MI**



   - Click **Search**. The search will return records for all current clients who meet the criteria. Current clients are determined by fields H0100. Individual is deceased or has been discharged? and H0150. Deceased/ Discharged Date of the PL.

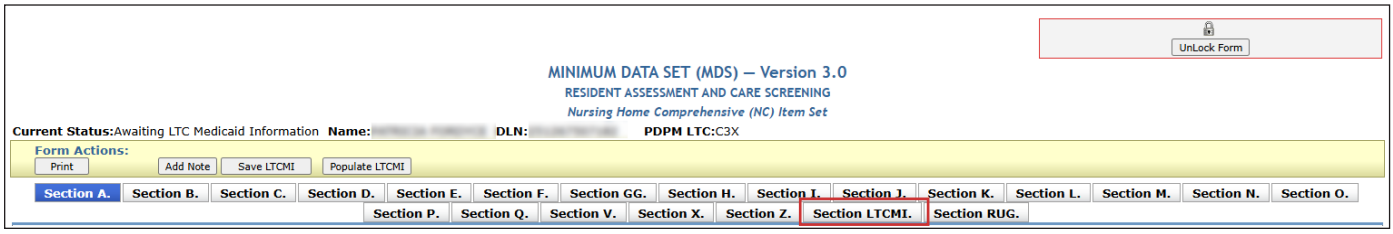


Note: The PASRR Eligibility Type field will appear on the FSI page to LAs who can select an MDS 3.0 or MDSQTR 3.0 assessment; however, LAs can not obtain FSI search results using the PASRR Eligibility Type field.

How to Submit LTCMI

After you have found and opened the assessment set to status Awaiting LTC Medicaid Information using FSI or Current Activity:

1) Click the **Section LTCMI** tab.

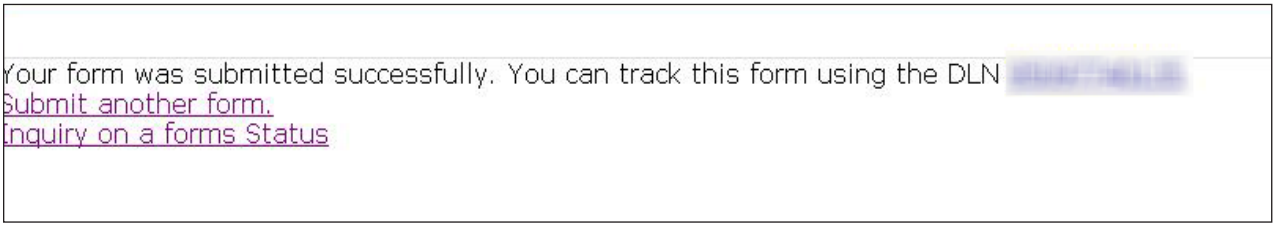


2) Enter data into remaining fields that are not autofilled. At this time, you have the option to manually enter information or click **Populate LTCMI** and modify data as necessary.
Note: To ensure that the LTCMI can be submitted after completion, first check for the **Submit Form** button at the bottom of the screen. If the assessment is being used (locked) by another user, the **Submit Form** button will not be 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."

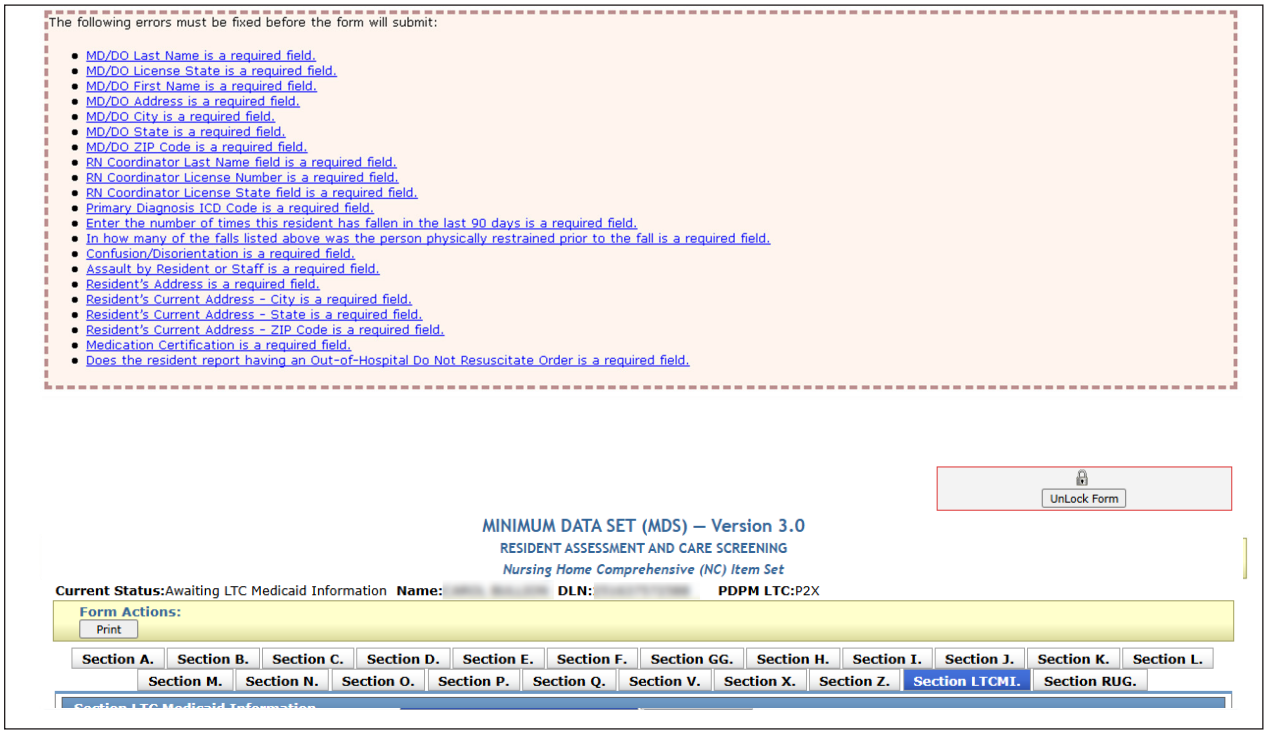
3) From here, you have two choices:

   a) Click **Submit Form** at the bottom right of the screen if the LTCMI is ready to submit for processing.

   b) Click **Save LTCMI** in the yellow Form Actions bar if you would like to save the LTCMI prior to submission. The saved LTCMI will remain in status Awaiting LTC Medicaid Information.
   Reminder: The LTCMI will not be saved to Drafts.
   Successful submission will display the DLN and the message "Your form was submitted successfully."



4) If the LTCMI is not submitted successfully, error messages will be displayed at the top of the page (scroll to the top of the page to see the errors).



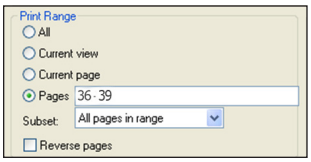
5) To print the submitted LTCMI for your records, open the document and click **Print** in the yellow Form Actions bar.

   a) Printer: Choose the appropriate printer name from the drop-down menu.

   b) Print Range: Click the **Pages** radio button.

   c) Enter the pages to print. As an example, pages for the LTCMI for the MDS 3.0 Comprehensive are 41–44.

Pages for the LTCMI for the MDS 3.0 Quarterly are 36–39.



d) Click **OK**.

Circumstances for LTCMI Submission

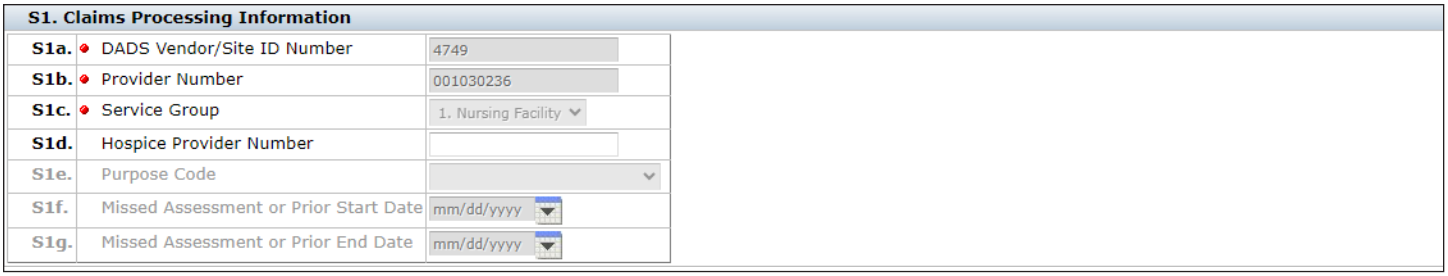
NFs are directed to complete the LTCMI when seeking full Medicaid reimbursement (when a client is moving to full Medicaid or continuation of Medicaid payment). The LTCMI is not required for Medicare recipients or coinsurance.

Note: HHSC recommends completing the LTCMI if the client may become eligible for full Medicaid during the time period the assessment represents. The LTCMI cannot be submitted until an admission, either Form 3618 or 3619, has been submitted.

LTCMI Fields

Important: Verify that the information entered in the LTCMI does not conflict with information entered in the MDS assessment. Information fields on the LTCMI are divided by section as follows:

S1. Claims Processing Information



S1a. HHS Vendor/Site ID Number

- This field is autofilled based on the National Provider Identifier (NPI) number in field A0100A.
- This field is not correctable.
- If A0100A NPI is not correct on the MDS, then the NPI must be fixed at the CMS level.

S1b. Provider Number

This field is autofilled based on the NPI number in field A0100A.

- This field is not correctable.
- If an NPI has more than one provider number associated with it, verify that the correct provider number is selected from the drop-down menu.

S1c. Service Group

- This field is autofilled based on the user's login credentials.
- This field is not correctable on the LTC Online Portal.

S1d. Hospice Provider Number

- Conditional
- This field is required if O0100K. Hospice care column 2, While a Resident, is checked.
- Enter the Medicaid hospice provider number assigned by HHSC. Entering the hospice provider number in this field will allow the hospice provider to view the assessment submitted on their behalf by the NF. This number will be validated and must contain a valid hospice provider number to be accepted onto the LTC Online Portal. If it is not valid, the provider will receive an error message stating "Hospice Provider Number is invalid."

