



TEXMEDCONNECT

LONG-TERM CARE (LTC) USER GUIDE



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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Terms and Abbreviations

Abbreviations	Terms
API	Atypical Provider Identifier
ARD	Assessment Reference Date
CBA	Community Based Alternatives
CMS	Centers for Medicare & Medicaid Services
CS	Community Services
CSI	Claim Status Inquiry
DLN	Document Locator Number
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOPS	Explanation of Pending Status
ETN	EDI Transaction Number
FFS	Fee For Service
FSI	Form Status Inquiry
HHSC	Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization (Note: HMO has been changed to MCO)
ICF/IID	Intermediate Care Facility/Facilities for Individuals with an Intellectual Disability or Related Conditions
ICN	Internal Control Number
ID	Intellectual Disabilities
IDD	Intellectual and Developmental Disabilities
LTC	Long-Term Care
MCO	Managed Care Organization (Formerly HMO)
MCO ICN	Managed Care Organization Internal Control Number
MESAV	Medicaid Eligibility and Service Authorization Verification
MN	Medical Necessity
NF	Nursing Facility
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OES	Office of Eligibility Services
OIG	Office of the Inspector General
PDF	Portable Document Format
R&S	Remittance and Status
RUG	Resource Utilization Group
SAS	Service Authorization System
SC	Service Code
SCSA	Significant Change in Status Assessment
SG	Service Group
SSN	Social Security Number
STAR+PLUS	State of Texas Access Reform (STAR) + PLUS
TAC	Texas Administrative Code
THCA	Texas Health Care Association
TMB	Texas Medical Board

Abbreviations	Terms
TMHP	Texas Medicaid & Healthcare Partnership

Training and Support

TexMedConnect Training

The TexMedConnect for Long-Term Care (LTC) Providers computer-based training (CBT) module is an online course that can be reviewed at your own pace. It is available in the Provider Education section of the Texas Medicaid & Healthcare Partnership (TMHP) Learning Management System (LMS) at learn.tmhp.com.

Technical Support

For LTC technical issues, call the TMHP Electronic Data Interchange (EDI) Help Desk at 888-863-3638, option 4, Monday through Friday from 7:00 a.m. to 7:00 p.m. Central time. The TMHP EDI Help Desk provides technical assistance for TexMedConnect and the TMHP EDI Gateway. Contact your system administrator for assistance with modem, hardware, or Internet connectivity issues.

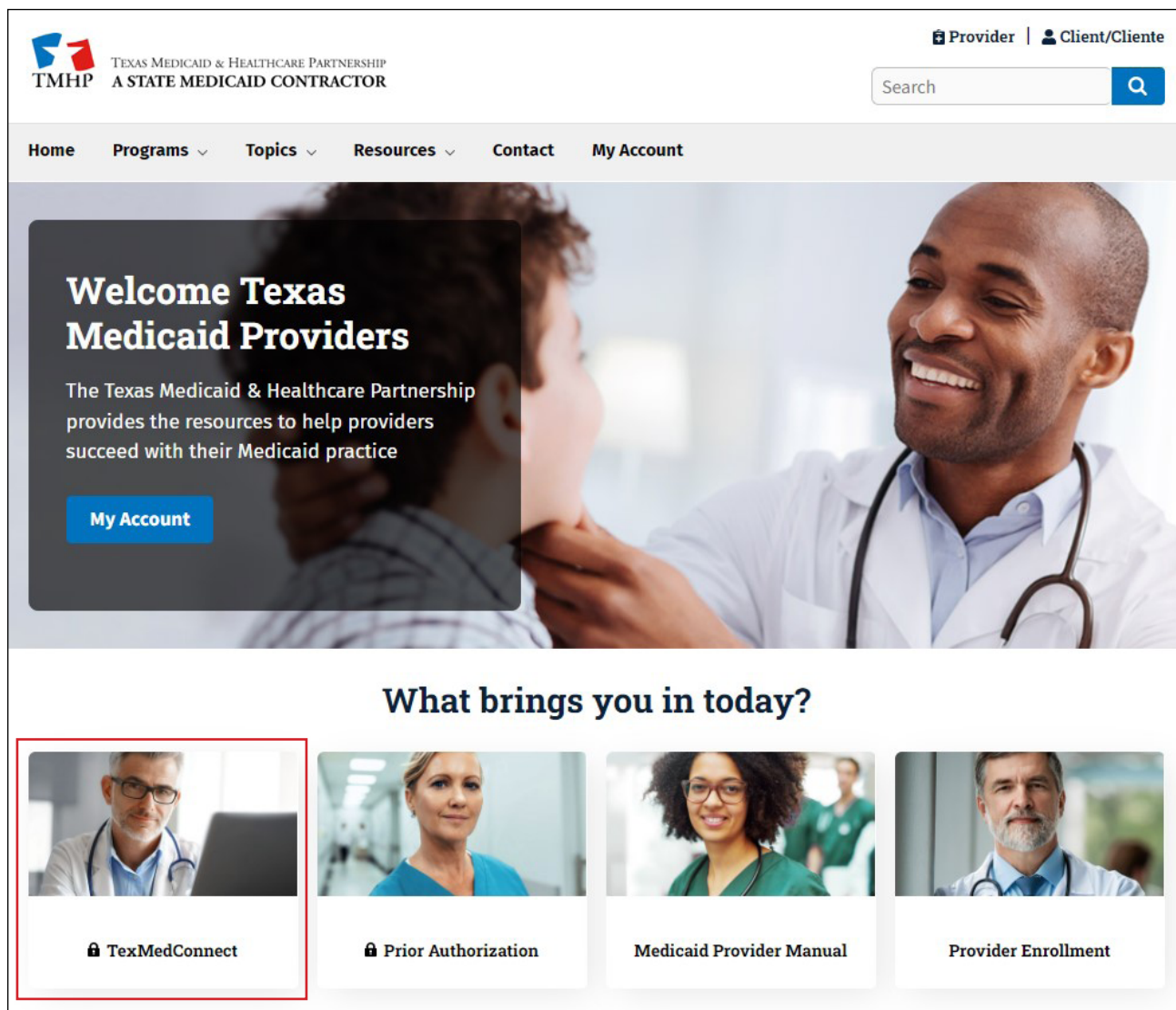
Claims Support

For questions about claims, call the TMHP LTC Help Desk at 800-626-4117, option 1 then option 2, Monday through Friday from 7:00 a.m. to 7:00 p.m Central time.

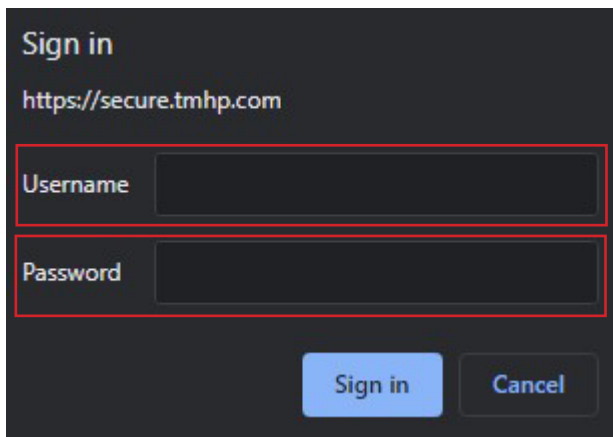
Getting Started

You can access TexMedConnect from the LTC home page of the TMHP website. To use TexMedConnect, you must already have an account on the TMHP website. If you do not have an account, you can set one up using the information provided in the [TMHP Website Security Provider Training Manual](#).

- 1) On the tmhp.com home page, click **TexMedConnect**.



- 2) Enter your user name and password and click **Sign in**.



A sign-in form with a dark background. At the top, it says "Sign in" and "https://secure.tmhp.com". Below this are two input fields: "Username" and "Password", both outlined in red. At the bottom right are two buttons: "Sign in" (blue) and "Cancel" (grey).

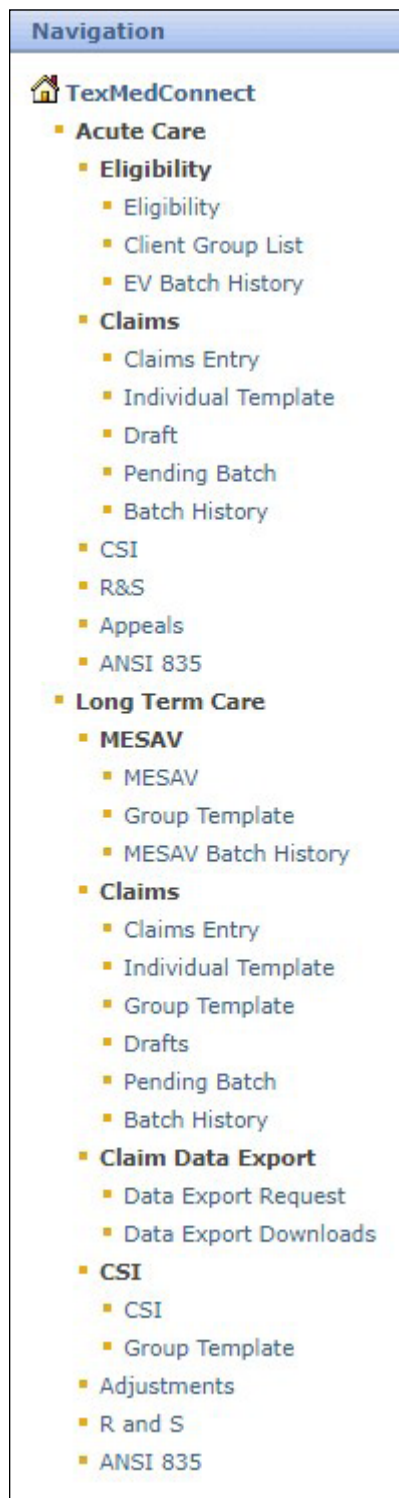
- 3) The TexMedConnect page will open to display the Navigation panel.



TexMedConnect Navigation Panel

All the available TexMedConnect LTC functions are located under the Long Term Care portion of the left navigation panel. You can select any feature you are allowed to access. A user's access permissions determine which options are available in the navigation panel. The provider administrator will grant access rights to the account. The

complete details about how to set up access rights can be found in the [TMHP Portal Security Training Manual](#).



MESAVs

Providers can view Medicaid Eligibility and Service Authorization Verifications (MESAVs) electronically by using TexMedConnect. To prevent claim denials, providers must verify a person's eligibility for Medicaid services.

Providers can interactively verify eligibility for specific dates of service for a single person. The date range is restricted to three calendar months. The service authorization section of a MESAV indicates the billable or allowable services for the person.

To verify eligibility for a group of people at one time, create a MESAV Group Template. Each MESAV Group Template can contain up to 250 people. You can create up to 100 Group Templates for each National Provider Identifier (NPI) number.

Note: People in a nursing facility (NF) with managed care eligibility segments must have service authorizations verified by the appropriate managed care organization (MCO). NFs should contact MCOs directly to determine service authorizations. NFs can use the Managed Care eligibility section at the bottom of the MESAV to verify enrollment with an MCO.

Submitting a MESAV Interactively

To verify a person's eligibility:

- 1) Click the **MESAV** link under the MESAV section on the navigation panel.



2) Complete the following required fields:

- Provider NPI/API & Provider No. (API stands for Atypical Provider Identifier)

Note: If you perform more than one interactive MESAV, the NPI or API and provider number on the MESAV Entry page will default to the last one that you used.

- Eligibility Start Date
- Eligibility End Date

Note: The date range may not exceed three calendar months. Selecting a date range greater than three months will result in an error.

- The Eligibility Start Date cannot be more than 36 months before the current date or be more than three consecutive months from the Eligibility End Date.
- The Eligibility End Date can include future dates of service but cannot be more than three consecutive months from the Eligibility Start Date. For example, if the Eligibility Start Date of the MESAV is today, the Eligibility End Date can be up to three months in the future.

MESAV Entry

Please enter the required information and click "Submit" to view the eligibility of the client.

NPI/API & Provider No. :

Eligibility Start Date:
Format: mm/dd/ccyy

Eligibility End Date:
Format: mm/dd/ccyy

Client Information:

Please enter one of the following valid field combinations:
Medicaid/Client# and Last Name
or Medicaid/Client# and DOB
or Medicaid/Client# and SSN
or SSN and Last Name
or SSN and DOB
or Last Name, First Name and DOB

Medicaid/Client No.:
Format: 123456789

Social Security Number:
Format: 123-45-6789 or 123456789

Date of Birth:
Format: mm/dd/ccyy

Last Name:

First Name:

3) You must also enter additional information in any of the following field combinations:

- Medicaid/Client No. and Last Name
- Medicaid/Client No. and Date of Birth

- Medicaid/Client No. and Social Security Number
- Social Security Number and Last Name
- Social Security Number and Date of Birth (DOB)
- Last Name, First Name, and DOB

4) Click the **Submit** button.

MESAV Entry

Please enter the required information and click "Submit" to view the eligibility of the client.

NPI/API & Provider No. :

Eligibility Start Date:
Format: mm/dd/ccyy

Eligibility End Date:
Format: mm/dd/ccyy

Client Information:

Please enter one of the following valid field combinations:
Medicaid/Client# and Last Name
or Medicaid/Client# and DOB
or Medicaid/Client# and SSN
or SSN and Last Name
or SSN and DOB
or Last Name, First Name and DOB

Medicaid/Client No.:
Format: 123456789

Social Security Number:
Format: 123-45-6789 or 123456789

Date of Birth:
Format: mm/dd/ccyy

Last Name:

First Name:

5) The MESAV results screen will then be displayed. This screen shows the person's demographic information as well as their Medicaid Recert Review Due Date.

Note: Knowing the Medicaid recertification review due date allows providers and MCOs to perform tasks that help Medicaid recipients meet their recertification dates.

MESAV Results

[New Lookup](#)
[Return with Search criteria](#)

General Disclaimer

Payment is not based solely on any single piece of information listed below. This data may change. Outstanding claims may affect the number of units. Nursing Facility clients with managed care eligibility segments must have service authorizations verified by the appropriate MCO.

Client Information	
Client No./Trainee SSN	123456789
DOB	1/1/11
Gender	M
SSN	
Name	JOHN DOE
Address	4567 MAIN STREET
County	
Medicare No.	
Medicaid Recert Review Due Dt	

Inquiry Information	
NPI/API	111111111
Eligibility From	1/1/20
Eligibility Through	12/31/20
Medicaid /Client No.	123456789
Social Security Number	
Date of Birth	
Last Name	DOE
First Name	JOHN
M.I.	
Suffix	

Note: The Medicaid recertification review due date is not available for some LTC clients, including children who are enrolled in foster care and Medicaid clients who are enrolled through Social Security (Coverage Code R, Program Type 13).

- The MESAV results screen will allow you to print the MESAV results in a Portable Document Format (PDF) file. To print the PDF, click the **PDF** icon at the top right of the screen. If you want to print a paper copy of the results, click **Print** on your browser's toolbar.

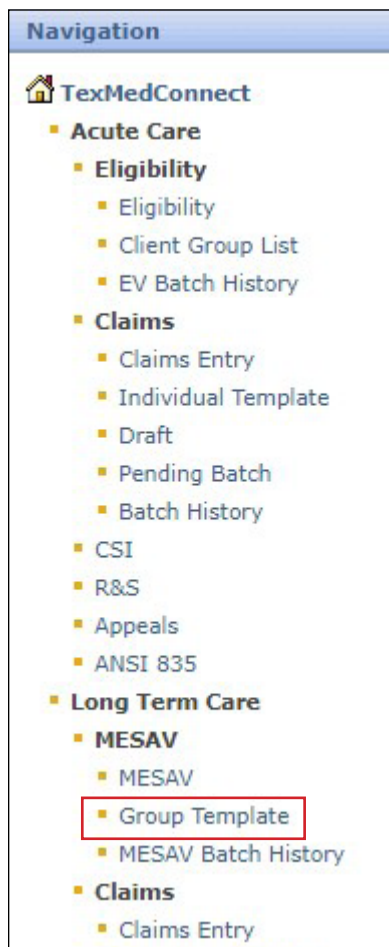
Note: PDF copies of MESAVs are current only at the time of printing and are not necessarily accurate afterwards. MESAV information can change daily. For the most up-to-date information, you should perform another MESAV electronically.

Creating a MESAV Group Template

The Group Template feature allows you to create a list of people for whom you would like to verify eligibility.

To create a MESAV Group Template and add a person:

- 1) Click **Group Template** under the MESAV section in the navigation panel.



- 2) The MESAV/CSI Group Template screen will open. Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

The screenshot displays the 'MESAV/CSI Group Template' screen. At the top, the title 'MESAV/CSI Group Template' is shown in blue. Below the title, there is a label 'Select NPI/API & Provider No. :' followed by a drop-down menu. At the bottom of the screen, a button labeled 'Continue >>' is highlighted with a red rectangular border.

- 3) If you have already created a group and want to add a person to an existing Group Template, click the link from the list that is displayed under the “Name of the group” column and skip to Step 5.

MESAV/CSI Group Template

NPI/API / Provider No.

New Group:

Name of the group	User ID	Created Date	Last Updated Date	
NewGroup1	portaluser	02/02/2022	02/02/2022	Delete
NewGroup2	portaluser	02/02/2022	02/02/2022	Delete

- 4) If you have not created a group or want to add a person to a new Group Template, enter the New Group name of your choice and click **Add Group**.

MESAV/CSI Group Template


NPI/API / Provider No.


New Group:

- 5) To add a person to the Group Template, click **Add Client**.

MESAV/CSI Group Template - NewGroup1

NPI/API / Provider No.

From Date of Service:  Format mm/dd/yyyy

To Date of Service:  Format mm/dd/yyyy


Select All <input type="checkbox"/>	First Name	Last Name	Client #	SSN	Date of Birth	MESAV	CSI	Delete
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	MESAV	CSI	Delete

- 6) The Add Client page will open. Enter the person’s information. If you do not have the person’s Client Number, you must use one of the following combinations to find the person:
- Social Security number and last name
 - Social Security number and date of birth

- Last name, first name, and date of birth

Add Client

NPI/API
/ Provider No.

Client Number:
Social Security Number:
Date of birth: 
First name:
Last name:

Lookup Criteria
Client #
or Combination of SSN and DOB
or First Name, Last Name and DOB
or SSN and Last Name.


Lookup

Go Back

- 7) Click **Lookup**.

Add Client

NPI/API
/ Provider No.

Client Number:
Social Security Number:
Date of birth: 
First name:
Last name:

Lookup Criteria
Client #
or Combination of SSN and DOB
or First Name, Last Name and DOB
or SSN and Last Name.


Lookup

Go Back

- 8) To add the person, click **Add to group**.

Add Client

NPI/API
/ Provider No.

Client Number:
Social Security Number:
Date of birth: 
First name:
Last name:

Lookup Criteria
Client #
or Combination of SSN and DOB
or First Name, Last Name and DOB
or SSN and Last Name.

Lookup

First Name	Last Name	Client #	SSN	Date of Birth	
					Add to group

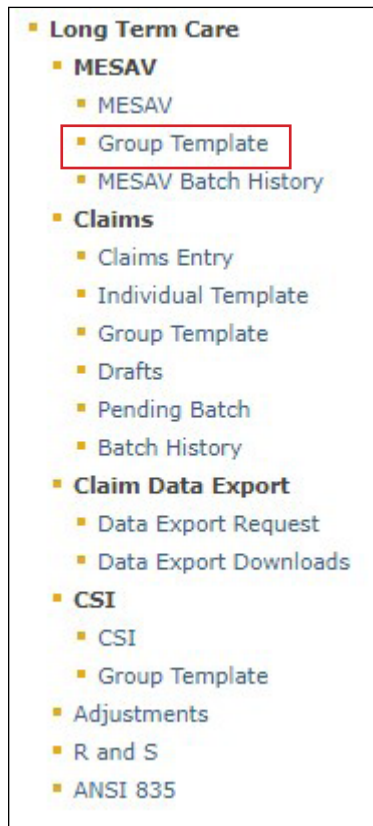
Go Back

The person will be added to the MESAV Group Template that you are working on. The MESAV group template feature allows you to create up to 100 groups for each NPI or API and provider number. Each group can contain up to 250 people, and you have the option to view, add, and delete people from the groups

Submitting a MESAV Group Template

To verify eligibility using a Group Template, perform the following steps:

- 1) Click **Group Template** under the MESAV section in the left navigation panel.



