



# Long-Term Care (LTC) User Guide for TexMedConnect



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP  
A STATE MEDICAID CONTRACTOR

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# Terms and Abbreviations

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
HHS	Health and Human Services
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
TMHP	Texas Medicaid & Healthcare Partnership

# Adjustments

## Creating an Adjustment for a Fee-For-Service Claim

An adjustment is a change made to a previously paid claim. Adjustments reimburse Health and Human Services (HHS) for overpayments and to reimburse providers if units were underbilled and must be paid correctly. Only claims that are set to status **Paid** can be adjusted using TexMedConnect. If you submit an Adjustment, 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.*

- 1) To make an adjustment on a fee-for-service claim, click the **Adjustments** link under the CSI section on the navigation panel.



2) Option one, enter the claim number, and click the **Lookup** button.

### 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

3) Option two, if you do not know the claim number, you can search for the claim using the person's information. Enter the required information, and click the **Search** button.

- The date range must be no more than three months long.
- 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 of the fields that are indicated by a red dot.

### 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

4) 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 only adjust the claim with the most current processing (or status) date. Click the claim number to begin adjusting the claim. Providers can determine the most recent claim by comparing the Claim Status Dates, also known as the Effective Date. To determine which claim is the most recent, click on the hyperlink for each claim in the list for your date range and compare the effective dates of each claims. Whichever claim has the most recent Effective Date is the one that needs to be adjusted.

#### CSI Search Results

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

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**Search Criteria**

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

**Search Results**

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	<a href="#">000000123456789</a>	P	\$218.60	\$175.00
11/16/2012	11/16/2012	JOHN DOE	0123456789	<a href="#">123456789000000</a>	P	\$3,324.75	\$3,324.75
11/29/2012	11/29/2012	JOHN DOE	0123456789	<a href="#">000123456789000</a>	P	\$152.75	\$152.75
12/10/2012	12/10/2012	JOHN DOE	0123456789	<a href="#">000001234567890</a>	PZ	\$0.00	\$0.00

5) Select the appropriate Claim Type from the drop-down box, and click the **Adjust Claim** button.

Select the appropriate Claim Type for this Claim to Adjust

Claim Type: Unknown Adjust Claim

Claim Information		Client Information	
Claim No.	000000123456789	Client/Medicaid No./Trainee SSN	0123456789
Dates of Service	9/3/2012 - 9/6/2012	Name	JOHN DOE
Status	P	Gender	M
Effective Date	12/7/2012	Date of Birth	10/11/1949
Service Group	1	Patient Account No.	
Warrant Number	10005	Medical Record No.	
		Referral No.	

Financial Information		Provider Information	
Total Billed Amount	\$175.00	Provider NPI/API	1234567890
Total Paid Amount	\$218.60	Provider Name	REGIONAL MEDICAL CEN
Total Applied Other Insurance Amount	\$60.00	Medicare Patient Days %	0
Budget Number		Private Patient Days %	0
		Medicaid Patient Days %	0

DLI No	Detail Status	Service Begin	Service End	Billing Code	Billed Amount	Paid Amount	OI Paid Amount	Applied OI Amount	Billed Units
1	P	9/3/2012	9/3/2012	RG002	\$65.00	\$109.30	\$30.00	\$30.00	1.00

6) Verify that all of the required fields that are indicated by a red dot are populated for each tab.

7) **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	JOHN DOE	1234567890 / 00000000	New	

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

Client Identification Numbers

Client ID: 0123456789 | Patient Account No.: | Medical Record No.: |

Name and Address

First Name: JOHN | Last Name: DOE | MI: | Suffix: |  
 Street Address: 123456 MAIN AVE | Street Address 2: | City: ANY TOWN | State: TX | Zip: 12345-6789

Client General Information

Gender: Male | Date Of Birth: 10/11/1949 | Referral No.: 0000000123

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

- 8) **Provider Tab.** Select the ID qualifier from the ID Qual drop-down box and enter the Other ID number in the Other ID field.

**Claim Submission - Step 2**

Claim Type	Client	Provider	Status	Claim No.
Professional	JOHN DOE	1234567890 / 00000000	New	

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

**Billing Provider**

NPI: 1234567890

Name: REGIONAL MEDICAL CENTER NPI/API: 1234567890

Address: 1234567 FIRST STREET ANY TOWN, TX 01234-5678

Contact Name:

Contact Phone:

ID Qual:

Other ID:

**Performing Provider**

NPI/API: 0123456789 First Name: FRANK Last Name: SMITH MI: Suffix:

Save Draft Save Template Save To Group Prev Next Finish

- 9) **Claim Tab.** Select a Claim File Indicator Code from the drop-down box. Select a Place of Service from the drop-down box. Both institutional and professional claims require a valid diagnosis code. Inputting an invalid diagnosis code may result in an error message (and a 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.

**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

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			
1	<input type="text"/>	<input type="text"/>	<a href="#">Delete</a>

- 10) **Details Tab.** On the details tab, the system will auto populate the negative row(s) with the data that was initially paid on the initial claim. The fields Unit, Unit Rate, and Line Item Total will be auto populated and read only. The fields OI and AI/Co-Pay on the negative row(s) will always be auto populated with 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, 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 the **Add New Details Row(s)** button.

Claim Submission - Step 2

Line Item Control	Start	End	Qualifier	Code	1	2	3	4	Units	Unit Rate	Line Item Tot	Applied Incom	Rev Code	OI Paid Amount	NPI/API	First Name	Last Name	HI	Suffix	Delete
1	10/1/2012	10/1/2012							-1.00	\$92.83	(\$92.83)	\$0.00	0100	\$0.00						Delete

Co-Pay  
 Applied Income  
 Claim Total: (\$92.83)  
 Total Applied Income: \$0.00  
 Total Other Insurance: \$0.00 (from Details Tab)  
 Total Other Insurance: (from Other Insurance/Finish Tab)

Save Draft Save Template Save To Group Prev Next Finish

- 11) To bill positive units for the same adjusted claim, click the **Add New Details Row(s)** button. 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 display. The provider should also fill in the OI field on the positive line (if applicable).

Claim Submission - Step 2

Line Item Control	Start	End	Qualifier	Code	1	2	3	4	Units	Unit Rate	Line Item Tot	Applied Incom	Rev Code	OI Paid Amount	NPI/API	First Name	Last Name	HI	Suffix	Delete
1	10/1/2012	10/1/2012							-1.00	\$92.83	(\$92.83)	\$0.00	0100	\$0.00						Delete
2	10/1/2012	10/1/2012							11.00	\$92.83	\$504.16	\$436.97	0100	\$0.00						Delete

Co-Pay  
 Applied Income  
 Claim Total: \$491.33  
 Total Applied Income: \$436.97  
 Total Other Insurance: \$0.00 (from Details Tab)  
 Total Other Insurance: (from Other Insurance/Finish Tab)

Save Draft Save Template Save To Group Prev Next Finish

## Saving and Submitting an Adjustment

All adjustments must be submitted as batches.

- 1) To save a Professional or Dental claim adjustment as a batch, click the **Other Insurance / Finish** tab, click the **Save to Batch** radio button, check the **We Agree** box, and then click the **Finish** button 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.**

Client	Provider	Claim	Details	Other Insurance / Finish
<div style="border: 1px solid gray; padding: 10px; margin: 10px auto; width: 80%;"> <p style="text-align: center;"><b>Finish Options</b></p> <p style="text-align: center;">Please select one of the following and click finish</p> <p style="text-align: center;"> <input type="radio"/> <b>Submit</b>  <small>Submits the claim interactively</small> </p> <p style="text-align: center;"> <input checked="" type="radio"/> <b>Save to Batch</b>  <small>Saves the claim to batch for processing later.</small> </p> </div>				

**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**

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

**Note:** For claims in Service Group 1, 6, and 8, the OI Paid Amount entered in the Details tab will have to equal the OI Paid Amount in the Other Insurance/Finish Tab.

Claim Submission - Step 2

Claim Type: Draft    Client: DOROTHY HAMDINK    Provider: 121994929/00103228    Status: Adjustment    Claims No:

**\* 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 MESA 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](#)

**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)    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  
Submit the claim interactively

Save to Batch  
Save 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   

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** once additional system edits are applied. Refer to the Submitting a Batch section of this User Guide for information about submitting batches.

# Training and Support

## TexMedConnect Training

The TexMedConnect for Long-Term Care 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 TMHP learning management system at [learn.tmhp.com](http://learn.tmhp.com).

## Technical Support

You can contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638, Option 4, Monday through Friday 7:00 a.m. to 7:00 p.m., for Long-Term Care technical issues. 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

You can contact the TMHP LTC Helpdesk at 1-800-626-4117, Option 1, then Option 2, for questions about claims, Monday through Friday 7:00 a.m. to 7:00 p.m.

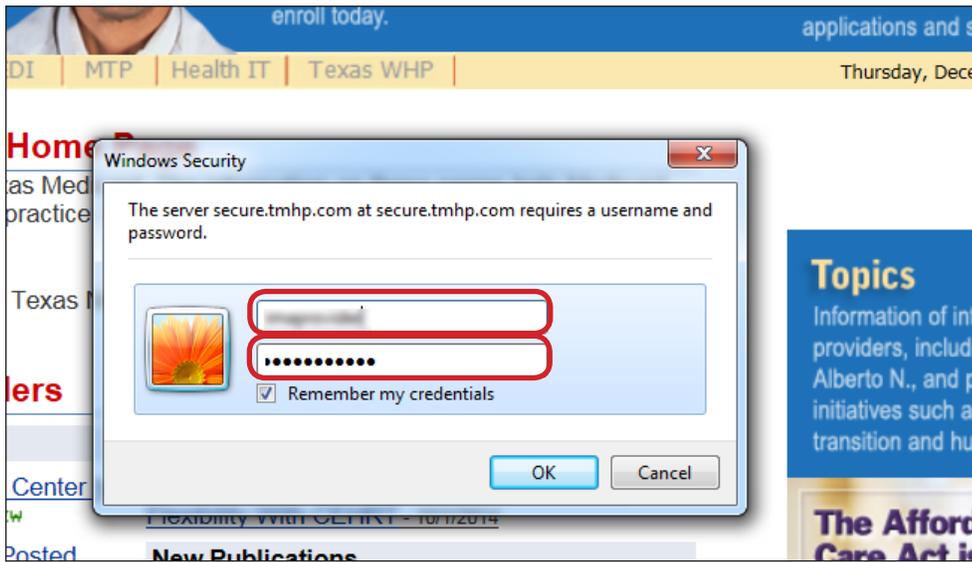
# Getting Started

You can access TexMedConnect from the Long-Term Care 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 Long-Term Care Home page, click the **Log In to TexMedConnect** button.

The screenshot shows the TMHP Long-Term Care Home page. At the top left is the TMHP logo and the text "TEXAS MEDICAID & HEALTHCARE PARTNERSHIP A STATE MEDICAID CONTRACTOR". A search bar and "Advanced" link are at the top right. The main header includes "Providers" and "Long-Term Care". A navigation bar lists various services like "Texas Medicaid", "CSHCN", "Family Planning", etc. A left sidebar contains links for "Long-Term Care Home", "Program Information/FAQ", "Information Letters", "Reference Material", "Forms", "Provider Support Services", "Provider Education", "Long-Term Care Webinars", "Helpful Links", and "Need Help?". The main content area features a "Mark Your Calendar!" banner for "Register Now for Long-Term Care Webinars in November and December 2019". Below this is a "Long-Term Care Home Page" section with a description of services and a list of "News Articles - Last 7 Days" with links and dates. A right sidebar includes a "TexMedConnect" section with a "Log In to TexMedConnect" button circled in red, and an "MDS 3.0" section.

- 2) Enter your user name and password, and click the **OK** button. As an option, you can save your login information by putting a check in the Remember my credentials box.



- 3) The My Account page will open to display all of the website features to which you have access. Click the **TexMedConnect** link.

Welcome to My Account. This section allows a user to perform various maintenance activities for the user. Click the appropriate link for access to the maintenance options.

<b>LTC Online Portal</b> <a href="#">Submit Form</a> <a href="#">TexMedConnect</a> <a href="#">Inquire about a form status</a>	<b>LTC Online Portal</b> <a href="#">Medicaid Client Portal for Providers</a>
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**Manage Provider Accounts**

- [Administer a Provider Identifier](#)  
Become a Provider Administrator for a Provider Identifier (authorization required).
- [Administer a Provider Enrollment Transaction](#)  
Open the provider enrollment application
- [Modify Permissions](#)  
Add remove permissions and/or unlink users for a Provider Identifier that you administer.
- [Create a new user](#)  
Create a new user for existing Provider Identifier.
- [Link an existing user](#)  
Link an existing user to a Provider Identifier that you administer.
- [Texas Medicaid EHR Incentive Program](#)

## **TexMedConnect Navigation Panel**

All of the available TexMedConnect Long-Term Care functions are located under the Long-Term Care branch in the left navigation panel. You can select any feature to which you have access. A user's access permissions determine which options are available in the left navigation panel. The provider administrator will grant access rights to the account. The complete details of how to setup access rights can be found in the [TMHP Website Security Provider Training Manual](#).

# MESAVs

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

Providers can interactively verify the 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.  
\*National Provider Identifier (NPI)/Atypical Provider Identifier (API)
- 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 3 consecutive months from the Eligibility End Date.
- The Eligibility End Date can include future dates of service, but cannot be more than 3 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 3 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. : [dropdown menu] [red error icon]

Eligibility Start Date: [date picker] [red error icon] Format: mm/dd/ccyy

Eligibility End Date: [date picker] [red error icon] 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.: [text box] [red error icon] Format: 123456789

Social Security Number: [text box] [red error icon] Format: 123-45-6789 or 123456789

Date of Birth: [date picker] [red error icon] Format: mm/dd/ccyy

Last Name: [text box] [red error icon]

First Name: [text box] [red error icon]

[Submit]

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

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.

- 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:**

**Submit**

- 5) 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 the **Print** button on your browser's toolbar.

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

perform another MESAV electronically.