S1e. Purpose Code

- Optional
- E. Missed Assessment
- M. Coverage Code must be P.
- Providers should verify that the MESAV coverage code is P prior to submitting a PC M.
- This field is not removable after a PC has been selected and the assessment has been successfully submitted on the LTC Online Portal.

S1f. Missed Assessment or Prior Start Date (the first date the facility was not paid)

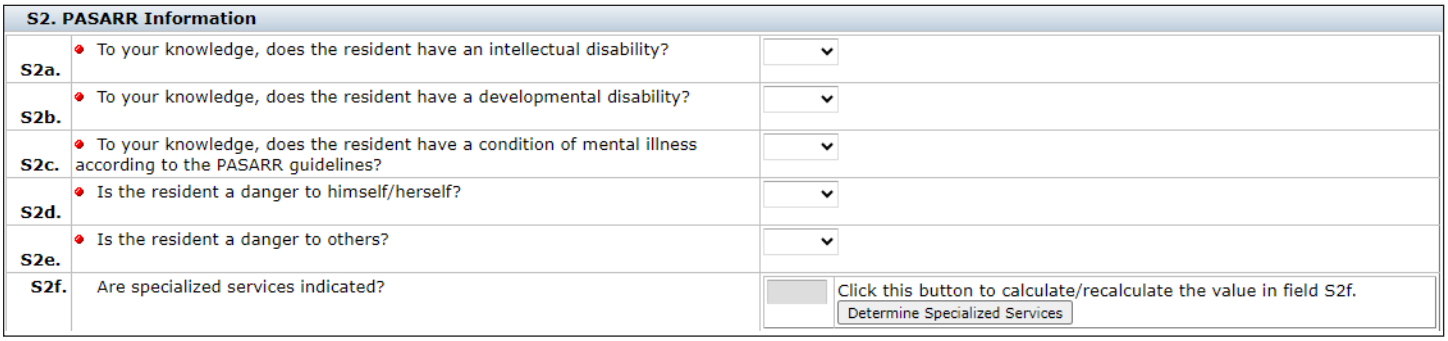
- Conditional
- This field is required if the S1e. Purpose Code is E or M.
- This would be the first missed assessment date (check MESAV for gaps).
- Enter the date of the missed assessment start date in mm/dd/yyyy format.
- Start Date cannot be prior to September 1, 2008.
- The field is correctable.

S1g. Missed Assessment on Prior End Date (the last date the facility was not paid)

- Conditional
- This field is required if the S1e. Purpose Code is E or M.
- This would be the last missed assessment date (check MESAV for gaps).
- Enter the date of the missed assessment or three-month prior retro eligibility (coverage code must be P) end date in mm/dd/yyyy format.
- Date cannot be later than the date of submission (e.g., today's date).
- End Date cannot be prior to the Start Date.

- This field is correctable.
- 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. Providers can submit an MDS Purpose Code E with a missed assessment date range greater than 92 days. This allows providers to submit one MDS PC E to cover large gaps in dates.

S2. PASRR Information



S2a. To your knowledge, does the resident have an intellectual disability?

- Required
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

S2b. To your knowledge, does the resident have a developmental disability?

- Required
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

S2c. To your knowledge, does the resident have a condition of mental illness according to the PASRR guidelines?

- Required
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

S2d. Is the resident a danger to himself/herself?

- Required
- Choose from the drop-down menu:

- **0. No**
- **1. Yes**

If unknown, then reply with **0. No**.

S2e. Is the resident a danger to others?

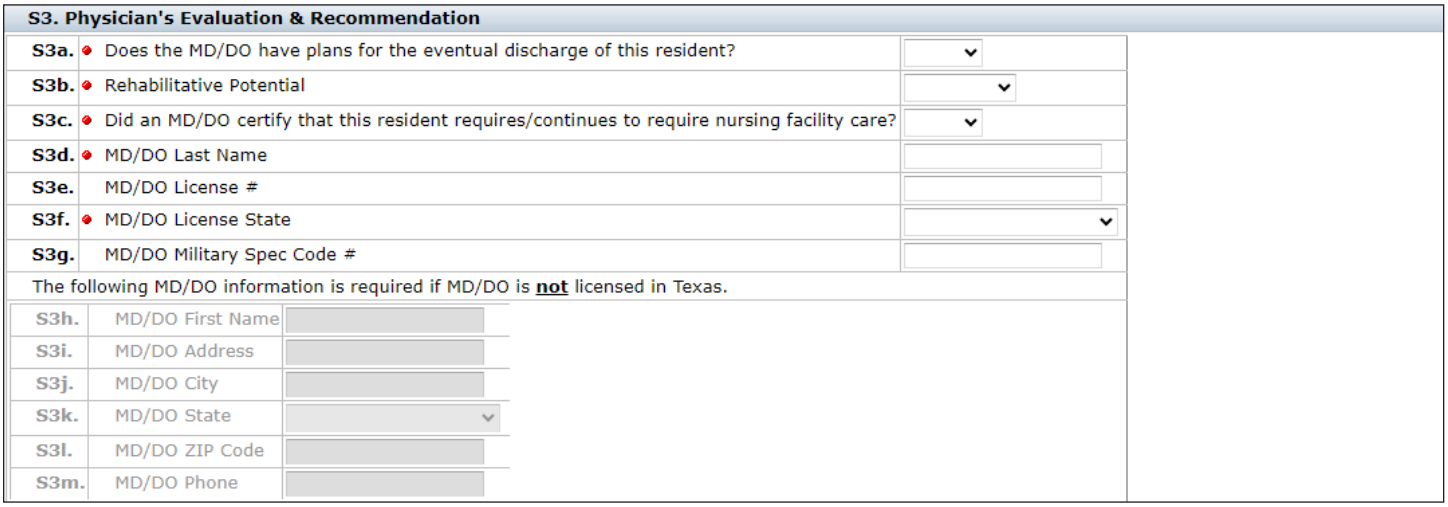
- Required
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

If unknown, then reply with **0. No**.

S2f. Are specialized services indicated?

- Disabled
  - Click **Determine Specialized Services** to calculate and populate a value in S2f.

S3. Physician's Evaluation & Recommendation



S3a. Does the MD/DO have plans for the eventual discharge of this resident?

- Conditional
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

This field is required if the LTCMI is for an admission assessment, SCSA, or recovery of lost payment (PC E).

S3b. Rehabilitative Potential.

- Conditional
- Choose from the drop-down menu:
  - **1. good**
  - **2. fair**
  - **3. minimal**

This field is required if the LTCMI is for an admission assessment, SCSA, or recovery of lost payment (PC E).

S3c. Did an MD/DO certify that this resident requires/continues to require nursing facility care?

- Conditional
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

This field is required if the LTCMI is for an admission assessment, SCSA, or recovery of lost payment (PC E).

S3d. MD/DO Last Name

- Required
- Enter the last name of the Doctor of Medicine/Doctor of Osteopathy (MD/DO).

S3e. MD/DO License

- Conditional
- This field is required if S3g. 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.
  Note: An error will occur if the license number does not pass validation. The assessment cannot be submitted until all errors are resolved.

S3f. MD/DO License State

- Required
- Choose the license state in which the MD/DO is licensed from the drop-down menu.

S3g. MD/DO Military Spec Code

- Conditional
- This field is required if S3e. MD/DO License # is not populated.
- Enter the Military Spec Code number of the MD/DO.
- Fields S3h through S3i (MD/DO information) are required if the MD/DO is not licensed in Texas.

S3h. MD/DO First Name

- Conditional
- This field is required if the S3f License State is *not* Texas.
- Enter the first name of the resident's MD/DO.
- This information is used to mail MN determination letters.

S3i. MD/DO Address

- Conditional
- This field is required if the S3f License State is *not* Texas.
- Enter the street address of the resident's MD/DO.
- This information is used to mail MN determination letters.

S3j. MD/DO City

- Conditional
- This field is required if the S3f License State is *not* Texas.
- Enter the city of the resident's MD/DO mailing address.
- This information is used to mail MN determination letters.

S3k. MD/DO State

- Conditional
- This field is required if the S3f License State is *not* Texas.
- Enter the state of the resident's MD/DO mailing address.
- This information is used to mail MN determination letters.

S3l. MD/DO ZIP Code

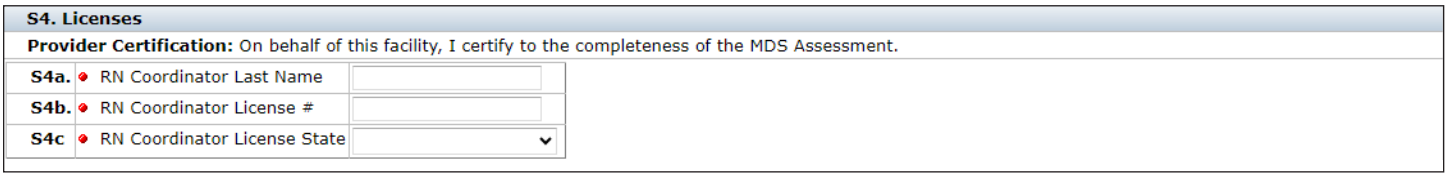
- Conditional
- This field is required if the S3f License State is *not* Texas.
- Enter the ZIP code of the resident's MD/DO mailing address.
- This information is used to mail MN determination letters.

S3m. MD/DO Phone

- Optional
- This field is optional if the S3f License State is *not* Texas.
- Enter the telephone number of the resident's MD/DO.

- This information is used to contact MD/DO if necessary.

S4. Licenses



- Provider Certification: On behalf of this facility, I certify to the completeness of the MDS Assessment.

S4a. RN Coordinator Last Name

- Required
- Enter the last name of the RN assessment coordinator.