- 2) Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

The screenshot shows a form titled 'MESAV/CSI Group Template'. Below the title, there is a label 'Select NPI/API & Provider No. :' followed by a drop-down menu. The drop-down menu is highlighted with a red rectangular box. At the bottom of the form, there is a button labeled 'Continue >>' which is also highlighted with a red rectangular box.

- 3) Select one of the templates listed under “Name of the group” to open the group list.

MESAV/CSI Group Template

NPI/API / Provider No.

New Group: Add Group


Name of the group	User ID	Created Date	Last Updated Date	
NewGroup1	portaluser	02/02/2022	02/02/2022	Delete
NewGroup2	portaluser	02/02/2022	02/02/2022	Delete

- 4) Enter a date range in the From Date of Service and To Date of Service fields. The date range can be up to three months long.

MESAV/CSI Group Template - NewGroup1

Go Back Add Client

NPI/API / Provider No.

From Date of Service:  Format mm/dd/yyyy

To Date of Service:  Format mm/dd/yyyy

Select All <input type="checkbox"/>	First Name	Last Name	Client #	SSN	Date of Birth	MESAV	CSI	Delete
<input type="checkbox"/>								


Submit MESAV Batch


- 5) Check the individual boxes of the templates that you want to submit, or to submit all the templates check the **Select All** box.

MESAV/CSI Group Template - NewGroup1

Go Back Add Client

NPI/API / Provider No.

From Date of Service:  Format mm/dd/yyyy

To Date of Service:  Format mm/dd/yyyy

Select All <input type="checkbox"/>	First Name	Last Name	Client #	SSN	Date of Birth	MESAV	CSI	Delete
<input type="checkbox"/>								

- 6) Click **Submit MESAV Batch** at the bottom left of the screen. The batch will be processed and be ready for viewing within 24 hours.

MESAV/CSI Group Template - NewGroup1

Go Back
Add Client

NPI/API / Provider No.

From Date of Service:
To Date of Service:

Format mm/dd/yyyy
Format mm/dd/yyyy

Select All	First Name	Last Name	Client #	SSN	Date of Birth	MESAV	CSI	Delete
<input type="checkbox"/>								

Submit MESAV Batch

Viewing a MESAV Batch History

To view a MESAV Batch History, perform the following steps:

- 1) Click **MESAV Batch History** under the MESAV section on the navigation panel.

Long Term Care

MESAV

MESAV

Group Template

MESAV Batch History

Claims

Claims Entry
Individual Template
Group Template
Drafts
Pending Batch
Batch History

Claim Data Export

Data Export Request
Data Export Downloads

CSI

CSI
Group Template
Adjustments
R and S
ANSI 835

- 2) Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

Mesav Batch History

Select NPI/API & Provider No. :

Continue >>

- 3) Click the **Batch ID** of the MESAV batch that you would like to view.

Batch History						
NPI/API <div></div> / Provider No. <div></div>						
	Batch ID	Status	Claim Count	Total Billed Amount	Transmission Date	Submitted By
✓	G184L8CZ	Processed	2	\$ 5,477.40	08/06/2014 01:03:57 PM	<div></div>
✓	G244LBSX	Processed	1	\$ 3,800.32	08/12/2014 11:51:16 AM	<div></div>
✓	G254LCS2	Processed	1	\$ 10.00	08/13/2014 04:11:45 PM	<div></div>
✓	G274LEBU	Processed	2	\$ 2,748.70	08/14/2014 08:35:09 AM	<div></div>
✓	G374LIU3	Processed	1	\$ 10.00	08/25/2014 09:37:49 AM	<div></div>
✓	G374LIU6	Processed	1	\$ 3,800.32	08/25/2014 10:17:28 AM	<div></div>
✓	G374LIU7	Processed	1	\$ 10.00	08/25/2014 10:25:21 AM	<div></div>
✓	G374LIUA	Processed	1	\$ 2,738.70	08/25/2014 10:28:15 AM	<div></div>
✓	G374LIUB	Processed	1	\$ 3,800.32	08/25/2014 10:32:19 AM	<div></div>
✓	G374LIUC	Processed	1	\$ 120.00	08/25/2014 10:38:17 AM	<div></div>
✓	G654MVJN	Processed	2	\$ 2,748.70	09/22/2014 12:34:54 PM	<div></div>
✓	G654MVJO	Processed	2	\$ 2,748.70	09/22/2014 12:42:28 PM	<div></div>
✓	G654MVJP	Processed	1	\$ 3,800.32	09/22/2014 12:42:28 PM	<div></div>
✓	H144PPGP	Processed	1	\$ 2,738.70	11/10/2014 11:12:12 AM	<div></div>
✓	H184TXMH	Processed	3	\$ 8,216.10	11/14/2014 02:07:00 PM	<div></div>

- 4) The MESAV will open in a new window. Review the status for each client number that you selected.

General Disclaimer																
Payment is not based solely on any single piece of information listed below. This data may change. Outstanding claims may affect the number of units. Nursing Facility clients with managed care eligibility segments must have service authorizations verified by the appropriate MCO.																
Client Information										Inquiry Information						
Client No./Trainee SSN										NPI/API						
DOB										Eligibility From	1/1/2016					
Gender	F									Eligibility Through	3/31/2016					
SSN										Medicaid / Client No.						
Name										Social Security Number						
Address										Date of Birth						
County	Lampasas									Last Name						
Medicare No.										First Name						
										M.I.						
										Suffix						
Service Authorization Information/Details																
Effective Date	End Date	Referral Number	Status	Svc Grp	Svc Grp Desc	Svc Code	Svc Code Desc	Client Control No.	Units Paid	Unit Type	Units	Proc. Code	Proc. Type	NPI/API	Provider Number	
1/1/2016	1/9/2016		Active	1	Nursing Facility	D	ECF			Daily	1.00					
1/4/2016	3/28/2016		Active	1	Nursing Facility	I	Daily Care			Daily	1.00					
Agent																
-No Data-																
Authorization Message																
-No Data-																
Monthly Units																
-No Data-																
Eligibility																
Begin Date	End Date	Coverage Code	Secondary Coverage Code	Program Type	Coverage Category											
10/1/2015	3/29/2016	R		14	1											
3/30/2016	6/30/2016	R		14	1											
Other Insurance Policies																
-No Data-																
Medicare																
Effective Date	Termination Date	Add Date	Medicare Type	CMS Code (Federal)	Plan ID	Provider Number Link										
7/1/2015	12/31/9999	11/26/2015	C		010	CMS ID Info: Connected MAPs										
5/1/2015	12/31/9999	10/22/2015	B													
5/1/2015	12/31/9999	10/22/2015	A													
Medical Necessity																
Begin Date	End Date	Medical Necessity ID														

MESAV – Other Insurance (OI) Applicable to Service Groups (SGs) 1, 6, 8

For NF (SG 1), non-state Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) (SG 6), and Hospice (SG 8) providers, there is an LTC TexMedConnect MESAV screen titled “Other Insurance Policies.” Providers in SGs 1, 6, and 8 can view the policies that a person in their care has for the service dates that are entered on the MESAV. The OI section contains all the active lines of coverage that have been reported to TMHP.

Note: Each listing contains detailed information about the insurance company, subscriber information, and lines of coverage (including types of coverage, effective date, termination date fields, and whether or not the coverage is LTC relevant).

The OI information should be used to assist providers in filing claims with insurance companies and obtaining the disposition of those claims as paid or denied. For claims to be submitted for people with Medicaid, the insurance company claim disposition information must be provided, or the claim may be denied.

If, as a result of filing the insurance claim, it is discovered that the insurance information on the MESAV is incorrect for a person, the TMHP Third-Party Liability (TPL) Resource Line is available to handle updates to the insurance information. Call the LTC Help Desk at 800-626-4117 and choose option 6 for answers to inquiries about OI insurance referrals.

MESAV Medicare Eligibility

The Medicare section includes the policy’s Effective Date, Termination Date, Add Date, Medicare Type, CMS Code (federal), Plan ID, and Provider Number Link. The MESAV Medicare section will be displayed underneath the

Other Insurance Policies section of the MESAV.

Medicare						
Effective Date	Termination Date	Add Date	Medicare Type	CMS Code (Federal)	Plan ID	Provider Number Link
7/1/2015	12/31/3999	11/26/2015	C		010	CMS ID Info: Contracted MAPs
5/1/2015	12/31/3999	10/22/2015	B			
5/1/2015	12/31/3999	10/22/2015	A			

Filing a Claim

Claims filed on TexMedConnect by NFs for people who have transitioned to managed care will be forwarded to an MCO. If any issues or questions arise regarding a claim that has been forwarded to an MCO, providers must contact the MCO directly. TMHP cannot answer questions regarding claims that are rejected by an MCO. Claims that are submitted by NF providers regarding people who are not transitioning to managed care will not be forwarded.

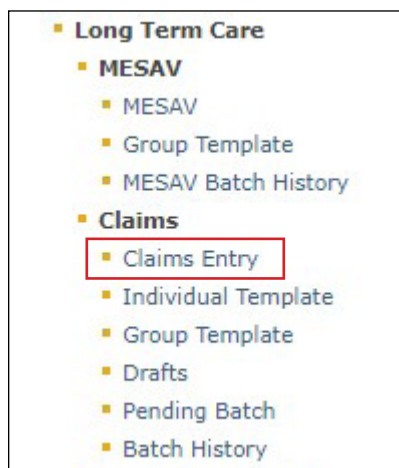
Users may submit the following claim types:

- Professional: Services rendered by an individual provider
- Dental: Services rendered by a dental provider and billed by the LTC provider
- Institutional: Services rendered in a facility
- Nurse Aide Training (NAT): Classes, testing, and materials for nurse aides

Entering a Claim on TexMedConnect

The following steps are used to begin the process of submitting all claim types (Professional, Dental, Institutional, and NAT):

- 1) Click **Claims Entry** under the Claims section in the navigation panel.



- 2) A list of NPIs/APIs, provider numbers, and related data will be displayed according to the user's login information. Select the appropriate NPI/API and provider number from the NPI drop-down menu.

Choose the appropriate claim type from the drop-down menu. You also have the option to enter a client number at this time.

Note: Although a client number is not required, providing one will save time. The system will use the client number to autofill many of the required fields. If a client number is not entered, you must manually enter information into the required fields under the Client tab (this includes the referral number even though there is no red dot in this field).

3) Click **Proceed to Step 2**.

The screenshot shows the 'Claim Submission - Step 1' interface. On the left is a 'Navigation' sidebar with the following menu items: 'TexMedConnect' (with a home icon), 'Acute Care', 'Eligibility' (with sub-items: 'Eligibility', 'Client Group List', 'EV Batch History'), 'Claims' (with sub-items: 'Claims Entry', 'Individual Template', 'Draft', 'Pending Batch', 'Batch History'), and 'CSI'. The main content area is titled 'Claim Submission - Step 1' and contains three dropdown menus: 'NPI:' (with a red diamond icon), 'Claim Type:' (with a red diamond icon), and 'Client No.:' (with a red diamond icon). The 'Client No.:' dropdown is highlighted with a red rectangular box. At the bottom of the main content area, there is a button labeled 'Proceed to Step 2 >>' which is also highlighted with a red rectangular box.

- 4) The Claim Submission screen will be displayed for the claim type that you selected. It will default to the Client tab. The type of claim you are working on appears in the Claim Type box in the upper right of the screen. You must complete all the required fields (indicated by a red dot) on each tab. If you entered the client number on the Claims Entry - Step 1 screen, many of these fields will be autofilled. Most fields can be edited if needed. After the claim has been submitted successfully, an Internal Control Number (ICN) will be displayed in the Claim No. field. The ICN is also known as a claim number.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional			Template	

Client

Provider

Claim

Details

Other Insurance / Finish

Client Identification Numbers

Client ID

Patient Account No.

Medical Record No.

Name and Address

First Name

Last Name

MI

Suffix

Street Address

Street Address 2

City

State

Zip

Client General Information

Gender

Date Of Birth

Referral No.

Save Draft

Save Template

Save To Group

Prev

Next

Finish

Entering a Professional Claim

To enter a professional claim:

- 1) Begin on the Client tab. You must complete all required fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field.

Claim Submission - Step 2					Claim Type Professional	Client	Provider	Status New	Claim No.
<div style="display: flex; border-bottom: 1px solid #ccc; margin-bottom: 10px;"> <div style="width: 15%; padding: 5px; border: 1px solid #ccc; background-color: #f0f0f0;">Client</div> <div style="width: 15%; padding: 5px; border: 1px solid #ccc; background-color: #f0f0f0;">Provider</div> <div style="width: 15%; padding: 5px; border: 1px solid #ccc; background-color: #f0f0f0;">Claim</div> <div style="width: 15%; padding: 5px; border: 1px solid #ccc; background-color: #f0f0f0;">Details</div> <div style="width: 40%; padding: 5px; border: 1px solid #ccc; background-color: #f0f0f0;">Other Insurance / Finish</div> </div> <div style="border: 1px solid #ccc; padding: 10px;"> <p>Client Identification Numbers</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 30%;"> <p>• Client ID</p> <input style="width: 90%;" type="text"/> </div> <div style="width: 30%;"> <p>• Patient Account No.</p> <input style="width: 90%;" type="text"/> </div> <div style="width: 30%;"> <p>Medical Record No.</p> <input style="width: 90%;" type="text"/> </div> </div> </div> <div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <p>Name and Address</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 20%;"> <p>• First Name</p> <input style="width: 95%;" type="text"/> </div> <div style="width: 20%;"> <p>• Last Name</p> <input style="width: 95%;" type="text"/> </div> <div style="width: 10%;"> <p>MI</p> <input style="width: 95%;" type="text"/> </div> <div style="width: 20%;"> <p>Suffix</p> <input style="width: 95%;" type="text"/> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 20%;"> <p>• Street Address</p> <input style="width: 95%;" type="text"/> </div> <div style="width: 20%;"> <p>Street Address 2</p> <input style="width: 95%;" type="text"/> </div> <div style="width: 20%;"> <p>• City</p> <input style="width: 95%;" type="text"/> </div> <div style="width: 10%;"> <p>• State</p> <div style="border: 1px solid #ccc; padding: 2px; text-align: center;">▼</div> </div> <div style="width: 20%;"> <p>• Zip</p> <input style="width: 95%;" type="text"/> </div> </div> </div> <div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <p>Client General Information</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 15%;"> <p>• Gender</p> <div style="border: 1px solid #ccc; padding: 2px; text-align: center;">▼</div> </div> <div style="width: 25%;"> <p>• Date Of Birth</p> <div style="border: 1px solid #ccc; padding: 2px; position: relative;"> <input style="width: 90%;" type="text"/> <div style="position: absolute; right: 5px; top: 5px; font-size: 10px;">ID</div> </div> </div> <div style="width: 60%;"> <p>Referral No.</p> <input style="width: 95%;" type="text"/> </div> </div> </div>									

Save Draft

Save Template

Save To Group

Prev

Next

Finish

Note: If more than one contract is associated with an NPI number, you must include a referral number on the claim or the claim will be denied. As noted earlier, you can use the MESAV function to search a person's eligibility and access the referral number.


- 2) Select the Provider tab. You must complete all required fields that are indicated by a red dot. TexMedConnect autofills the billing provider information using the NPI/API that was selected on the Claims Entry screen.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Professional			New	

Client	Provider	Claim	Details	Other Insurance / Finish

Billing Provider

NPI: 

<p>Name: <input type="text"/></p> <p>NPI/API: <input type="text"/></p> <p>Address: <input type="text"/></p>	<p>Contact Name <input type="text"/></p> <p>♦ ID Qual <input type="text"/></p> <p>Employer/Tax ID <input type="text"/></p>	<p>Contact Phone <input type="text"/></p> <p>♦ Other ID <input type="text"/></p>
--	---	--

- 3) Select the Claim tab. You must complete all required fields that are indicated by a red dot.
- A valid principal diagnosis code is required for professional claims. Inputting an invalid diagnosis code may result in an error message (and not allow a claim to submit) in TexMedConnect.
 - To add more diagnosis codes, click **Add New Diagnosis**.
 - To view the diagnosis description, click the magnifying glass icon.

Note: The Qualifier field is used to indicate an *International Classification of Diseases, Tenth Revision (ICD-10)* diagnosis code. Select from the drop-down menu based on the diagnosis code entered.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Professional			New	

Client	Provider	Claim	Details	Other Insurance / Finish
--------	----------	-------	---------	--------------------------

Claim

Claim File Indicator Code

MC Medicaid
VA Veteran Administration Plan Refers to Veteran's Affairs Plans

Budget Number

Place of Service

03 School
04 Homeless Shelter
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
22 Outpatient Hospital
24 Ambulatory Surgical Center
33 Custodial Care Facility
34 Hospice
41 Ambulance Land
42 Ambulance - Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
53 Community Mental Health Center
62 Comprehensive Outpatient Rehabilitation
71 State or Local Public Health Clinic
72 Rural Health Clinic
99 Other Place of Service

Diagnosis

Qualifier

Add New Diagnosis

	Code	Description	
1			Delete

Note: The HHSC-LTC Bill code crosswalk requires that modifiers start in position 1 and for any subsequent modifier to be in sequential order and not be duplicated. Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate the SG, residence SG, and budget number. Instead, billing providers will indicate the SG, residence SG, and budget number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.

- The Service Group drop-down menu is to be used on LTC Professional, Institutional, and Dental claims by billing providers with multiple SGs linked to the same LTC Provider Contract number. It will not appear for other providers.

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there are tabs for 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The 'Claim' tab is active. Below the tabs, there are two dropdown menus: 'Claim File Indicator Code' and 'Place of Service'. Below these, the 'Service Group' dropdown menu is highlighted with a red rectangular box. At the bottom of the form, there are buttons for 'Save Draft' and 'Save Template'.

- The Budget Number drop-down menu will appear only for providers billing LTC Professional claims for Title XX services. Providers will need to select the correct budget number from the drop-down menu.

Note: The provider can be linked to multiple service groups. SG 7 or SG 20 needs to be selected in the Service Group field for the Budget Number field to display. If the provider is linked only to SG 7 or SG 20, the Service Group field is not displayed.

This screenshot shows the 'Claim Submission - Step 2' interface with more fields visible. The 'Claim' tab is active. In addition to the 'Service Group' dropdown, a 'Budget Number' dropdown menu is now visible next to it, and both are highlighted with a red rectangular box. Below these, there is a 'Diagnosis' section with a 'Qualifier' dropdown and an 'Add New Diagnosis' button. At the bottom, there is a table with columns for 'Code' and 'Description'. The table has one row with the number '1' in the 'Code' column.

Note: Billing providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC-LTC Bill Code Crosswalk. It is important to remember that modifier placements changed as of February 1, 2019, so providers should consult the Crosswalk to update their previously saved claims and templates to reflect the new modifier positions.

4) Select the Details tab. You must complete all fields that are indicated by a red dot.

- To add a blank row, click **Add New Detail row(s)**. To duplicate an existing row, highlight the row and click **Copy Row**. To delete a row, scroll over and click **Delete** at the end of the row.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Professional			New	

Client Provider **Claim** Details Other Insurance / Finish

Number of details to add: 1 Add New Details Row(s) Copy Row

Line Item Control N	Service Dates	POS	Procedure Code	Qualifier	Code	Units	Unit Rate	Line Item Total	Co-Pay	NPI/APL	Performing Provider				Rental Unit	Length	Rental Price	Purchase Price	Co-Pay Exempt	Delete
											First Name	Last Name	MI	Suffix						
1						0	\$0.00	\$0.00	\$0.00						0	\$0.00	\$0.00			

☒ Co-Pay
☐ Applied Income
 Claim Total: \$0.00
 Total Co-Pay: \$0.00

5) Select the Other Insurance/Finish tab.