MESAV Results

Logged in as: [User] | Log Off

Print Options [Icon]

[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		Inquiry Information	
Client No./Trainee SSN	XXXXXXXXXX	NPI/API	XXXXXXXXXX
DOB	XXXXXXXXXX	Eligibility From	XXXXXXXXXX
Gender	M	Eligibility Through	XXXXXXXXXX
SSN	XXXXXXXXXX	Medicaid /Client No.	XXXXXXXXXX
Name	XXXXXXXXXX	Social Security Number	XXXXXXXXXX
Address	XXXXXXXXXX	Date of Birth	XXXXXXXXXX
County	XXXXXXXXXX	Last Name	XXXXXXXXXX
Medicare No.	XXXXXXXXXX	First Name	XXXXXXXXXX
		M.I.	XXXXXXXXXX
		Suffix	XXXXXXXXXX

**Agent**  
-No Data-

**Authorization Message**  
-No Data-

**Monthly Units**  
-No Data-

**Eligibility**

## 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 the **Group Template** link under the MESAV section on 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 box, and then click the **Continue** button.

MESAV/CSI Group Template

Select NPI/API & Provider No. :

**Continue >>**

- 3) If you have already created a group and want to add a person to one of the existing Group Templates, 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:  **Add Group**

Name of the group	User ID	Created Date	Last Updated Date	
XXXXXXXXXX	XXXXXXXXXX	10/01/2008	10/16/2008	<a href="#">Delete</a>
XXXXXXXXXX	XXXXXXXXXX	10/01/2008	09/02/2014	<a href="#">Delete</a>
XXXX	XXXXXXXXXX	10/08/2008	08/14/2009	<a href="#">Delete</a>
XXXX	XXXXXXXXXX	10/08/2008	10/08/2008	<a href="#">Delete</a>

- 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 the **Add Group** button.

MESAV/CSI Group Template

NPI/API  / Provider No.

New Group:  **Add Group**

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

MESAV/CSI Group Template -

**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	First Name	Last Name	Client #	SSN	Date of Birth	MESA	CSI	Delete
<input type="checkbox"/>	XXXX	XXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	MESA	CSI	<a href="#">Delete</a>

Submit MESA Batch

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

The screenshot shows the 'Add Client' form. At the top, there is a title 'Add Client' and a header 'NPI/API [redacted] / Provider No. [redacted]'. Below this, there is a section for entering client information. A red rectangular box highlights the following fields: 'Client Number:', 'Social Security Number:', 'Date of birth:' (with a calendar icon), 'First name:', and 'Last name:'. To the right of these fields is the 'Lookup Criteria' section, which lists: 'Client #', 'or Combination of SSN and DOB', 'or First Name, Last Name and DOB', and 'or SSN and Last Name.'. Below the highlighted fields is a 'Lookup' button. At the bottom left of the form is a 'Go Back' button.

7) Click the **Lookup** button.

This screenshot is identical to the previous one, showing the 'Add Client' form. However, the 'Lookup' button is now highlighted with a red rectangular box, indicating the next step in the process. The 'Go Back' button remains at the bottom left.

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

**Add Client**

NPI/API : [REDACTED] / Provider No. [REDACTED]

Client Number: [REDACTED]

Social Security Number: [REDACTED]

Date of birth: [REDACTED]

First name: [REDACTED]

Last name: [REDACTED]

**Lookup**

**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	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	<a href="#">Add to group</a>

**Go Back**

9) The person will be added to the MESAV Group Template that you are working on.

- You can create up to 100 groups for each NPI or API and provider number.
- Each group can contain up to 250 people.
- You can view, add, and delete people from the list.

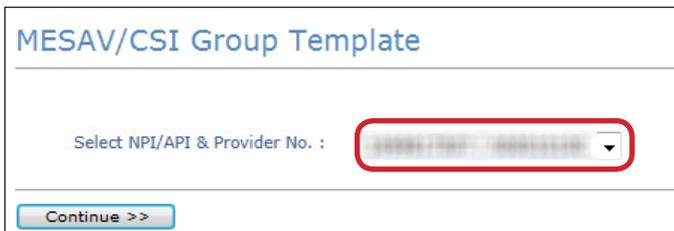
## Submitting a MESAV Group Template

To verify eligibility using a group template:

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



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

A screenshot of the "MESAV/CSI Group Template" form. The form has a title bar and a main content area. In the main content area, there is a label "Select NPI/API & Provider No. :" followed by a dropdown menu. The dropdown menu is highlighted with a red rectangular box. Below the dropdown menu is a "Continue >>" button.

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

**MESAV/CSI Group Template**

NPI/API [REDACTED] / Provider No. [REDACTED]

New Group:

Name of the group	User ID	Created Date	Last Updated Date	
[REDACTED]	[REDACTED]	10/01/2008	09/02/2014	<a href="#">Delete</a>
[REDACTED]	[REDACTED]	10/08/2008	10/14/2015	<a href="#">Delete</a>
[REDACTED]	[REDACTED]	10/08/2008	10/08/2008	<a href="#">Delete</a>
[REDACTED]	[REDACTED]	10/08/2008	09/09/2015	<a href="#">Delete</a>
[REDACTED]	[REDACTED]	04/06/2009	09/09/2015	<a href="#">Delete</a>
[REDACTED]	[REDACTED]	04/06/2009	09/09/2015	<a href="#">Delete</a>
[REDACTED]	[REDACTED]	07/14/2009	09/17/2015	<a href="#">Delete</a>
[REDACTED]	[REDACTED]	07/30/2009	09/25/2015	<a href="#">Delete</a>

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 - [REDACTED]**

NPI/API [REDACTED] / Provider No. [REDACTED]

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"/>	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	MESAV	CSI	<a href="#">Delete</a>

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

The screenshot shows the 'MESA/CSI Group Template' interface. On the left is a navigation menu with categories like 'Long Term Care', 'MESAV', 'Claims', and 'CSI'. The main area displays a table of client information. A red box highlights the 'Select All' checkbox in the table header.

Select All	First Name	Last Name	Client #	SSN	Date of Birth			
<input type="checkbox"/>	DEBRA	WYMAN	300000002		03/26/1978	MESAV	CSI	Delete
<input type="checkbox"/>	RONALD	BARBER	300076275		08/28/1955	MESAV	CSI	Delete
<input type="checkbox"/>	DAVID	BLAND	300000000		05/28/1966	MESAV	CSI	Delete
<input type="checkbox"/>	DEBORAH	BROWN	300000000		08/14/1966	MESAV	CSI	Delete
<input type="checkbox"/>	BLAINE	BRIDGEMAN	300000000		11/22/1947	MESAV	CSI	Delete
<input type="checkbox"/>	CLARENCE	BRUNY	300000000		08/12/1959	MESAV	CSI	Delete
<input type="checkbox"/>	MORRIS	HENDERSON	300000000		02/12/1967	MESAV	CSI	Delete
<input type="checkbox"/>	CAROL	JACKSON	270700000		12/28/1971	MESAV	CSI	Delete
<input type="checkbox"/>	WILLIAM	LAMBERT	300000000		10/21/1962	MESAV	CSI	Delete
<input type="checkbox"/>	LOUIE	LEWIS	307000074		11/24/1940	MESAV	CSI	Delete
<input type="checkbox"/>	ISA	MARSHALL	300077800		04/18/1946	MESAV	CSI	Delete
<input type="checkbox"/>	DAVID	MOORE	300000007	400070040	11/22/1962	MESAV	CSI	Delete
<input type="checkbox"/>	BERNARD	PAUL	300077700		10/22/1954	MESAV	CSI	Delete
<input type="checkbox"/>	ISA	PALM	300000000		08/24/1964	MESAV	CSI	Delete
<input type="checkbox"/>	MARCO	QUATTARONE	300000004		08/24/1962	MESAV	CSI	Delete
<input type="checkbox"/>	DAVID	WHITE	300000074		08/24/1942	MESAV	CSI	Delete

At the bottom left, there is a button labeled 'Submit MESA/CSI Batch'.

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

This is a close-up view of the 'Submit MESA/CSI Batch' button, which is highlighted with a red box. The button is located at the bottom left of the table area.

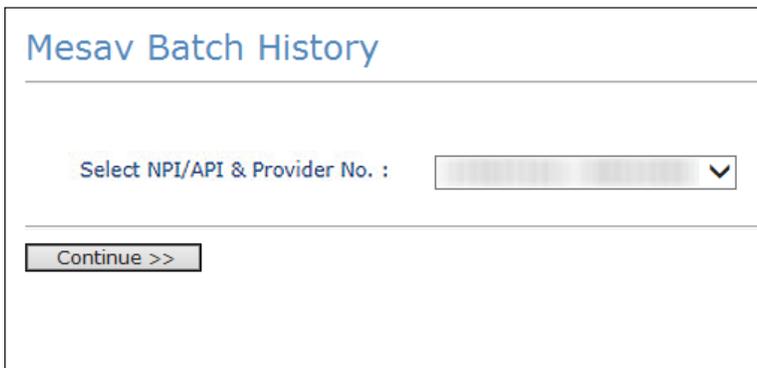
## Viewing a MESAV Batch History

To view a MESAV Batch History:

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



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

A screenshot of the 'Mesav Batch History' form. The form has a title 'Mesav Batch History' at the top. Below the title is a horizontal line. Underneath the line is a label 'Select NPI/API & Provider No. :' followed by a drop-down menu. The drop-down menu is currently closed, showing a downward-pointing arrow. Below the drop-down menu is another horizontal line. Underneath this second line is a button labeled 'Continue >>'.

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

### Batch History

NPI/API [REDACTED] / Provider No. [REDACTED]

Batch ID	Status	Claim Count	Total Billed Amount	Transmission Date	Submitted By
<a href="#">G184L8CZ</a>	Processed	2	\$ 5,477.40	08/06/2014 01:03:57 PM	[REDACTED]
<a href="#">G244LBSX</a>	Processed	1	\$ 3,800.32	08/12/2014 11:51:16 AM	[REDACTED]
<a href="#">G254LCS2</a>	Processed	1	\$ 10.00	08/13/2014 04:11:45 PM	[REDACTED]
<a href="#">G274LEBU</a>	Processed	2	\$ 2,748.70	08/14/2014 08:35:09 AM	[REDACTED]
<a href="#">G374LIU3</a>	Processed	1	\$ 10.00	08/25/2014 09:37:49 AM	[REDACTED]
<a href="#">G374LIU6</a>	Processed	1	\$ 3,800.32	08/25/2014 10:17:28 AM	[REDACTED]
<a href="#">G374LIU7</a>	Processed	1	\$ 10.00	08/25/2014 10:25:21 AM	[REDACTED]
<a href="#">G374LIUA</a>	Processed	1	\$ 2,738.70	08/25/2014 10:28:15 AM	[REDACTED]
<a href="#">G374LIUB</a>	Processed	1	\$ 3,800.32	08/25/2014 10:32:19 AM	[REDACTED]
<a href="#">G374LIUC</a>	Processed	1	\$ 120.00	08/25/2014 10:38:17 AM	[REDACTED]
<a href="#">G654MVJN</a>	Processed	2	\$ 2,748.70	09/22/2014 12:34:54 PM	[REDACTED]
<a href="#">G654MVJO</a>	Processed	2	\$ 2,748.70	09/22/2014 12:42:28 PM	[REDACTED]
<a href="#">G654MVJP</a>	Processed	1	\$ 3,800.32	09/22/2014 12:42:28 PM	[REDACTED]
<a href="#">H144PPGP</a>	Processed	1	\$ 2,738.70	11/10/2014 11:12:12 AM	[REDACTED]
<a href="#">H184TXMH</a>	Processed	3	\$ 8,216.10	11/14/2014 02:07:00 PM	[REDACTED]

4) The MESAV will open in a new window. Review the Status for each client number 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	[REDACTED]	NPI/API	[REDACTED]
DOB	[REDACTED]	Eligibility From	1/1/2016
Gender	F	Eligibility Through	3/31/2016
SSN	[REDACTED]	Medicaid /Client No.	[REDACTED]
Name	[REDACTED]	Social Security Number	[REDACTED]
Address	[REDACTED]	Date of Birth	[REDACTED]
County	Lampasas	Last Name	[REDACTED]
Medicare No.	[REDACTED]	First Name	[REDACTED]
		M.I.	[REDACTED]
		Suffix	[REDACTED]

**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	1/3/2016	[REDACTED]	Active	1	Nursing Facility	3	ECF	[REDACTED]		Daily	1.00			[REDACTED]	[REDACTED]
1/4/2016	3/28/2016	[REDACTED]	Active	1	Nursing Facility	1	Daily Care	[REDACTED]		Daily	1.00			[REDACTED]	[REDACTED]

**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	12/31/1999	11/26/2015	C	[REDACTED]	010	<a href="#">CMS ID Info: Contracted MAPs</a>
5/1/2015	12/31/1999	10/22/2015	B			
5/1/2015	12/31/1999	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 Nursing Facility (SG 1), non-state Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (SG 6), and Hospice (SG 8) providers, there is an LTC TexMedConnect MESAV screen titled “Other Insurance Policies.” Providers in service groups 1, 6, and 8 can view the policies that a person in their care has for the service dates entered on the MESAV. The OI section contains all active lines of coverage that have been reported to TMHP.

- Each listing contains detailed information about the insurance company, subscriber information, and the lines of coverage (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. Not having the insurance company claim disposition information available for the claims to be submitted for people with Medicaid could cause a denial for lack of OI information.

If, as a result of filing the insurance claim, it is discovered that the insurance information on the MESAV is incorrect for the person, the TMHP Third-Party Liability (TPL) Resource Line will be available to handle updates to the insurance information. Call the LTC Help Desk at 1-800- 626-4117 and choose Option 6: LTC Other Insurance for answers to incoming LTC Other Insurance Referral Inquiries.

## 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 display 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	<a href="#">CMS ID Info: Contracted MAPs</a>
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 nursing facilities for people who have transitioned to managed care will be forwarded to a managed care organization (MCO). If there are any issues or questions 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. Claims submitted by nursing facility providers whose people are not transitioning to managed care will not be forwarded.