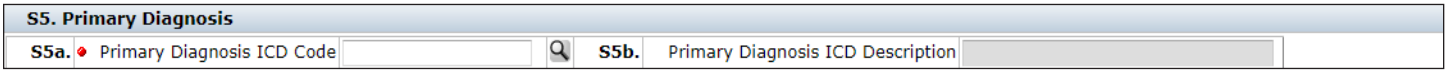
S4b. RN Coordinator License

- Required
- Enter the license number of the RN coordinator.
- Licenses issued in Texas will be validated against the Texas Board of Nursing (BON). Compact licenses will be validated with the issuing state's nursing board.
  Note: An error will occur if the license number does not pass validation. The assessment cannot be submitted until all errors are resolved.

S4c. RN Coordinator License State

- Required
- Choose the license state in which the RN coordinator is licensed from the drop-down menu.

S5. Primary Diagnosis



S5a. Primary Diagnosis ICD Code

- Required
- Enter a valid International Classification of Diseases (ICD) code for the client's primary diagnosis. Use your best clinical judgment.

S5b. Primary Diagnosis ICD Description

- Optional
- Click the **magnifying glass** icon and the description will be autofilled based on the primary diagnosis ICD code.

S6. Additional MN Information

S6. Additional MN Information		
S6a.	Tracheostomy Care	
S6b.	Ventilator/Respirator	
S6c.	Number of hospitalizations in the last 90 days	
S6d.	Number of emergency room visits in the last 90 days	
S6e.	Oxygen Therapy	
S6f.	Special Ports/Central Lines/PICC	
S6g.	At what developmental level is the resident functioning?	
S6h.	Enter the number of times this resident has fallen in the last 90 days.	
S6i.	In how many of the falls listed above was the person physically restrained prior to the fall?	
S6j.	In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.)	
S6j1.	Environmental (debris, slick or wet floors, lighting, etc.)	
S6j2.	Medication(s)	
S6j3.	Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.)	
S6j4.	Poor Balance/Weakness	
S6j5.	Confusion/Disorientation	
S6j6.	Assault by Resident or Staff	

S6a. Tracheostomy Care

- Conditional
- Choose from the drop-down menu:
  - **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**
- This field is required and available for data entry only if O0100E. Tracheostomy care column 2 While a Resident is checked *and* the resident is 21 years of age or younger.

Entry Tip: This field will be disabled if field O0100E2. Tracheostomy Care is not checked on the MDS. The provider must submit an MDS Modification if field O0100E2 is not checked and S6a should be claimed for the add-on rate.

S6b. Ventilator/Respirator

- Conditional
- Choose from the drop-down menu:
  - **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**

- This field is required and available for data entry only if O0100F Ventilator or Respirator column 2 While a Resident is checked. Do not include Bilevel positive airway pressure/Continuous positive airway pressure (BiPAP/CPAP).

S6c. Number of hospitalizations in the last 90 days

- Required
- Record the number of times the resident was admitted to hospital with an overnight stay in the last 90 days (or since last assessment if less than 90 days). Enter **0** (zero) if no hospital admissions have occurred.
- Valid range includes 0–90.

S6d. Number of emergency room visits in the last 90 days

- Required
- Record the number of times the resident visited the emergency room (ER) without an overnight stay in the last 90 days (or since the last assessment if less than 90 days). Enter **0** (zero) if no ER visits have occurred.
- Valid range includes 0–90.

S6e. Oxygen Therapy

- Conditional
- Choose from the drop-down menu:
  - **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**
- This is a required field that is available for data entry only if O0100C Oxygen therapy column 2 While a Resident is checked.

S6f. Special Ports/Central Lines/PICC

- Optional
- Choose from the drop-down menu:
  - **0. N = none present**
  - **1. Y = 1 or more implantable access system or CVC**
  - **2. U = unknown**

Note: Use this field to indicate if the resident has any type of implantable access system or central venous catheter (CVC). This includes epidural, intrathecal, or venous access or peripherally inserted central catheter (PICC) devices. This does *not* include hemodialysis or peritoneal dialysis access devices.

S6g. At what developmental level is the resident functioning?

- Conditional
- Choose from the drop-down menu:
  - **'–' Unknown or unable to assess**
  - **1. < 1 Infant**
  - **2. 1 – 2 Toddler**
  - **3. 3 – 5 Pre-School**
  - **4. 6 – 10 School age**
  - **5. 11 – 15 Young Adolescence**
  - **6. 16 – 20 Older Adolescence**
- This is a required field for all assessments for clients who are 20 years of age or younger (based on birth date minus date of submission [TMHP received date]).
- This field is not available for data entry if the client is 21 years of age or older.

S6h. Enter the number of times this resident has fallen in the last 90 days

- This field is required.
- Record the number of times that the client has fallen in the last 90 days. Enter **0** (zero) if there have been no falls.
- Each fall should be counted separately. If the client has fallen multiple times in one day, count each fall individually.
- Valid range includes 0 (zero)–999. Leading zeroes may be included or omitted from the submitted value. A decimal point and decimal values may not be included on the LTC Online Portal.

S6i. In how many of the falls listed above was the client physically restrained prior to the fall?

- Conditional
- This is a required field if S6h indicates that the client has fallen.

- Valid range includes 0 (zero) with a maximum being the number entered in S6h.

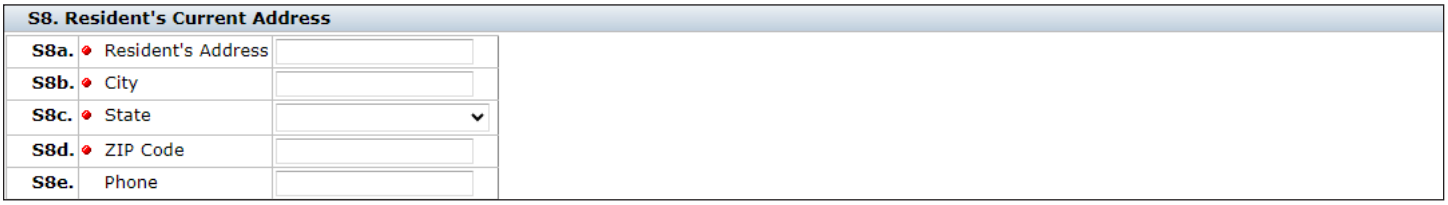
S6j. In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.)

- Conditional
- S6j1 through S6j6 are required only if S6h indicates that the client has fallen.
- Valid range includes 1 (one) with a maximum being the number entered in S6h.
  - **S6j1. Environmental (debris, slick or wet floors, lighting, etc.)**
  - **S6j2. Medication(s)**
  - **S6j3. Major Change in Medical Condition (Myocardial Infarction [MI/Heart. Attack], Cerebrovascular Accident [CVA/Stroke], Syncope [Fainting], etc.)**
  - **S6j4. Poor Balance/Weakness**
  - **S6j5. Confusion/Disorientation**
  - **S6j6. Assault by Resident or Staff**

S7. For HHS Only – PDPM LTC

Section 7 is for HHSC use only and only appears on the MDS PDF document. When the LTCMI is printed, field S7b will show the calculated PDPM LTC value.

S8. Resident's Current Address



S8a. Resident's Address

- Required
- Enter the street address where the client is presently living.
- This information is used to mail MN determination letters.

S8B. City

- Required
- Enter the city where the client is presently living.
- This information is used to mail MN determination letters.

S8c. State

- Required
- Enter the state where the client is presently living.
- This information is used to mail MN determination letters.

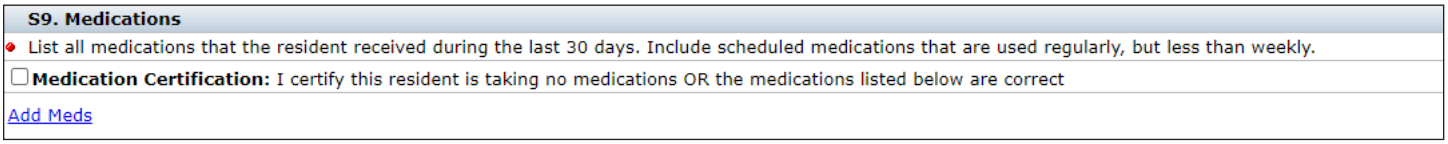
S8d. ZIP Code

- Required
- Enter the ZIP code where the client is presently living.
- This information is used to mail MN determination letters.

S8e. Phone

- Optional
- Enter the contact telephone number for the client, if known. If the client resides in an NF and no other direct contact telephone number is known, enter the telephone number of the NF.

S9. Medications



Medication Certification checkbox

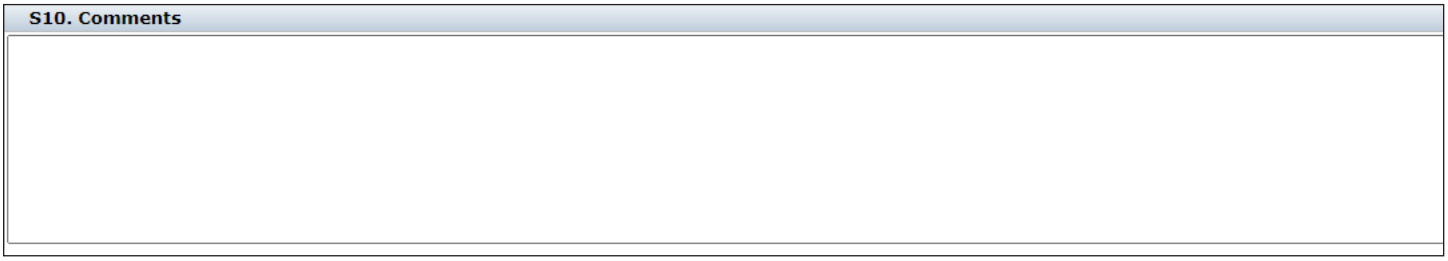
- Required
- Providers are required to check the **Medication Certification** checkbox to certify that the client is not taking medication or that the medications listed are correct.
- S9. Medications.
  - S9 (1.) Medication Name and Dose Ordered. Free-form text.
  - Identify and record all medications that the client has received in the last 30 days. Also identify and record any medications that may not have been given in the last 30 days, but are part of the client's regular medication regimen (e.g., monthly B-12 injections). Do not record *Pro Re Nata* (PRN) medications that were not administered in the last 30 days.
  - S9 (2.) RA (Route of Administration). Select from the list of options.
  - Determine the route of administration (RA) used to administer each medication. The Medication Administration Record (MAR) and the physician's orders should identify the RA for each medication. Record the RA in column 2.
  - S9 (3.) Freq (Frequency). Select from the list of options.
  - Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3.