Note: OI information is not required on a Professional claim, only an Institutional claim.

- Select either the **Submit** radio button or the **Save to Batch** radio button.
- Check the **We Agree** box.
- Click **Finish**.
- If the claim is submitted successfully, an ICN will be displayed at the top of the page.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Professional			New	

Client Provider Claim Details **Other Insurance / Finish**

Finish Options

Please select one of the following and click finish

☒ **Submit**
 Submits the claim interactively

☐ **Save to Batch**
 Saves the claim to batch for processing later.

Certification, Terms And Conditions

Please review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

☐ **We Agree**

Save Draft Save Template Save To Group Prev Next **Finish**

To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**.

To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide. If there is any missing or invalid information, an error message will be displayed. Click the tab that is indicated in the error message. Error fields are indicated with red exclamation marks. After you have made the necessary corrections, click **Finish** in the lower right corner of the screen.

Claim Submission - Step 2

- Procedure Code is required.
- Procedure Code must be 4 to 6 alphanumeric characters.

- 6) In each tab, any field with an error is marked with a yield sign. You must correct these errors before you can resubmit the claim. You can navigate through the claim by clicking each tab or by clicking **Prev** or **Next** at the bottom of the Claim Submission – Step 2 screen.

Client	Provider	Claim	Details	Other Insurance / Finish
<h4>Client Identification Numbers</h4> <div> <div>• Client ID</div> <div>• Patient Account No.</div> <div>Medical Record No.</div> </div>				
<h4>Name and Address</h4> <div> <div>• First Name</div> <div>• Last Name</div> <div>MI</div> <div>Suffix</div> <div>• Street Address</div> <div>Street Address 2</div> <div>• City</div> <div>• State</div> <div>• Zip</div> </div>				
<h4>Client General Information</h4> <div> <div>• Gender</div> <div>• Date Of Birth</div> <div>Referral No.</div> </div>				
<div> <div>Save Draft</div> <div>Save Template</div> <div>Save To Group</div> <div>Prev</div> <div>Next</div> <div>Finish</div> </div>				

Entering a Dental Claim

To enter a Dental claim:

- 1) Select the Client tab. You must complete all required fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Dental			New	

Client

Provider

Claim

Details

Other Insurance / Finish

Client Identification Numbers

Client ID

Patient Account No.

Name and Address

First Name

Last Name

MI

Suffix

Street Address

Street Address 2

City

State

Zip

Client General Information

Gender

Date Of Birth

Referral No.

Save Draft

Save Template

Prev

Next

Finish

- 2) Select the Provider tab. TexMedConnect autofills the billing provider information using the NPI that was selected on the Claims Entry screen. You can enter the NPI/API and contact name in the Performing Provider

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section, but it is not required.

- 3) Select the Claim tab. Enter the general claim information. You must choose a claim File Indicator Code and Place of Service.

Note: The HHSC-LTC Bill Code Crosswalk requires that modifiers start in position 1, and for any subsequent modifier to be in sequential order and not be duplicated. Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate the SG, residence SG, and budget number. Instead, billing providers will indicate the SG, residence SG, and budget number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect. The Service Group drop-down menu is to be used by billing providers with multiple SGs that are linked to the same LTC provider contract number.

Claim Submission - Step 2

Client Provider **Claim** Details Other Insurance / Finish

Claim

* Claim File Indicator Code * Place of Service

Service Group

Note: Billing providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC LTC Bill Code Crosswalk. It is important to remember that modifier placement has changed as of February 1, 2019, so providers should consult the Crosswalk after that date and update their previously saved claims and templates to reflect the new modifier positions.

- 4) Select the Details tab. You must complete all required fields that are indicated by a red dot. Entering a future date is not allowed in the Service Date field.

Claim Submission - Step 2

Claim Type Client Provider Status Claim No.

Dental 1699817007/000010100 New

Client Provider Claim **Details** Other Insurance / Finish

Number of details to add: 1 Add New Details Row(s) Copy Row

Line Item Control N	*Service Date	Place of Service	*Code	Mods				*Units	*Unit Rate	Line Item Total	Co-Pay	Tooth ID	*Oral Ca
				1	2	3	4						
1								0	\$0.00	\$0.00	\$0.00		

☒ Co-Pay
☐ Applied Income
 Claim Total: \$0.00
 Total Co-Pay: \$0.00

- To add more rows, click **Add New Detail Row(s)**.
- To copy the information from the previous detail, click **Copy Row**.
- To delete a row, scroll over and click **Delete** at the end of the row.

Note: When completing the Code field, if there is no HCPCS or CPT code, enter the Bill Code. For the Oral Cavity, select the best option from the drop-down menu.

5) Click **Other Insurance/Finish**.

Note: OI information is not required on a Dental claim, only an Institutional claim.

- Select either the **Submit** or **Save to Batch** radio button.
- Check the **We Agree** box in the Certification, Terms, and Conditions section.
- Click **Finish** in the lower right corner of the screen.
- If the claim is submitted successfully, an ICN will be displayed at the top of the page.

To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**.

To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

Entering an Institutional Claim

TMHP will forward certain Institutional claims to MCOs. These claims can be set to the following statuses:

- Forwarded: The claim has been forwarded to (but not yet accepted or rejected by) an MCO.
- Rejected: The claim has been rejected by TMHP or the MCO to which it was forwarded.
- Accepted: The claim has been accepted by TMHP or an MCO. When a claim is accepted by an MCO, it is assigned a 28-character alphanumeric EDI transaction number (ETN).

Claims that are handled by TMHP, not by an MCO, can also be set to the following statuses:

- I: In Process
- D: Denied
- A: Approved for Payment
- FT: Forced Transfer
- S: Suspended
- T: Transferred
- P: Paid
- PF: Paid Forced Transfer
- PT: Paid Transfer
- PZ: Zero Net Balance to the Provider

To enter an Institutional claim:

- 1) Select the Client tab. You must complete all the required fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field. After you have completed all the required fields, click **Next** or select the Provider tab.

Claim Submission - Step 2

Client | **Provider** | Claim | Details | Other Insurance / Finish

Billing Provider

NPI: [] / []

Names: [] NPI/API: []

Address: []

Taxonomy: []

Contact Name: []

Contact Phone: []

• ID Qual []

• Other ID []

Employer/Tax ID []

Attending Provider (Name must be a person, not an organization)

• NPI/API [] First Name [] Last Name [] MI [] Suffix [] Taxonomy []

Rendering Provider (Not required, only enter if Rendering Provider is different than Attending Provider. Name must be a person, not an organization)

NPI/API [] First Name [] Last Name [] MI [] Suffix []

Referring Provider (Not required, only enter if Referring Provider is different than Billing Provider. Name must be a person, not an organization)

NPI/API [] First Name [] Last Name [] MI [] Suffix []

Save Draft Save Template Save To Group Prev **Next** Finish

- 2) Select the Provider tab. You must complete all required fields that are indicated by a red dot.

Claim Submission - Step 2

Client | **Provider** | Claim | Details | Other Insurance / Finish

Billing Provider

NPI: [] / []

Names: [] NPI/API: []

Address: []

Taxonomy: []

Contact Name: []

Contact Phone: []

• ID Qual []

• Other ID []

Employer/Tax ID []

Attending Provider (Name must be a person, not an organization)

• NPI/API [] First Name [] Last Name [] MI [] Suffix [] Taxonomy []

Rendering Provider (Not required, only enter if Rendering Provider is different than Attending Provider. Name must be a person, not an organization)

NPI/API [] First Name [] Last Name [] MI [] Suffix []

Referring Provider (Not required, only enter if Referring Provider is different than Billing Provider. Name must be a person, not an organization)

NPI/API [] First Name [] Last Name [] MI [] Suffix []

Save Draft Save Template Save To Group Prev Next Finish

- 3) The Taxonomy drop-down menu is autofilled with three values. Taxonomy codes further define the type, classification, or specialization of the healthcare provider. If a provider attempts to submit a claim to TMHP without a valid taxonomy code, regardless of the date of service, the claim will be rejected, and the provider will receive an error message.

According to the Centers for Medicare & Medicaid Services, all healthcare providers must select a taxonomy code(s) when applying for an NPI. The values in the Taxonomy drop-down menu are:

- 314000000X (for skilled NFs)
- 313M00000X (for other NFs)
- Other

Choose the provider taxonomy code that was used by your facility when it initially applied for an NPI. If neither of the two autofilled codes applies, choose **Other**. If you choose **Other**, a text box called Other Taxonomy will be displayed and must be filled in.

Claim Submission - Step 2

Claim Type: Institutional | Client: | Provider: | Status: New | Claim No.:

Client | **Provider** | Claim | Details | Other Insurance / Finish

Billing Provider

NPI: [dropdown] Taxonomy: [314000000X, 313M00000X, Other] • Other Taxonomy: [text box]

Names: [text box] NPI/API: [text box] Contact Name: [text box] Contact Phone: [text box]

Address: [text box] • ID Qual: [dropdown] • Other ID: [text box]

Employer/Tax ID: [dropdown]

Attending Provider (Name must be a person, not an organization)

• NPI/API: [text box] First Name: [text box] Last Name: [text box] MI: [text box] Suffix: [text box] Taxonomy: [text box]

Rendering Provider (Not required, only enter if Rendering Provider is different than Attending Provider. Name must be a person, not an organization)

NPI/API: [text box] First Name: [text box] Last Name: [text box] MI: [text box] Suffix: [text box]

Referring Provider (Not required, only enter if Referring Provider is different than Billing Provider. Name must be a person, not an organization)

NPI/API: [text box] First Name: [text box] Last Name: [text box] MI: [text box] Suffix: [text box]

Save Draft | Save Template | Save To Group | Prev | Next | Finish

Note: If an API was chosen, the Taxonomy field will not be displayed.

- 4) The Attending Provider is required to enter their NPI/API and name. If the Rendering Provider is different from the Attending Provider, that provider information should be added.

Claim Submission - Step 2

Claim Type: Institutional

Client: [Redacted] Provider: [Redacted] Status: New Claim No.: [Redacted]

Client Provider Claim Details Other Insurance / Finish

Billing Provider

NPI: [Redacted] Taxonomy: [Redacted]

Names: [Redacted] Contact Name: [Redacted] Contact Phone: [Redacted]

Address: [Redacted] ID Qual: [Redacted] Other ID: [Redacted]

Employer/Tax ID: [Redacted]

Attending Provider (Name must be a person, not an organization)

NPI/API: [Redacted] First Name: [Redacted] Last Name: [Redacted] MI Suffix: [Redacted] Taxonomy: [Redacted]

Rendering Provider (Not required, only enter if Rendering Provider is different than Attending Provider. Name must be a person, not an organization)

NPI/API: [Redacted] First Name: [Redacted] Last Name: [Redacted] MI Suffix: [Redacted]

Referring Provider (Not required, only enter if Referring Provider is different than Billing Provider. Name must be a person, not an organization)

NPI/API: [Redacted] First Name: [Redacted] Last Name: [Redacted] MI Suffix: [Redacted]

Save Draft Save Template Save To Group Prev Next Finish

Note: For the claim to be successfully processed, the NPI/API for the Attending Provider, Billing Provider, and Rendering Provider (if entered) must be different. Additionally, the NPI/API for both the Attending Provider and Rendering Provider must be for a person, not a facility.

- 5) Select the Claim tab. You must complete all the required fields that are indicated by a red dot. Choose the appropriate indicator from the Claim File Indicator Code drop-down menu.

Claim Submission - Step 2

Claim Type: Institutional

Client: [Redacted] Provider: [Redacted] Status: New Claim No.: [Redacted]

Client Provider Claim Details Other Insurance / Finish

Claim

Claim File Indicator Code: [Redacted] Patient Discharge Status: [Redacted] Place of Service: [Redacted] Claim Frequency: [Redacted]

Diagnosis

Qualifier: [Redacted]

Add New Diagnosis

Code	Description	Delete
1	[Redacted]	Delete

Save Draft Save Template Save To Group Prev Next Finish

Note: The HHSC-LTC Bill Code Crosswalk requires that modifiers start in position 1, and for any subsequent modifier to be in sequential order and not be duplicated. Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate the SG, residence SG, and budget number. Instead, billing providers will indicate the SG, residence SG, and budget number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.

The Service Group drop-down menu is to be used by billing providers with multiple SGs linked to the same LTC provider contract number.

Claim Submission - Step 2

Client Provider **Claim** Details Other Insurance / Finish

Claim

* Claim File Indicator Code * Place of Service

Service Group

The Residence Service Group drop-down menu will be used by SG 8 (hospice) billing providers to indicate the person's residence at the time of service for LTC institutional claims. It will be a conditional field, but claims will be rejected if the field is not filled out when required (that is, when people are in an ICF/IID or nursing facility and the correct SG is either left blank or not selected).

Note: The provider can be linked to multiple SGs. SG 8 needs to be selected in the Service Group field for the Residence Service Group field to be displayed. If the provider is linked only to SG 8, the Service Group field is not displayed.

Claim Submission - Step 2

Client Provider **Claim** Details Other Insurance / Finish

Claim

* Claim File Indicator Code * Patient Discharge Status * Place of Service * Claim Frequency

Service Group Residence Service Group

Diagnosis

* Qualifier

Add New Diagnosis

	* Code	Description	Delete
1			

Save Draft Save Template Save To Group

Note: Billing providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC-LTC Bill Code Crosswalk. It is important to remember that modifier placements changed as of February 1, 2019, so providers should consult the Crosswalk to update their previously saved claims and templates to reflect the new modifier positions.

6) Choose the appropriate status from the Patient Discharge Status drop-down menu.

The screenshot shows the 'Claim Submission - Step 2' form. The 'Patient Discharge Status' dropdown menu is open, displaying a list of discharge codes and their descriptions. The 'Place of Service' dropdown menu is also visible. The 'Claim Frequency' dropdown menu is set to 'Monthly'. The 'Qualifier' dropdown menu is set to '1'. The 'Add New Diagnosis' button is visible. The 'Save Draft', 'Save Template', and 'Save To Group' buttons are at the bottom left. The 'Prev', 'Next', and 'Finish' buttons are at the bottom right.

Code	Description	Delete
01	Discharged to home or self care (routine discharge)	
02	Discharged/Transferred to a short-term general hospital for inpatient care	
03	Discharged/Transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care	
04	Discharged/Transferred to an intermediate care facility (ICF)	
05	Discharged/Transferred to home under care of organized home health service organization in anticipation of covered skilled care	
06	Left against medical advice or discontinued care	
07	Expired	
08	Discharged/Transferred to Court/Incarceration	
09	Discharged/Transferred to a federal health care facility	
10	Hospice - Home	
11	Hospice - Medical Facility	
12	Discharged/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital	
13	Discharged/Transferred to a Medicare certified long-term care hospital (LTCH)	
14	Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare	
15	Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital	
16	Discharged/Transferred to a Designated Disaster Alternative Care Site	
17	Discharged/Transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List	

7) Choose the appropriate facility type from the Place of Service drop-down menu.

The screenshot shows the 'Claim Submission - Step 2' form. The 'Place of Service' dropdown menu is open, displaying a list of facility types. The 'Patient Discharge Status' dropdown menu is also visible. The 'Claim Frequency' dropdown menu is set to 'Monthly'. The 'Qualifier' dropdown menu is set to '1'. The 'Add New Diagnosis' button is visible. The 'Save Draft', 'Save Template', and 'Save To Group' buttons are at the bottom left. The 'Prev', 'Next', and 'Finish' buttons are at the bottom right.

Code	Description	Delete
18	Swing Bed	
21	SNF Inpatient (Including Medicare Part A)	
22	SNF Inpatient (Medicare Part B)	
23	Swing Bed - Nursing Facility	
32	Home Health - Inpatient	
34	Home Health Outpatient - Other	
62	Intermediate Care Facility - Level I	
66	Intermediate Care Facility - Level II	
74	Outpatient Rehabilitation Center	
75	Comprehensive Outpatient Rehabilitation Center	
76	Clinic - Other	
81	Hospice - Special Facility	
86	Residential Facility (Medical Only)	
89	Special Facility - Other	

8) Choose the appropriate claim frequency from the Claim Frequency drop-down menu:

- Choose **1 Admit Through Discharge Claim** when the claim will cover the duration of the stay.
- Choose **2 Interim-First Claim** if this is the first claim billed for the person.
- Choose **3 Interim-Continuing Claim** for all dates of service between the first and last claims.
- Choose **4 Interim-Last Claim** if this is the last claim billed for the person.

Claim Submission - Step 2

Claim Type: Institutional

Client: [Redacted] Provider: [Redacted] Status: New Claim No.: [Redacted]

Client Provider Claim Details Other Insurance / Finish

Claim

Claim File Indicator Code Patient Discharge Status Place of Service Claim Frequency

Diagnosis

Qualifier

Add New Diagnosis

Code	Description	Delete
1		

Save Draft Save Template Save To Group Prev Next Finish

9) Depending on the value selected in the Claim Frequency field, the Admit Date field may be required. The admit date is the date that the person was admitted to the facility.

Claim Submission - Step 2

Claim Type: Institutional

Client: [Redacted] Provider: [Redacted] Status: New Claim No.: [Redacted]

Client Provider Claim Details Other Insurance / Finish

Claim

Claim File Indicator Code Patient Discharge Status Place of Service Claim Frequency Admit Date

Diagnosis

Qualifier

Add New Diagnosis

Code	Description	Delete
1		

Save Draft Save Template Save To Group Prev Next Finish

10) The Principal Diagnosis code is required for institutional claims. Entering an improper diagnosis code may result in a claim rejection by an MCO. The Admitting Diagnosis is conditional for certain values in the Claim Frequency field.

To add more diagnosis codes, click **Add New Diagnosis**. You may list up to three diagnosis codes. The third Diagnosis field is intended to be used with External Cause of Morbidity codes for ICD-10.

To view the diagnosis description, click the magnifying glass icon.

The Qualifier field is used to indicate an ICD-10 diagnosis code. Select from the drop-down menu based on the diagnosis code(s) entered.

Claim Submission - Step 2

Claim Type: Institutional

Client: [Redacted] Provider: [Redacted] Status: New Claim No.: [Redacted]

Client Provider Claim Details Other Insurance / Finish

Claim

• Claim File Indicator Code • Patient Discharge Status • Place of Service • Claim Frequency

Diagnosis

• Qualifier [Redacted]

Add New Diagnosis

	Code	Description	Delete
1	[Redacted]	[Redacted]	Delete

Save Draft Save Template Save To Group Prev Next Finish

- 11) Select the Details tab. You must complete all the required fields that are indicated by a red dot. If the person is in SG 1, 6, or 8, enter the total amount paid by the person's OI in the OI Paid Amount field.

Claim Submission - Step 2

Claim Type: Institutional

Client: [Redacted] Provider: [Redacted] Status: New Claim No.: [Redacted]

Client Provider Claim Details Other Insurance / Finish

Number of details to add: 1 Add New Details Row(s) Copy Row

Line Item Control No.	Service Dates		Procedure Code	Qualifier	Code	Units			Line Item Total	Co-Pay	Rev Code	OI Paid Amount	Rendering Provider					Delete
	Start	End				1	2	3					4	Units	Unit Rate	First Name	Last Name	
1																		

☒ Co-Pay
☐ Applied Income
 Claim Total: \$0.00
 Total Co-Pay: \$0.00
 Total Other Insurance: \$0.00 (from Details Tab)
 Total Other Insurance: \$0.00 (from Other Insurance/Finish Tab)

Save Draft Save Template Save To Group Prev Next Finish

To add more rows, click **Add New Detail Row(s)**. To copy the information from the previous detail, click **Copy Row**. To delete a row, scroll over and click **Delete** at the end of the row.