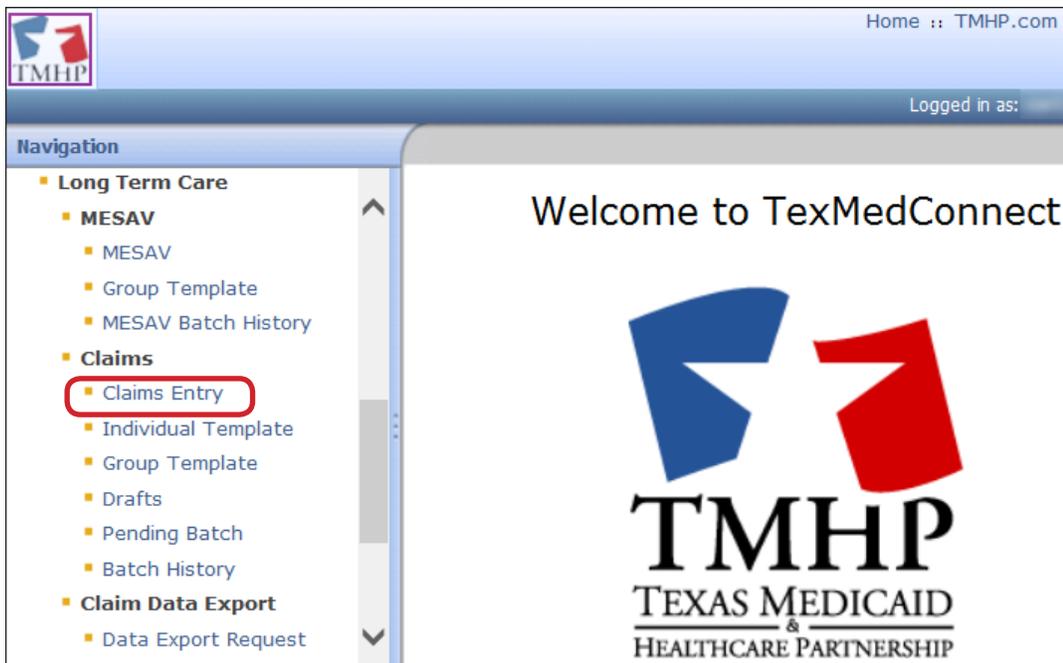
Users may submit the following claim types:

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

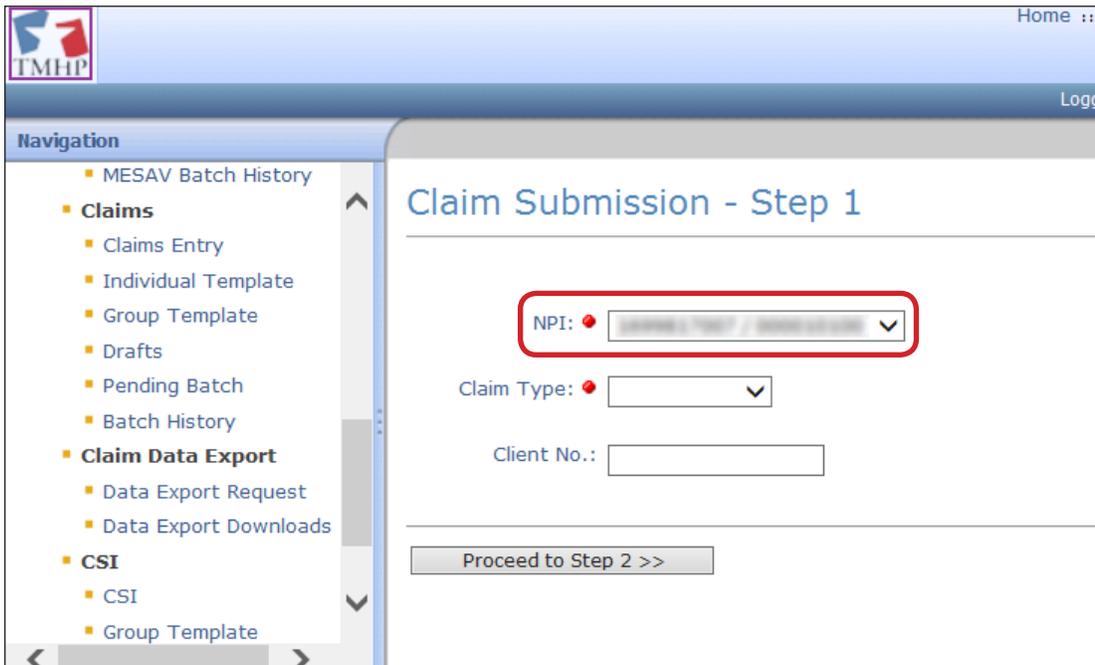
## Entering a Claim on TexMedConnect

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

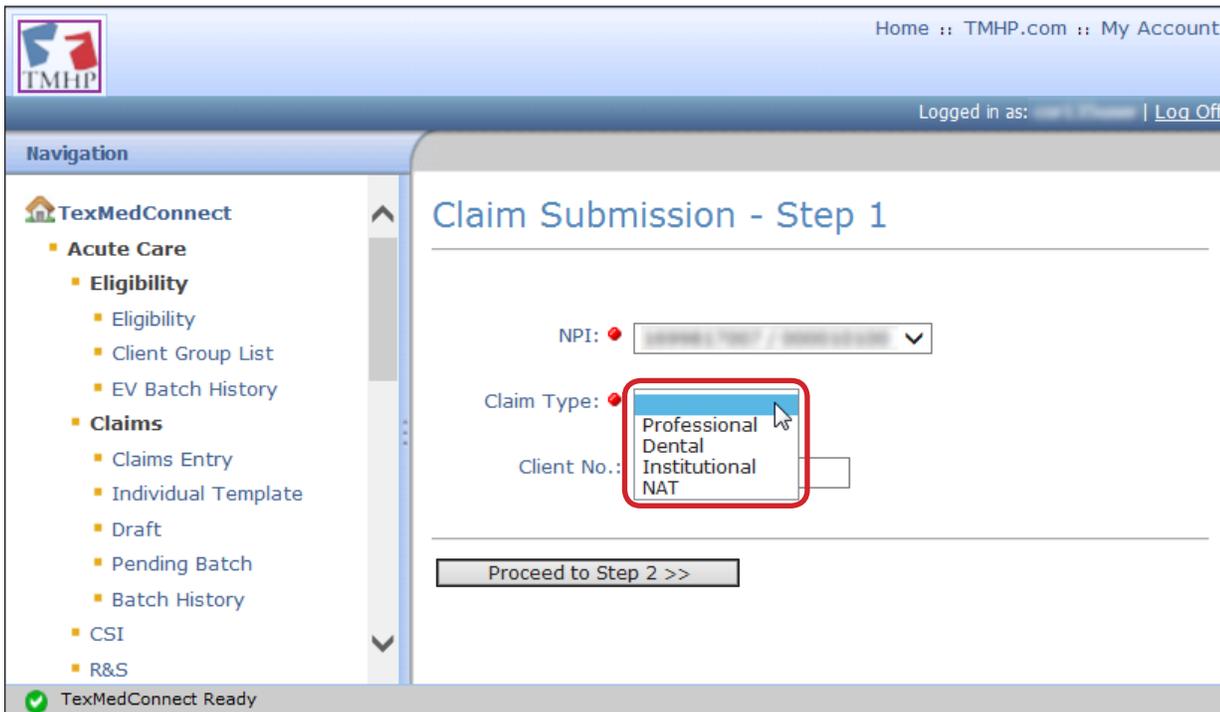
- 1) Click the **Claims Entry** link under the Claims section on the navigation panel.



- 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 box.



- 3) Choose the appropriate claim type from the drop-down box.



- 4) As an option, you may enter a client number at this time.

**Note:** Although a client number is not required, providing one saves time. The system will use the client number to auto-populate 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.

5) Click the **Proceed to Step 2** button.

The screenshot shows the 'Claim Submission - Step 1' interface. On the left is a navigation menu with the following items:

- 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

The main content area is titled 'Claim Submission - Step 1' and contains the following form elements:

- NPI: [Dropdown menu]
- Claim Type: [Dropdown menu]
- Client No.: [Text input field]
- Proceed to Step 2 >> [Button]

Red boxes highlight the 'Client No.' field and the 'Proceed to Step 2 >>' button.

- 6) The Claim Submission screen will display for the claim type that you selected. It will default to the Client tab. The type of claim you are working on is indicated in the Claim Type box in the upper right of the screen. You must complete all 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 auto-populated. If necessary, most fields can be edited. 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.
Professional			New	

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

**Client Identification Numbers**

Client ID <span style="color: red;">●</span> <input type="text"/>	Patient Account No. <span style="color: red;">●</span> <input type="text"/>	Medical Record No. <input type="text"/>
--	--	--

**Name and Address**

First Name <span style="color: red;">●</span> <input type="text"/>	Last Name <span style="color: red;">●</span> <input type="text"/>	MI <input type="text"/>	Suffix <input type="text"/>	Street Address <span style="color: red;">●</span> <input type="text"/>	Street Address 2 <input type="text"/>	City <span style="color: red;">●</span> <input type="text"/>	State <span style="color: red;">●</span> <input type="text" value="v"/>	Zip <span style="color: red;">●</span> <input type="text"/>
---	--	----------------------------	--------------------------------	---	--	---	--	--

**Client General Information**

Gender <span style="color: red;">●</span> <input type="text" value="v"/>	Date Of Birth <span style="color: red;">●</span> <input type="text" value="31"/>	Referral No. <input type="text"/>
---	---	--------------------------------------

## 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	Client	Provider	Status	Claim No.
Professional			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 | Save To Group | Prev | Next | Finish

**Note:** If there is more than one contract 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 access the referral number by searching a person's eligibility with the MESAV function.

- 2) Click the **Provider** tab. You must complete all required fields that are indicated by a red dot. TexMedConnect auto-populates the billing provider information using the NPI 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:

**Name:**  **NPI/API:**

**Address:**

**Contact Name**

**Contact Phone**

**ID Qual**

**Other ID**

**Performing Provider**

**NPI/API**  **First Name**  **Last Name**  **MI**  **Suffix**

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

- Click the **Claim** tab. You must complete all of the 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 a subsequent inability to submit a claim) in TexMedConnect.
  - To add more diagnosis codes, click the **Add New Diagnosis** button.
  - To view the diagnosis description, click the magnifying glass icon.
  - The Qualifier field is used to indicate an *International Classification of Diseases*, Ninth Revision (ICD-9) or *International Classification of Diseases*, Tenth Revision (ICD-10) diagnosis code. Select

from the drop-down box based on the diagnosis code entered.

**Note:** The HHSC-LTC Bill Code crosswalk requires that modifiers start in position 1 and any subsequent modifier will be in sequential position order and not be the same (duplicate). Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate Service Group, Residence Service Group, and Budget Number. Instead, Billing providers will indicate Service Group, Residence Service Group, and Budget Number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.

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

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

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

**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) Click the **Details** tab. You must complete all of the fields that are indicated by a red dot.
  - To add a blank row, click the **Add New Detail row(s)** button.
  - To duplicate an existing row, highlight the row and click the **Copy Row** button.
  - To delete a row, scroll over and click the **Delete** link at the end of the row.

- 5) Click the **Other Insurance/Finish** tab.

**Note:** Other insurance information is not required on a Professional Claim, only an Institutional Claim.

- a) Click either the **Submit** radio button or the **Save to Batch** radio button;
- b) Check the **We Agree** box;
- c) Click the **Finish** button.

- d) If the claim is submitted successfully, an Internal Control Number (ICN) will be displayed at the top of the page. This is also known as a claim number.

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

- 6) 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. Once you have made all of the necessary corrections, click the **Finish** button 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.

- 7) In each of the tabs, 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 the **Prev** and **Next** buttons at the bottom of the Claim Submission – Step 2 screen.

Client	Provider	Claim	Details	Other Insurance / Finish
<b>Client Identification Numbers</b>				
Client ID 0123456789	Patient Account No. <input type="text"/>	Medical Record No. <input type="text"/>		
<b>Name and Address</b>				
First Name JOHN	Last Name DOE	MI <input type="text"/>	Suffix <input type="text"/>	
Street Address 123456 MAIN AVE	Street Address 2 <input type="text"/>	City ANY TOWN	State TX	Zip 12345-6789
<b>Client General Information</b>				
Gender Male	Date Of Birth 10/11/1949	Referral No. 0000000123		

## Entering a Dental Claim

To enter a Dental claim:

- 1) Click the **Client** tab. You must complete all of the 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 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) Click the **Provider** tab. You must complete all of the fields that are indicated by a red dot. TexMedConnect auto-populates 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 section, but it is not required.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Dental			New	

Billing Provider

NPI: Name: NPI/API: 1962982888

ID Qual Other ID

Performing Provider

NPI/API First Name Last Name MI Suffix

Save Draft Save Template Prev Next Finish

3) Click 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 any subsequent modifier will be in sequential position order and not be the same (duplicate). Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate Service Group, Residence Service Group, and Budget Number. Instead, Billing providers will indicate Service Group, Residence Service Group, and Budget Number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.

- The Service Group drop down is to be used by Billing providers with multiple service groups linked to the same LTC Provider contract number.



**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 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) Click the **Details** tab. You must complete all of the fields that are indicated by a red dot. Entering a future date is not allowed in the Service Date field.

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

- 5) Click the **Other Insurance/Finish** button.

**Note:** *Other insurance information is not required on a Dental Claim, only an Institutional Claim.*

- a) Click the **Submit** or **Save to Batch** radio button.
- b) Check the **We Agree** box in the Certification, Terms, and Conditions section.
- c) Click the **Finish** button in the lower, right corner of the screen.
- d) If the claim is submitted successfully, an Internal Control Number (ICN) will be displayed at the top of the page. This is also known as a claim number.

- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- 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 managed care organizations (MCOs). These claims can be set to the following statuses:

- **Forwarded:** means that the claim has been Forwarded to (but not yet Accepted or Rejected by) an MCO.
- **Rejected:** means that the claim has been rejected by TMHP or the MCO to which it was forwarded.
- **Accepted:** means that 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, or ETN.

Claims handled by TMHP (not 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) Click the **Client** tab. You must complete all of the 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 of the required fields, click the **Next** button or click on the Provider tab.

**Claim Submission - Step 2**

<b>Claim Type</b> Institutional	Client	Provider	Status New	Claim No.
------------------------------------	--------	----------	---------------	-----------

**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

- 2) Click the **Provider** tab. You must complete all of the fields that are indicated by a red dot.

**Claim Submission - Step 2**

<b>Claim Type</b> Institutional	Client	Provider	Status New	Claim No.
------------------------------------	--------	----------	---------------	-----------

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

**Billing Provider**

NPI:  Taxonomy:   
 Name:  NPI/API:  Contact Name:  Contact Phone:   
 Address:  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

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

3) The Taxonomy drop-down box is auto-populated with three values. Taxonomy codes further define the type, classification, or specialization of the health-care 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 health-care providers must select a taxonomy code(s) when applying for an NPI. The values in the Taxonomy drop-down box 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 a National Provider Identifier ( NPI).