- S9 (4.) PRN-n (number of doses) as necessary: number of times in the last 30 days.

Note: PRN means "as needed" in Latin. The PRN-n column is completed only for medications that have a frequency as PR. Record the number of times in the past 30 days that each medication coded as PR was given. Stat medications are recorded as a PRN medication. Remember, if a PRN medication was not given in the past 30 days, it should not be listed here.

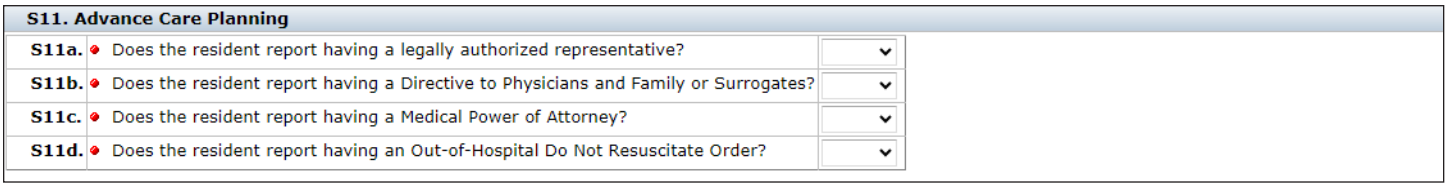
- Section N on MDS 3.0 assessments reflects the number of medications, and section S9 allows for more detailed information to be submitted (e.g., name of medications).

S10. Comments



- Adding comments is optional.
- Enter up to 500 characters. It is essential that you include signs and symptoms that present an accurate picture of the client's condition.
- The comment section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:
  - Pertinent medical history.
  - Ability to understand medication.
  - Ability to understand changes in condition.
  - Abnormal vital signs.
  - Previous attempts at outpatient management of medical condition.
  - Results of abnormal lab work.

S11. Advance Care Planning



Advance care planning means planning ahead for how the client wants to be treated if ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die, they cannot talk or to let others know how they feel.

S11a. Does the resident report having a legally authorized representative?

- Required
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

Note: A legally authorized representative (LAR) is a person authorized by law to act on behalf of a person with regard to a matter and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

S11b. Does the resident report having a Directive to Physicians and Family or Surrogates?

- Required
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

Note: In states other than Texas, this document may be referred to as a Living Will. Directive to Physician/Living Will is a document that communicates a resident's wishes about medical treatment at some point in the future when they cannot make their wishes known because of illness or injury.

S11c. Does the resident report having a Medical Power of Attorney?

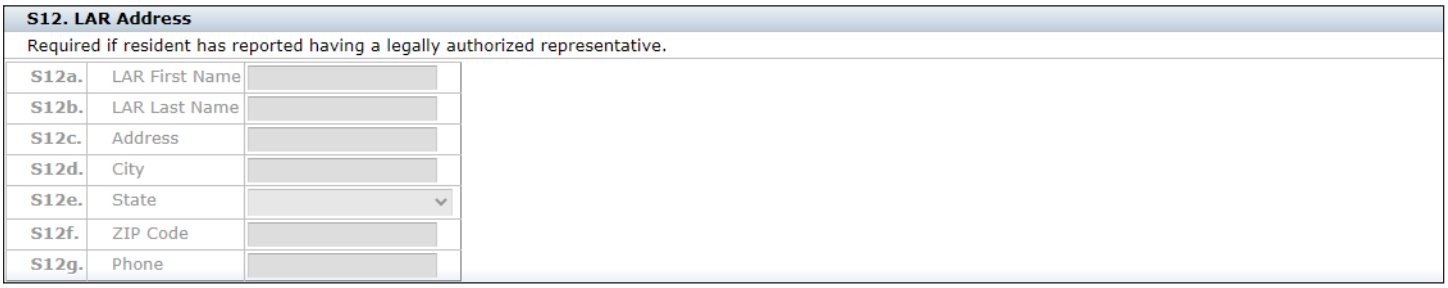
- This field is required.
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

S11d. Does the resident report having an Out-of-Hospital Do Not Resuscitate Order?

- This field is required.
- Choose from the drop-down menu:
  - **0. No**
  - **1. Yes**

Note: This form is for use when a client is not in the hospital. It lets the person tell health care workers, including emergency medical services (EMS) workers, *not* to do certain things if the client stops breathing or their heart stops. If a client does not have one of these forms filled out, EMS workers will *always* give the client cardiopulmonary resuscitation (CPR) or advanced life support even if the advance care planning forms say not to. A client should complete this form as well as the Directive to Physicians and Family or Surrogates and the Medical Power of Attorney form if they do *not* want CPR.

S12. LAR Address



The LAR Address is required if the field S11a. Does the resident report having a legally authorized representative? is indicated as 1. Yes.

S12a. LAR First Name

- Conditional
- This field is required if field S11a is **1. Yes**.
- Enter the first name of the LAR.

S12b. LAR Last Name

- Conditional
- This field is required if field S11a is **1. Yes**.
- Enter the last name of the LAR.

S12c. Address

- Conditional
- This field is required if field S11a is **1. Yes**.
- Enter the street address of the LAR.

S12d. City

- Conditional
- This field is required if field S11a is **1. Yes**.
- Enter the city of the LAR.

S12e. State

- Conditional
- This field is required if field S11a is **1. Yes**.
- Enter the state of the LAR.

S12f. ZIP Code

- Conditional

- This field is required if field S11a is **1. Yes**.
- Enter the ZIP code of the LAR.

S12g. Phone

- Optional
- This field is optional if field S11a is **1. Yes**.
- Enter the contact telephone number for the LAR, if known.

MDS Purpose Code E (PC E – Missed Assessment)

The PC E is used for a missed assessment.

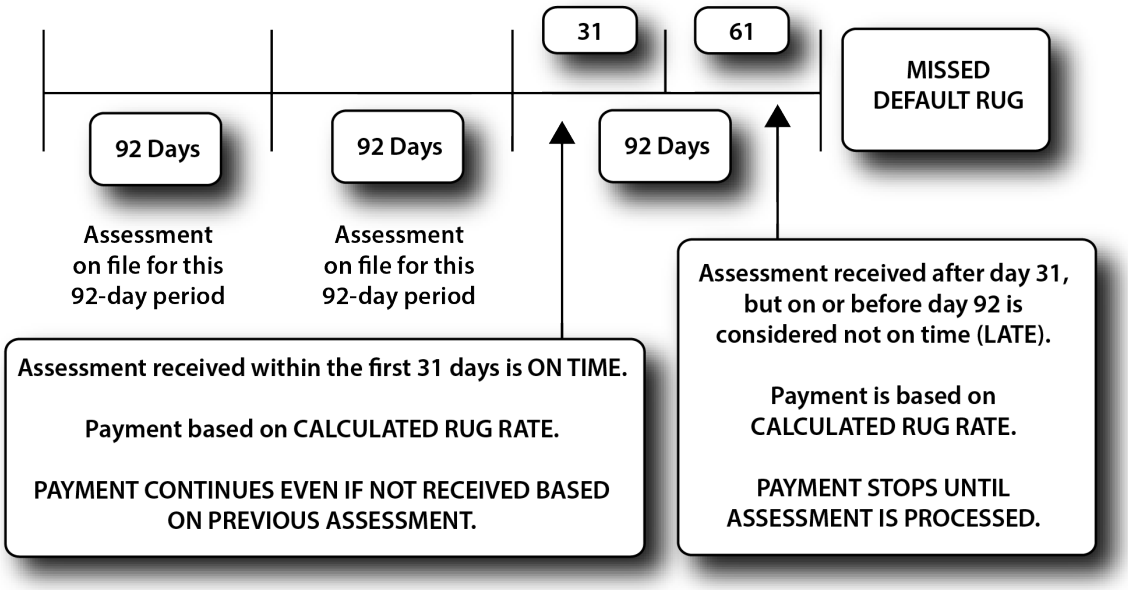
According to 26 *Texas Administrative Code* (TAC) §554.2413:

(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, HHSC pays the nursing facility a default PDPM LTC 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 a Z0500B (MDS 3.0) 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 A1600(MDS 3.0) of that Admission assessment, the Admission assessment must be submitted as a PC E. Payment for this gap will be made at the PC E default rate. MDS PC E is used to recover missed assessment timeframes. A missed assessment occurs when an MDS is not submitted within the anticipated quarter timeframe. 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 from the effective date of the assessment. PC 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 Provider Tips for When to Submit an MDS PC E

The following provides information to help NF providers determine when to submit an MDS PC E.

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

1) Level of Service (RUG or PDPM LTC) Gap. After the client has been established with an NF level of service, a PC E will be needed if the next MDS assessment submission misses the anticipated assessment quarter. Each Z0500B (MDS 3.0) establishes a 92-day period (Z0500B + 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.

    a) The level of service of the current assessment will expire 31 days after the covering quarter (Z0500B + 91 days) unless the next MDS assessment has been successfully completed. HHSC cannot pay for services on days when a level of service has expired.

    b) The next MDS assessment will not be considered missed if it has a Z0500B 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 Z0500B date.

    c) If the new MDS assessment is submitted after the expiration of the level of service on file but within the anticipated quarter, the gap following the 31 days and prior to the new Z0500B date will automatically be filled with the new calculated level of service.

    d) If the new MDS is not submitted within the anticipated quarter or the LTCMI is not completed within 91 days of the Z0500B date, a gap will be created following the 31 days until the Z0500B 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 or Prior Assessment Start Date (S1f).
        - The Missed or Prior Assessment End Date (S1g).

Note: To submit a PC E for a one-day gap, the Missed Assessment Start Date and the Missed Assessment End Date must be the same.

    e) For an admission assessment, the date will be based off of field A1600. All other forms will be based off of field Z0500B.