When billing for managed care claims with consecutive service dates without a change in the level of service Resource Utilization Group (RUG) or gap in service dates, providers must enter these claim transactions as one line item on the Details tab. Entering multiple rows for consecutive service dates can result in an initial claim denial by the MCO during processing.

Note: The Rendering Provider information in the Details tab should be added only if it is different from

the Rendering Provider listed in the Provider tab. The Rendering Provider in the Details tab should also be different from the Attending Provider and Billing Provider listed in the Provider tab.

12) Click the **Other Insurance/Finish** tab.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional		XXXXXXXXXX/XXXXXXXXXX	New	

Client Provider Claim Details Other Insurance / Finish

Finish Options

Please select one of the following and click finish

☒ **Submit**
Submits the claim interactively

☐ **Save to Batch**
Saves the claim to batch for processing later.

Certification, Terms And Conditions

Please review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

☐ We Agree

Save Draft Save Template Save To Group Prev Next Finish

When submitting an Institutional claim, there are four scenarios for the Other Insurance/Finish section. They are:

- Scenario 1. Other Insurance/Finish tab** – The options that are available on the Other Insurance/Finish tab are the same as those for a Professional claim unless the person is in SG 1, 6, or 8.

Note: If your claim will be forwarded to an MCO, it is recommended to submit the OI information directly to the MCO. Otherwise, the claim may be held for manual review by the MCO.

Note: For people with Medicare in SG 1, Service Code 3 (Extended Care Facility), enter either the Medicare Part A or Part C amount in the Medicare Information section. The Medicare attestation box must also be checked when billing for SG 1, Service Code 3.

 - Select the **Submit** radio button.
 - Check the **We Agree** box in the Certification, Terms And Conditions section.
 - Click **Finish** in the lower right corner of the screen.

To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**.

To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

- **Scenario 2. Other Insurance/Finish tab (no known OI coverage)** – For providers in SG 1, 6, or 8.
 - If you are aware of additional OI coverage for the person that is relevant to LTC, you are required to add that coverage to the claim using the **Add Policy** function.
 - a) Check the box under Attestation.
 - b) Click the **Submit** radio button.
 - c) Check the **We Agree** box in the Certification, Terms And Conditions section.
 - d) Click **Finish** in the lower right corner of the screen.

Client	Provider	Claim	Details	Other Insurance / Finish
<p>TMHP records indicate that this client has the following Long Term Care-relevant other insurance coverage for the date(s) of service billed on this claim. In order for this claim to be considered for Medicaid reimbursement, the identified third party resources must be billed prior to Medicaid, and the resulting disposition must be entered below. If any of the identified third party resources are not liable for the services billed on this claim, you must indicate the reason the other insurance carrier denied the claim.</p> <p>If you believe the information on file at TMHP for this client is invalid, please call the TMHP Third Party Liability department at 1-800-626-4117, Option 6. Real time insurance updates are viewable upon click of the Insurance Refresh tool. Please note: Any data entered on this tab during your current user session will be lost when the Insurance Refresh tool is clicked.</p> <p> Insurance Refresh</p> <p>If you believe the information on file at TMHP for this client is valid but requires an update, please click the 'Update Policy' button. Modified information will be sent to the TMHP Third Party Liability department for verification prior to permanently updating TMHP records. Check the client's MESAV within 10 business days for updated policy information. (Please note: This claim will be processed using the information currently on file at TMHP.)</p> <p>Client has no known Long Term Care-relevant other insurance coverage for the date(s) of service on file at TMHP</p> <p>If you are aware of additional Long Term Care-relevant other insurance coverage for this client that is not on file at TMHP, you are required to add that coverage on the claim and enter the disposition information. To enter a new policy, click the 'Add New Policy' button.</p> <p><input type="button" value="Add Policy"/></p> <p>Attestation</p> <p><input type="checkbox"/> By checking this box, you attest to the fact that you understand that Federal regulations dictate that the Medicaid Program is the payer of last resort and that the client has no additional third party coverage that is relevant to the service(s) billed on this claim. You further attest that all Other Insurance information entered on this claim is true and accurate when present and that every Explanation of Benefits (EOB) received from the other insurance carrier(s) is kept on file.</p> <p>Medicare Information</p> <p>Claims for Nursing Facility Medicare Skilled stays must be billed separately from other claims. When billing a Medicare Skilled stay, an amount must be entered in only one of the fields below. For clients with traditional Medicare, enter the total coinsurance amount due per the Medicare Remittance Advice in the Medicare Part A Total Amount field. For clients with non-traditional Medicare Part C, enter the total copay/deductible amount due per the Medicare Part C Explanation of Benefits (EOB) in the Medicare Part C Total Amount field. The amount entered below must equal the sum of all Medicare Skilled stay detail lines on this claim.</p> <p>Medicare Part A Total Amount (based on standard rate) <input type="text"/> </p> <p>Medicare Part C Total Amount <input type="text"/></p> <p><input type="checkbox"/> By checking this box, you attest to the fact that the Medicare Part A or Part C documentation to support this claim is kept on file. You further attest that the Medicare Part A or Part C information entered on this claim is true and accurate, and that you understand that Medicaid is the payer of last resort.</p> <p>Finish Options</p> <p>Please select one of the following and click finish</p> <p><input checked="" type="radio"/> Submit Submits the claim interactively</p> <p><input type="radio"/> Save to Batch Saves the claim to batch for processing later.</p> <p>Certification, Terms And Conditions</p> <p>Please review the following certification and the terms and conditions. The terms and conditions can be reviewed by clicking here.</p> <p>The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.</p> <p>By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".</p> <p><input type="checkbox"/> We Agree</p> <p><input type="button" value="Save Draft"/> <input type="button" value="Save Template"/> <input type="button" value="Save To Group"/> <input type="button" value="Prev"/> <input type="button" value="Next"/> <input type="button" value="Finish"/></p>				

To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**. To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

- Scenario 3. Other Insurance/Finish Tab add OI policy.** The OI policy will be validated by TMHP's Third-Party Liability department before it is added to the OI database. However, any amount paid by OI will be taken into consideration on the submission of the claim.
 - Complete the required fields as indicated by the red dots.
Note: To avoid processing errors, enter either the employer name or group number, but not both, when applicable.
 - Check the box under Attestation.
 - Select the **Submit** radio button.
 - Check the **We Agree** box in the Certification, Terms And Conditions section.

- e) Click **Finish** in the lower right corner of the screen.

The screenshot shows the 'Other Insurance / Finish' tab. At the top, there's a navigation bar with tabs: Client, Provider, Claim, Details, and Other Insurance / Finish (which is active). Below the navigation bar, there's a warning message about TMHP records and a note about insurance refresh. The main form area is titled 'Other Insurance Policy #1' and contains several sections:

- Other Insurance Policy #1:** Includes fields for Effective Date, Termination Date, Company Name, Company Address, Company City, Company State, Company ZIP Code, Company Phone #, Subscriber Relationship to Client, Subscriber First Name, Subscriber Last Name, Subscriber SSN, Subscriber DOB, Employer Name, Subscriber/Policy #, Group Number, and Other Insurance Disposition.
- Medicare Information:** Includes a checkbox for attestation and a section for Medicare Part A and Part C Total Amounts.
- Finish Options:** Includes a section for selecting one of the following and clicking finish, with options for 'Submit' (Submit the claim interactively) and 'Save to Batch' (Saves the claim to batch for processing later).
- Certification, Terms And Conditions:** Includes a checkbox for 'We Agree' and a link to review terms and conditions.

At the bottom of the form, there are buttons for 'Save Draft', 'Save Template', 'Save To Group', 'Prev', 'Next', and 'Finish' (which is highlighted in red).

To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**. To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

- **Scenario 4. Other Insurance/Finish Tab (with known OI coverage).** For people in SGs 1, 6, or 8, TexMedConnect will display any known OI coverage that is relevant to LTC that is currently on file with TMHP.
 - Verify that the OI information is valid and correct.
 - Fill in all required OI policy information as indicated by a red dot.
 - Choose the appropriate option in the Other Insurance Disposition drop-down menu. If no response has been received and it has been more than 110 calendar days since the billing date, choose **No response (initial bill for services)** or **No response (subsequent bill for services)**.
 - If you chose **Paid** in the Other Insurance Disposition drop-down menu, choose an option in the Other Insurance Disposition Reason drop-down menu as shown below, and if applicable, enter the Other Insurance Paid Amount.

Note: The amount entered in this field must match the total amount entered on the Details tab in the OI Paid Amount field.
 - If you chose **Denied** in the Other Insurance Disposition drop-down menu, choose an option in the

Other Insurance Disposition Reason drop-down menu.

- f) Enter the appropriate date in the Other Insurance Billed Date field. If you choose either of the No response options in the Other Insurance Disposition drop-down menu, the Other Insurance Billed Date must be at least 110 calendar days prior to the submission date.
- g) If you need to update the OI policy, click **Update Policy** to display the Other Insurance Policy fields. After the information is updated, click **Save Changes**.
- h) If you need to add another insurance policy, click **Add Policy** to display the Other Insurance Policy field.
- i) Check the box under Attestation.
- j) Select either the **Submit** radio button or the **Save to Batch** radio button.
- k) Check the **We Agree** box in the Certification, Terms And Conditions section.
- l) Click **Finish**.

Note: The OI policy will be validated by the TMHP Third-Party Liability department before it is added to the OI database.

Claim Submission - Step 2

Claim Type: Institutional

Client: [Name] **Provider:** [Name] **Status:** New **Claim No.:** [Number]

Client | Provider | Claim | Details | Other Insurance / Finish

TMHP records indicate that this client has the following Long Term Care-relevant other insurance coverage for the date(s) of service billed on this claim. In order for this claim to be considered for Medicaid reimbursement, the identified third party resources must be billed prior to Medicaid, and the resulting disposition must be entered below. If any of the identified third party resources are not liable for the services billed on this claim, you must indicate the reason the other insurance carrier denied the claim.

If you believe the information on file at TMHP for this client is invalid, please call the TMHP Third Party Liability department at 1-800-626-4117, Option 6. Real time insurance updates are viewable upon click of the Insurance Refresh tool. Please note: Any data entered on this tab during your current user session will be lost when the Insurance Refresh tool is clicked.

Insurance Refresh

If you believe the information on file at TMHP for this client is valid but requires an update, please click the 'Update Policy' button. Modified information will be sent to the TMHP Third Party Liability department for verification prior to permanently updating TMHP records. Check the client's MESAV within 10 business days for updated policy information. (Please note: This claim will be processed using the information currently on file at TMHP.)

Other Insurance Policy #1

Update Policy Note: All policy information will be validated by TMHP on every referral, regardless of the information submitted on the referral.

Effective Date: [Date] Termination Date: [Date] Company Name: [Text] Company Address: [Text] Company City: [Text] Company State: [Text] Company ZIP Code: [Text] Company Phone #: [Text]

Subscriber Relationship to Client: [Text] Subscriber First Name: [Text] Subscriber Last Name: [Text] Subscriber SSN: [Text] Subscriber DOB: [Text] Employer Name: [Text] Subscriber/Policy #: [Text]

Group Number: [Text] Other Insurance Disposition: [Dropdown] Other Insurance Disposition Reason: [Dropdown] Other Insurance Billed Date: [Date] Other Insurance Disposition Date: [Date] Other Insurance Claim No.: [Text]

If you are aware of additional Long Term Care-relevant other insurance coverage for this client that is not on file at TMHP, you are required to add that coverage on the claim and enter the disposition information. To enter a new policy, click the 'Add New Policy' button.

Add New Policy

Attestation

☒ By checking this box, you attest to the fact that you understand that Federal regulations dictate that the Medicaid Program is the payer of last resort and that the client has no additional third party coverage that is relevant to the service(s) billed on this claim. You further attest that all Other Insurance information entered on this claim is true and accurate when present and that every Explanation of Benefits (EOB) received from the other insurance carrier(s) is kept on file.

Medicare Information

Claims for Nursing Facility Medicare Skilled stays must be billed separately from other claims. When billing a Medicare Skilled stay, an amount must be entered in only one of the fields below. For clients with traditional Medicare, enter the **total coinsurance amount due** per the Medicare Remittance Advice in the Medicare Part A Total Amount field. For clients with non-traditional Medicare Part C, enter the **total copay/deductible amount due** per the Medicare Part C Explanation of Benefits (EOB) in the Medicare Part C Total Amount field. The amount entered below must equal the sum of all Medicare Skilled stay detail lines on this claim.

Medicare Part A Total Amount (based on standard rate): [Text] Medicare Part C Total Amount: [Text]

☐ By checking this box, you attest to the fact that the Medicare Part A or Part C documentation to support this claim is kept on file. You further attest that the Medicare Part A or Part C information entered on this claim is true and accurate, and that you understand that Medicaid is the payer of last resort.

Finish Options

Please select one of the following and click finish

☒ **Submit**
Submits the claim interactively

☐ **Save to Batch**
Saves the claim to batch for processing later.

Certification, Terms And Conditions

Please review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

☒ **We Agree**

Save Draft | Save Template | Save To Group | Prev | Next | Finish

To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save**

Template. To save the claim as part of a group, click **Save To Group**. To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

Entering an NAT Claim

To enter an NAT claim:

- 1) Select the Header Information tab. Complete all the required fields as indicated by a red dot. The Provider No. field and the NPI/API field will be autofilled based on the information entered in Step 1.

Note: The percentages entered for Medicaid Patient Days, Medicare Patient Days, and Private Patient Days must total 100%.

Claim Type	Trainee SSN	Provider	Status	Claim No.
NAT			New	

Claim Submission - Step 2

Header Information

Line Item Information

Other Insurance / Finish

Provider Information

Service Group

Provider No.

NPI/API

Medicaid Patient Days:

0.0 %

Medicare Patient Days:

0.0 %

Private Patient Days:

0.0 %

Trainee Information

Trainee SSN

Last Name

First Name

MI

- 2) Click the Line Item Information tab. Complete all the required fields as indicated by a red dot. No future date is allowed in the Service Start Date or Service End Date field.

Claim Submission - Step 2

Claim Type	Trainee SSN	Provider	Status	Claim No.
NAT			New	

Header Information

Line Item Information

Other Insurance / Finish

Number of details to add: 1
Add New Details Row(s)
Copy Row

Start Date	Service End Date	Billing Code	Training Hours	No. of Units	Unit Rate	Line Item Total	Delete
							Delete

Claim Total: \$0.00

If you want to add more rows, click **Add New Detail Row(s)**. If you want to copy the information from the previous detail, click **Copy Row**.

3) Click **Other Insurance/Finish**.

Note: OI information is not required on an NAT claim, only an Institutional claim.

- Select either the **Submit** or the **Save to Batch** radio button.
- Check the **We Agree** box in the Certification, Terms And Conditions section.
- Click **Finish** in the lower right corner of the screen.
- If the claim is submitted successfully, the ICN will be displayed in the Claim No. field at the top of the page.

Claim Submission - Step 2

Claim Type	Trainee SSN	Provider	Status	Claim No.
NAT			New	

Header Information

Line Item Information

Other Insurance / Finish

Finish Options

Please select one of the following and click finish

☒ **Submit**
Submits the claim interactively

☐ **Save to Batch**
Saves the claim to batch for processing later.

Certification, Terms And Conditions

Please review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

☐ We Agree

Save Draft

Save Template

Save To Group

Prev

Next

Finish

To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**.

To submit the claim as part of a batch, refer to the “Submitting a Batch” section of this user guide.

Saving a Claim

There are four options available for saving a claim:

- 1) Save Draft – The claim will be added to the draft list, to be completed later.
- 2) Save Template – The claim will be added to the template list for faster claims creation in the future.
- 3) Save To Group – The claim will be added to a group template, which includes templates for many people.
- 4) Save To Batch – The claim will be added to a batch of claims that can be submitted as a group.

Header Information	Line Item Information	Other Insurance / Finish
<div> Finish Options <p>Please select one of the following and click finish</p> <div> <input checked="" type="radio"/> Submit <small>Submits the claim interactively</small> </div> <div> <input type="radio"/> Save to Batch <small>Saves the claim to batch for processing later.</small> </div> </div>		
<div> Certification, Terms And Conditions <p>Please review the following certification and the terms and conditions. The terms and conditions can be reviewed by clicking here.</p> <p>The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.</p> <p>By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".</p> <p><input type="checkbox"/> We Agree</p> </div>		
<div> <div> <div>Save Draft</div> <div>Save Template</div> <div>Save To Group</div> </div> <div> <div>Prev</div> <div>Next</div> <div>Finish</div> </div> </div>		

Draft Claims

Saving the claim as a draft allows the user to come back to the claim at a later time and complete it. To save a claim as a draft:

- 1) Click **Save Draft** at the bottom of the screen.

Header Information | **Line Item Information** | **Other Insurance / Finish**

Finish Options

Please select one of the following and click finish

☒ **Submit**
Submits the claim interactively

☐ **Save to Batch**
Saves the claim to batch for processing later.

Certification, Terms And Conditions

Please review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

☐ We Agree

Save Draft | Save Template | Save To Group | Prev | Next | Finish

- 2) Enter a name for the draft and click **Save**. The claim will be added to the draft list. A maximum of 500 claims can be saved as drafts. Saved drafts are available for 45 days after the last time they were accessed. After 45 days have elapsed, any saved drafts are automatically deleted.

Street Address | Street Address 2 | City | State | Zip

Client General Information

Gender | Date Of Birth | Referral No.

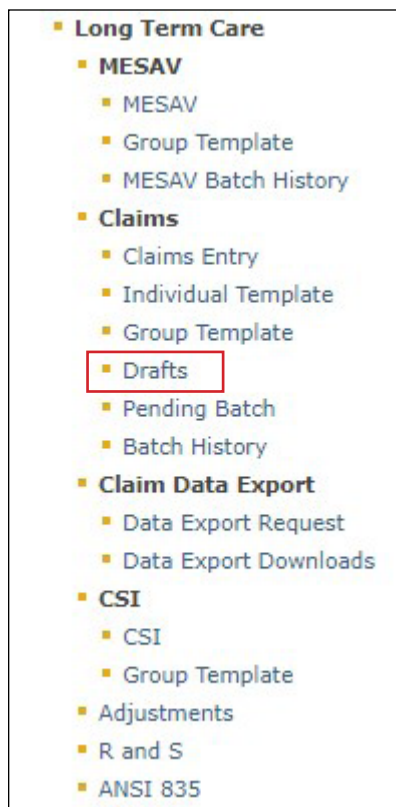
Save Draft | Save Template | Save To Group | Prev | Next | Finish

Name: Draft Drafts | **Save** | Cancel

Viewing Draft Claims

To view a list of all your draft claims:

- 1) Click **Drafts** under the Claims section on the navigation panel.



- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

The screenshot shows a form titled "Draft List". Below the title is a label "Select NPI/API & Provider No. :" followed by a drop-down menu. Below the menu is a button labeled "Continue >>". Both the drop-down menu and the button are highlighted with red boxes.

- 3) If there are multiple drafts, you can click a column heading to sort the list by that column category. Click a draft name to view the saved claim.
 - After a claim from the draft list has been submitted, that draft claim is removed from the draft list.
 - After 45 days, all drafts will automatically be deleted from the draft list.

- A maximum of 500 drafts can be created for each NPI or API and provider number.

Drafts						
NPI/API [REDACTED] / Provider No. [REDACTED]						
Draft Name	Claim Type	User ID	Created	Last Updated		
[REDACTED]	Expedited	[REDACTED]	07/28/2009	07/28/2009	Delete	

Individual Templates

Saving as an Individual Template

To save an individual claim as a template, complete a claim and then:

- 1) Click **Save Template**.

Save Draft	Save Template	Save To Group	Back to Template List	Prev	Next	Finish
----------------------------	-------------------------------	-------------------------------	---------------------------------------	----------------------	----------------------	------------------------

- 2) Enter a template name, and click **Save**. The claim will be added to the Individual Template list.
- 3) Templates do not disappear when they are used and can be used an unlimited number of times. However, they will be removed automatically if they have not been used for 365 days.
- 4) A maximum of 1,000 individual claim templates can be created for each NPI or API and provider number.

