



LONG-TERM CARE (LTC) USER GUIDE

FOR TEXMEDCONNECT



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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Contents

Terms and Abbreviations	1
Training and Support	3
TexMedConnect Training	3
Technical Support.	3
Claims Support	3
Getting Started	4
TexMedConnect Navigation Panel	5
MESAVs	7
Submitting a MESAV Interactively	7
Creating a MESAV Group Template	10
Submitting a MESAV Group Template.	14
Viewing a MESAV Batch History	16
MESAV – Other Insurance (OI) Applicable to Service Groups (SGs) 1, 6, 8.	18
MESAV Medicare Eligibility.	18
Filing a Claim	20
Entering a Claim on TexMedConnect	20
Entering a Professional Claim	24
Entering a Dental Claim	30
Entering an Institutional Claim	33
Entering an NAT Claim	46
Saving a Claim	49
Draft Claims	49
Viewing Draft Claims	50
Individual Templates	52
Saving as an Individual Template.	52
Viewing Individual Templates.	52
Group Templates	54
Viewing Existing Group Templates.	54
Creating New Group Templates.	55
Saving as a Group Template	58
Batch Claims.	59
Saving to a Batch	59

Submitting a Batch	60
View Batch History	62
Claims Data Export	69
More Information about Claims Data Export	73
Claims Status Inquiry (CSI).	74
CSI Search: Lookup Fee For Service Claim by Claim Request	75
CSI Search: Lookup Fee For Service Claim by Client Claim Request	76
CSI Search: Lookup Managed Care Claim by Transaction Number	77
CSI Search: Lookup Managed Care Claim by MCO ICN	80
Creating a CSI Group Template	82
Submitting a CSI Group Template	85
Adjustments	88
Creating an Adjustment for an FFS Claim.	88
Saving and Submitting an Adjustment.	94
Remittance and Status (R&S) Reports.	97
Viewing the PDF Version	97
Downloading the ANSI 835 Version	99
Claims Identified for Potential Recoupment (CIPR) Reports	101
Appendix: Using the LICN Field for HCS and TxHmL Waiver Programs	103

Terms and Abbreviations

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

Abbreviations	Terms
TMHP	Texas Medicaid & Healthcare Partnership

Training and Support

TexMedConnect Training

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

Technical Support

You can call the TMHP Electronic Data Interchange (EDI) Help Desk at 888-863-3638, Option 4, Monday through Friday from 7:00 a.m. to 7:00 p.m., for LTC 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 Help Desk at 800-626-4117, Option 1 then Option 2, for questions about claims, Monday through Friday from 7:00 a.m. to 7:00 p.m.

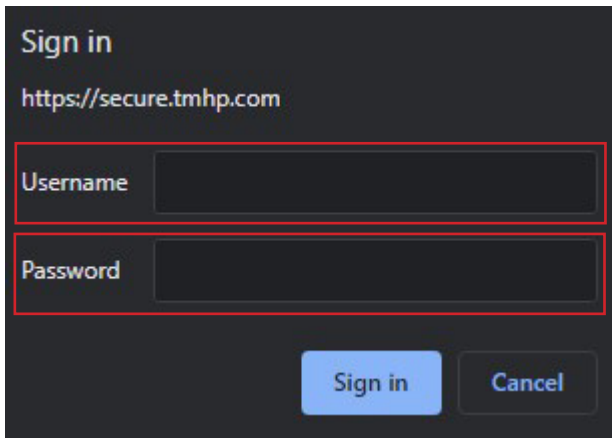
Getting Started

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

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

The screenshot shows the TMHP website home page. At the top left is the TMHP logo with the text "TEXAS MEDICAID & HEALTHCARE PARTNERSHIP" and "A STATE MEDICAID CONTRACTOR". At the top right are links for "Provider" and "Client/Cliente", and a search bar. Below the header is a navigation menu with "Home", "Programs", "Topics", "Resources", "Contact", and "My Account". The main content area features a large banner with the text "Welcome Texas Medicaid Providers" and a "My Account" button. Below the banner is a section titled "What brings you in today?" with four tiles: "TexMedConnect" (highlighted with a red border), "Prior Authorization", "Medicaid Provider Manual", and "Provider Enrollment".