2) Missed MDS. If an LTCMI is submitted more than 91 days after the Z0500B 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:

    a) The S1e field on the LTCMI completed as the PC E.

    b) The Missed or Prior Assessment Start Date (S1f).

    c) The Missed or Prior Assessment End Date (S1g).

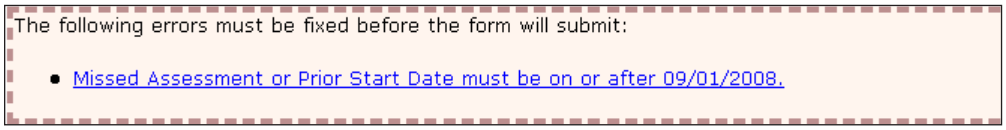
Prior to adding a PC to an LTCMI, validate whether payment has been made based on the MDS. Entering a PC, start date, and end date cancels any prior service dates that the assessment represented. If necessary, submit an off-cycle MDS 3.0 assessment to submit a PC E or M.

Note: When an MDS LTCMI has been completed as a PC E, any future modifications or corrections must also be completed as a PC E (it cannot be changed to a PC M).

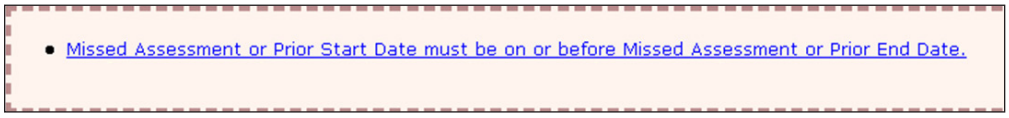
PC E Start and End Date Limitations (MDS 3.0)

The following limitations apply for the PC E Start and End Date:

- Only applicable for MDS 3.0 admission, quarterly review, and annual assessments.
- Start date cannot be prior to September 1, 2008.



- End date cannot be prior to the start date.



MDS Purpose Code M (PC M – Prior Medicaid Eligibility)

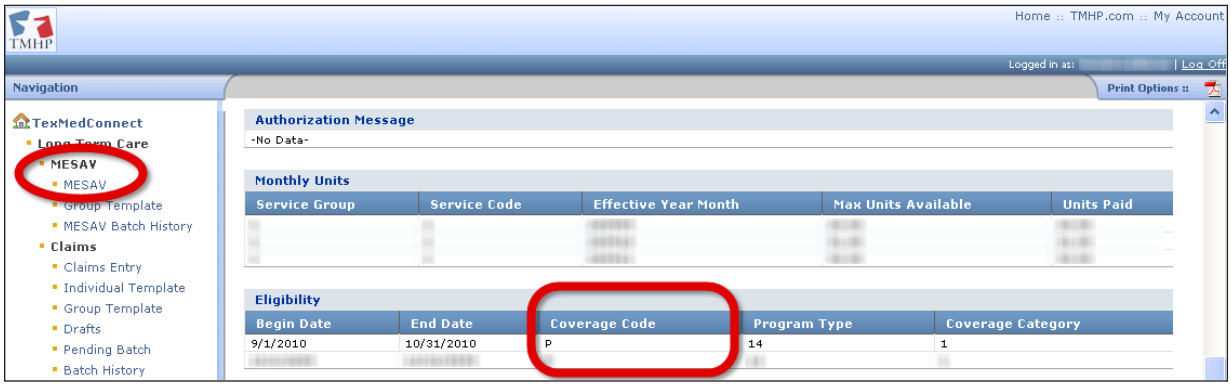
The PC M is used when prior Medicaid eligibility has been established. Prior eligibility can begin up to three months prior to certification of Medicaid. PC M can only be submitted on the admission assessment, annual assessment, or quarterly review assessment.

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).

Note: PC M can only fill a gap for which prior eligibility has previously been established. Payment is made at the full calculated RUG or PDPM LTC rate. Check MESAV to verify eligibility code of P or TP11 *before* the submission of a PC M.

The LTCMI section should specify:

- S1e = M (Purpose Code) Coverage Code (must be P).



- S1f = Missed Assessment or Prior Start Date (this is the prior eligibility start date).
- S1g = Missed Assessment or Prior End Date.

The correction of an existing LTCMI PC to an E or M invalidates the original timeframe. If the LTCMI is changed to indicate a PC E or PC M and the assessment had been part of the person's cycle, the original timeframe is voided (i.e., set to status Corrected) and only the PC E or M dates will be covered.

More information on purpose codes E and M can be found at:
www.HHS.state.tx.us/providers/communications/2009/letters/IL2009-27.pdf

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

What is a Purpose Code M, and How Do You Complete a Purpose Code M?

PC M on an MDS submitted 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 Medicaid-eligible, the worker considers the three months prior to the application to determine if the client may have been financially eligible at an earlier date. PC M allows the provider to submit an MDS to cover those three months so the payment can be made at a RUG or PDPM LTC value rather

than the default PC E rate. Retroactive Medicaid is shown on the MESAV as a TP 14 coverage code P or TP 11, which indicates retroactive TP13 SSI coverage.

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

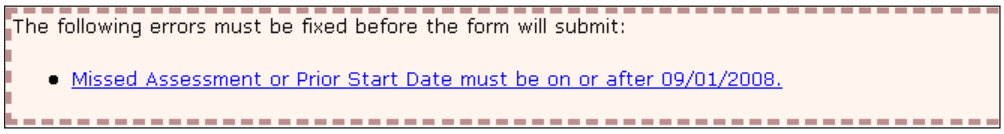
1) Submit an off-cycle MDS quarterly assessment including the LTCMI by completing:
   - The S1e field on the LTCMI completed as the PC M.
   - The start date of the approved prior period (S1f).
   - The end date of the approved prior period (S1g).
2) Modify an earlier MDS that has not been used for the Medicaid cycle and fill out 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).
   - The end date of the approved prior period (S1g).

Note: To submit a PC M for one day, the missed assessment start date and the missed assessment end date must be the same.

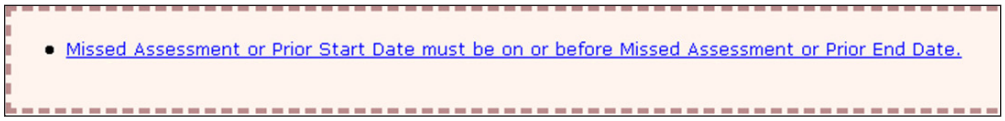
PC M Start and End Date Limitations (MDS 3.0)

The following limitations apply for the PC M Start and End Date:

- Only applicable for MDS 3.0 admission, quarterly review, and annual assessments.
- Start date cannot be prior to September 1, 2008.



- End date cannot be prior to the start date.



Corrections and Updates

Corrections can be made to certain fields in the LTCMI section of the MDS 3.0. Providers should not correct assessments that are already in status Processed/Complete. This may result in payment ceasing.

Note: Forms 3618 and 3619 or the LTCMI section of a MDS assessment that have been set to status Form Inactivated at any time in the assessment's history will not allow corrections to the form or assessment. The **Correct this form** or **Update Form** button will not be displayed in the yellow Form Actions bar on any form that cannot be corrected or updated. This includes submission of these forms or assessments by a third-party software vendor for your facility.

LTCMI Corrections

Corrections to the LTCMI section data can be submitted directly on the LTC Online Portal.

Note: If no PC is identified in field S1e., it may be corrected to reflect either E or M. A PC M may be corrected to a PC E. However, after an assessment is classified as a PC E, the entry in field S1e cannot be corrected.

Prior to correcting or adding a PC on an LTCMI, validate whether payment has been made based on the MDS. Entering a PC start and end date cancels any prior service dates that the assessment represented. If necessary, submit an off-cycle MDS 3.0 assessment to submit a PC E or M.

To submit LTCMI corrections:

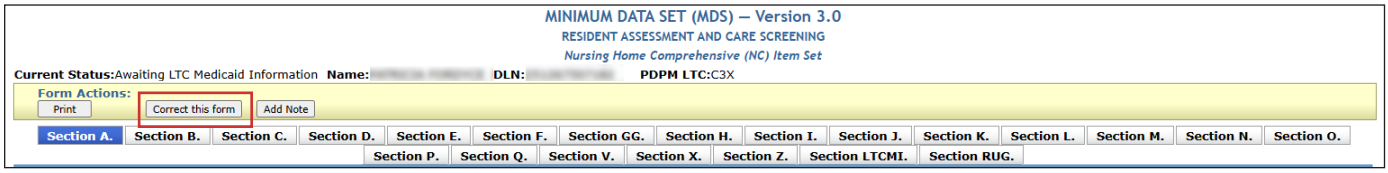
1) Log in to the LTC Online Portal.

2) Use either **Form Status Inquiry** or **Current Activity** to access the applicable document.

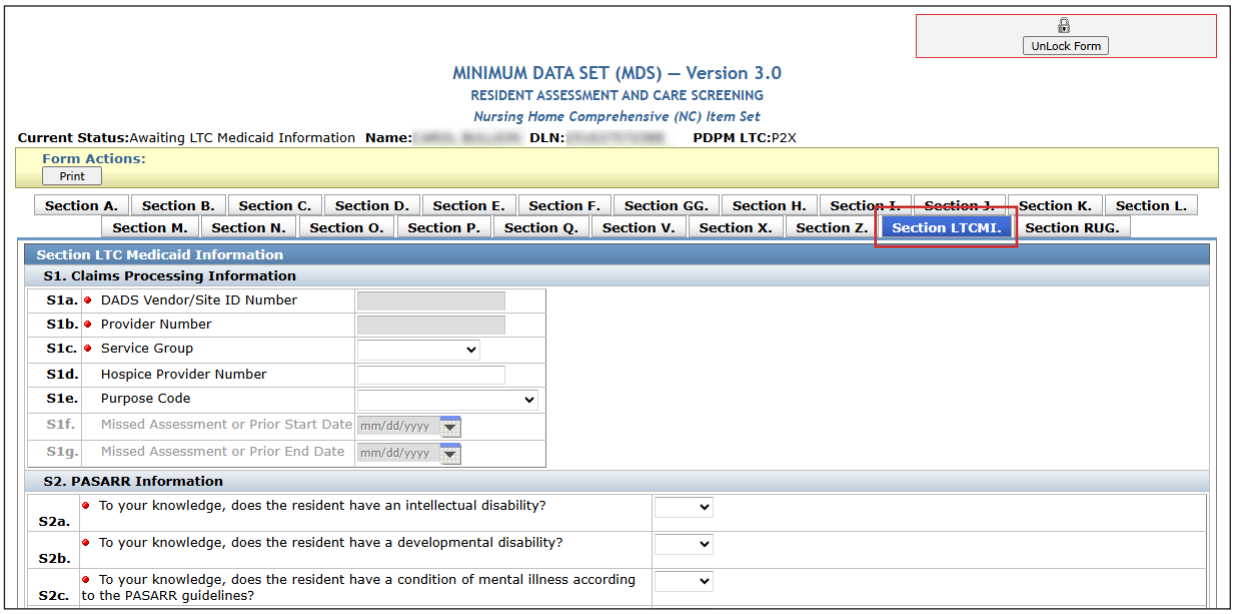
   a) If using FSI, you may search for an MDS using the SSN, Medicaid number, or DLN. Click **Search**, and then click **View Detail**.

   b) If using Current Activity, click **DLN**.