Viewing Individual Templates

To view individual templates:

- 1) Click **Individual Template** under the Claims section in the navigation panel. Templates are displayed by NPI.

Navigation	Individual Template List
<ul style="list-style-type: none"> Claims <ul style="list-style-type: none"> Claims Entry Individual Template Group Template Drafts Pending Batch Batch History Claim Data Export <ul style="list-style-type: none"> Data Export Request Data Export Downloads CSI 	<p>Select NPI/API & Provider No. : <input type="text" value="[REDACTED]"/></p> <p>Continue >></p>

- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

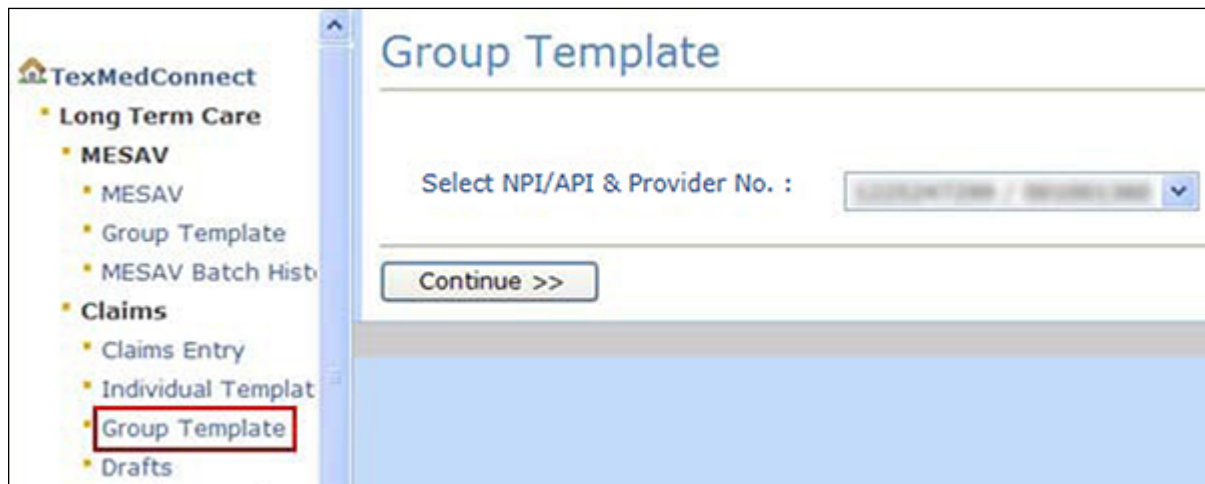
- 3) If there are multiple drafts, you can click a column heading to sort the list by that column category. Click on the template name to open it.

Individual Template					
NPI/API 0000000000 / Provider No 0000000000					
Template Name	Claim Type	User ID	Created	Last Updated	
COR135 EDI Test CPT REV	Institutional	0000000000	11/25/2014	12/01/2014	Delete
dental	Dental	0000000000	09/04/2014	12/03/2014	Delete
dental_TaxonomycodeBatch_Testing	Dental	0000000000	10/03/2014	10/03/2014	Delete
Inst_Taxonomycode_Batch_Testing	Institutional	0000000000	10/03/2014	10/03/2014	Delete
Multiple Plan Codes	Institutional	0000000000	08/21/2014	11/25/2014	Delete
Multiple Plan Codes E0015	Institutional	0000000000	08/21/2014	09/18/2014	Delete
Multiple Plan Codes E0016	Institutional	0000000000	08/21/2014	08/25/2014	Delete
Multiple Plan Codes E0016 Addon SC1	Institutional	0000000000	08/25/2014	09/15/2014	Delete
Professional_Taxonomy_Batch_Testing	Professional	0000000000	10/03/2014	10/03/2014	Delete

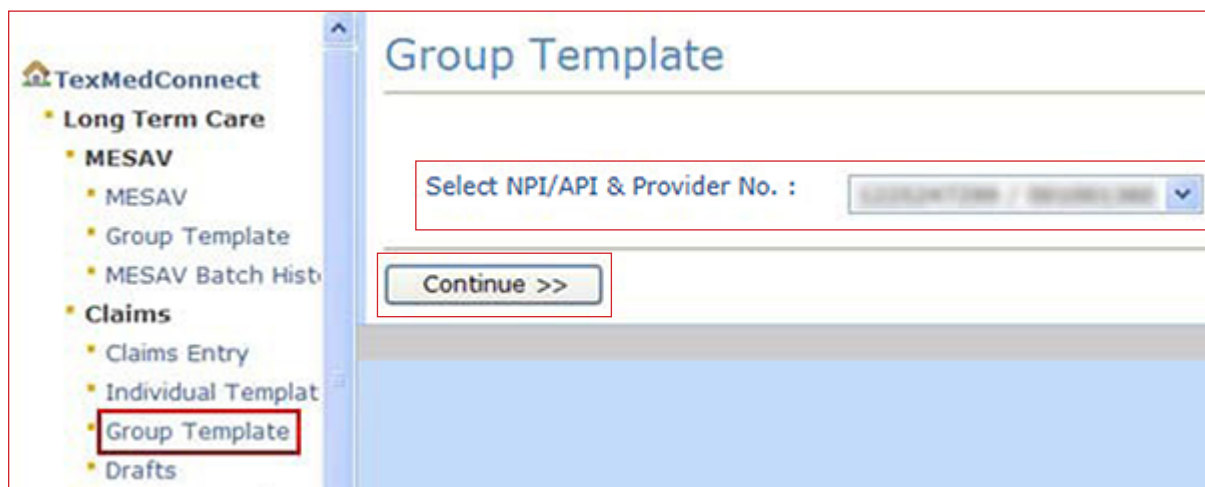
Group Templates

Viewing Existing Group Templates

- 1) Click **Group Template** under the Claims section in the navigation panel.



- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.



- Under the **Template Name** column, click the name of the template that you want to work on.

Group Template List

NPI/API / Provider No.

New Group: Claim Type:

Template Name	Template Type	UserID	Date Cre.	Updated		
MESAV	Institutional		04/06/2009	12/09/2014	Rename	Delete
MESAV	Institutional		10/30/2013	10/30/2013	Rename	Delete
MESAV	Professional		04/08/2009	04/08/2009	Rename	Delete
MESAV	NAT		12/03/2014	12/03/2014	Rename	Delete
MESAV	Professional		04/08/2009	12/03/2014	Rename	Delete
MESAV	Institutional		02/25/2013	12/03/2014	Rename	Delete
MESAV	Professional		05/12/2009	12/03/2014	Rename	Delete
MESAV	Institutional		05/12/2009	12/03/2014	Rename	Delete
MESAV	Professional		12/10/2008	12/09/2014	Rename	Delete
MESAV	Institutional		02/11/2013	12/03/2014	Rename	Delete
MESAV	Institutional		07/14/2009	12/03/2014	Rename	Delete
MESAV	NAT		07/01/2009	12/03/2014	Rename	Delete
MESAV	Professional		04/08/2009	07/10/2013	Rename	Delete
MESAV	Professional		04/06/2009	05/07/2014	Rename	Delete

Creating New Group Templates

To create a new Group Template:

- Click **Group Template** under CSI in the navigation panel.

<ul style="list-style-type: none"> Long Term Care <ul style="list-style-type: none"> MESAV <ul style="list-style-type: none"> MESAV Group Template MESAV Batch History Claims <ul style="list-style-type: none"> Claims Entry Individual Template Group Template Drafts Pending Batch Batch History Claim Data Export <ul style="list-style-type: none"> Data Export Request Data Export Downloads CSI <ul style="list-style-type: none"> CSI Group Template Adjustments

- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

- 3) Enter the name of a group in the **New Group** field, choose the claim type from the drop-down menu, and click **Add Group Template**.

Template Name	Template Type	UserID	Date Created	Date Last Updated	
...	Institutional	...	4/6/2009	10/27/2015	Rename
...	Institutional	...	10/30/2013	2/2/2015	Rename
...	Professional	...	4/8/2009	9/25/2015	Rename
...	NAT	...	12/3/2014	9/25/2015	Rename
...	Professional	...	4/8/2009	10/13/2015	Rename

- 4) After you have created the Group Template, the Group Template Summary page will be displayed. To add a person, go to step 5. To return to the Group Template List page, click **Go Back**.

Global Update **Submit**

Procedure Code: ● All v

Start Date:

End Date:

No. of Units:

Unit Rate:

☒ Apply Co-Pay Only
☐ Apply Applied Income Only
☐ Apply Neither Co-Pay Nor Applied Income

Update Group Template

Effective February 22, 2013, an Institutional claim for individuals in Service Groups 1,6, or 8 will be denied if third-party insurance is detected when the claim is submitted and the third party insurance information has not been addressed on the claim. NOTE: Applicable Individual Templates for Institutional claims included in a Group Template must be updated to address OI. Insurance policy information for LTC individuals can be viewed on the MESAV.

This will force TexMedConnect to use Co-Pay as the client responsibility for every client in the template. Note that this means that all claims updated in the Group Template will utilize Co-Pay where appropriate. If the client does not have an active Co-Pay record, TexMedConnect will calculate using an amount of \$0.00.

- 5) To add a person to the group, click the **Add Client** button.

Claims - Group Template Summary - Alpha TMC II

Go Back **Add Client**

NPI/API / Provider No.

Global Update **Submit**

Procedure Code: ● All ▼

Start Date:

End Date:

No. of Units:

Unit Rate:

☒ **Apply Co-Pay Only**
☐ **Apply Applied Income Only**
☐ **Apply Neither Co-Pay Nor Applied Income**

Update Group Template

Effective February 22, 2013, an Institutional claim for individuals in Service Groups 1,6, or 8 will be denied if third-party insurance is detected when the claim is submitted and the third party insurance information has not been addressed on the claim. NOTE: Applicable Individual Templates for Institutional claims included in a Group Template must be updated to address OI. Insurance policy information for LTC individuals can be viewed on the MESAV.

This will force TexMedConnect to use Co-Pay as the client responsibility for every client in the template. Note that this means that all claims updated in the Group Template will utilize Co-Pay where appropriate. If the client does not have an active Co-Pay record, TexMedConnect will calculate using an amount of \$0.00.

- 6) You can define the start date and end date, the number of units, and the unit rate for all claims in the template. You must select one of the following three radio buttons:

- **Apply Co-Pay Only**
- **Apply Applied Income Only**
- **Apply Neither Co-Pay Nor Applied Income**

If you choose **Apply Co-Pay Only**, TexMedConnect will use Co-Pay as the individual responsibility for every person in the template. This means that all claims that are updated in the template will use Co-Pay where it is appropriate to do so. If the person does not have an active Co-Pay record, TexMedConnect will make calculations using an amount of \$0.00.

If you choose **Apply Applied Income Only**, TexMedConnect will use Applied Income as the individual responsibility for every person in the template. This means that all claims updated in the Group Template will use Applied Income where appropriate. If the person does not have an active Applied Income record, TexMedConnect will make calculations using an amount of \$0.00.

If you choose **Apply Neither Co-Pay Nor Applied Income**, TexMedConnect will use no individual responsibility for every person in the template. This means that the individual responsibility field will be set to zero whether or not the person has an active individual responsibility record. The total payment calculated by TexMedConnect will be higher than the actual payment if any of the claims should have had

individual responsibility deducted.

Claims - Group Template Summary - Alpha TMC II

Go Back Add Client

NPI/API / Provider No.

Global Update Submit

Procedure Code: All

Start Date: End Date:

No. of Units: Unit Rate:

☒ Apply Co-Pay Only
☐ Apply Applied Income Only
☐ Apply Neither Co-Pay Nor Applied Income

Effective February 22, 2013, an Institutional claim for individuals in Service Groups 1,6, or 8 will be denied if third-party insurance information has not been addressed on the claim. NOTE: Applicable Individual Templates for Institutional claims included in a Group Template must be updated to address OI. Insurance policy information for LTC individuals can be viewed on the MESAV.

Update Group Template

- When you have entered all the required information, click **Update Group Template** to apply that information to all of the claims in the group.

A template will remain in the system after each use. However, if a template has not been used for 365 days, it will be deleted from the system. A maximum of 100 group templates can be created for each NPI or API and provider number. Each group template can store up to 250 claims.

☒ Apply Co-Pay Only
☐ Apply Applied Income Only
☐ Apply Neither Co-Pay Nor Applied Income

Update Group Template

This will force TexMedConnect to use Co-Pay as the client responsibility for every client in the template. Note that this means that all claims updated in the Group Template will utilize Co-Pay where appropriate. If the client does not have an active Co-Pay record, TexMedConnect will calculate using an amount of \$0.00.

Saving as a Group Template

To create a group template, enter the information for a claim, but before you submit the claim:

- Click **Save To Group**.

Save Draft Save Template Save To Group

- Enter a group template name and click **Save**.

Note: If you enter the name of an existing template, the claim will be added to that existing group template.

Note: If you enter the name of a new group template, a new template will be added to the Group Template list. To modify the settings for the new template, see the Group Templates section of this user guide.

Group Template List

NPI/API / Provider No.

New Group: Claim Type: Add Group Template

Template Name	Template Type	UserID	Date Cre	Updated		
	Institutional		04/06/2008	12/08/2014	Rename	Delete

Batch Claims

Saving to a Batch

To save a claim as part of a batch:

- 1) After completing a claim, select the **Save to Batch** radio button.

Finish Options

Please select one of the following and click finish

☐ Submit

Submits the claim interactively

☒ Save to Batch

Saves the claim to batch for processing later.

- 2) Check the **We Agree** box and then click **Finish**. The claim will be saved as part of a batch, and you will be returned to the cliaims entry screen so you can continue to enter more claims.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional		1699817007/000010100	New	

Client Provider Claim Details Other Insurance / Finish

Finish Options

Please select one of the following and click finish

☒ Submit

Submits the claim interactively

☐ Save to Batch

Saves the claim to batch for processing later.

Certification, Terms And Conditions

Please review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

☐ We Agree

Save Draft Save Template Save To Group

Prev Next Finish

You can save up to 250 claims to a batch. Pending batches that are not submitted after 45 days are deleted from the system. You can view or edit claims in a pending batch before you submit them.

Submitting a Batch

To submit a batch:

- 1) Click **Pending Batch** under the Claims section in the navigation panel.



- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.
- 3) The Pending Batch page will display for the selected NPI or API and provider number. The pending batch list shows the claims that are ready to be submitted. Clicking a column heading will sort the list by the data in that column.

Pending Batch - List of Claims

NPI/API / Provider No.

Client #	Account No	Last Name	First Name	Start Date Of Service	Billed Amount	Claim Form	User ID			
				10/01/2012	\$ 2,738.70	Institutional		View	Edit	Delete
				10/04/2012	\$ 2,738.70	Institutional		View	Edit	Delete
				10/01/2012	\$ 2,738.70	Institutional		View	Edit	Delete

Total Billed Amount: \$8,216.10

- 4) If there are more claims than can fit on one screen, click **Continue** to go to the next page.
- 5) If you want to return to a previous page, use your internet browser's **Back** button.
- 6) On the last screen of the pending batch list, click **Submit Batch**. All claims in that batch will be submitted, even those created by other users.

Pending Batch - List of Claims

NPI/API / Provider No.

Client #	Account No	Last Name	First Name	Start Date Of Service	Billed Amount	Claim Form	User ID			
				10/01/2012	\$ 2,738.70	Institutional		View	Edit	Delete
				10/04/2012	\$ 2,738.70	Institutional		View	Edit	Delete
				10/01/2012	\$ 2,738.70	Institutional		View	Edit	Delete

Total Billed Amount: \$8,216.10

- 7) When the batch is submitted, a confirmation message will inform the user whether the submission was successful and will provide the number of claims that were submitted in the batch.

View Batch History

You can view the batch history of previously submitted claim batches. Batches that are more than 120 days old are automatically deleted.

To view a batch history:

- 1) Click **Batch History** under the Claims section in the navigation panel.

- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

- 3) Click on a Batch ID to view the list of claims included in that batch. The Batch History will display all available batches.

Note: The Claim Count column indicates the total number of processed claims, not necessarily the total number of paid claims.

Batch History						
NPI/API 1234567890 / Provider No. 1234567890						
	Batch ID	Status	Claim Count	Total Billed Am	Transmission Date	Submitted By
✓	G394LS8R	Processed	1	\$ 200.00	08/27/2014 03:52:59 PM	1234567890
✓	G394LS8W	Processed	1	\$ 200.00	08/27/2014 03:54:10 PM	1234567890
✓	G484MGG4	Processed	1	\$ 159.09	09/05/2014 03:31:04 PM	1234567890
✓	G484MGG5	Processed	1	\$ 159.09	09/05/2014 03:47:48 PM	1234567890
✓	G514MGGH	Processed	1	\$ 159.09	09/08/2014 01:58:05 PM	1234567890
✓	G514MGGV	Processed	1	\$ 100.00	09/08/2014 04:24:17 PM	1234567890
✓	G524MGH8	Processed	2	\$ 318.18	09/09/2014 11:04:12 AM	1234567890
✓	G524MGH9	Processed	1	\$ 120.00	09/09/2014 11:18:10 AM	1234567890
✓	G524MGHA	Processed	2	\$ 200.00	09/09/2014 11:41:18 AM	1234567890

- 4) You will see a list of the claims for the batch that you clicked. The claims that are listed can be a mix of claims to different MCOs and to TMHP. Claims can be set to the following three statuses:

- Forwarded: The claim has been forwarded (but not yet accepted or rejected) by an MCO.
- Rejected: The claim has been rejected by TMHP or the MCO to which it was forwarded.
- Accepted: The claim has been accepted by TMHP or an MCO.

Claims that are handled by TMHP can also be set to the following statuses:

- I: In Process
- D: Denied
- A: Approved for Payment
- FT: Forced Transfer
- S: Suspended
- T: Transferred
- P: Paid
- PF: Paid Forced Transfer
- PT: Paid Transfer
- PZ: Zero Net Balance to the Provider

In addition to the status of the claims and other information, there is a Payer Name column. The Payer Name column will display the name of the MCO that the claim was forwarded to, rejected, or accepted by. TMHP will be

displayed when the claim is accepted by TMHP. A blank column indicates that TMHP has rejected the claim.

Batch History - List of Claims -

NPI/API / Provider No.

Status	Client #	Account No	Payer Name	Last Name	First Name	Start Date Of Service	Billed Amount	Claim Form	User ID
Rejected						07/30/2014	\$ 159.09	Institutional	
Accepted						07/30/2014	\$ 159.09	Institutional	

Total Billed Amount: \$318.18

BatchID: G534MJ7O

Go Back

5) Click the status of a claim to view the details of that claim.

Batch History - List of Claims -

NPI/API / Provider No.

Status	Client #	Account No	Payer Name	Last Name	First Name	Start Date Of Service	Billed Amount	Claim Form	User ID
Rejected						07/30/2014	\$ 159.09	Institutional	
Accepted						07/30/2014	\$ 159.09	Institutional	

Total Billed Amount: \$318.18

BatchID: G534MJ7O

Go Back

If the status of the claim that you clicked was Forwarded:

- The forwarded claim will have a 28-character alphanumeric ETN. This is not the same as the internal control number (ICN) associated with fee for service (FFS) claims.
- The first eight characters of the ETN are the same as the Batch ID.
- The claim will remain in the Forwarded status until the MCO responds with either Accept or Reject.

As shown in the image below, the name and contact information of the MCO are identified in multiple places on the screen. After a claim has been forwarded to the MCO, providers must work directly with the MCO regarding any issues with the claim.

When TMHP forwards a claim to an MCO, TMHP will assign an Explanation of Benefits (EOB) code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB code.

The last section on the screen, the Detail Service Line, will list information such as the billing code and the Informational Pricing column (which is how TMHP would have priced the claim if it was processed as FFS for SG 1, Service Codes 1 and 3).