If neither of the two auto populated codes apply, choose **Other**. If you choose **Other**, a text box called Other Taxonomy will display and is required.

**NOTE: If an API was chosen, the Taxonomy field will not display.**

Home :: TMHP.com :: My Account  
 Logged in as: Cor135user | Log Off

Claim Submission - Step 2

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

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

**Billing Provider**

NPI:

Name:  NPI/API:

Address:

Taxonomy:

Contact Name:  Contact Phone:

ID Qual:  Other 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:

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

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

**Claim Submission - Step 2**

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

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

**Billing Provider**

NPI: [ ] Taxonomy: [ ]

Name: [ ] NPI/API: [ ]

Address: [ ]

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: [ ]

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) Click the **Claim** tab. You must complete all of the fields that are indicated by a red dot. Choose the appropriate indicator from the Claim File Indicator Code drop-down box.

**Claim Submission - Step 2**

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

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

**Note:** The HHSC-LTC Bill Code Crosswalk requires that modifiers start in position 1 and any subsequent modifier will be in sequential position order and not be the same (duplicate). Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate Service Group, Residence Service Group, and Budget Number. Instead, Billing providers

will indicate Service Group, Residence Service Group, and Budget Number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.

- The Service Group drop down is to be used by Billing providers with multiple service groups linked to the same LTC Provider contract number.

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 several dropdown menus: 'Claim File Indicator Code', 'Place of Service', and 'Service Group'. The 'Service Group' dropdown is highlighted with a red rectangular box. There is also a partially visible 'Residence Service Group' dropdown to the right.

- The Residence Service Group drop down will be utilized 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 will result in claim rejections if not filled out when required (when people are in an ICF/IID facility and the correct service group is either left blank or not selected).

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

This screenshot shows the 'Claim Submission - Step 2' form with more fields visible. The 'Claim' tab is still selected. In addition to the 'Service Group' field, there is now a 'Residence Service Group' field. Above these, there are 'Patient Discharge Status' and 'Claim Frequency' dropdowns. Below the 'Service Group' and 'Residence Service Group' fields, there is a 'Diagnosis' section with a 'Qualifier' dropdown and an 'Add New Diagnosis' button. A table with the following structure is shown:

	Code	Description	Delete
1			

At the bottom of the form, there are buttons for 'Save Draft', 'Save Template', and '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 box.

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there are tabs for 'Claim Type' (Institutional), 'Client', 'Provider', 'Status' (New), and 'Claim No.'. Below this, there are tabs for 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The 'Claim' section contains a 'Claim File Indicator Code' dropdown and a 'Patient Discharge Status' dropdown menu that is open. The menu lists the following options:

- 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)
- 06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
- 07 Left against medical advice or discontinued care
- 20 Expired
- 21 Discharged/transferred to Court/Law Enforcement
- 30 Still Patient
- 43 Discharged/transferred to a federal health care facility
- 50 Hospice - home
- 51 Hospice - medical facility
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 69 Discharged/transferred to a Designated Disaster Alternative Care Site
- 70 Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

Other fields visible include 'Place of Service' and 'Claim Frequency' dropdowns, and a 'Diagnosis' section with a 'Qualifier' dropdown and an 'Add New Diagnosis' button.

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

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there are tabs for 'Claim Type' (Institutional), 'Client', 'Provider', 'Status' (New), and 'Claim No.'. Below this, there are tabs for 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The 'Claim' section contains a 'Claim File Indicator Code' dropdown, a 'Patient Discharge Status' dropdown, and a 'Place of Service' dropdown menu that is open. The menu lists the following options:

- 18 Swing Bed
- 21 SNF Inpatient (Including Medicare Part A)
- 22 SNF Inpatient (Medicare Part B)
- 28 Swing Bed - Nursing Facility
- 32 Home Health - Inpatient
- 34 Home Health Outpatient - Other
- 66 Intermediate Care Facility
- 74 Outpatient Rehabilitation Center
- 75 Comprehensive Outpatient Rehabilitation Center
- 79 Clinic - Other
- 81 Hospice - Special Facility
- 86 Residential Facility (Medicaid Only)
- 89 Special Facility - Other

Other fields visible include 'Claim Frequency' dropdown, and a 'Diagnosis' section with a 'Qualifier' dropdown and an 'Add New Diagnosis' button. At the bottom, there are buttons for 'Save Draft', 'Save Template', 'Save To Group', 'Prev', 'Next', and 'Finish'.

- 8) Choose the appropriate claim frequency from the Claim Frequency drop-down box.
- Choose **1 Admit Through Discharge Claim** when the claim will cover the entire 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 in the Claim Frequency field you selected, the Admit Date field may be required. The admit date is the date that the person is 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		

Today: 11/4/2015

- 10) The Principal Diagnosis code is required for institutional claims. Inputting 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 the **Add New Diagnosis** button. You may list up to three diagnosis codes. The third Diagnosis field is intended for use with External Cause of Injury codes for ICD-9 or 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-9 or ICD-10 diagnosis code. Select from the drop-down box 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

Add New Diagnosis

Code	Description	Delete
1		

Save Draft Save Template Save To Group Prev Next Finish

- 11) Click the **Details** tab. You must complete all of the fields that are indicated by a red dot. If the person is in Service Group 1, 6, or 8, enter the total amount paid by the person's other insurance 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	Start	End	Qualifier	Code	1	2	3	4	Units	Unit Rate	Line Item Total	Co-Pay	Rev Code	OI Paid Amount	NPI/API	First Name	Last Name	MI	Suffix	Delete
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)

Save Draft Save Template Save To Group Prev Next Finish

- To add more rows, click the **Add New Detail Row(s)** button.
- To copy the information from the previous detail, click the **Copy Row** button.
- To delete a row, scroll over and click the **Delete** link 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 Detail tab should only be added if it is different from the Rendering Provider listed in the Provider tab. The Rendering Provider in the Detail tab should also be different from the Attending Provider and Billing Provider listed in the Provider tab.*

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

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there is a header with 'Claim Type' set to 'Institutional', 'Client', 'Provider', 'Status' (New), and 'Claim No.'. Below this is a navigation bar with tabs for 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The 'Other Insurance / Finish' tab is highlighted. Under this tab, there is a 'Finish Options' section with two radio buttons: 'Submit' (selected) and 'Save to Batch'. Below this is a 'Certification, Terms And Conditions' section with a paragraph of text and a 'We Agree' checkbox. At the bottom of the form are buttons for 'Save Draft', 'Save Template', 'Save To Group', 'Prev', 'Next', and '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 a Professional claim, unless the person is in Service Group 1, 6, or 8.

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

**Note:** *For people with Medicare in Service Group 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.*

- Click the **Submit** radio button.

- b) Check the **We Agree** box in the Certification, Terms And Conditions section.
- c) Click the **Finish** button in the lower right corner of the screen.

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there are tabs for 'Claim Type' (Institutional), 'Client', 'Provider', 'Status' (New), and 'Claim No.'. Below this is a navigation bar with tabs for 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The 'Other Insurance / Finish' tab is active. In the center, there is a 'Finish Options' section with the instruction 'Please select one of the following and click finish'. There are two radio buttons: 'Submit' (selected) and 'Save to Batch'. Below this is a 'Certification, Terms And Conditions' section with a 'We Agree' checkbox. At the bottom, there are buttons for 'Save Draft', 'Save Template', 'Save To Group', 'Prev', 'Next', and 'Finish'.

- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- 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 Long-Term Care relevant, you are required to add that coverage on the claim by using the **Add Policy** button.
  - 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 the **Finish** button 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><b>Client has no known Long Term Care-relevant other insurance coverage for the date(s) of service on file at TMHP</b></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><b>Attestation</b></p> <p><input checked="" 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><b>Medicare Information</b></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 <b>total coinsurance amount due</b> per the Medicare Remittance Advice in the Medicare Part A Total Amount field. For clients with non-traditional Medicare Part C, enter the <b>total copay/deductible amount due</b> 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"/> <input type="button" value="Search"/> Medicare Part C Total Amount <input type="text"/></p> <p><input checked="" 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><b>Finish Options</b></p> <p>Please select one of the following and click finish</p> <p><input checked="" type="radio"/> <b>Submit</b> Submits the claim interactively</p> <p><input type="radio"/> <b>Save to Batch</b> Saves the claim to batch for processing later.</p>				
<p><b>Certification, Terms And Conditions</b></p> <p>Please review the following certification and the <a href="#">terms and conditions</a>. The terms and conditions can be reviewed by clicking <a href="#">here</a>.</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 checked="" type="checkbox"/> <b>We Agree</b></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 checked="" type="button" value="Finish"/></p>				

- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- 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 Other Insurance Policy will be validated by TMHP Third-Party Liability department before being added to the OI database. However, any Other Insurance Paid Amount will be taken into consideration on the submission of the claim.
  - a) Enter the required fields as indicated by the red dots.
  - b) Check the box under Attestation.
  - c) Click the **Submit** radio button.
  - d) Check the **We Agree** box in the Certification, Terms And Conditions section.
  - e) Click the **Finish** button in the lower right corner of the screen.

**Note:** To avoid processing errors, enter either Employer Name or Group Number but not both, when applicable.

- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- 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 Long-Term Care-relevant OI coverage currently on file with TMHP.
  - a) Verify the OI information is valid and correct.
  - b) Fill in all required Other Insurance Policy information as indicated by a red dot.
  - c) Choose the appropriate option in the Other Insurance Disposition drop-down box. 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)**.
  - d) If you chose **Paid** in the Other Insurance Disposition drop-down box, choose an option in the Other Insurance Disposition Reason drop-down box 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.*

- e) If you chose **Denied** in the Other Insurance Disposition drop-down box, choose an option in the Other Insurance Disposition Reason drop-down box.
- 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 box, the Other Insurance Billed Date must be at least 110 calendar days prior to the submission date.
- g) If you need to update the other insurance policy, click the **Update Policy** button to display the Other Insurance Policy fields. Once information is updated, click the **Save Changes** button.
- h) If you need to add another insurance policy, click the **Add Policy** button to display the Other Insurance Policy field.
- i) Check the box under Attestation.
- j) Click 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 the **Finish** button.

**Note:** *The Other Insurance Policy will be validated by the TMHP Third-Party Liability department before being added to the Other Insurance database.*

**Claim Submission - Step 2**

Claim Type: Institutional

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

**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: [Redacted] Termination Date: [Redacted] Company Name: [Redacted] Company Address: [Redacted] Company City: [Redacted] Company State: [Redacted] Company ZIP Code: [Redacted] Company Phone #: [Redacted]

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

Group Number: [Redacted] Other Insurance Disposition: Denied Other Insurance Billed Date: [Redacted] Other Insurance Disposition Date: [Redacted] Other Insurance Claim No.: [Redacted]

Other Insurance Disposition Reason: [Redacted]

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 insurance 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 copy/ 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): [Redacted] Medicare Part C Total Amount: [Redacted]

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**  
Submit the claim interactively.

**Save to Batch**  
Save 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 Prev Next **Finish**

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

## Nurse Aide Training (NAT)

To enter a NAT claim:

- 1) Click the **Header Information** tab. Complete all of the required fields as indicated by a red dot. The Provider No. field and the NPI/API field will be auto-populated 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 percent.

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

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

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

**Note:** Other insurance information is not required on a Nurse Aide Training Claim, only an Institutional Claim.

- a) Click the **Submit** or **Save to Batch** radio button.
- b) Check the **We Agree** box in the Certification, Terms and Conditions section. Click the **Finish** button in the lower right corner of the screen.
- c) If the claim is submitted successfully, an Internal Control Number (ICN) will be displayed in the Claim No. field at the top of the page. The ICN is also known as a claim number.

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

The screenshot shows the 'Other Insurance / Finish' tab selected. Under 'Finish Options', there are two radio buttons: 'Submit' (selected) and 'Save to Batch' (highlighted with a red box). Below this is a 'Certification, Terms And Conditions' section with a 'We Agree' checkbox. At the bottom, there are four buttons: 'Save Draft', 'Save Template', 'Save To Group', and 'Finish'. The first three buttons are highlighted with red boxes.

## Draft Claims

### Saving Draft Claims

To save a claim as a draft:

- 1) Click the **Save Draft** button 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 the **Save** button. 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, 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:  x **Save** | Cancel

## Viewing Draft Claims

To view a list of all your draft claims:

- 1) Click the **Drafts** link 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 box, and click the **Continue** button.



- 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.

- Once a claim from the draft list has been submitted, that draft claim is removed from the draft list.
- After 45 days, drafts will automatically be deleted from the draft list.
- A maximum of 50 drafts can be created for each NPI or API and provider number.

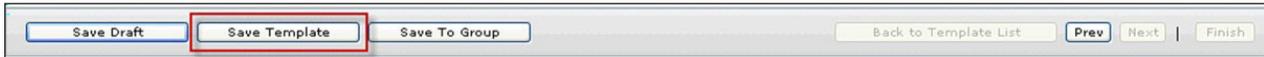
Drafts					
NPI/API [REDACTED] / Provider No. [REDACTED]					
Draft Name	Claim Type	User ID	Created	Last Updated	Delete
[REDACTED]	Expedited	[REDACTED]	07/28/2009	07/28/2009	Delete

## Individual Templates

### Saving as an Individual Template

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

- 1) Click the **Save Template** button.