2) Enter your user name and password and click the **OK** button.



A dark-themed sign-in dialog box with the title "Sign in" and the URL "https://secure.tmhp.com". It contains two input fields: "Username" and "Password", both highlighted with red rectangular boxes. At the bottom, there are two buttons: "Sign in" (highlighted in blue) and "Cancel".

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




TexMedConnect Navigation Panel

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

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

Navigation

 **TexMedConnect**

- **Acute Care**
 - **Eligibility**
 - Eligibility
 - Client Group List
 - EV Batch History
 - **Claims**
 - Claims Entry
 - Individual Template
 - Draft
 - Pending Batch
 - Batch History
 - CSI
 - R&S
 - Appeals
 - ANSI 835
- **Long Term Care**
 - **MESAV**
 - MESAV
 - Group Template
 - MESAV Batch History
 - **Claims**
 - Claims Entry
 - Individual Template
 - Group Template
 - Drafts
 - Pending Batch
 - Batch History
 - **Claim Data Export**
 - Data Export Request
 - Data Export Downloads
 - **CSI**
 - CSI
 - Group Template
 - Adjustments
 - R and S
 - ANSI 835

MESAVs

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

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

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

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

Submitting a MESAV Interactively

To verify a person's eligibility:

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



2) Complete the following required fields:

- Provider NPI/API & Provider No. (API stands for Atypical Provider Identifier)
- Eligibility Start Date
- Eligibility End Date

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

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

MESAV Entry

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

NPI/API & Provider No. :

Eligibility Start Date: Format: mm/dd/ccyy

Eligibility End Date: Format: mm/dd/ccyy

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

Medicaid/Client No.: Format: 123456789

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

Date of Birth: Format: mm/dd/ccyy

Last Name:

First Name:

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

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

- Social Security Number and Last Name
 - Social Security Number and Date of Birth (DOB)
 - Last Name, First Name, and DOB
- Note:** If you perform more than one interactive MESAV, the NPI or API and provider number on the MESAV Entry page will default to the last one that you used.

4) Click the **Submit** button.

MESAV Entry

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

NPI/API & Provider No. :

Eligibility Start Date: Format: mm/dd/ccyy

Eligibility End Date: Format: mm/dd/ccyy

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

Medicaid/Client No.: Format: 123456789

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

Date of Birth: Format: mm/dd/ccyy

Last Name:

First Name:

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

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

MESAV Results

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

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

Client Information		Inquiry Information	
Client No./Trainee SSN	123456789	NPI/API	111111111
DOB	1/1/11	Eligibility From	1/1/20
Gender	M	Eligibility Through	12/31/20
SSN		Medicaid /Client No.	123456789
Name	JOHN DOE	Social Security Number	
Address	4567 MAIN STREET	Date of Birth	
County		Last Name	DOE
Medicare No.		First Name	JOHN
Medicaid Recert Review Due Dt		M.I.	
		Suffix	

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

- 6) 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.

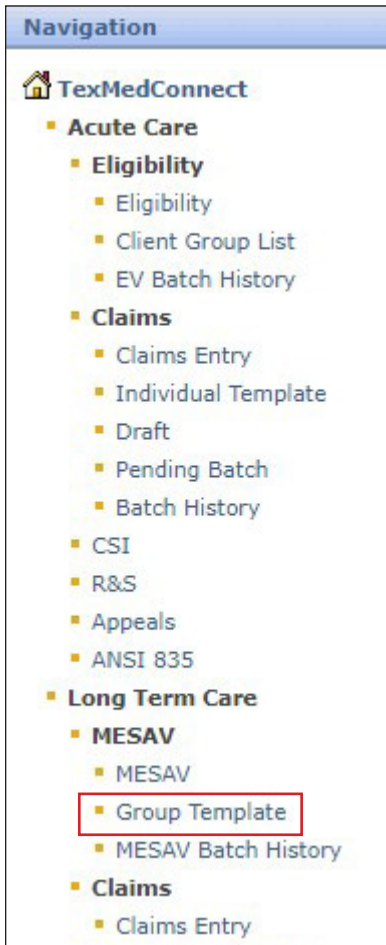
Note: PDF copies of MESAVs are current only at the time of printing and are not necessarily accurate afterwards. MESAV information can change daily. For the most up-to-date information, you should perform another MESAV electronically.