MCO CSI Search Details

[New Lookup](#)

[Return To List](#)

ETN

Claim Information

TMHP EDI Trans No	
Status	Forwarded
Status Date	12/8/2014 4:07:46 PM
MCO Name	Medicaid Long Term Support
MCO Phone No	1-800-455-2786
MCO ICN	

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

EOB / EOPS codes messages

EOB Code	EOB Description
01745	has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at for questions about processing of this claim.

This claim has been forwarded to for processing. Contact at : for questions related to this claim.

The following data is for informational purposes. For actual payments please contact the MCO.

Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	\$159.09	\$140.57	\$0.00	\$0.00	\$18.52

- a) If the status of the claim that you clicked was Rejected, you will see a yellow message box at the top of the screen that lists the rejected EOBs. The MCO may choose to list the EOBs with a description. If a description is not present, then only the EOB number will be displayed.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional			Rejected	

- EOB from MCO for Rejected Claim.
- Claim Detail# 1: Testing EOB Description for detail.

Client
Provider
Claim
Details
Other Insurance / Finish

Client Identification Numbers

Client ID

Patient Account No.

Medical Record No.

Name and Address

First Name

Last Name

MI

Suffix

Street Address

Street Address 2

City

State

Zip

Client General Information

Gender

Date Of Birth

Referral No.

Save Draft

Save Template

Save To Group

Cancel Edit

Prev

Next

Finish

- b) If the status of the claim that you clicked was Accepted and the payer is an MCO, then the MCO CSI Search Details page will display.

After a forwarded claim has been accepted by an MCO, the MCO ICN field will autofill. The MCO ICN is a unique identifier that the MCO assigns to a forwarded claim.

The header EOBs and descriptions returned by the MCO for the accepted claim will be displayed in the EOB/EOPS codes messages column. If the MCO does not return the description of the EOB, it will appear as blank. The provider will need to use the MCOs EOB Crosswalk to interpret the EOBs.

MCO CSI Search Details

[New Lookup](#) [Return To List](#)

Claim Information

TMHP EDI Trans No	XXXXXXXXXXXXXXXXXXXX
Status	Accepted
Status Date	12/8/2014 4:00:49 PM
MCO Name	Medicaid Managed Care Organization
MCO Phone No	1-800-455-1776
MCO ICN	XXXXXXXXXX

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

EOB / EOPS codes messages

EOB Code	EOB Description
EOB100	XXXXXXXXXX has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at XXXXXX-XXXX for questions about processing of this claim.
EOB100	EOB from MCO for Accepted Claim.

This claim has been accepted to XXXXXX-XXXX for processing. Contact XXXXXX-XXXX at 1-800-455-1776 for questions related to this claim.

The following data is for informational purposes. For actual payments please contact the MCO.

Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	\$159.09	\$0.00	\$0.00	\$0.00	\$169.35

- c) If the status of the claim that you clicked was Accepted and the payer is TMHP, the CSI Search Details page will display.

CSI Details

[New Lookup](#)

Claim Information

Claim No.	XXXXXXXXXX
Dates of Service	8/1/2014 - 8/1/2014
Status	D
Effective Date	9/10/2014
Service Group	1
Warrant Number	

Financial Information

Total Billed Amount	\$100.00
Total Paid Amount	\$0.00
Total Applied Other Insurance Amount	\$0.00
Budget Number	

Client Information

Client/Medicaid No./Trainee SSN	XXXXXXXXXX
Name	XXXXXXXXXX
Gender	F
Date of Birth	8/24/1984
Patient Account No.	XXXXXXXXXX
Medical Record No.	XXXXXXXXXX
Referral No.	XXXXXXXXXX

Provider Information

Provider NPI/API	XXXXXXXXXX
Provider Name	XXXXXXXXXX
Medicare Patient Days %	0
Private Patient Days %	0
Medicaid Patient Days %	0

Dtl No	Detail Status	Service Begin	Service End Date	Billing Code	Billed Amount	Paid Amount	OI Paid Amount	Applied OI Amount	Billed Units	Paid Units	Estimated Paid Unit Rate	Nat'l EOB1	Nat'l EOB2	Modifier 1
1	D	8/1/2014	8/1/2014	RG008	\$100.00	\$0.00	\$0.00	\$0.00	1.00	0.00	\$0.00			

- 6) Click **Return To List** to return to Batch History. The results are saved for 60 days.

MCO CSI Search Details

[New Lookup](#)
[Return To List](#)

Claim Information	
TMHP EDI Trans No	001-00000000000000000000000000000000
Status	Accepted
Status Date	12/8/2014 4:00:49 PM
MCO Name	Westinghouse Long Term Support
MCO Phone No	1-800-456-1234
MCO ICN	00000000000000000000000000000000

Claims Data Export

If you want to request an extract of claims data for a particular date range, you can use the Claims Data Export feature. The maximum date range between From Dates of Service and To Dates of Service for each search is six months.

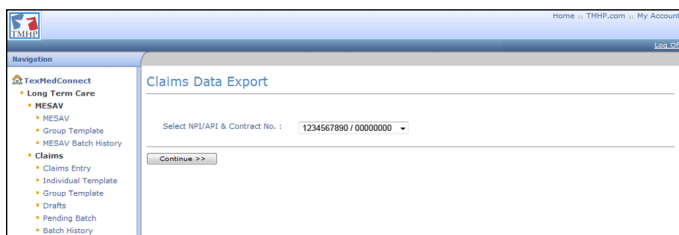
Note: Claims Data Export is available only to users with administrative rights on their account.

To request the claims data to be exported:

- 1) Click **Data Export Request** under the Claims Data Export section in the left navigation panel.



- 2) Select the NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.



- 3) Enter your submitter ID, password, Service Begin Date, and Service End Date and then click **Request Data**. The date range must be no more than six months long.

The Service Begin Date cannot be more than three years prior to the current date.

If you do not know your submitter ID and password, contact the EDI Help Desk at 888-863-3638 from 7:00 a.m. to 7:00 p.m. Central time, Monday through Friday.


The requested data will be available on the next business day (the data will be in MS Excel® format).

Claims Data Export

Submitter ID: *


Password : *

Service Begin Date: *



Format: mm/dd/yyyy

Service End Date: *



Format: mm/dd/yyyy

- Date range cannot span a length of time greater than six months.

- Service Begin Date cannot be more than three years prior to current date.

Request Data

- 4) To download the requested data, click **Data Export Downloads** under the Claims Data Export section in the left navigation panel.

- Long Term Care
 - MESAV
 - MESAV
 - Group Template
 - MESAV Batch History
 - Claims
 - Claims Entry
 - Individual Template
 - Group Template
 - Drafts
 - Pending Batch
 - Batch History
 - Claim Data Export
 - Data Export Request
 - Data Export Downloads
 - CSI
 - CSI
 - Group Template
 - Adjustments
 - R and S
 - ANSI 835

- 5) Enter your submitter ID and password, and click **Submit**.

Claim Data Export Result

Submitter ID:

Password :

- 6) The Claim Data Export Result page will display the requested file when it is ready to be downloaded. Check the **Select** box and then click **Download**.

Claim Data Export Result

Select	File Name
<input type="checkbox"/>	EKT1461152530010073642023-05-04_12_40_38.743478.csv
<input type="checkbox"/>	EKT1461152530010075142023-05-04_12_41_49.421606.csv
<input type="checkbox"/>	EKT146115253001007772023-05-04_14_21_46.752142.csv
<input type="checkbox"/>	EKT1461152530010100842023-05-04_12_36_36.722433.csv
<input type="checkbox"/>	EKT1461152530010100842023-05-04_13_26_05.798758.csv
<input type="checkbox"/>	EKT1461152530010100842023-05-04_13_37_24.900794.csv
<input type="checkbox"/>	EKT1461152530010100842023-05-05_10_19_44.572240.csv
<input type="checkbox"/>	EKT1461152530010105152023-05-04_15_50_57.994157.csv
<input type="checkbox"/>	EKT1461152530010105152023-05-04_15_55_14.541964.csv
<input type="checkbox"/>	EKT1461152530010105152023-05-04_16_08_16.297433.csv
<input type="checkbox"/>	EKT1461152530010105152023-05-05_10_09_13.601408.csv
<input type="checkbox"/>	EKT1461152530010105152023-05-05_10_10_49.405776.csv
<input type="checkbox"/>	EKT1461152530010105152023-05-10_11_47_04.436893.csv
<input type="checkbox"/>	EKT1461152530010105152023-05-12_10_34_29.452370.csv
<input type="checkbox"/>	EKT1461152530010106712023-04-20_13_08_10.950081.csv
<input type="checkbox"/>	EKT1461152530010106712023-05-11_15_07_25.092345.csv
<input type="checkbox"/>	EKT1461152530010106712023-05-12_09_37_39.976444.csv
<input type="checkbox"/>	EKT1461152530010106712023-05-12_10_36_00.142314.csv
<input type="checkbox"/>	EKT1461152530010106712023-05-12_13_58_24.399548.csv
<input type="checkbox"/>	EKT1461152530010106712023-05-12_14_09_06.908967.csv
<input type="checkbox"/>	EKT1461152530010132622023-05-03_15_32_04.979825.csv
<input type="checkbox"/>	EKT1461152530010132622023-05-03_15_35_37.692349.csv
<input type="checkbox"/>	EKT1461152530010132622023-05-03_15_47_28.095705.csv
<input type="checkbox"/>	EKT1461152530010132622023-05-05_10_24_02.517605.csv
<input type="checkbox"/>	EKT1461152530010151172023-05-09_15_14_09.049998.csv
<input type="checkbox"/>	EKT1461152530010151172023-05-12_11_25_12.843916.csv
<input type="checkbox"/>	EKT1461152530010158952023-04-27_14_58_07.269806.csv

- 7) A File Download dialog box will be displayed. Click **Save** and save the file to a location on your computer. The requested data will remain available for download for six months.

Note: Your computer must be able to open WinZip® files (zipped files) or you will not be able to open the saved file.



These are some of the data elements you will see:

- Begin and End date
- Provider number
- Claim number (ICN)
- Service Group
- Total billed amount
- Total paid amount
- Current status
- Member's first and last names
- R and S report date
- R and S report number
- Detail number (indicates the number of rows in a claim)
- Billing code
- Billing units
- Paid units
- Paid rate
- Modifiers
- Service code (example: 10c would be Day Habilitation)
- EOB codes

More Information about Claims Data Export

For those who would like more information, a video detailing the Claims Data Export feature of TexMedConnect is available on the Texas Medicaid & Healthcare Partnership's (TMHP's) YouTube channel. The [Claims Data Export](#) video is for LTC providers and financial management services agencies (FMSAs) and covers the following topics:

- Converting a Claims Data Export file to Excel
- Viewing cost reporting information in the Claims Data Export
- Working with data in the Claims Data Export

For more information, contact the LTC Help Desk at 800-626-4117, option 1.

Claims Status Inquiry (CSI)

CSI is used to determine the status of submitted claims. There are four different ways to perform a CSI:

- 1) Lookup Fee For Service Claim by Claim Request
- 2) Lookup Fee For Service Claim by Client Claim Request
- 3) Lookup Managed Care Claim by Transaction Number
- 4) Lookup Managed Care Claim by MCO ICN

TMHP will forward certain Institutional claims to MCOs. These claims can be set to the following statuses:

- Forwarded: The claim has been forwarded to (but not yet accepted or rejected by) an MCO.
- Rejected: The claim has been rejected by TMHP or the MCO to which it was forwarded.
- Accepted: The claim has been accepted by TMHP or an MCO.

Claims that are handled by TMHP, instead of an MCO, can be set to the following statuses:

- I: In Process
- D: Denied
- A: Approved for Payment
- FT: Forced Transfer
- S: Suspended
- T: Transferred
- P: Paid
- PF: Paid Forced Transfer
- PT: Paid Transfer
- PZ: Zero Net Balance to the Provider

Three years of claims history are available. The system returns a maximum of 250 results for each search. If your search returns more than 250 results, you may want to use the Claim Data export function. The CSI Search screen is shown below:

CSI Search

Lookup Fee For Service Claim by Claim Request

Claim Number: Format: 15 digits with no spaces

Lookup Fee For Service Claim by Client Claim Request

Provider NPI/API:

Service Begin Date: Format: mm/dd/ccyy

Service End Date: Format: mm/dd/ccyy

Select the appropriate Request Type

☒ Client ☐ Trainee

Client Information

Medicaid No.

Last Name

First Name

M.I.

Suffix

Lookup Managed Care Claim by Transaction Number

Transaction Number

Transaction Number Type

CSI Search: Lookup Fee For Service Claim by Claim Request

To search for a claim by Claim Request:

- 1) Enter the claim number in the Claim Number field and click **Lookup**.

CSI Search

Lookup Fee For Service Claim by Claim Request

Claim Number: Format: 15 digits with no spaces

- 2) The CSI Details page will be displayed and will autofill most of the fields, including the status of the claim. For SGs 1, 6, and 8, the detailed claim information includes the Total Applied OI Amount, as well as the OI Paid

Amount and Applied OI amount.

CSI Details
[New Lookup](#)

Claim Information

Claim No.	
Dates of Service	8/1/2014 - 8/1/2014
Status	D
Effective Date	9/10/2014
Service Group	1
Warrant Number	

Client Information

Client/Medicaid No./Trainee SSN	
Name	
Gender	
Date of Birth	
Patient Account No.	
Medical Record No.	
Referral No.	

Financial Information

Total Billed Amount	\$100.00
Total Paid Amount	\$0.00
Total Applied Other Insurance Amount	\$0.00
Budget Number	

Provider Information

Provider NPI/API	
Provider Name	
Medicare Patient Days %	0
Private Patient Days %	0
Medicaid Patient Days %	0

DTL No	Detail Status	Service Begin	Service End Date	Billing Code	Billed Amount	Paid Amount	OI Paid Amount	Applied OI Amount	Billed Units	Paid Units	Estimated Paid Unit Rate	Nat'l EOB1	Nat'l EOB2	Modifier 1
1	D	8/1/2014	8/1/2014		\$100.00	\$0.00	\$0.00	\$0.00	1.00	0.00	\$0.00			

CSI Search: Lookup Fee For Service Claim by Client Claim Request

When searching by client information, the following conditions apply:

- You must enter both a Service Begin Date and a Service End Date. The end date cannot be more than three consecutive months from the begin date.
 - The Service Begin Date cannot be more than 36 months before the current date.
- Click the **CSI** link under the CSI section on the navigation panel. The search criteria page will display.

Lookup Fee For Service Claim by Client Claim Request

Provider NPI/API: SEARCH / CLEAR

Service Begin Date: Format: mm/dd/ccyy

Service End Date: Format: mm/dd/ccyy

Select the appropriate Request Type

☒ Client ☐ Trainee

Client Information

Medicaid No.:

Last Name:

First Name:

M.I.:

Suffix:

Search

- Complete all fields that are indicated by a red dot.
- Click **Search**.

- 4) The CSI Details page will be displayed and will autofill with the client information.

CSI Details

[New Lookup](#)

Claim Information				Client Information			
Claim No.	[REDACTED]			Client/Medicaid No./Trainee SSN	[REDACTED]		
Dates of Service	8/1/2014 - 8/1/2014			Name	[REDACTED]		
Status	D			Gender	F		
Effective Date	9/10/2014			Date of Birth	8/24/1984		
Service Group	1			Patient Account No.	[REDACTED]		
Warrant Number	[REDACTED]			Medical Record No.	[REDACTED]		
Referral No.	[REDACTED]						

Financial Information				Provider Information			
Total Billed Amount	\$100.00			Provider NPI/API	[REDACTED]		
Total Paid Amount	\$0.00			Provider Name	[REDACTED]		
Total Applied Other Insurance Amount	\$0.00			Medicare Patient Days %	0		
Budget Number	[REDACTED]			Private Patient Days %	0		
				Medicaid Patient Days %	0		

DTL No	Detail Status	Service Begin	Service End Date	Billing Code	Billed Amount	Paid Amount	OI Paid Amount	Applied OI Amount	Billed Units	Paid Units	Estimated Paid Unit Rate	Nat'l EOB1	Nat'l EOB2	Modifier 1
1	D	8/1/2014	8/1/2014	RG008	\$100.00	\$0.00	\$0.00	\$0.00	1.00	0.00	\$0.00			

CSI Search: Lookup Managed Care Claim by Transaction Number

This section allows providers to use a transaction number to search for claims that have been forwarded to MCOs. An ETN is needed to search for these forwarded claims. An ETN is not the same as an MCO internal control number (MCO ICN) or as an ICN associated with FFS claims. An ETN is a 28-character alphanumeric value, the first eight characters of which are the Batch ID.

The status of the claim is shown in the Claim Information section on the Status line. The three possible statuses for a claim that has been forwarded to an MCO are:

- Forwarded
- Accepted (by the MCO)
- Rejected (by the MCO)

- In the Transaction Number field, enter the ETN of the claim that you are searching for, choose **TMHP EDI Trans No** from the Transaction Number Type drop-down menu, and click **Lookup**.

Lookup Managed Care Claim by Transaction Number

Transaction Number ◆

Transaction Number Type ◆

- 2) The MCO CSI Search Details page will be displayed and will autofill with the ETN in the Claim Information section.

MCO CSI Search Details

[New Lookup](#)
[Return To List](#)

Claim Information	
TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	
MCO Phone No	
MCO ICN	

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

EOB / EOPS codes messages	
EOB Code	EOB Description
01745	has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at for questions about processing of this claim.
JAH001AC	EOB from MCO for Accepted Claim.

This claim has been accepted to Long Term Support for processing. Contact Long Term Support at for questions related to this claim.

The following data is for informational purposes. For actual payments please contact the MCO.

Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	\$159.09	\$0.00	\$0.00	\$0.00	\$169.35

- 3) The status of the claim will be shown in the Claim Information section on the Status line.

MCO CSI Search Details

[New Lookup](#)
[Return To List](#)

Claim Information	
TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	
MCO Phone No	
MCO ICN	

- 4) The name and contact information of the MCO that received the forwarded claim is located in the Claim Information section.

Note: If any issues or questions arise regarding a claim that has been forwarded to an MCO, providers must

contact the MCO directly. TMHP cannot answer questions regarding claims rejected by an MCO.

MCO CSI Search Details

[New Lookup](#)
[Return To List](#)

Claim Information	
TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	
MCO Phone No	
MCO ICN	

5) The name and contact information of the MCO are identified in multiple places on the screen.

When TMHP forwards a claim to an MCO, TMHP will assign an EOB code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB code.

The last section on the screen, the Detail Service Line, will list information such as the billing code and the Informational Pricing amount (which is how TMHP would have priced the claim if it was processed as FFS for NF

Daily Care [SG 1, Service Code 1] and Medicare Coinsurance [Service Code 3]).

MCO CSI Search Details

[New Lookup](#) [Return To List](#)

Claim Information	
TMHP EDI Trans No	
Status	Forwarded
Status Date	12/8/2014 4:07:46 PM
MCO Name	
MCO Phone No	
MCO ICN	

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

EOB / EOPS codes messages	
EOB Code	EOB Description
01745	has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at for questions about processing of this claim.

This claim has been forwarded to for processing. Contact at 1-800- for questions related to this claim.

The following data is for informational purposes. For actual payments please contact the MCO.

Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	\$159.09	\$140.57	\$0.00	\$0.00	\$18.52

CSI Search: Lookup Managed Care Claim by MCO ICN

Providers can use an MCO ICN to search for claims that have been forwarded to MCOs. The ICN is assigned by the MCO that accepted the claim.

- 1) In the Transaction Number field, enter the **MCO ICN** of the claim for which you are searching and choose MCO ICN from the Transaction Number Type drop-down menu. Because multiple MCOs may have similar ICN numbering strategies, you must choose the appropriate payer name from the drop-down menu, and click **Lookup**.