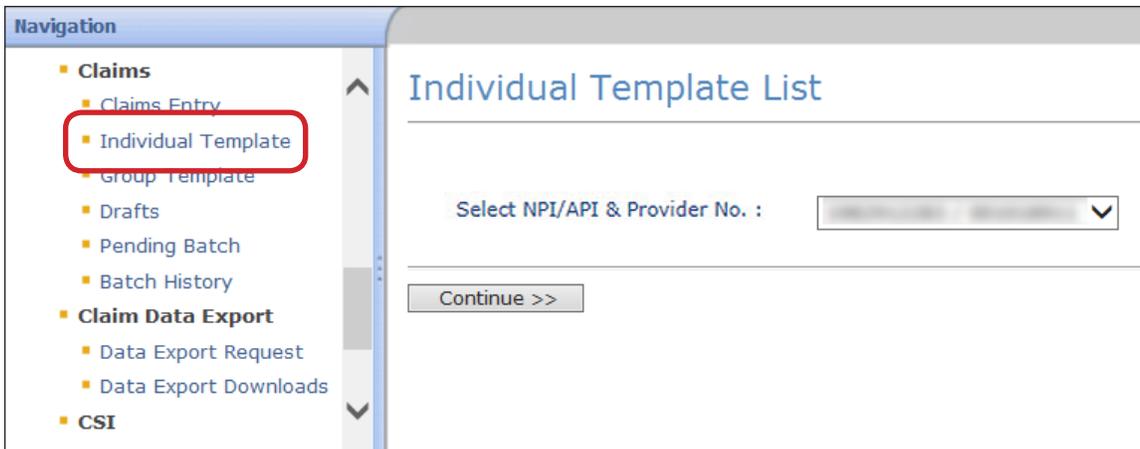


- 2) Enter a template name, and click the **Save** button. The claim will be added to the Individual Template list.
- 3) Templates do not disappear when they are used and can be used an unlimited number of times. However, they will be automatically removed if they have not been used for 365 days.
- 4)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

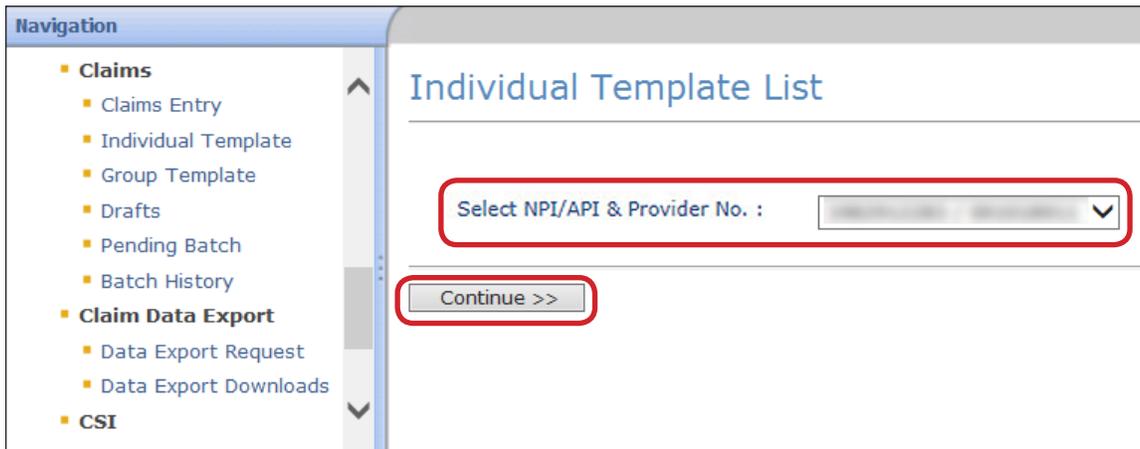
### Viewing Individual Templates

To view individual templates:

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



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



- 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

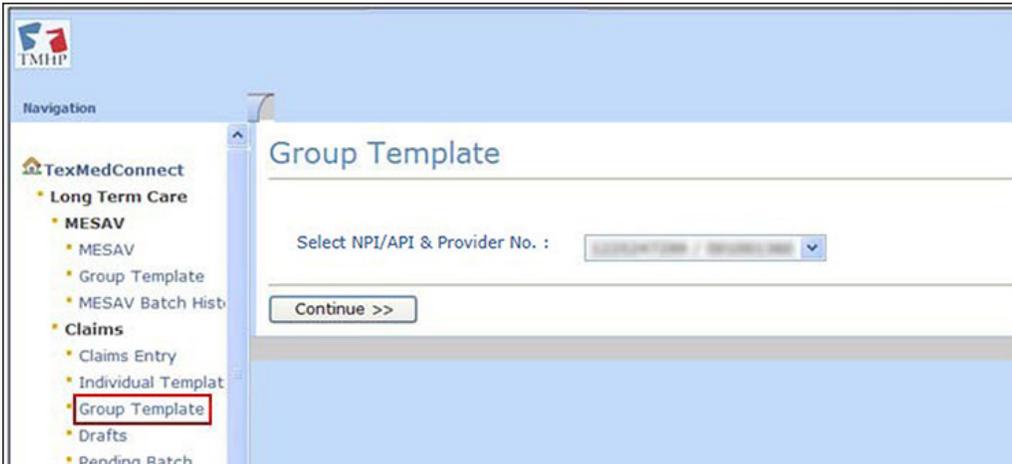
NPI/API [REDACTED] / Provider No [REDACTED]

Template Name	Claim Type	User ID	Created	Last Updated	
<a href="#">COR135 EDI Test CPT REV</a>	Institutional	[REDACTED]	11/25/2014	12/01/2014	<a href="#">Delete</a>
<a href="#">dental</a>	Dental	[REDACTED]	09/04/2014	12/03/2014	<a href="#">Delete</a>
<a href="#">dental TaxonomycodeBatch Testing</a>	Dental	[REDACTED]	10/03/2014	10/03/2014	<a href="#">Delete</a>
<a href="#">Inst Taxonomycode Batch Testing</a>	Institutional	[REDACTED]	10/03/2014	10/03/2014	<a href="#">Delete</a>
<a href="#">Multiple Plan Codes</a>	Institutional	[REDACTED]	08/21/2014	11/25/2014	<a href="#">Delete</a>
<a href="#">Multiple Plan Codes E0015</a>	Institutional	[REDACTED]	08/21/2014	09/18/2014	<a href="#">Delete</a>
<a href="#">Multiple Plan Codes E0016</a>	Institutional	[REDACTED]	08/21/2014	08/25/2014	<a href="#">Delete</a>
<a href="#">Multiple Plan Codes E0016 Addon SC1</a>	Institutional	[REDACTED]	08/25/2014	09/15/2014	<a href="#">Delete</a>
<a href="#">Professional Taxonomy Batch Testing</a>	Professional	[REDACTED]	10/03/2014	10/03/2014	<a href="#">Delete</a>

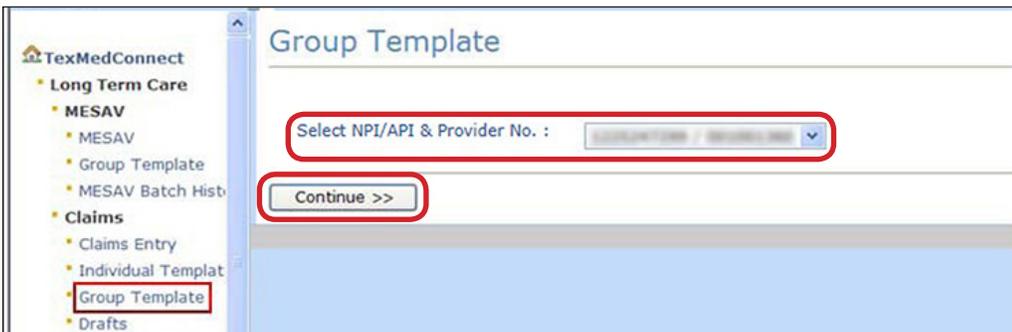
## Group Templates

### Viewing Existing Group Templates

- 1) Click the **Group Template** link 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 box, and click the **Continue** button.



3) Under the **Template Name** column, click the template name on which you want to work.

**Group Template List**

NPI/API  / Provider No.

New Group:  Claim Type:

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

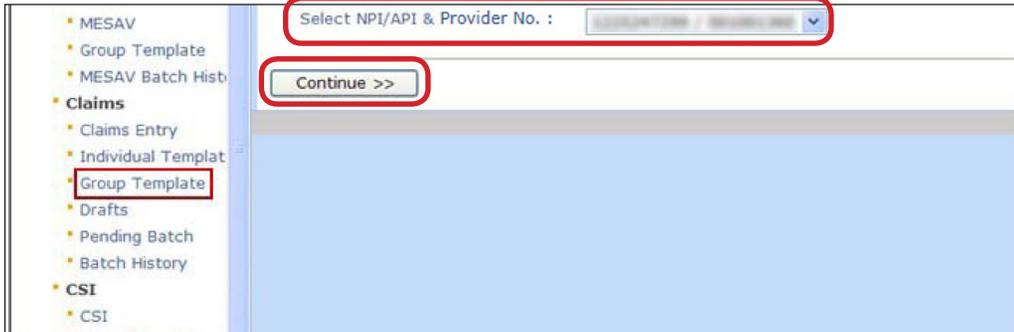
## Creating New Group Templates

To create a new Group Template:

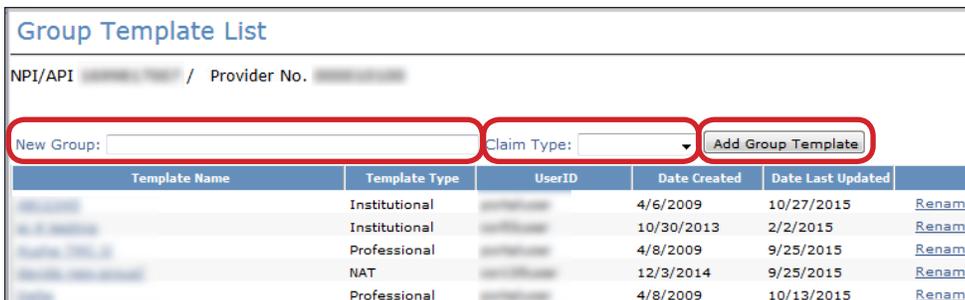
1) Click the **Group Template** link under the CSI on the navigation panel.



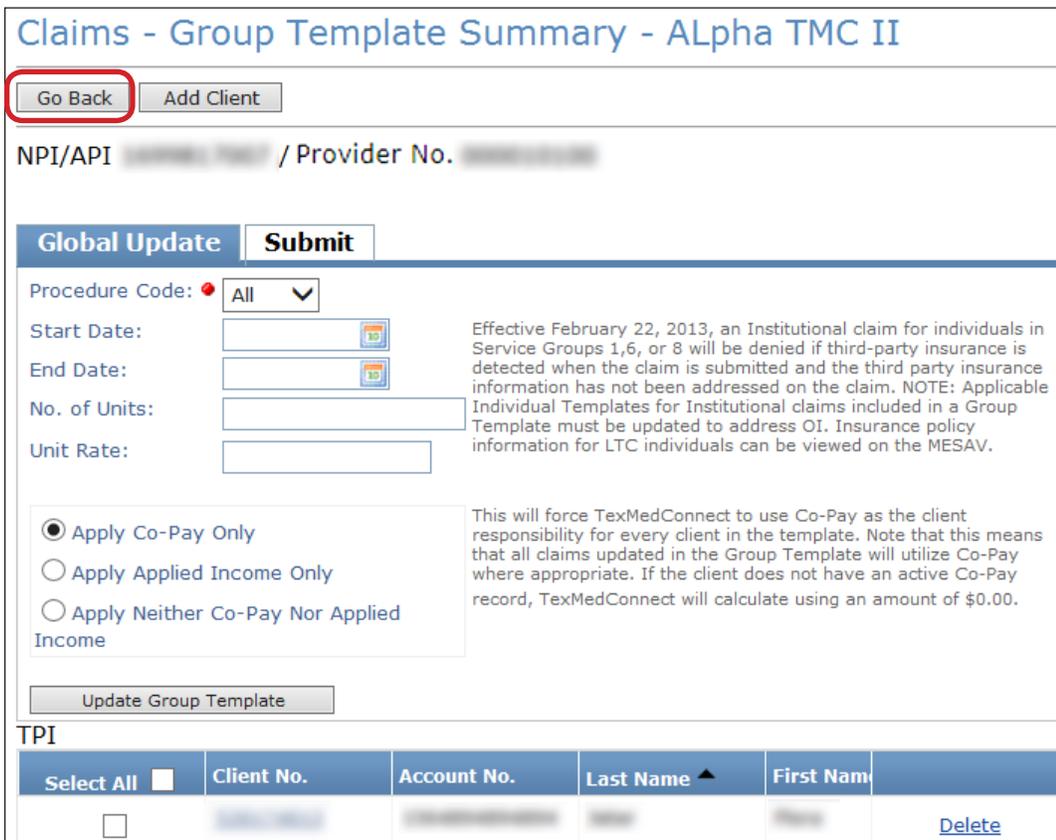
- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.



- 3) Enter the name of a group in the **New Group** field, choose the Claim Type from the drop-down box, and then click the **Add Group Template** button.



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



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 [REDACTED] / Provider No. [REDACTED]

**Global Update** **Submit**

Procedure Code:  All  [REDACTED]

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 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.

**Update Group Template**

**TPI**

Select All <input type="checkbox"/>	Client No.	Account No.	Last Name ▲	First Name	
<input type="checkbox"/>	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	<a href="#">Delete</a>

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

- **Apply Co-Pay Only;** or
- **Apply Applied Income Only;** or
- **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 of the 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 utilize Applied Income where appropriate. If the person does not have an active Applied Income record, TexMedConnect will calculate 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.

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

A template will remain in the system as a template 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.

## Saving as a Group Template

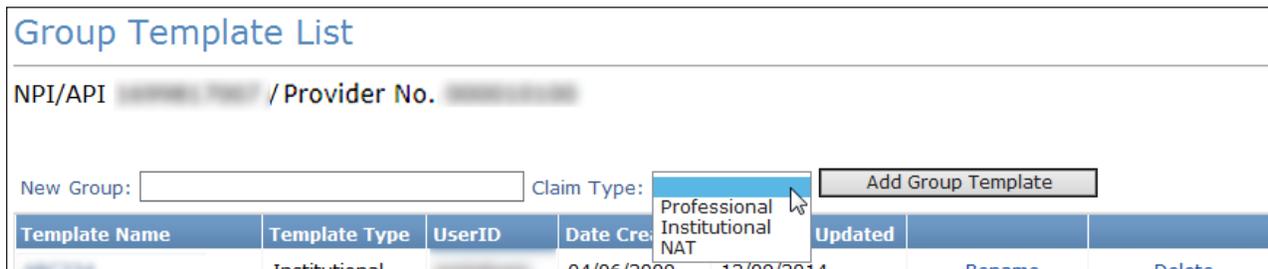
To create a group template, enter the information for a claim, but before you submit the claim:

1) Click the **Save To Group** button.



2) Enter a group template name, and click the **Save** button.

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

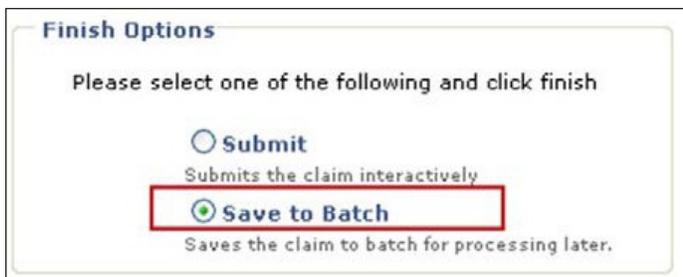


## Batch Claims

### Saving To a Batch

To save a claim as part of a batch:

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



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

- 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.