3) Click **Correct this form**.

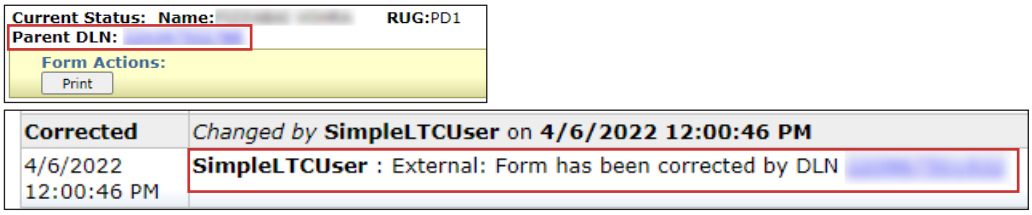


4) Click the **Section LTCMI** tab and complete only the fields needing correction.



5) Click **Submit Form**.

6) The original assessment (parent) is set to status Corrected and the new assessment (child) DLN is assigned, creating a parent and child DLN relationship. The new child assessment replaces the parent assessment. However, if the parent assessment is in status Processed/Complete or PCS Processed/Complete, it will not move to a Corrected status until the child form is in status Processed/Complete or PCS Processed/Complete.



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

Form 3618 and 3619 Corrections

NF providers must submit Forms 3618 and 3619 corrections directly on the LTC Online Portal.

The following fields can be corrected on Forms 3618 and 3619:

- Administrator Signature Date
- Administrator License Number
- Comment Section
- Date of Above Transaction
- Dates of Qualifying Stay (Form 3619)
- Discharge Type
- Location
- Recipient Address
- Recipient First Name
- Recipient Middle Initial
- Recipient Name Suffix

The entries in the correctable fields can be changed even if the form has been processed into the system. For example, if the form indicates that a client receiving Medicare transferred to Medicaid on the fifth of the month, and then it is discovered that the transfer was actually on the eighth of the month instead, two corrections should be submitted. The original Form 3619 discharge and Form 3618 admission must both be corrected to the eighth rather than submitting new forms.

TMHP places the original form in a status of Corrected and gives the new form a DLN, creating a parent and child DLN relationship.

If a form contains incorrect information in a field that cannot be corrected and the form is set to the status Processed/Complete, a counteracting form must be submitted. If the form is not set to a Processed/Complete status, inactivate the form and resubmit it with the correct information. Refer to the Counteracting Forms section of this user guide for additional information.

Making Corrections to Forms 3618 or 3619

Log in to the LTC Online Portal.

1) Click **Search** in the blue navigational bar.

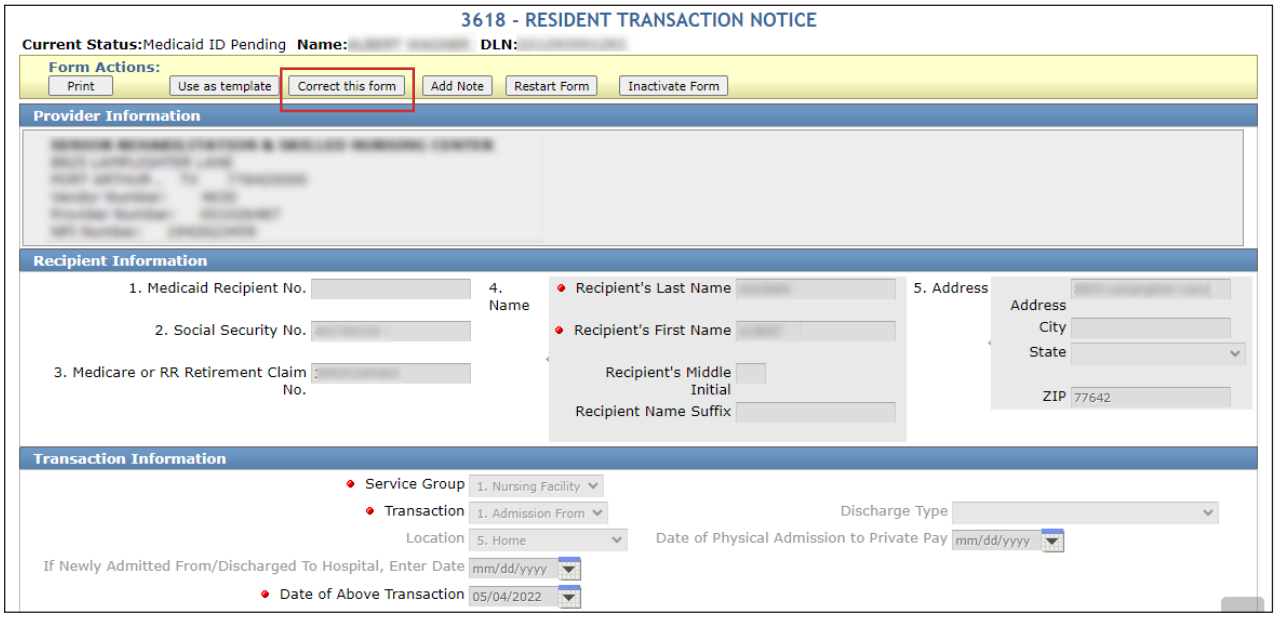
2) Choose **Form Status Inquiry** from the drop-down box.

3) Search for Form 3618 or 3619 using the person's SSN, Medicaid number, first and last name, or DLN.

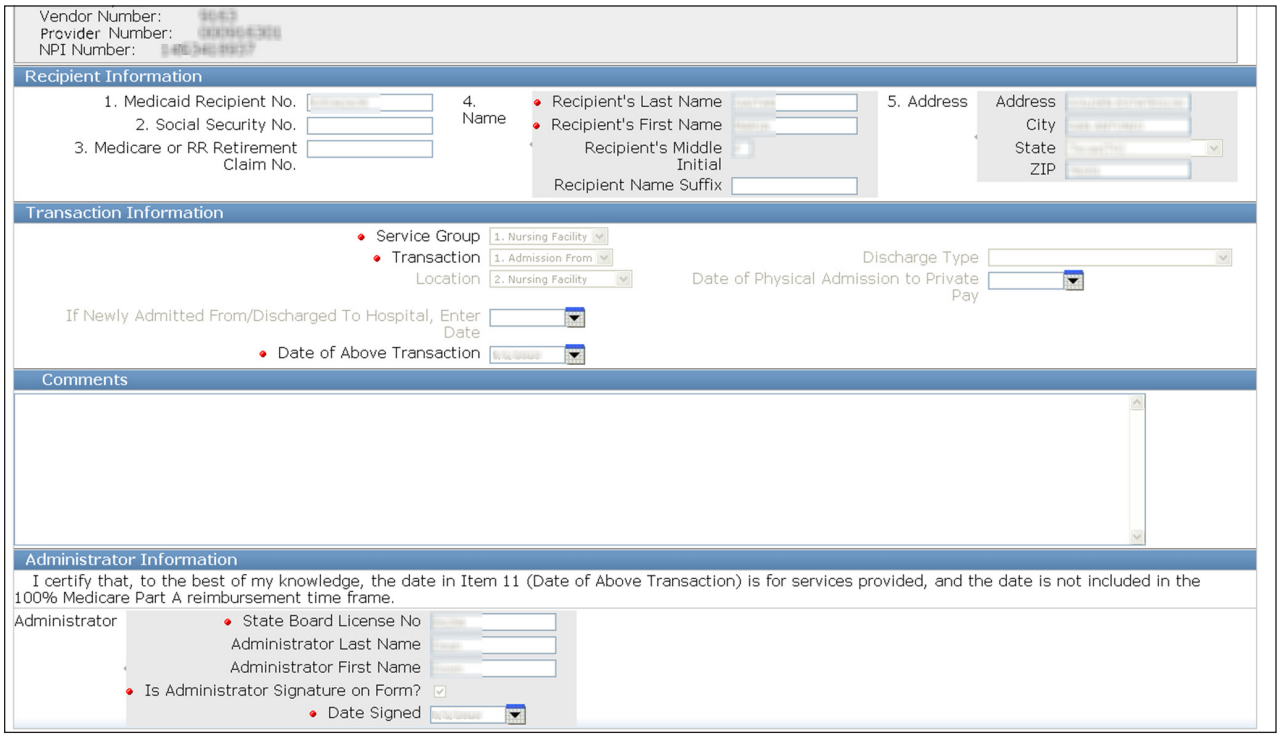
4) Click **Search**.

5) Click the **View Detail** link.

6) Click **Correct this form**.



7) Change the information in the fields needing correction.



8) Click **Submit Form**.
Note: If the form is submitted, a DLN will be assigned, and the LTC Online Portal will display the message "Your form was submitted successfully." If there are errors, they will be displayed in a box at the top of the screen. These errors must be resolved before the form can be submitted. After all errors are resolved, click **Submit Form**.

9) Click **DLN** in the **Your form was submitted successfully** message to return to the form.

10) Click **Print** in the yellow Form Actions bar to print the completed form.