Lookup Managed Care Claim by Transaction Number

Transaction Number *		Payer Name *	<div>Select</div> <div> Amerigroup Long Term Support Cigna Long Term Care Molina Long Term Care Superior Nursing Facility United Healthcare Long Term Care </div>
Transaction Number Type *	MCO ICN		
<input type="button" value="Lookup"/>			

- 2) The MCO CSI Search Details page will be displayed and will autofill with the MCO ICN in the Claim Information section. This MCO CSI Search Details screen will be identical to the one that is generated when searching using an ETN or clicking the hyperlink from the Batch History screen.

TMHP will assign an EOB code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB code.

The last section on the screen, the Detail Service Line, will list information such as the billing code and details in the Informational Pricing amount (which is how TMHP would have priced the claim if it was processed as FFS for NF Daily Care [SG 1, Service Code 1] and Medicare Coinsurance [Service Code 3]).

MCO CSI Search Details

[New Lookup](#)
[Return To List](#)

Claim Information	
TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	
MCO Phone No	
MCO ICN	

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

EOB / EOPS codes messages	
EOB Code	EOB Description
01745	has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at for questions about processing of this claim.
JAH001AC	EOB from MCO for Accepted Claim.

This claim has been accepted to Long Term Support for processing. Contact Long Term Support at for questions related to this claim.

The following data is for informational purposes. For actual payments please contact the MCO.

Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	\$159.09	\$0.00	\$0.00	\$0.00	\$169.35

Creating a CSI Group Template

The Group Template feature allows you to create a list of people for whom you would like to verify eligibility.

To create a CSI group template and add a person:

- 1) Click **Group Template** under the CSI section in the navigation panel.



- 2) The MESAV/CSI Group Template screen will open. Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and then click **Continue**.

A screenshot of the 'MESAV/CSI Group Template' screen. The title 'MESAV/CSI Group Template' is at the top in blue. Below the title, there is a label 'Select NPI/API & Provider No. :' followed by a drop-down menu. The drop-down menu shows the selected value '1447881974 / 001031045' with a downward arrow. At the bottom of the screen, there is a button labeled 'Continue >>' which is highlighted with a red rectangular box.

- 3) If you have already created a group and want to add a person to an existing group template, click the link from the list displayed in the Name of the group column and skip to Step 5.

MESAV/CSI Group Template

NPI/API XXXXXXXXXX / Provider No. XXXXXXXXXX

New Group:

Name of the group	User ID	Created Date	Last Updated Date	
XXXXXXXXXX	XXXXXXXXXX	10/01/2008	10/16/2008	Delete
XXXXXXXXXX	XXXXXXXXXX	10/01/2008	09/02/2014	Delete
XXXX	XXXXXXXXXX	10/08/2008	08/14/2009	Delete
XXXX	XXXXXXXXXX	10/08/2008	10/08/2008	Delete

- 4) If you have not created a group or want to add a person to a new group template, enter the New Group name of your choice and click **Add Group**.

MESAV/CSI Group Template


NPI/API XXXXXXXXXX / Provider No. XXXXXXXXXX


New Group:

- 5) To add a person to the group template, click **Add Client**.

MESAV/CSI Group Template - XXXXXXXXXX

NPI/API XXXXXXXXXX / Provider No. XXXXXXXXXX

From Date of Service:  Format mm/dd/yyyy

To Date of Service:  Format mm/dd/yyyy

Select All	First Name	Last Name	Client #	SSN	Date of Birth			
<input type="checkbox"/>	XXXX	XXXX	XXXXXXXXXX		XXXX/XXXX	MESAV	CSI	Delete

6) The Add Client page will open. Enter the person's information. If you do not have the person's client number, you must use one of the following combinations to find the person:


- Social Security number and last name
- Social Security number and date of birth
- Last name, first name, and date of birth

Add Client

NPI/API XXXXXXXXXX / Provider No. XXXXXXXXXX

Client Number:

Social Security Number:

Date of birth: 

First name:

Last name:

Lookup Criteria

Client #
or Combination of SSN and DOB
or First Name, Last Name and DOB
or SSN and Last Name.

Lookup

Go Back


7) Click **Lookup**.

Add Client

NPI/API XXXXXXXXXX / Provider No. XXXXXXXXXX

Client Number:

Social Security Number:

Date of birth: 

First name:

Last name:

Lookup Criteria

Client #
or Combination of SSN and DOB
or First Name, Last Name and DOB
or SSN and Last Name.


Lookup

Go Back

8) To add the person, click **Add to group**.

Add Client

NPI/API / Provider No.

Client Number:
Social Security Number:
Date of birth: 
First name:
Last name:

Lookup Criteria
Client #
or Combination of SSN and DOB
or First Name, Last Name and DOB
or SSN and Last Name.

First Name	Last Name	Client #	SSN	Date of Birth	
					<input type="button" value="Add to group"/>

9) The person will be added to the CSI group template that you are working on.

The Group Template feature allows you to create up to 100 groups for each NPI or API and provider number. Each group can contain up to 250 people, and you have the option to view, add, and delete people from the groups.

Submitting a CSI Group Template

To verify eligibility using a group template:

1) Click **Group Template** under the CSI section in the left navigation panel.

- Long Term Care
 - MESAV
 - MESAV
 - Group Template
 - MESAV Batch History
 - Claims
 - Claims Entry
 - Individual Template
 - Group Template
 - Drafts
 - Pending Batch
 - Batch History
 - Claim Data Export
 - Data Export Request
 - Data Export Downloads
 - CSI
 - Group Template**
 - Adjustments
 - R and S
 - ANSI 835

- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

MESAV/CSI Group Template

Select NPI/API & Provider No. :

- 3) Select one of the templates listed in the Name of the group column to open the group list.

MESAV/CSI Group Template

NPI/API / Provider No.

New Group:

Name of the group	User ID	Created Date	Last Updated Date	
<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	10/01/2008	09/02/2014	Delete
<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	10/08/2008	10/14/2015	Delete
<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	10/08/2008	10/08/2008	Delete
<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	10/08/2008	09/09/2015	Delete
<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	04/06/2009	09/09/2015	Delete
<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	04/06/2009	09/09/2015	Delete
<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	07/14/2009	09/17/2015	Delete
<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	07/30/2009	09/25/2015	Delete

- 4) Enter a date range in the From Date of Service and To Date of Service fields. The date range can be up to three months long.

MESAV/CSI Group Template -

NPI/API / Provider No.

From Date of Service: Format mm/dd/yyyy

To Date of Service: Format mm/dd/yyyy

Select All	First Name	Last Name	Client #	SSN	Date of Birth			
<input type="checkbox"/>	<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	<input type="text" value="0000000000"/>	MESAV	CSI	Delete

- 5) Check the individual boxes of the templates that you want to submit, or to submit all templates check the **Select All** box.

MESAV/CSI Group Template - [\[Link\]](#)

[Go Back](#) [Add Client](#)

NPI/API [\[Link\]](#) / Provider No. [\[Link\]](#)

From Date of Service: Format mm/dd/yyyy
 To Date of Service: Format mm/dd/yyyy

Select All	First Name	Last Name	Client #	SSN	Date of Birth			
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete

[Submit MESAV Batch](#)

- 6) Click **Submit MESAV Batch** at the bottom left of the screen. The batch will process and be ready for viewing within 24 hours.

<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete
<input type="checkbox"/>	ALAN	ALAN	000000000		00/00/0000	MESAV	CSI	Delete

[Submit MESAV Batch](#)

Adjustments

Creating an Adjustment for an FFS Claim

An adjustment is a change made to a previously paid claim. Adjustments are made to reimburse the Texas Health and Human Services Commission (HHSC) for overpayments and to allow providers to modify claims that were initially billed incorrectly. Only claims that are set to the Paid status can be adjusted using TexMedConnect. If you submit an adjustment then, you must return the amount that you were paid, not the amount that was billed.

Note: Providers must contact MCOs directly to make adjustments to claims forwarded by TMHP.

To make an adjustment on an FFS claim:

- 1) Click **Adjustments** under the CSI section in the navigation panel.



You may search for the claim by Claim Request, Client Claim Request, or Transaction Number.

Adjustment

To proceed, please search for the claim to be adjusted

Lookup Fee For Service Claim by Claim Request

Claim Number: Format: 15 digits with no spaces

Lookup Fee For Service Claim by Client Claim Request

Provider NPI/API:

Service Begin Date: Format: mm/dd/ccyy

Service End Date: Format: mm/dd/ccyy

Select the appropriate Request Type

☒ Client ☐ Trainee

Client Information

Medicaid No.

Last Name

First Name

M.I.

Suffix

Lookup Managed Care Claim by Transaction Number

Transaction Number

Transaction Number Type

- a) To search by Claim Request, enter the claim number and click **Lookup**.

Adjustment

To proceed, please search for the claim to be adjusted

Lookup Fee For Service Claim by Claim Request

Claim Number: Format: 15 digits with no spaces

- b) If you do not know the claim number, you can search for the claim using the person's demographic information. Enter the required information and click **Search**.

Lookup Fee For Service Claim by Client Claim Request

Provider NPI/API: ●

Service Begin Date: ●

Service End Date: ●

Format: mm/dd/ccyy

Format: mm/dd/ccyy

Select the appropriate Request Type

☒ Client ☐ Trainee

Client Information

Medicaid No. ●

Last Name ●

First Name ●

M.I.

Suffix

Search

- The date range cannot be longer than three months.
- You must enter both a Service Begin Date and a Service End Date.
- The Service Begin Date cannot be more than 36 months before the current date.
- You must complete all the fields that are indicated by a red dot.

Lookup Fee For Service Claim by Client Claim Request

Provider NPI/API: ●

Service Begin Date: ●

Service End Date: ●

Format: mm/dd/ccyy

Format: mm/dd/ccyy

Select the appropriate Request Type

☒ Client ☐ Trainee

Client Information

Medicaid No. ●

Last Name ●

First Name ●

M.I.

Suffix

Search

- c) You can also search for the claim by using the transaction number. Enter the transaction number and select the transaction number type from the drop-down menu. Then click **Lookup**.

Lookup Managed Care Claim by Transaction Number

Transaction Number ●

Transaction Number Type ●

Select ▼

Lookup

- 2) The search result is displayed. If more than one claim number with the same service dates and bill code is displayed as a result of your search, you can adjust the claim only with the most recent processing (or status) date. Providers can determine the most recent claim by comparing the Claim Status Dates, which are also known as the Effective Dates. To determine the most recent claim, click on the hyperlink for each claim in the list for the date range and compare the Effective Dates of each claim. Adjust the claim number with the most recent Effective Date. Click the claim number to begin adjusting the claim.

CSI Search Results

[New Lookup](#)
[Return with Search Criteria](#)

Search Criteria
 NPI/ Provider No. 1234567890
 Dates of Service 11/1/2012 - 12/31/2012
 Client No./Trainee SSN 0123456789

Service Dates		Client Information		Claim Information			
From	To	Name	Client No. / Trainee SSN #	Provider Number	Status	Billed Amt	Paid Amt
11/2/2012	11/2/2012	JOHN DOE	0123456789	000000123456789	P	\$218.60	\$175.00
11/16/2012	11/16/2012	JOHN DOE	0123456789	1234567890000000	P	\$3,324.75	\$3,324.75
11/29/2012	11/29/2012	JOHN DOE	0123456789	000123456789000	P	\$152.75	\$152.75
12/10/2012	12/10/2012	JOHN DOE	0123456789	000001234567890	PZ	\$0.00	\$0.00

- 3) Select the appropriate Claim Type from the drop-down menu and click **Adjust Claim**.

Select the appropriate Claim Type for this Claim to Adjust

Claim Type: ●

Unknown
 Unknown
 Professional
 Institutional
 Dental
 NAT
 Expedited

Adjust Claim

Claim Information

Claim No.	000000123456789
Dates of Service	9/3/2012 - 9/6/2012
Status	P
Effective Date	12/7/2012
Service Group	1
Warrant Number	10005

Financial Information

Total Billed Amount	\$175.00
Total Paid Amount	\$218.60
Total Applied Other Insurance Amount	\$60.00
Budget Number	

Client Information

Client/Medicaid No./Trainee SSN	0123456789
Name	JOHN DOE
Gender	M
Date of Birth	10/11/1949
Patient Account No.	
Medical Record No.	
Referral No.	

Provider Information

Provider NPI/API	1234567890
Provider Name	REGIONAL MEDICAL CENTER
Medicare Patient Days %	0
Private Patient Days %	0
Medicaid Patient Days %	0

DL No	Detail Status	Service Begin	Service End	Billing Code	Billed Amount	Paid Amount	QI Paid Amount	Applied QI Amount	Billed Unit
1	P	9/3/2012	9/3/2012	R0002	\$65.00	\$109.30	\$30.00	\$30.00	1.00

- 4) Verify that all the required fields that are indicated by a red dot are filled out for each tab.

- 5) On the Client tab, verify that the information is correct and that there is a referral number on the Professional claim.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Professional		1699817007/000010100	New	

Client

Provider

Claim

Details

Other Insurance / Finish

Client Identification Numbers

Client ID

Patient Account No.

Medical Record No.

Name and Address

First Name

Last Name

MI

Suffix

Street Address

Street Address 2

City

State

Zip

Client General Information

Gender

Date Of Birth

Referral No.

Save Draft

Save Template

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Finish

- 6) On the Provider tab, select the ID qualifier from the ID Qual drop-down menu and enter the other ID number in the Other ID field. If the Rendering Provider is different from the Attending Provider, that person's information should be added.

Claim Submission - Step 2

Claim Type | Client | Provider | Status | Claim No.

Professional | XXXXXXXXXXXX | New

Client | Provider | Claim | Details | Other Insurance / Finish

Billing Provider

NP/ID: XXXXXXXXXX / XXXXXXXXXX ▼

Name: XXXXXXXXXX / XXXXXXXXXX / XXXXXXXXXX

Address: XXXXXXXXXX / XXXXXXXXXX / XXXXXXXXXX

City: XXXXXXXXXX / XXXXXXXXXX / XXXXXXXXXX

State: XXXXXXXXXX / XXXXXXXXXX / XXXXXXXXXX

Zip: XXXXXXXXXX / XXXXXXXXXX / XXXXXXXXXX

• ID Qual XXXXXXXXXX ▼

• Other ID XXXXXXXXXX

Performing Provider

NP/ID/PI First Name Last Name MI Suffix

XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX

Referring Provider (Not required, only enter if Referring Provider is different than Billing Provider. Name must be a person, not an organization)

NP/ID/PI First Name Last Name MI Suffix

XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX XXXXXXXXXX

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- 7) On the Claim tab, select a Claim File Indicator Code from the drop-down menu. Select a Place of Service from the drop-down menu. Both institutional and professional claims require a valid diagnosis code. Entering an invalid diagnosis code may result in an error message (and subsequent inability to submit a claim) in TexMedConnect. Use the Qualifier field to indicate whether the diagnosis code is an ICD-9 or ICD-10 code. The correct value is an ICD-10 code.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Professional			New	

Client	Provider	Claim	Details	Other Insurance / Finish
<p>Claim</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <ul style="list-style-type: none"> • Claim File Indicator Code <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> MC Medicaid VA Veteran Administration Plan Refers to Veteran's Affairs Plans </div> <p>Diagnosis</p> <div style="margin-top: 10px;"> <ul style="list-style-type: none"> • Qualifier ▼ <div style="border: 1px solid gray; padding: 2px; margin-top: 5px;">Add New Diagnosis</div> </div> </div> <div style="width: 50%;"> <ul style="list-style-type: none"> • Place of Service <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 03 School 04 Homeless Shelter 11 Office 12 Home 13 Assisted Living Facility 14 Group Home 22 Outpatient Hospital 24 Ambulatory Surgical Center 33 Custodial Care Facility 34 Hospice 41 Ambulance Land 42 Ambulance - Air or Water 49 Independent Clinic 50 Federally Qualified Health Center 53 Community Mental Health Center 62 Comprehensive Outpatient Rehabilitation 71 State or Local Public Health Clinic 72 Rural Health Clinic 99 Other Place of Service </div> </div> </div>				

	+ Code			
1				Delete

- 8) On the Details tab, the system will autofill the negative row(s) with the data that was paid on the initial claim. The Unit, Unit Rate, and Line Item Total fields will be autofilled and read-only. The fields OI and AI/Co-Pay on the negative row(s) will always be autofilled to 0. The user should not attempt to modify these fields on the negative row(s). If the initial claim to be adjusted had multiple details, all the claim detail rows will show up as negative line details. If the provider does not wish to adjust all the rows on the initial claim, then they will need to delete the rows they do not wish to adjust by using the **Delete** button on the right side of the row. The line item total will be in parentheses. If the adjustment is to return the entire amount of the claim, there is no need to click **Add New Details Row(s)**.

Claim Submission - Step 2

Claims Type

Client

Provider

Status

Claim No.

Client

Provider

Claim

Details

Other Insurance / Finish

Number of details to add: 1

Add New Details Row(s)

Copy Row

Line Item Control N	Service Dates		Procedure Code		Mode				Units	Unit Rate	Line Item Total	Co-Pay	Rev Code	OI Paid Amount	Rendering Provider					Delete	
	Start	End	Qualifier	Code	1	2	3	4							NPI/API	First Name	Last Name	MI	Suffix		
1									0	\$0.00	\$0.00	\$0.00		\$0.00							Delete

☒ Co-Pay
 ☐ Applied Income

Claim Total: \$0.00

Total Co-Pay: \$0.00

Total Other Insurance: \$0.00

(from Details Tab)

Total Other Insurance: \$0.00

(from Other Insurance/Finish Tab)

- 9) To bill positive units for the same adjusted claim, click **Add New Details Row(s)**. On the new row, you will add the dates of service and the accurate number of units that are to be paid. After the rate is entered, tab over to the Applied Income field. The Applied Income or Co-Pay will be calculated automatically. At the bottom left of the screen, the Claim Total and the Total Applied Income or Co-Pay that was deducted from the positive line will be displayed. The provider should also fill in the OI field on the positive line (if applicable).

Claim Submission - Step 2

Client

Provider

Claim

Details

Other Insurance / Finish

Number of details to add: 1

Add New Details Row(s)

Copy Row

Line Item Control ID	Service Dates		Procedure Code	Mod				Units	Unit Rate	Line Item Total	Applied Income	Rev Code	OT Paid Amount	Rendering Provider					Delete	
	Start	End		Qualifier	Code	1	2							3	4	NPI/API	First Name	Last Name		MI
1								0	\$0.00	\$0.00	\$0.00		\$0.00							Delete

☐ Co-Pay
 ☒ Applied Income

Claim Total: \$0.00

Total Applied Income: \$0.00

Total Other Insurance: \$0.00

(from Details Tab)

Total Other Insurance: \$0.00

(from Other Insurance/Finish Tab)

Saving and Submitting an Adjustment

All adjustments must be submitted as batches.

To save a Professional or Dental claim adjustment as a batch:

- 1) Select the Other Insurance/Finish tab, select the **Save to Batch** radio button, check the **We Agree** box, and click **Finish** in the lower right corner.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Professional	DOROTHY HARDINK	1215969829/001013238	Adjustment	491016264002316

• You are logged on as a TMHP Employee. By clicking the Finish button, this claim will be sent to CMS for front end edits only. This claim will not be fully processed by CMS. Test claims should only be submitted interactively. DO NOT SAVE TO BATCH.

ClientProviderClaimDetailsOther Insurance / Finish

Finish Options

Please select one of the following and click finish

☐ Submit
Submits the claim interactively

☒ Save to Batch
Saves the claim to batch for processing later.

Certification, Terms And Conditions

Please review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Providers and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP "Terms and Conditions".

☐ We Agree

Save DraftSave TemplateSave To GroupPrevNextFinish

- 2) For Institutional claims, check the box under Attestation, select the **Save to Batch** radio button, check the **We Agree** box, and click **Finish**.

Note: For claims in SG 1, 6, and 8, the OI Paid Amount entered in the Details tab must equal the OI Paid Amount in the Other Insurance/Finish Tab.