The screenshot shows the 'Claim Submission - Step 2' interface. At the top right, there are tabs for 'Claim Type' (Institutional), 'Client', 'Provider', 'Status', and 'Claim No.'. Below this is a navigation bar with 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The main content area is titled 'Finish Options' and contains the text: 'Please select one of the following and click finish'. There are two radio buttons: 'Submit' (selected) and 'Save to Batch'. Below this is a 'Certification, Terms And Conditions' section with a 'We Agree' checkbox checked. At the bottom right, a 'Finish' button is highlighted with a red box.

## Submitting a Batch

To submit a batch:

- 1) Click the **Pending Batch** link 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 box, and click the **Continue** button.
- 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 [redacted] / Provider No. [redacted]

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

Total Billed Amount: \$8,216.10

Submit Batch

- 4) If there are more claims than can fit on one screen, click the **Continue** button 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 the **Submit Batch** button. All of the claims in that batch will be submitted, even those created by other users.

Pending Batch - List of Claims

NPI/API [redacted] / Provider No. [redacted]

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

Total Billed Amount: \$8,216.10

Submit Batch

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

Pending Batch - List of Claims

NPI/API [redacted] / Provider No. [redacted]

The pending batch was successfully submitted. 4 claims have been submitted in this batch. The status and details for this batch can be viewed in the Batch History Screen.

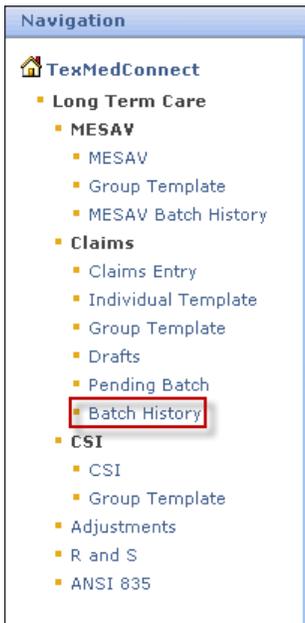
Total Billed Amount: \$ 0.00

## 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 the **Batch History** link 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 box, and click the **Continue** button.



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

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

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

Claims 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. The **Payer Name** column will display TMHP when the claim is accepted by TMHP. If the column is blank, that indicates that TMHP has Rejected the claim.

Batch History - List of Claims - G534MJ70									
NPI/API [REDACTED] / Provider No. [REDACTED]									
Status	Client #	Account No	Payer Name	Last Name	First Name	Start Date Of Service	Billed Amount	Claim Form	User ID
Rejected	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	07/30/2014	\$ 159.09	Institutional	[REDACTED]
Accepted	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	07/30/2014	\$ 159.09	Institutional	[REDACTED]
<b>Total Billed Amount:</b>		\$318.18							
<b>BatchID:</b>		G534MJ70							
<input type="button" value="Go Back"/>									

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

Batch History - List of Claims - G534MJ70									
NPI/API [REDACTED] / Provider No. [REDACTED]									
Status	Client #	Account No	Payer Name	Last Name	First Name	Start Date Of Service	Billed Amount	Claim Form	User ID
Rejected	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	07/30/2014	\$ 159.09	Institutional	[REDACTED]
Accepted	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	07/30/2014	\$ 159.09	Institutional	[REDACTED]
Total Billed Amount:		\$318.18							
BatchID:		G534MJ70							
Go Back									

a) If the status of the claim that you clicked was **Forwarded**:

- The Forwarded claim will have a 28-character, alphanumeric EDI Transaction Number (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 EDI Transaction Number ETN are the same as the Batch ID.
- The claim will remain in the **Forwarded** status until the MCO responds with either an Accept or Reject.

As you can see in the image below, the name and contact information of the MCO is identified in multiple places on the screen. Once 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 in the Informational Pricing column (how TMHP would have priced the claim if

processed as FFS for Service Group 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	
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 : 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

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

Claim Submission - Step 2

Claim Type Institutional	Client	Provider	Status Rejected	Claim No.
-----------------------------	--------	----------	--------------------	-----------

- :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

c) If the status of the claim that you clicked was **Accepted** and the Payer is an MCO, the MCO CSI Search Details page will display.

Once a Forwarded Claim has been Accepted by an MCO, the MCO ICN field will populate. 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	[REDACTED]
Status	Accepted
Status Date	12/8/2014 4:00:49 PM
MCO Name	[REDACTED]
MCO Phone No	[REDACTED]
MCO ICN	[REDACTED]

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
[REDACTED]	[REDACTED] has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at [REDACTED] for questions about processing of this claim.
[REDACTED]	EOB from MCO for Accepted Claim.

This claim has been accepted to [REDACTED] for processing. Contact [REDACTED] at [REDACTED] 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

d) 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		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		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		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 the **Return To List** link 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	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Status	Accepted
Status Date	12/8/2014 4:00:49 PM
MCO Name	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
MCO Phone No	XXXXXXXXXXXX
MCO ICN	XXXXXXXXXXXX

# 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 three months.

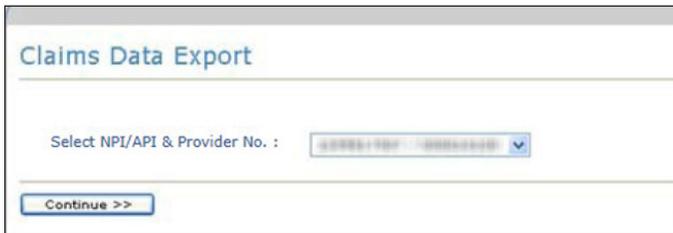
**Note:** *Claims Data Export is only available to users with administrative rights on their account.*

To request the claims data to be exported:

- 1) Click the **Data Export Request** link under the Claims Data Export section on the left navigation panel



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



- 3) Enter your Submitter ID, Password, Service Begin Date, and Service End Date, and then click the **Request Data** button.

- The date range must be no more than three months long.
- The Service Begin Date cannot be more than three years prior to current date.
- If you do not know your Submitter ID and Password, contact the EDI Helpdesk at 1-888-863-3638, Option 4, from 7:00 a.m. to 7:00 p.m., Monday through Friday.
- The requested data will be available on the next business day.

**Claims Data Export**

Submitter ID:

Password :

Service Begin Date:   Format: mm/dd/yyyy

Service End Date:   Format: mm/dd/yyyy

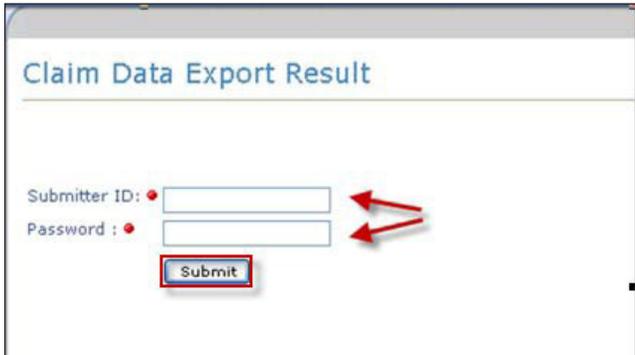
- Date range cannot span a length of time greater than three months.  
- Service Begin Date cannot be more than three years prior to current date.

**Request Data**

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



- 5) Enter your Submitter ID and Password, and click the **Submit** button.



The screenshot shows a web form titled "Claim Data Export Result". It contains two input fields: "Submitter ID:" and "Password:". Below these fields is a "Submit" button. Two red arrows point to the right from the right side of each input field, indicating the direction of data flow or the next step in the process.

- 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 the **Download** button.

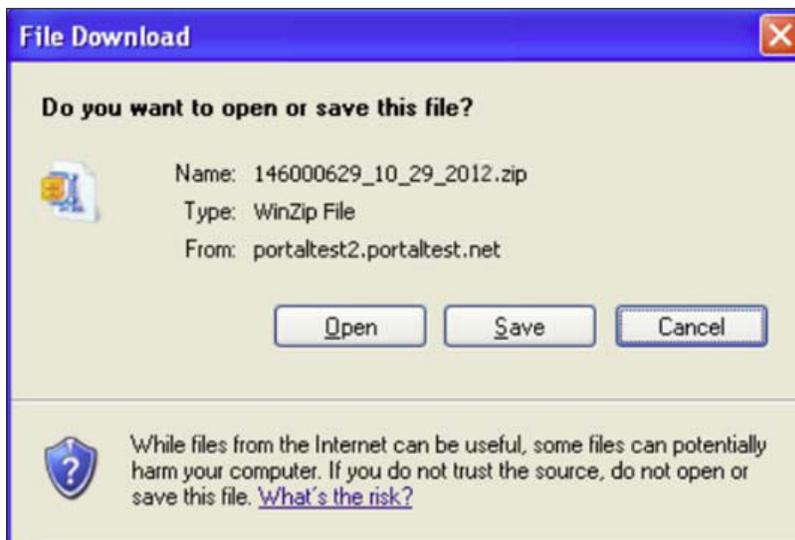


The screenshot shows the same "Claim Data Export Result" page. A table is displayed with two columns: "Select" and "File Name". The "Select" column contains a checkbox, which is circled in red. The "File Name" column contains the text "EXT1460006290006529002007-10-26\_12\_54\_15.056147.csv". Below the table is a "Download" button, also circled in red.

Select	File Name
<input type="checkbox"/>	EXT1460006290006529002007-10-26_12_54_15.056147.csv

- 7) A File Download dialog box will be displayed. Click the **Save** button and save the file to a location on your computer.

- The requested data will remain available for download for three months.
- Your computer must be able to open WinZip® files (Zipped files) or you will not be able to open the file once you have saved it.



# Claims Status Inquiry (CSI)

Claims Status Inquiry is used to determine the status of submitted claims. There are several 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:** means that the claim has been forwarded to (but not yet Accepted or Rejected by) an MCO.
- **Rejected:** means that the claim has been rejected by TMHP or the MCO it was forwarded to.
- **Accepted:** means that the claim has been Accepted by TMHP or an MCO.

Claims handled by TMHP (not 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:

The screenshot shows the 'CSI Search' interface with three distinct search sections, each highlighted with a red border:

- Lookup Fee For Service Claim by Claim Request:** Features a 'Claim Number' input field with a red asterisk and a 'Lookup' button. The format is specified as '15 digits with no spaces'.
- Lookup Fee For Service Claim by Client Claim Request:** Includes fields for 'Provider NPI/API' (a dropdown menu), 'Service Begin Date' and 'Service End Date' (calendar pickers), and radio buttons for 'Client' (selected) and 'Trainee'. Below this is a 'Client Information' section with fields for 'Medicaid No.', 'Last Name', 'First Name', 'M.I.', and 'Suffix', followed by a 'Search' button.
- Lookup Managed Care Claim by Transaction Number:** Contains a 'Transaction Number' input field, a 'Transaction Number Type' dropdown menu, and a 'Lookup' button.

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

- 1) To search for a Claim by Claim Request enter the Claim Number in the Claim Number field and click the **Lookup** button.

This close-up screenshot focuses on the first search section. The 'Claim Number' input field and the 'Lookup' button are both circled in red. The text 'Format: 15 digits with no spaces' is visible to the right of the input field.

- 2) The CSI Details page will display and auto populate most of the fields, including the status of the claim. For Service Groups 1, 6, and 8, the detailed claim information includes the Total Applied Other

Insurance Amount, as well as the OI Paid Amount and Applied OI Amount.

CSI Details

[New Lookup](#)

Claim Information		Client Information	
Claim No.		Client/Medicaid No./Trainee SSN	
Dates of Service	8/1/2014 - 8/1/2014	Name	
Status	D	Gender	
Effective Date	9/10/2014	Date of Birth	
Service Group	1	Patient Account No.	
Warrant Number		Medical Record No.	
		Referral No.	
Financial Information		Provider Information	
Total Billed Amount	\$100.00	Provider NPI/API	
Total Paid Amount	\$0.00	Provider Name	
Total Applied Other Insurance Amount	\$0.00	Medicare Patient Days %	0
Budget Number		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.
- You must complete all of the fields indicated by a red dot.

1) 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: ♦

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

2) You must complete all of the fields that are indicated by a red dot.

3) Click the **Search** button.

4) The CSI Search Details page will display and auto populate with the client information.

CSI Details

[New Lookup](#)

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

Financial Information		Provider Information	
Total Billed Amount	\$100.00	Provider NPI/API	XXXXXXXXXX
Total Paid Amount	\$0.00	Provider Name	XXXXXXXXXX
Total Applied Other Insurance Amount	\$0.00	Medicare Patient Days %	0
Budget Number		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 EDI Transaction Number (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 fee-for-service (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 line labeled Status. There are three possible statuses for a Claim that has been forwarded to an MCO:

- **Forwarded;**
- **Accepted** (by the MCO); or
- **Rejected** (by the MCO).

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

Lookup Managed Care Claim by Transaction Number

Transaction Number ♦

Transaction Number Type ♦

2) The MCO CSI Search Details page will display and auto populate with the ETN in the Claim Information section.

MCO CSI Search Details								
<a href="#">New Lookup</a> <a href="#">Return To List</a>								
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.							
<p><b>This claim has been accepted to Long Term Support for processing. Contact Long Term Support at for questions related to this claim.</b></p>								
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

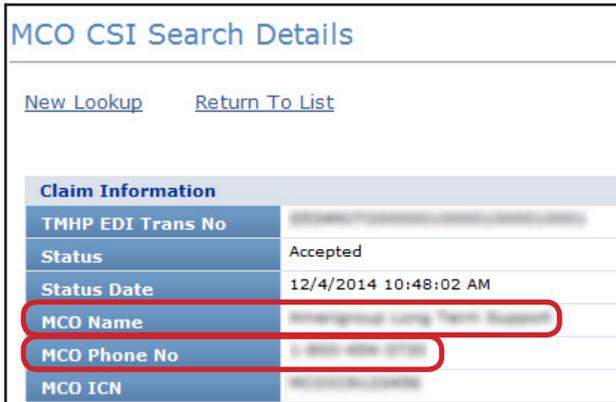
3) The status of the claim will be shown in the Claim Information section on the line labeled Status. Recall that there are three possible statuses for a claim:

- **Forwarded;**
- **Accepted** (by the MCO); or
- **Rejected** (by the MCO).