Counteracting Forms

A counteracting form is a submitted form that indicates the opposite transaction of the incorrect form (admission versus discharge) and has the same date in the **Date of Above Transaction** field.

Examples:

- A discharge to the hospital is submitted in error because the admission to the hospital was for observation only, and no form should have been submitted. If the discharge is processed before the mistake is corrected, submit a counteracting form indicating an admission in the **Transaction** field and use the same date in the **Date of Above Transaction** field.
- A Form 3618 admission is submitted, but the client is classified as Medicare. If the admission processes before the mistake is corrected, submit a counteracting form indicating Discharge to NF in the **Transaction** field and use the same date in the **Date of Above Transaction** field.
- If an admission is submitted under the wrong contract and it is processed onto the file, a discharge must be submitted for the same incorrect contract, using the same Date of Above Transaction. After both forms are available on the LTC Online Portal and are set to status Processed/Complete or Provider Action Required, you must contact HHSC LTC PCS. The correct admission cannot be submitted until HHSC has set the status of both forms with the incorrect contract to Invalid/Complete.
- It is beneficial to add a note in the comment section of the counteracting form detailing the desired action.

Note: When submitting a counteracting form for an admission that has payment, recoupment will occur unless additional processing occurs at the same time. Coordinate with HHSC LTC PCS to verify the appropriate payment.

Modifications

NF providers must submit all MDS correction requests to CMS in accordance with the *RAI User's Manual*. Corrections that are classified as a modification are retrieved by TMHP for processing. In field X0900 on MDS 3.0 corrections, select the reason for modification. TMHP then sets the original assessment to status Corrected and gives the new assessment a DLN, creating a parent and 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: You are allowed to submit modifications to an on-time MDS without requiring a PC for up to one year. For modifications to an MDS assessment that did not originally meet the timeliness rules, a PC E will be required upon submission of the LTCMI.

Note: If the parent assessment is in status Processed/Complete or PCS Processed/Complete, it will not move to a Corrected status until the child form is in status Processed/Complete or PCS Processed/Complete.

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

Inactivating and Deleting Forms and Assessments

Inactivating an MDS Assessment

For MDS inactivations, NF providers complete the MDS Correction Request Form, ensuring field X1050 on 3.0 corrections (reason for inactivation) was completed prior to submission to CMS. TMHP will retrieve all successfully submitted MDS inactivation requests from CMS for processing. When the inactivation is placed on the LTC Online Portal, TMHP will automatically inactivate the associated LTCMI and the assessment will be set to status Form Inactivated unless the original assessment has been set to status Processed/Complete. However, the LTCMI will not automatically be inactivated on the LTC Online Portal if the assessment had a previous status of Processed/Complete, which means that it was already processed by the Service Authorization System (SAS). The assessment status will be set to SAS Request Pending and will be processed by SAS during the nightly batch routines. Any MDS assessment set to status Form Inactivated or Invalid/Complete cannot be corrected or resubmitted.

The inactivation request will be submitted against assessments that have been processed. If the assessment can be located and the HHSC Office of Inspector General (OIG) has not addressed the assessment, the assessment will be canceled and any associated payments will be recouped. If the inactivation is submitted on an assessment that has been chosen by OIG, the inactivation will be rejected with an appropriate error message. If the system fails to identify the assessment, the inactivation will also be rejected, and HHSC will manually research it. In each situation, a response will be posted on the LTC Online Portal.

Note: Refer to the MDS 3.0 *RAI User's Manual*, Chapter 5, for detailed instructions on completing an MDS Inactivation.

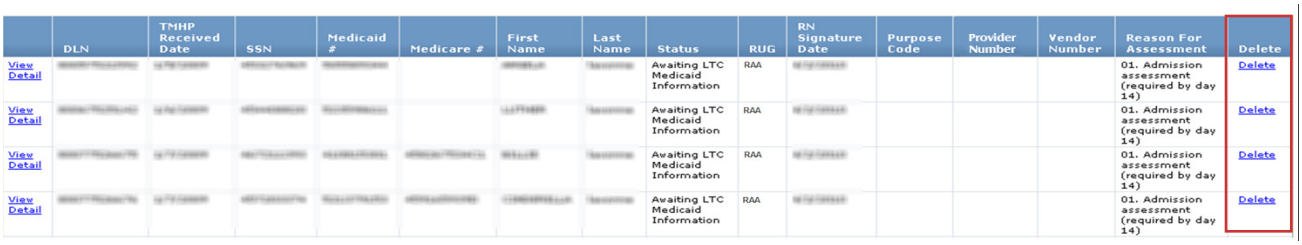
Note: Providers should submit an inactivation on dually coded assessments only after attempting to submit a modification through CMS. An inactivation will affect Medicare and Medicaid reimbursements.

Deleting an MDS Assessment

MDS assessments in ***Awaiting LTC Medicaid Information*** status can also be deleted from the LTC Online Portal by following these steps:

1) Locate the assessment to be deleted using Form Status Inquiry (FSI).

2) Select the assessment you want to delete from the FSI search results page. Click the **Delete** link in the far right column.



	DLN	TMHP Received Date	SSN	Medicaid #	Medicare #	First Name	Last Name	Status	RUG	RN Signature Date	Purpose Code	Provider Number	Vendor Number	Reason For Assessment	Delete
View Detail								Awaiting LTC Medicaid Information	RAA					01. Admission assessment (required by day 14)	Delete
View Detail								Awaiting LTC Medicaid Information	RAA					01. Admission assessment (required by day 14)	Delete
View Detail								Awaiting LTC Medicaid Information	RAA					01. Admission assessment (required by day 14)	Delete
View Detail								Awaiting LTC Medicaid Information	RAA					01. Admission assessment (required by day 14)	Delete

3) You will receive a message reading "Warning – If you delete this MDS assessment from the Portal, you will have to submit a correction request to the State MDS database to allow the Portal to extract it at a later time. Please confirm that you would like to delete the MDS assessment from the Portal."

4) Click the **OK** button to delete the assessment. Click the **Cancel** button if you do not want to delete the assessment.
Note: Once deleted, the MDDS assessment will no longer be available on the LTC Online Portal, but it will *not* be deleted from CMS. If an MDS assessment is deleted from the LTC Online Portal, TMHP will not re-extract the assessment unless it is modified through CMS.

Inactivating Forms 3618 and 3619

Use FSI or Current Activity to search for Forms 3618 and 3619 that need to be inactivated. When you find the forms, submit the inactivations on the LTC Online Portal. Once the inactivation has been submitted and accepted, the form is then set to Form Inactivated status and is unavailable for further action.

To inactivate Forms 3618 and 3619, perform the following steps:

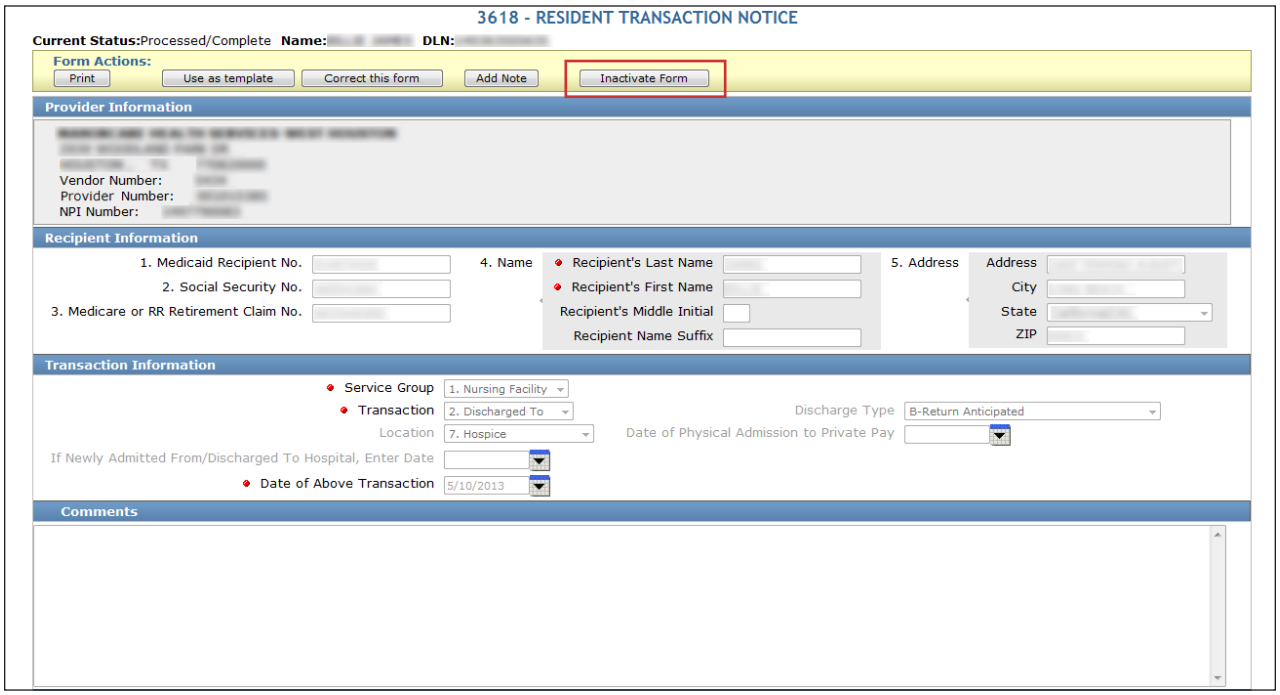
1) Log in to the LTC Online Portal.

2) Search for the form that is being deactivated by using either the **Form Status Inquiry** or **Current Activity** in the blue navigational bar.

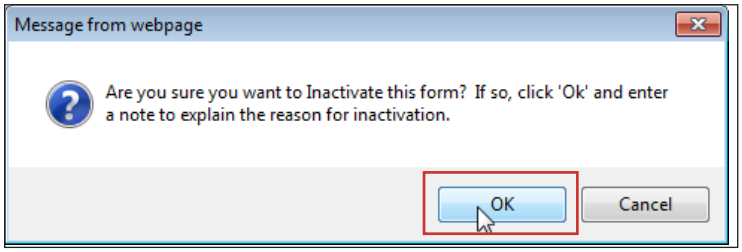
   a) If using FSI, you may search for Form 3618 or 3619 using SSN, Medicaid number, or DLN. Click **Search**, and then click **View Detail**.

   b) If using Current Activity, click **DLN**.