Creating a MESAV Group Template

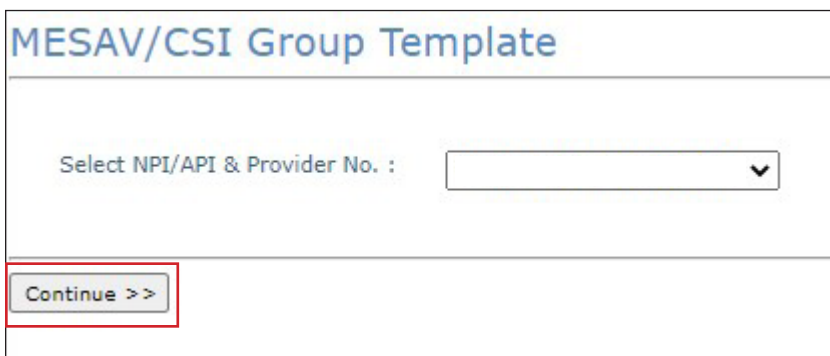
The Group Template feature allows you to create a list of people for whom you would like to verify eligibility.

To create a MESAV Group Template and add a person:

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



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



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

MESAV/CSI Group Template

NPI/API / Provider No.

New Group:

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

- 4) If you have not created a group or want to add a person to a new Group Template, enter the New Group name of your choice, and click 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 - NewGroup1

NPI/API / Provider No.

From Date of Service:  Format mm/dd/yyyy

To Date of Service:  Format mm/dd/yyyy

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

- 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 with the following fields: Client Number, Social Security Number, Date of birth (with a calendar icon), First name, and Last name. A red box highlights these five input fields. To the right, the 'Lookup Criteria' section lists: Client #, or Combination of SSN and DOB, or First Name, Last Name and DOB, or SSN and Last Name. Below the fields is a 'Lookup' button. At the bottom left is a 'Go Back' button.

- 7) Click the **Lookup** button.

This screenshot is identical to the previous one, but the 'Lookup' button is highlighted with a red box, indicating the next step in the process.

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

This screenshot shows the 'Add Client' form with the 'Lookup' button. Below the form is a table with the following columns: First Name, Last Name, Client #, SSN, Date of Birth, and Add to group. The 'Add to group' link is highlighted with a red box. A 'Go Back' button is located at the bottom left.

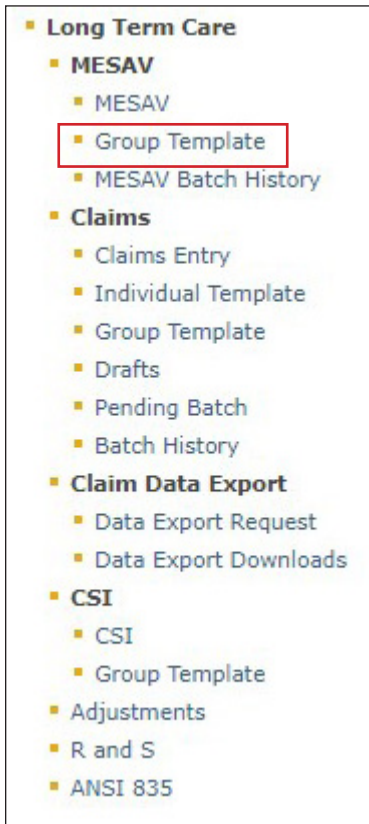
First Name	Last Name	Client #	SSN	Date of Birth	Add to group

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

Submitting a MESAV Group Template

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

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



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

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

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

MESAV/CSI Group Template

NPI/API _____ / Provider No. _____

New Group:

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

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

MESAV/CSI Group Template - NewGroup1

NPI/API _____ / Provider No. _____

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

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

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

MESAV/CSI Group Template - NewGroup1

NPI/API _____ / Provider No. _____

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

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

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

MESAV/CSI Group Template - NewGroup1

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

NPI/API / Provider No.

From Date of Service: Format mm/dd/yyyy

To Date of Service: Format mm/dd/yyyy

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

[Submit MESAV Batch](#)

Viewing a MESAV Batch History

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

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

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

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

Mesav Batch History

Select NPI/API & Provider No. : ▼

Continue >>

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

Batch History

NPI/API / Provider No.