MCO CSI Search Details	
<a href="#">New Lookup</a> <a href="#">Return To List</a>	
Claim Information	
TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	Managed Long Term Support
MCO Phone No	1-800-456-2700
MCO ICN	0000000000

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

**NOTE:** If there are any issues or questions 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.



The screenshot shows a table titled "MCO CSI Search Details". At the top, there are two links: "New Lookup" and "Return To List". Below the links is a section header "Claim Information". The table contains the following rows:

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

Red circles highlight the "MCO Name" and "MCO Phone No" rows in the table.

- 5) The name and contact information of the MCO is identified in multiple places on the screen. Once 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 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 column (how TMHP would have priced the claim if processed as FFS

for Nursing Facility Daily Care [Service Group 1, Service Code 1] and Medicare Coinsurance [Service Code 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	
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 [redacted] for questions about processing of this claim.

**This claim has been forwarded to [redacted] for processing. Contact [redacted] at 1-800-[redacted] 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 MCOs 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, choose MCO ICN from the Transaction Number Type drop-down box. Because multiple MCOs may have similar ICN numbering strategies, you must choose the appropriate Payer Name from the drop-down box, and then click the **Lookup** button.

**Lookup Managed Care Claim by Transaction Number**

Transaction Number

Transaction Number Type

Payer Name

- Amerigroup Long Term Support
- Cigna Long Term Care
- Molina Long Term Care
- Superior Nursing Facility
- United Healthcare Long Term Care

- The MCO CSI Search Details page will display and auto populate 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 in the Informational Pricing column (how TMHP would have priced the claim if processed as FFS for Nursing Facility Daily Care [Service Group 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.

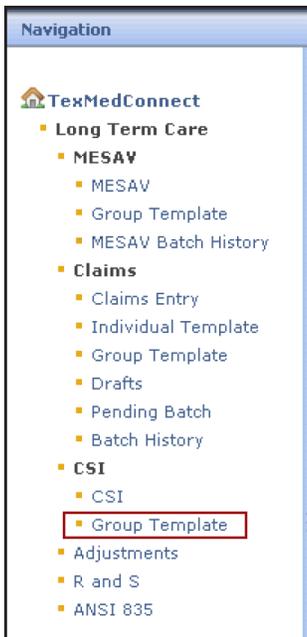
**The following data is for informational purposes. For actual payments please contact the MCO.**

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

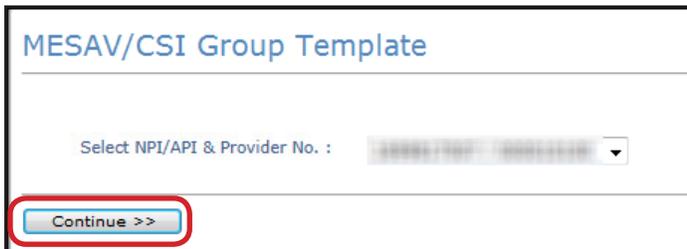
## Creating a CSI Group Template

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:

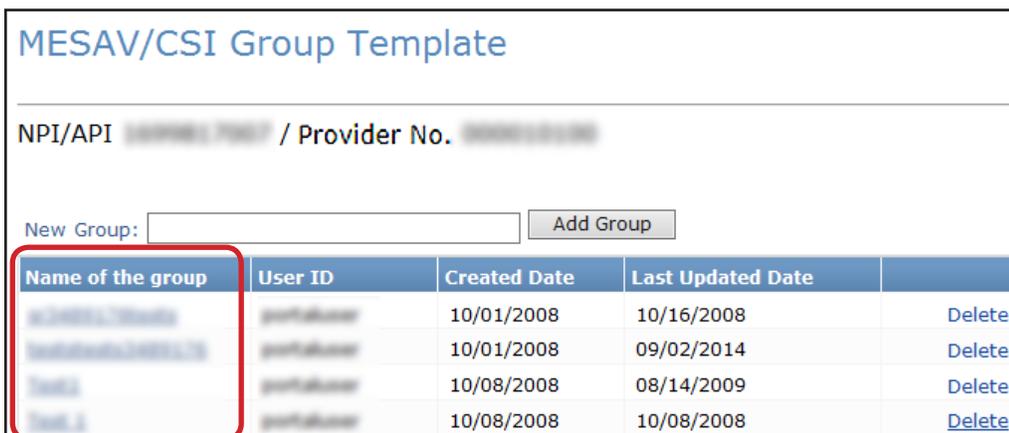
- 1) Click the **Group Template** link under the CSI section on the navigation panel.



- 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 box, and then click the **Continue** button.



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



- 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 the **Add Group** button.

MESAV/CSI Group Template

NPI/API / Provider No.

New Group:

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

MESAV/CSI Group Template - Add Client

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	MESA	CSI	Delete
<input type="checkbox"/>						<a href="#">MESA</a>	<a href="#">CSI</a>	<a href="#">Delete</a>

- 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

The screenshot shows the 'Add Client' form. At the top, there is a header 'Add Client' in blue. Below it, there are two fields: 'NPI/API' and 'Provider No.', both with blurred values. The main section contains several input fields: 'Client Number', 'Social Security Number', 'Date of birth' (with a calendar icon), 'First name', and 'Last name'. To the right of these fields is a 'Lookup Criteria' section with the text: 'Client # or Combination of SSN and DOB or First Name, Last Name and DOB or SSN and Last Name.' Below the input fields is a 'Lookup' button. At the bottom left, there is a 'Go Back' button. A red rectangular box highlights the 'Client Number', 'Social Security Number', 'Date of birth', 'First name', 'Last name', and 'Lookup Criteria' sections.

7) Click the **Lookup** button.

This screenshot is identical to the one above, showing the 'Add Client' form. However, in this version, the 'Lookup' button is highlighted with a red rectangular box, indicating the step to click it.

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

**Add Client**

NPI/API : 0000000000 / Provider No. 0000000000

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.

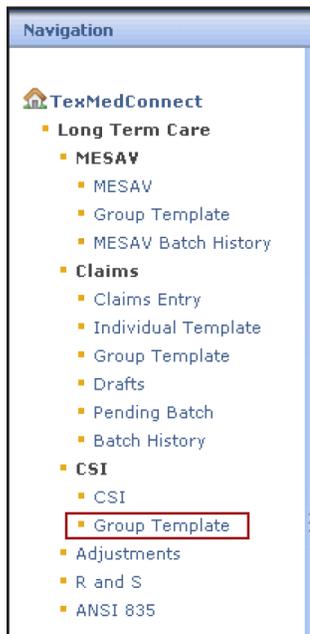
First Name	Last Name	Client #	SSN	Date of Birth	
00000000	00000000	00000000	00000000	00/00/0000	<a href="#">Add to group</a>

- 9) The person will be added to the CSI Group Template that you are working on.
- You can create up to 100 groups for each NPI or API and provider number.
  - Each group can contain up to 250 people.
  - You can view, add, and delete people from the list.

## Submitting a CSI Group Template

To verify eligibility using a group template:

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



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

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

Name of the group	User ID	Created Date	Last Updated Date	Delete
[Group Name]	[User ID]	10/01/2008	09/02/2014	<a href="#">Delete</a>
[Group Name]	[User ID]	10/08/2008	10/14/2015	<a href="#">Delete</a>
[Group Name]	[User ID]	10/08/2008	10/08/2008	<a href="#">Delete</a>
[Group Name]	[User ID]	10/08/2008	09/09/2015	<a href="#">Delete</a>
[Group Name]	[User ID]	04/06/2009	09/09/2015	<a href="#">Delete</a>
[Group Name]	[User ID]	04/06/2009	09/09/2015	<a href="#">Delete</a>
[Group Name]	[User ID]	07/14/2009	09/17/2015	<a href="#">Delete</a>
[Group Name]	[User ID]	07/30/2009	09/25/2015	<a href="#">Delete</a>

- 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.

Select All	First Name	Last Name	Client #	SSN	Date of Birth	MESAV	CSI	Delete
<input type="checkbox"/>	[Name]	[Name]	[ID]	[SSN]	[DOB]	MESAV	CSI	<a href="#">Delete</a>

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

The screenshot shows the 'MESA/CSI Group Template' page. On the left is a navigation menu with categories like 'Long Term Care', 'MESAV', 'Claims', and 'CSI'. The main area contains a table of client information. The 'Select All' checkbox at the top left of the table is highlighted with a red box. Below the table is a 'Submit MESA/CSI Batch' button.

Select All	First Name	Last Name	Client #	SSN	Date of Birth	MESA/CSI	Delete
<input type="checkbox"/>	DEBRA	WYCHER	900000000		01/01/1978	MESA/CSI	Delete
<input type="checkbox"/>	RONALD	BARBER	900000000		08/08/1965	MESA/CSI	Delete
<input type="checkbox"/>	DAVID	BLAND	900000000		05/08/1968	MESA/CSI	Delete
<input type="checkbox"/>	DEBORAH	BROWN	900000000		08/14/1968	MESA/CSI	Delete
<input type="checkbox"/>	BLAINE	BRIDGEMAN	900000000		11/03/1947	MESA/CSI	Delete
<input type="checkbox"/>	CLARENCE	BRUNY	900000000		03/12/1959	MESA/CSI	Delete
<input type="checkbox"/>	MORRIS	HEBERMAN	900000000		02/12/1947	MESA/CSI	Delete
<input type="checkbox"/>	CAROL	JACKSON	900000000		12/08/1971	MESA/CSI	Delete
<input type="checkbox"/>	WILLIAM	LAMBERT	900000000		10/01/1962	MESA/CSI	Delete
<input type="checkbox"/>	LOUIE	LEWIS	900000000		11/04/1948	MESA/CSI	Delete
<input type="checkbox"/>	ISA	MARSHALL	900000000		04/18/1948	MESA/CSI	Delete
<input type="checkbox"/>	DAVID	MOORE	900000000	408871040	11/02/1962	MESA/CSI	Delete
<input type="checkbox"/>	BERNARD	PAUL	900000000		10/02/1954	MESA/CSI	Delete
<input type="checkbox"/>	ISA	PALM	900000000		08/04/1964	MESA/CSI	Delete
<input type="checkbox"/>	MARION	QUITTENBACH	900000000		08/04/1962	MESA/CSI	Delete
<input type="checkbox"/>	DAVID	WHITE	900000000		08/04/1942	MESA/CSI	Delete

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

This is a close-up view of the bottom portion of the table from the previous screenshot. The 'Submit MESA/CSI Batch' button is highlighted with a red box.

# Adjustments

## Creating an Adjustment for a Fee-For-Service Claim

An adjustment is a change made to a previously paid claim. Adjustments reimburse Health and Human Services (HHS) for overpayments and to reimburse providers if units were underbilled and must be paid correctly. Only claims that are set to status **Paid** can be adjusted using TexMedConnect. If you submit an Adjustment, 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.*

- 1) To make an adjustment on a fee-for-service claim, click the **Adjustments** link under the CSI section on the navigation panel.



- 2) Option one, enter the claim number, and click the **Lookup** button.

### 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

- 3) Option two, if you do not know the claim number, you can search for the claim using the person's information. Enter the required information, and click the **Search** button.

- The date range must be no more than three months long.
- 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 of the fields that are indicated by a red dot.

### 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

- 4) 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 only adjust the claim with the most current processing (or status) date. Click the claim number to begin adjusting the claim. Providers can determine the most recent claim by comparing the Claim Status Dates, also known as the Effective Date. To determine which claim is the most recent, click on the hyperlink for each claim in the list for your date range and compare the effective dates of each claims. Whichever claim has the most recent Effective Date is the one that needs to be adjusted.

#### 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

**Search Results**

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	<a href="#">000000123456789</a>	P	\$218.60	\$175.00
11/16/2012	11/16/2012	JOHN DOE	0123456789	<a href="#">1234567890000000</a>	P	\$3,324.75	\$3,324.75
11/29/2012	11/29/2012	JOHN DOE	0123456789	<a href="#">000123456789000</a>	P	\$152.75	\$152.75
12/10/2012	12/10/2012	JOHN DOE	0123456789	<a href="#">000001234567890</a>	PZ	\$0.00	\$0.00

- 5) Select the appropriate Claim Type from the drop-down box, and click the **Adjust Claim** button.

Select the appropriate Claim Type for this Claim to Adjust

Claim Type: Unknown Adjust Claim

Claim Information		Client Information	
Claim No.	000000123456789	Client/Medicaid No./Trainee SSN	0123456789
Dates of Service	9/3/2012 - 9/6/2012	Name	JOHN DOE
Status	P	Gender	M
Effective Date	12/7/2012	Date of Birth	10/11/1949
Service Group	1	Patient Account No.	
Warrant Number	10005	Medical Record No.	
		Referral No.	

Financial Information		Provider Information	
Total Billed Amount	\$175.00	Provider NPI/API	1234567890
Total Paid Amount	\$218.60	Provider Name	REGIONAL MEDICAL CEN
Total Applied Other Insurance Amount	\$60.00	Medicare Patient Days %	0
Budget Number		Private Patient Days %	0
		Medicaid Patient Days %	0

DB No	Detail Status	Service Begin	Service End	Billing Code	Billed Amount	Paid Amount	OI Paid Amou	Applied OI A	Billed Unit
1	P	9/3/2012	9/3/2012	RG002	\$65.00	\$109.30	\$30.00	\$30.00	1.00

- 6) Verify that all of the required fields that are indicated by a red dot are populated for each tab.
- 7) **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	JOHN DOE	1234567890 / 00000000	New	

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

Client Identification Numbers

Client ID: 0123456789 | Patient Account No.: | Medical Record No.: |

Name and Address

First Name: JOHN | Last Name: DOE | MI: | Suffix: |  
 Street Address: 123456 MAIN AVE | Street Address 2: | City: ANY TOWN | State: TX | Zip: 12345-6789

Client General Information

Gender: Male | Date Of Birth: 10/11/1949 | Referral No.: 0000000123

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

- 8) **Provider Tab.** Select the ID qualifier from the ID Qual drop-down box and enter the Other ID number in the Other ID field.