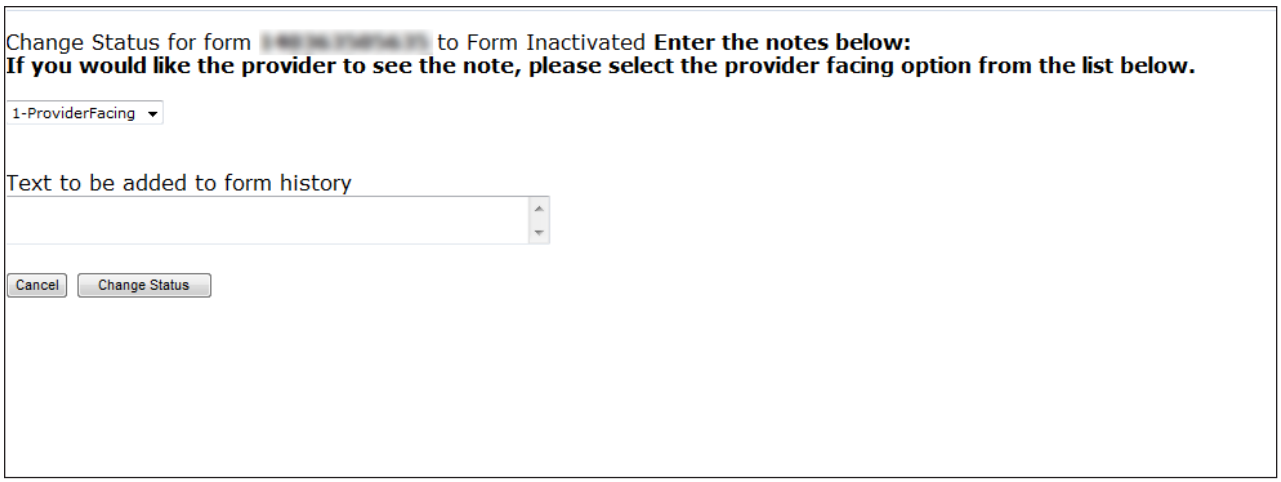
3) Click **Inactivate Form**.



4) Click **OK** when the pop-up window asks: Are you sure you want to Inactivate this form? and enter a note to explain the reason for inactivation.



5) When the Change Status window appears, enter a note for the inactivation and click **Change Status**. The form or screening will be set to status Form Inactivated.



The following Forms 3618 and 3619 cannot be inactivated:

- Forms with a status of Processed/Complete, Corrected, or Form Inactivated
- Forms that have been successfully processed
- Forms with the provider workflow message code GN-9004 anywhere in the History trail

If a provider attempts to inactivate a Form 3618 or 3619 and one of the above circumstances exists, the provider will receive the following error message "This form has been successfully processed at HHSC and cannot be inactivated. If this form is invalid (should not have been submitted), submit the appropriate form to counteract this form. Otherwise, correct this form and resubmit."

To cancel a form that is set to status Processed/Complete and has an error in a noncorrectable field or one that should not have been submitted, providers must submit the appropriate counteracting form. Refer to the Counteracting Forms section of this user guide for additional information.

Preventing Medicaid Fraud, Waste, and Abuse

Medicaid fraud is an intentional deceit or misrepresentation made by a person with the knowledge that deception may 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 Fraud, Waste, and Abuse

Reports may be made through the following website: https://oig.hhs.texas.gov/report-fraud-waste-or-abuse. 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 Texas Medicaid, report it to OIG and let the investigators decide. If you are uncomfortable about submitting a report online, call the Recipient Fraud and Abuse reporting line at 800-436-6184.

HIPAA Guidelines and Provider Responsibilities

Providers must comply with HIPAA. It is *your* responsibility to comply with HIPAA, to seek legal representation when needed, and to consult the manuals or speak to your TMHP provider representative when you have questions.

Resource Information

When to Call TMHP

Call TMHP at 800-626-4117 about the following:

- NF forms completion, including PL1 Screening Form, PCSP, and NFSS form
- LA forms completion, including PL 1 Screening Form, PE, and PCSP
- Rejection codes on the forms and PASRR Transaction Identifiers (PTIDs)
- Management of the Provider Action Required status
- Medicaid, SSN, Medicare number, or the client's name does not match the client's Medicaid ID card, and the form is set to status ID Invalid – call TMHP to discuss form resubmittal options.
- PL1 Screening Form, PE, PCSP, and NFSS form submission error messages.
- NFSS PTID and PE PTID error messages
- PL1 Screening Form, PE, PCSP, and NFSS status questions
- MN Determination on MDS
- MN Determination on PE
- TMHP LTC Online Portal and TexMedConnect account setup

When to Email the HHSC PASRR Unit

Email PASRR.Support@hhsc.state.tx.us about the following:

- Assistance or cooperation from an RE, NF, LIDDA, or LMHA/LBHA
- Assistance with locating information to complete and submit the PL1, PE, PCSP, and NFSS forms
- Assistance locating forms, people residing in or entering an NF, LIDDAs, LMHA/LBHAs, or additional training resources
- Policy guidance on PASRR processes, specialized services, and therapist assessments
- Questions specifically related to MI/ID/DD or related conditions

When to Call HHSC PCS

Call HHSC PCS at (512) 438-2200, option 1**,** about the following:

- Denials or pending denials of people who have established prior permanent MN, after verifying MDS 3.0: A0700, Medicaid number, contains a nine-digit numeric rather than + or N.

- A 3618/3619 admission submitted under the wrong contract; that process must have a counteracting discharge submitted, and you must call to request that HHSC PCS set the incorrect form to status Invalid/Complete. A third form for the same date of above transaction cannot be submitted until the forms with the incorrect contract have been set to status Invalid/Complete.
- Resolution of forms in manual workflow (such forms have been rejected by SAS and must be reviewed by HHSC PCS).
- Assistance with Processed/Complete forms that do not appear on MESAV.

When to Call an LA

Refer to an LA when the following occurs:

- A client at an NF has a PASRR Negative Letter.
- The NF must follow up after an alert was sent to the LA to complete and submit a PE for a Resident Review.
- You wish to invite the LA to participate in the IDT meeting.

Refer to the following link for a list of LA names and contact information: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/preadmission-screening-resident-review-pasrr/contact-program-staff

Helpful Contact Information

Texas Medicaid & Healthcare Partnership (TMHP)

General Customer Service 800-925-9126

Long-term Care (LTC) Department 800-727-5436/800-626-4117

- General Inquiries, MDS not in the LTC Online Portal, LTCMI questions, Claim Forms, Claim Submission, R&S Reports, PL1 Screening Form, and PE ..... Option 1
- Medical Necessity ..... Option 2
- Technical Support ..... Option 3
- Fair Hearings ..... Option 5
- LTC Other Insurance Information and Updates ..... Option 6

LTC Department (Fax) 512-514-4223

Medicaid Hotline 800-252-8263

Health and Human Services Commission (HHSC) 512-438-3011

Consumer Rights & Services Hotline 800-458-9858

- Complaint for LTC Facility/Agency ..... Option 2

Informational Websites

TMHP: www.tmhp.com

- HIPAA information: www.tmhp.com/hipaa-privacy-statement
- LTC Division: www.tmhp.com/programs/ltc
- NF LTCMI and PASRR information also available at: www.tmhp.com/programs/ltc
- LTC Provider News Archives: www.tmhp.com/news?program_id=56

HHSC: https://hhs.texas.gov/

All HHSC provider information can be found at https://hhs.texas.gov/doing-business-hhs/provider-portals. Choose your particular provider type for available online resources:

- Consumer Rights and Services (includes information about how to make a complaint): https://hhs.texas.gov/about-hhs/your-rights/consumer-rights-services
- Hospice: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/hospice
- Nursing Facilities: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf
- Nursing Facility MDS Coordinator Support Site: https://hhs.texas.gov/doing-business-hhs
- PASRR: https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr
- Provider Letters: www.dads.state.tx.us/providers/communications/letters.cfm
- Rate Analysis: https://pfd.hhs.texas.gov/long-term-services-supports (select the appropriate program)
- Resources for HHS Service Providers: https://hhs.texas.gov/doing-business-hhs
- HHS Regions: https://www.hhs.texas.gov/about/contact-us/community-services-regional-contacts
- Vendor Drug Program: www.txvendordrug.com
- Centers for Medicare & Medicaid Services: www.cms.gov
- Department of State Health Services: www.dshs.state.tx.us/
- To obtain a National Provider Identifier (NPI): https://nppes.cms.hhs.gov/NPPES
- Texas Administrative Code: www.sos.state.tx.us/tac/index.shtml
- Federal MDS 3.0 Site: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Minimum Data Set (MDS) Quick Reference Guide

MDS Telephone Numbers

CMSNet Remote User Support Helpdesk (Verizon).....888-238-2122
MDS Technical/Report Questions.....512-438-2396
MDS Clinical Questions/Training 210-619-8010
MDS/RAP/Care Plan Training ..... 512-458-1257 / 512-467-2242
CASPER QM/QI Clinical Questions..... 210-431-5106
CASPER QM/QI Report Questions.....512-438-2396
jRAVEN Help Desk.....800-339-9313
Swing Bed Automation/Technical.....800-339-9313
Swing Bed Clinical MDS.....210-619-8010

MDS Informational Websites

- QIES Technical Support Office (QTSO): www.qtso.com
- For validation messages and descriptions: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
- Federal MDS 3.0 site: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
- MDS Software Specifications: www.cms.gov/MDS20SWSpecs
- MDS/RAP/Care Planning Training: www.txhca.org
- jRAVEN: see Federal MDS 3.0
- Resident Assessment Instrument (RAI) 3.0 Manual: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
- State MDS Policy: www.HHS.state.tx.us/providers/mds/index.cfm
- NF MDS Coordinator Support Site: https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf/texas-minimum-data-set