* You are logged on as a TMHP Employee. By clicking the Finish button, this claim will be sent to CMS for front end edits only. This claim will not be fully processed by CMS. Test claims should only be submitted interactively. DO NOT SAVE TO BATCH.

Client Provider Claim Details **Other Insurance / Finish**

TMHP records indicate that this client has the following Long Term Care-relevant other insurance coverage for the date(s) of service billed on this claim. In order for this claim to be considered for Medicaid reimbursement, the identified third party resources must be billed prior to Medicaid, and the resulting disposition must be entered below. If any of the identified third party resources are not liable for the services billed on this claim, you must indicate the reason the other insurance carrier denied the claim.

If you believe the information on file at TMHP for this client is invalid, please call the TMHP Third Party Liability department at 1-800-626-4117, Option 6. Real time insurance updates are viewable upon click of the Insurance Refresh tool. Please note: Any data entered on this tab during your current user session will be lost when the Insurance Refresh tool is clicked.

[Insurance Refresh](#)

If you believe the information on file at TMHP for this client is valid but requires an update, please click the 'Update Policy' button. Modified information will be sent to the TMHP Third Party Liability department for verification prior to permanently updating TMHP records. Check the client's MESAV within 10 business days for updated policy information. (Please note: This claim will be processed using the information currently on file at TMHP.)

Client has no known Long Term Care-relevant other insurance coverage for the date(s) of service on file at TMHP

If you are aware of additional Long Term Care-relevant other insurance coverage for this client that is not on file at TMHP, you are required to add that coverage on the claim and enter the disposition information. To enter a new policy, click the 'Add New Policy' button.

[Add Policy](#)

☒ By checking this box, you attest to the fact that you understand that Federal regulations dictate that the Medicaid Program is the payer of last resort and that the client has no additional third party coverage that is relevant to the service(s) billed on this claim. You further attest that the information entered on this claim is true and accurate when present and that every Explanation of Benefits (EOB) received from the other insurance carrier(s) is kept on file.

Medicare Information

Claims for Nursing Facility Medicare Skilled stays must be billed separately from other claims. When billing a Medicare Skilled stay, an amount must be entered in only one of the fields below. For clients with traditional Medicare, enter the **total coinsurance amount due** per the Medicare Remittance Advice in the Medicare Part A Total Amount field. For clients with non-traditional Medicare Part C, enter the **total copay/deductible amount due** per the Medicare Part C Explanation of Benefits (EOB) in the Medicare Part C Total Amount field. The amount entered below must equal the sum of all Medicare Skilled stay detail lines on this claim.

Medicare Part A Total Amount (based on standard rate) Medicare Part C Total Amount

☐ By checking this box, you attest to the fact that the Medicare Part A or Part C documentation to support this claim is kept on file. You further attest that the Medicare Part A or Part C information entered on this claim is true and accurate, and that you understand that Medicaid is the payer of last resort.

Finish Options

Please select one of the following and click finish

☐ Submit

☒ **Save to Batch**
Saves the claim to batch for processing later

Certification, Terms And Conditions

Please review the following certification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

The Provider and Claim Submitter certify that the information supplied on the claim form and any attachments or accompanying information constitute true, correct, and complete information. The Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that falsifying entries, concealment of a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable Federal and/or state law. Fraud is a felony, which can result in fines or imprisonment.

By checking "We Agree", you agree and consent to the Certification above and to the TMHP Terms and Conditions:

☒ **We Agree**

Save Draft Save Template Save To Group [Print](#) [Next](#) [Finish](#)

Review your batch history to ensure that the adjustment was successfully processed. The submission of the pending batch is initially Accepted but can be Rejected after the additional system edits are applied. Refer to the “Submitting a Batch” section of this user guide for information about submitting batches.

Remittance and Status (R&S) Reports

R&S Reports are generated on Mondays and Wednesdays.

- R&S Reports that are generated on Mondays cover the claims that were submitted the previous week between Tuesday after close of business until close of business on Friday.
- R&S Reports that are generated on Wednesdays cover the claims that were submitted from the previous Friday after close of business until close of business Tuesday of the current week.

The R&S function in the left navigation panel has the following two options:

- PDF: Displays the R&S in a PDF version of the paper R&S.
- ANSI 835: Allows you to download the American National Standards Institute (ANSI) 835 version of the R&S Report. This file is for providers that use third-party billing software or third-party billing agents.

Note: An additional resource that can assist LTC providers with R&S Reports is the [Remittance and Status Reports for LTC Providers Quick Reference Guide \(QRG\)](#).

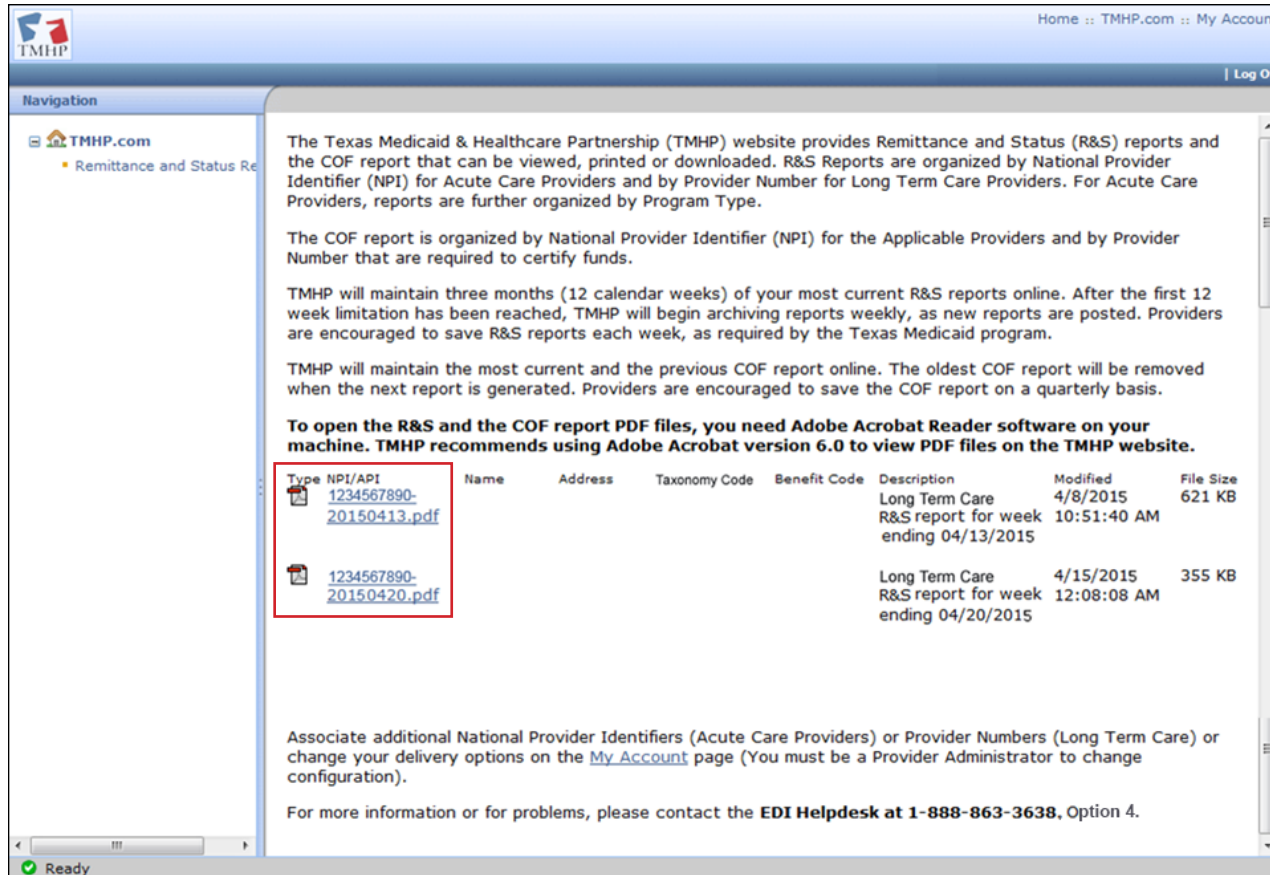
Viewing the PDF Version

To view the PDF version of the R&S Report:

- 1) Click **R and S** in the left navigation panel.



- 2) Select the NPI or API for which you'd like to view R&S Reports. Some providers will only have one NPI or API, whereas other providers will have more than one.





The Texas Medicaid & Healthcare Partnership (TMHP) website provides Remittance and Status (R&S) reports and the COF report that can be viewed, printed or downloaded. R&S Reports are organized by National Provider Identifier (NPI) for Acute Care Providers and by Provider Number for Long Term Care Providers. For Acute Care Providers, reports are further organized by Program Type.

The COF report is organized by National Provider Identifier (NPI) for the Applicable Providers and by Provider Number that are required to certify funds.

TMHP will maintain three months (12 calendar weeks) of your most current R&S reports online. After the first 12 week limitation has been reached, TMHP will begin archiving reports weekly, as new reports are posted. Providers are encouraged to save R&S reports each week, as required by the Texas Medicaid program.

TMHP will maintain the most current and the previous COF report online. The oldest COF report will be removed when the next report is generated. Providers are encouraged to save the COF report on a quarterly basis.

To open the R&S and the COF report PDF files, you need Adobe Acrobat Reader software on your machine. TMHP recommends using Adobe Acrobat version 6.0 to view PDF files on the TMHP website.

Type NPI/API	Name	Address	Taxonomy Code	Benefit Code	Description	Modified	File Size
 1234567890-20150413.pdf					Long Term Care R&S report for week ending 04/13/2015	4/8/2015 10:51:40 AM	621 KB
 1234567890-20150420.pdf					Long Term Care R&S report for week ending 04/20/2015	4/15/2015 12:08:08 AM	355 KB

Associate additional National Provider Identifiers (Acute Care Providers) or Provider Numbers (Long Term Care) or change your delivery options on the [My Account](#) page (You must be a Provider Administrator to change configuration).

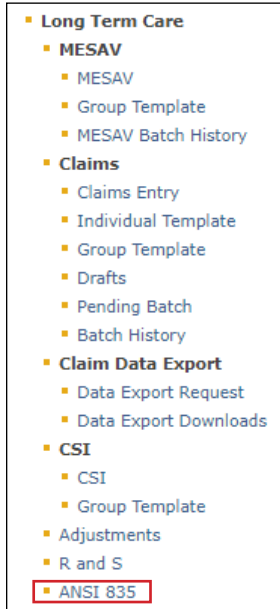
For more information or for problems, please contact the **EDI Helpdesk at 1-888-863-3638**, Option 4.

Downloading the ANSI 835 Version

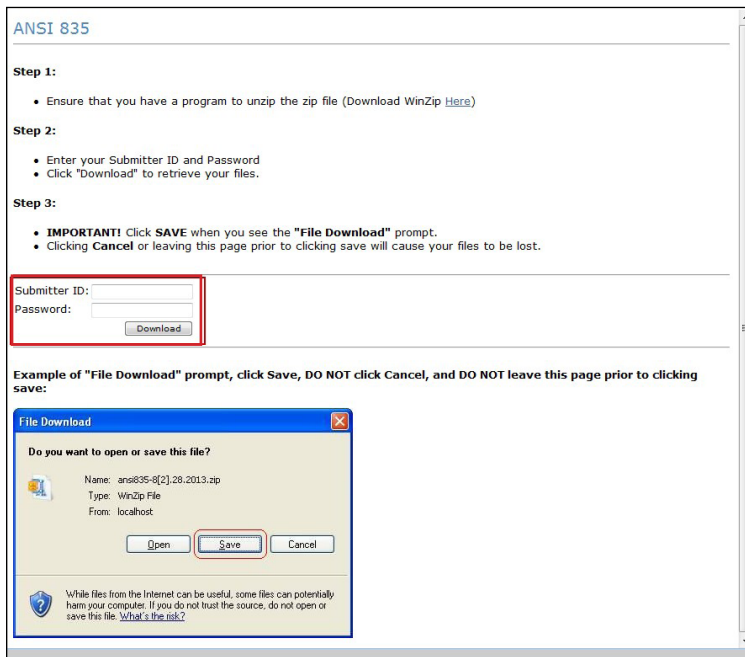
You can access the 835 non-pending Electronic Remittance and Status (ER&S) Report and the pending ER&S Report through TexMedConnect.

To download the ANSI 835 version of the R&S Report:

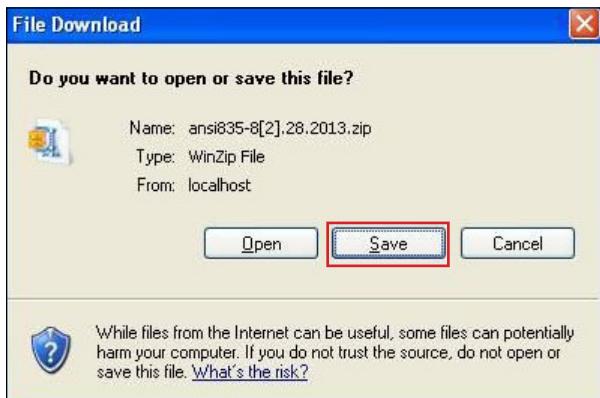
- 1) Click **ANSI 835** in the left navigation panel.



- 2) Enter your submitter ID and password and click **Download**. If you do not know your submitter ID and/or password, contact the EDI Help Desk at 888-863-3638, option 4, from 7:00 a.m. to 7:00 p.m. Central time, Monday through Friday.



3) Click **Save** and download the file to a location on your computer.



Note: Third-party software vendors, third-party billing services, and providers that program their own software can find information about the requirements for EDI ANSI X12 file types in the EDI Companion Guides, which are located on the EDI page of the TMHP website at www.tmhp.com.

Claims Identified for Potential Recoupment (CIPR) Reports

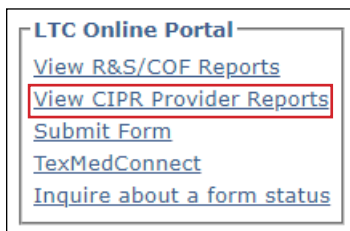
TMHP provides CIPR Provider Reports to LTC providers that can be downloaded and viewed. When TMHP learns of a person's third-party insurance policies with retroactive dates of coverage, claims previously reimbursed by Medicaid will be identified if the claim would have been processed differently based on the third-party resource. The CIPR Provider Report contains this list of impacted claims, along with the insurance company information for the corresponding policy. Providers have 120 calendar days to adjust any claims on a CIPR report to address the updated OI information. If the claims are not adjusted, the identified claims will be recouped after the 120 calendar days.

CIPR Provider Reports are generated on a weekly basis, and TMHP maintains each CIPR Provider Report for six months. The CIPR is available in PDF format. TMHP recommends using Adobe Acrobat® version 6.0 or higher to view PDF files on the TMHP website. If a provider believes that the OI information on file is incorrect, they should contact the TMHP TPL Resource Line at 800-626-4117.

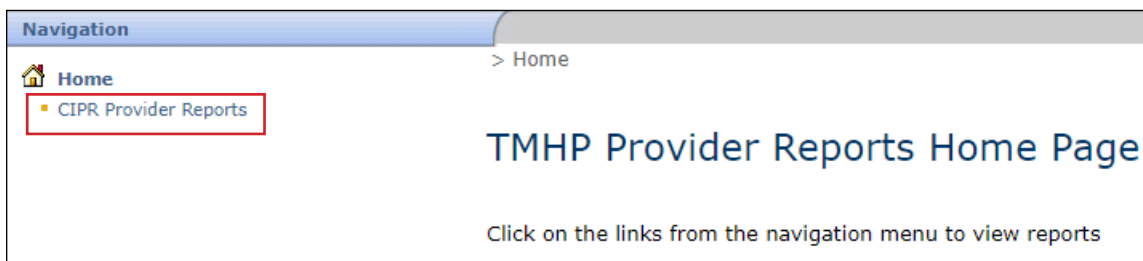
- 1) Click **My Account** in the top right corner of the TexMedConnect web page.



- 2) Click **View CIPR Provider Reports** under the LTC Online Portal section.



- 3) Click **CIPR Provider Reports** in the Navigation column to the left.



- 4) From the list of NPI/API numbers in the left column, click the number you want to see the report for.

Navigation

Home > CIPR Provider Reports

Home

CIPR Provider Reports

CIPR Provider Reports

The Texas Medicaid & Healthcare Partnership (TMHP) provides Claims Identification (CIPR) reports to providers. These reports identify claims that have been denied by third-party insurance policies with retroactive dates of coverage, claims previously paid by Medicaid, or claims that have been identified as impacted claims, along with the insurance company information for each claim.

For each claim identified on the CIPR Provider Report, providers are required to submit a CIPR Provider Report, indicating the Other Insurance Disposition Information required by the state.

If claims are not adjusted within 120 calendar days of identification (i.e. denied by third-party insurance), the claim will be identified as impacted. Reports will be generated on a weekly basis, and TMHP will maintain each report for 12 months.

To open the CIPR Provider report in PDF format, you need Adobe Acrobat Reader.

Click on NPI/API to view CIPR Provider Reports

NPI/API	Provider Number	Name
1225022908	001004638	PARK MANOR HEALTH CARE & REHABILITATION
1861428245	000729101	WELLES HARBOR
1861428245	001017222	TRINITY HOME HEALTH SERVICES

Note: For each claim identified on the CIPR Provider Report, providers are required to submit a claim to the appropriate third-party resource for the services that were previously submitted to Medicaid.

Appendix: Using the LICN Field for HCS and TxHmL Waiver Programs

The Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs use the line item control number (LICN) field in TexMedConnect. TMHP allows claims to be submitted per HHSC billing guidelines, where the individual who provided the HCS or TxHmL service delivery must be identified using the LICN field. These services are identified in the [HHSC LTC Bill Code Crosswalk](#) as either requiring a Staff ID, a Texas EVV Attendant ID, or, in the case of Nursing and Transportation Services, a label that indicates the accumulated units.

HCS and TxHmL Waiver Programs may refer to the [HHSC LTC Bill Code Crosswalk](#) for guidance on when the LICN field must be used and which segments of the LICN field are required. Proper use of the LICN field will prevent claim mismatches, denials, or rejections.

The current instruction for the HCS and TxHmL LICN field in TexMedConnect is the following:

- Positions 1–4 are in military-time format, are always required, and represent the claim sequence number.
 - Positions 1–2 will range from 00–23.
 - Positions 3–4 will range from 00–59.
 - Format edits apply to certain table-driven SGs and service codes.
 - The claim sequence number must be unique when there are multiple claim details for the same service on the same day.
- Positions 5–20 are for either the Texas EVV Attendant ID, the Dummy ID, or the Staff ID.
 - For billing an EVV service, use the Texas EVV Attendant ID. EVV visit units may be submitted rolled up by the NPI per existing functionality.
 - For CFC PAS/HAB claims, you must enter the Texas EVV Attendant ID from the visit displayed in the EVV system. If characters not matching the Texas EVV Attendant ID are entered on an EVV Claim, it will be denied.
 - The Texas EVV Attendant ID is not required by HCS and TxHmL programs for in-home respite and in-home day habilitation. Submit information in Positions 1–4 as instructed above in the LICN field to avoid receiving an EVV04 claim mismatch.
 - If positions 5–20 are not used, then the NPI or API will continue to be used for EVV claim matching. Refer to [HCS and TxHmL Best Practices to Avoid EVV Claim Mismatches](#) for more information.
 - For billing Nursing and Transportation Services, use one of the following Dummy IDs:
 - ACCUM.NUR
 - ACCUM.NUL
 - ACCUM.NURS
 - ACCUM.NULS

- ACCUM.TR
- For billing non-accumulated services, use the Staff ID in the “LastName,FirstName” (with no spaces) format.
- Positions 21–30 are for the internal claim ID. The internal claim ID will be used to reconcile the 837 claim to the 835 Remittance.

This document is produced by TMHP Training Services. Contents are current as of the time of publishing and are subject to change. Providers should always refer to the TMHP website for current and authoritative information.