**Claim Submission - Step 2**

Claim Type	Client	Provider	Status	Claim No.
Professional	JOHN DOE	1234567890 / 00000000	New	

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

**Billing Provider**

NPI: 1234567890

Name: REGIONAL MEDICAL CENTER NPI/API: 1234567890

Address: 1234567 FIRST STREET ANY TOWN, TX 01234-5678

Contact Name:

Contact Phone:

ID Qual:  Other ID:

**Performing Provider**

NPI/API: 0123456789 First Name: FRANK Last Name: SMITH MI: Suffix:

Save Draft Save Template Save To Group Prev Next Finish

- 9) **Claim Tab.** Select a Claim File Indicator Code from the drop-down box. Select a Place of Service from the drop-down box. Both institutional and professional claims require a valid diagnosis code. Inputting an invalid diagnosis code may result in an error message (and a 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.

**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

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		
1	<input type="text"/>	<input type="text"/>

Delete

- 10) **Details Tab.** On the details tab, the system will auto populate the negative row(s) with the data that was initially paid on the initial claim. The fields Unit, Unit Rate, and Line Item Total will be auto populated and read only. The fields OI and AI/Co-Pay on the negative row(s) will always be auto populated with 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, 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 the **Add New Details Row(s)** button.

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	Start	End	Procedure Code	Units	Unit Rate	Line Item Total	Applied Income	Rev Code	OI Paid Amount	Rendering Provider	Delete
1	10/1/2012	10/1/2012		-1.00	\$92.83	(\$92.83)	\$0.00	0100	\$0.00		Delete

Co-Pay  
 Applied Income  
 Claim Total: (\$92.83)  
 Total Applied Income: \$0.00  
 Total Other Insurance: \$0.00  
 Total Other Insurance: (from Details Tab)  
 Total Other Insurance: (from Other Insurance/Finish Tab)

Save Draft Save Template Save To Group

- 11) To bill positive units for the same adjusted claim, click the **Add New Details Row(s)** button. 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 display. 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	Start	End	Procedure Code	Units	Unit Rate	Line Item Total	Applied Income	Rev Code	OI Paid Amount	Rendering Provider	Delete
1	10/1/2012	10/1/2012		-1.00	\$92.83	(\$92.83)	\$0.00	0100	\$0.00		Delete
2	10/1/2012	10/1/2012		11.00	\$92.83	\$504.16	\$436.97	0100	\$0.00		Delete

Co-Pay  
 Applied Income  
 Claim Total: \$491.33  
 Total Applied Income: \$436.97  
 Total Other Insurance: \$0.00  
 Total Other Insurance: (from Details Tab)  
 Total Other Insurance: (from Other Insurance/Finish Tab)

Save Draft Save Template Save To Group

## Saving and Submitting an Adjustment

All adjustments must be submitted as batches.

- 1) To save a Professional or Dental claim adjustment as a batch, click the **Other Insurance / Finish** tab, click the **Save to Batch** radio button, check the **We Agree** box, and then click the **Finish** button 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.**

**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

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

**Note:** For claims in Service Group 1, 6, and 8, the OI Paid Amount entered in the Details tab will have to equal the OI Paid Amount in the Other Insurance/Finish Tab.

Claim Submission - Step 2

Claim Type: Draft    Client: DOROTHY HAMDINK    Provider: 121994929/00103228    Status: Adjustment    Claims No:

**\* 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 MESA 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](#)

**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)    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  
Submit the claim interactively

Save to Batch  
Save 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   

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

The R&S function on the left navigation panel has 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 who use third-party billing software or third-party billing agents.

**Note:** An additional resource that can assist Long-Term Care providers with R&S Reports is the *Remittance and Status Reports for LTC Providers Quick Reference Guide (QRG)*. Click the link provided and refer to the TMHP website to access the QRG.

## Viewing the PDF Version

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

- 1) Click the **R and S** link on 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, while 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
PDF	<a href="#">1234567890-20150413.pdf</a>					Long Term Care R&S report for week ending 04/13/2015	4/8/2015 10:51:40 AM	621 KB
PDF	<a href="#">1234567890-20150420.pdf</a>					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

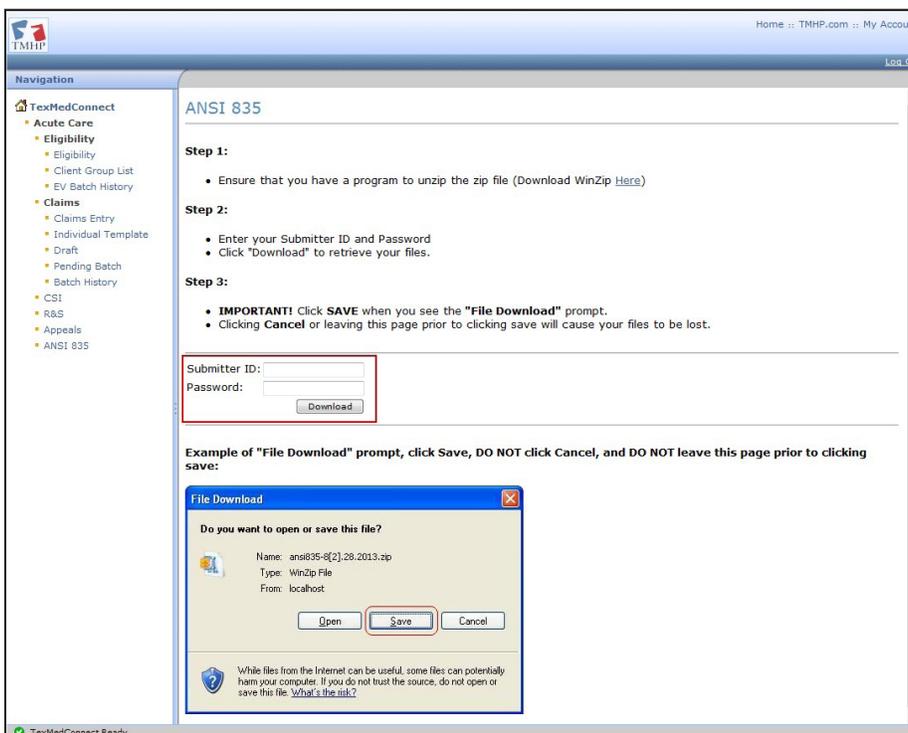
You can access the 835 non-pending Electronic Remittance and Status (ER&S) Report and the pending ER&S Report through TexMedConnect.

To download the ANSI 835 version of the R&S Report, follow these steps:

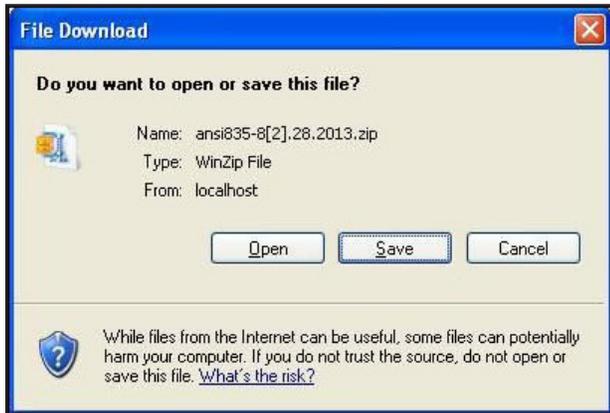
- 1) Click the **ANSI 835** link on the left navigation panel.



- 2) Enter your Submitter ID and Password, and click the **Download** button. If you do not know your Submitter ID and Password, contact the EDI Helpdesk at 1-888-863-3638, Option 4, from 7:00 a.m. to 7:00 p.m., Monday through Friday.



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



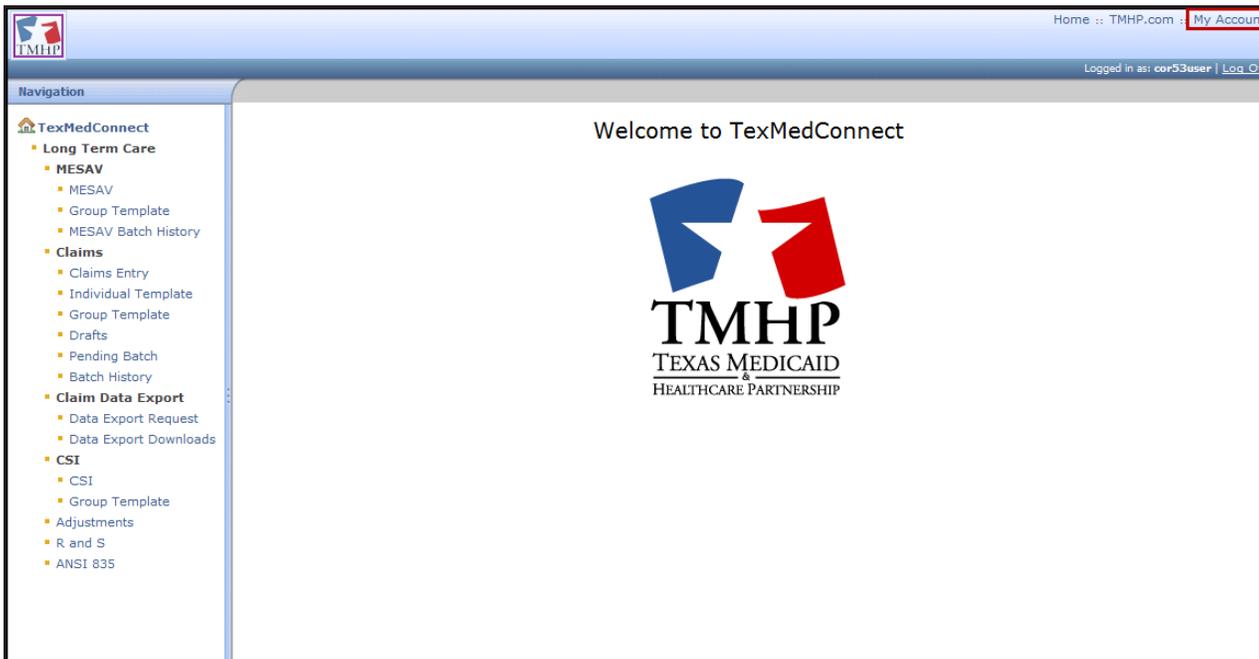
**Note:** *Third-party software vendors, third-party billing services, and providers who program their own software can find information about all of the requirements for EDI ANSI X12 file types in the EDI Companion Guides, which are located on the EDI page of the TMHP website at [www.tmhp.com](http://www.tmhp.com).*

# Claims Identified for Potential Recoupment (CIPR) Reports

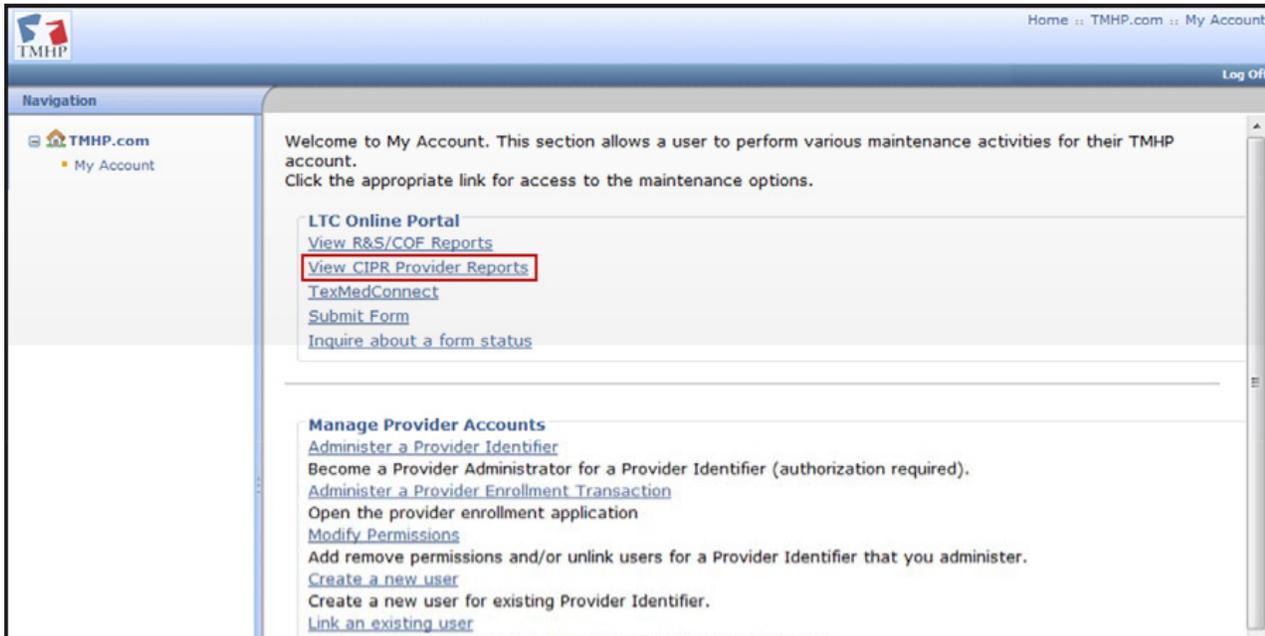
TMHP provides Claims Identified for Potential Recoupment (CIPR) Provider Reports to Long-Term Care providers that can be downloaded and viewed. As TMHP becomes aware of a person's third-party insurance policies with retroactive dates of coverage, claims previously reimbursed by Medicaid will be identified if the claim would have 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 claims on a CIPR report to address the updated OI information. If claims are not adjusted, the identified claims will be recouped after the 120 calendar days.

Reports are generated on a weekly basis, and TMHP maintains each CIPR Provider Report for a six-month period. 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 the provider believes that the other insurance information on file is incorrect, they should contact TMHP TPL Resource Line at 1-800-626-4117, Option 6.

1) Click the **My Account** link in the top right corner of the TexMedConnect Home Page.



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



- 3) Click the NPI/API to view the CIPR Report.

List of NPI/API		
NPI/API	Provider Number	Name
<a href="#">0000012345</a>	000000012	REGIONAL MEDICAL CENTER
<a href="#">0000045678</a>	000000001	CITY HEALTH CENTER
<a href="#">0000098765</a>	110000000	COUNTY CLINIC
<a href="#">0000023456</a>	220000000	EMERGENCY CARE FACILITY

- 4) Click on a File Name hyperlink to view CIPR Provider Reports. Click the **Date Created** column heading to sort.

<b>NPI: 0000012345</b>		
<b>Provider Number: 000000012</b>		
<b>Name: REGIONAL MEDICAL CENTER</b>		
File Name	Date Created	File Size
<a href="#">000000012-CIPR-20121220.pdf</a>	12/20/2012	5 KB
<a href="#">000000012-CIPR-20130103.pdf</a>	01/03/2013	5 KB

[Return to NPI list page](#)

**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 previously submitted to Medicaid.