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

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

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

Client Information		Inquiry Information	
Client No./Trainee SSN		NPI/API	
DOB		Eligibility From	1/1/2016
Gender	F	Eligibility Through	3/31/2016
SSN		Medicaid / Client No.	
Name		Social Security Number	
Address		Date of Birth	
County	Lampasas	Last Name	
Medicare No.		First Name	
		M.I.	
		Suffix	

Service Authorization Information/Details																
Effective Date	End Date	Referral Number	Status	Svc Grp	Svc Grp Desc	Svc Code	Svc Code Desc	Client Control No.	Units Paid	Unit Type	Units	Proc. Code	Proc. Type	NPI/API	Provider Number	
1/1/2016	1/9/2016		Active	1	Nursing Facility	3	ECF			Daily	1.00					
1/4/2016	3/28/2016		Active	1	Nursing Facility	1	Daily Care			Daily	1.00					

Agent
-No Data-

Authorization Message
-No Data-

Monthly Units
-No Data-

Eligibility						
Begin Date	End Date	Coverage Code	Secondary Coverage Code	Program Type	Coverage Category	
10/1/2015	3/29/2016	R		14	1	
3/30/2016	6/30/2016	R		14	1	

Other Insurance Policies
-No Data-

Medicare						
Effective Date	Termination Date	Add Date	Medicare Type	CMS Code (Federal)	Plan ID	Provider Number Link
7/1/2015	12/31/9999	11/26/2015	C		010	CMS ID Info Connected MAPs
5/1/2015	12/31/9999	10/22/2015	B			
5/1/2015	12/31/9999	10/22/2015	A			

Medical Necessity

Begin Date	End Date	Medical Necessity ID

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

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

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

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

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

MESAV Medicare Eligibility

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

Other Insurance Policies section of the MESAV.

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

Filing a Claim

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

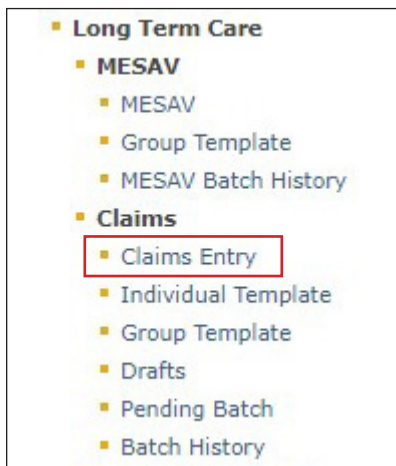
Users may submit the following claim types:

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

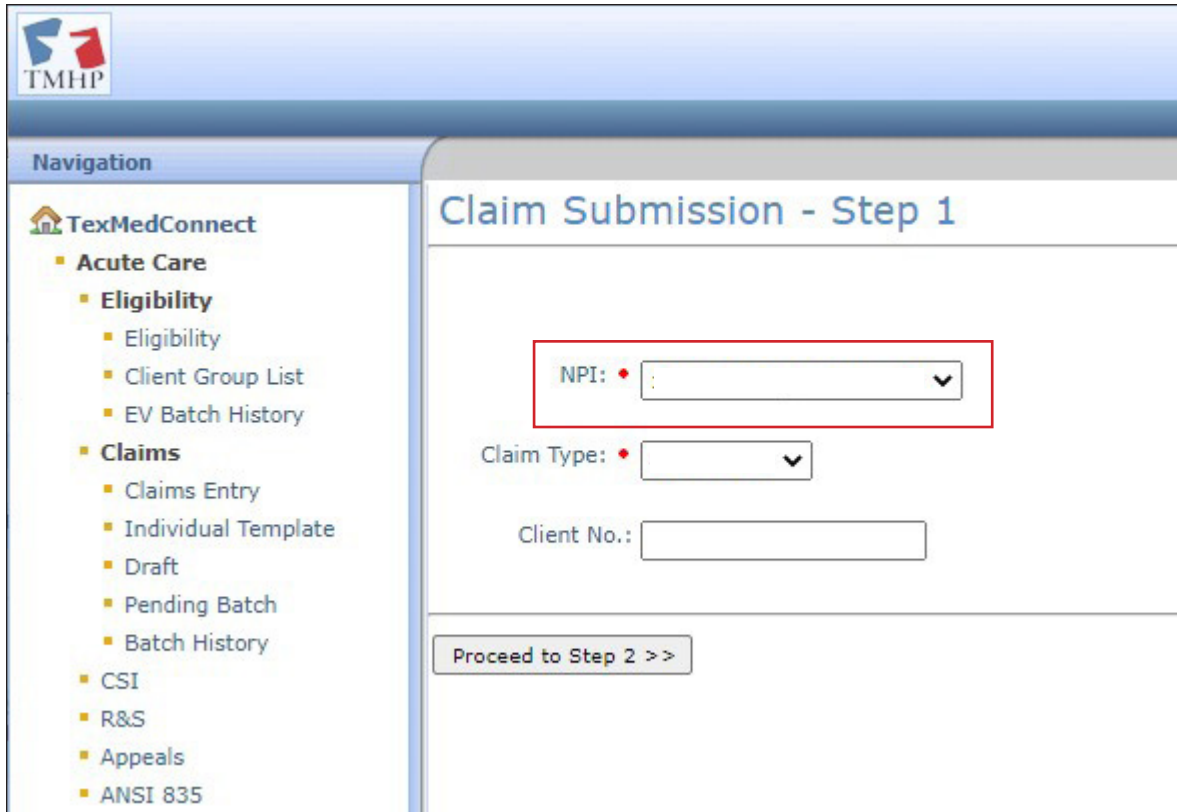
Entering a Claim on TexMedConnect

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

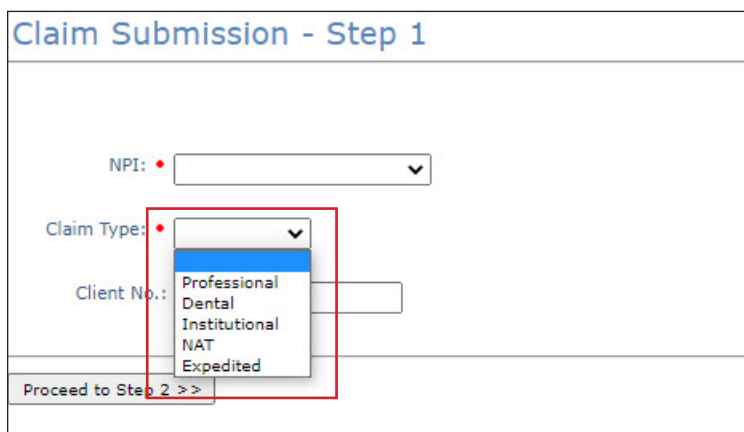
- 1) Click the **Claims Entry** link under the Claims section in the navigation panel.



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



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



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

3) 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:

- Navigation
 - TexMedConnect
 - Acute Care
 - Eligibility
 - Eligibility
 - Client Group List
 - EV Batch History
 - Claims
 - Claims Entry
 - Individual Template
 - Draft
 - Pending Batch
 - Batch History
 - CSI

The main content area contains the following fields:

- NPI:
- Claim Type:
- Client No.:
- Proceed to Step 2 >>

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

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

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional			Template	

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

Client Identification Numbers

♦ Client ID
♦ Patient Account No.
Medical Record No.

Name and Address

♦ First Name
♦ Last Name
MI
Suffix

♦ Street Address
Street Address 2
♦ City
♦ State
♦ Zip

Client General Information

♦ Gender
♦ Date Of Birth
Referral No.

Save Draft	Save Template	Save To Group	Prev Next Finish
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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 Type	Client	Provider	Status	Claim No.
Professional		-----	New	

Claim Submission - Step 2

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

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

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there is a table with columns: Claim Type (Professional), Client, Provider, Status (New), and Claim No. Below this is a navigation bar with tabs: Client, Provider (selected), Claim, Details, and Other Insurance / Finish. The 'Billing Provider' section is highlighted with a red box and contains the following fields:

- NPI: [Dropdown menu]
- Name: [Text field]
- Address: [Text area]
- NPI/API: [Text field]
- Contact Name: [Text field]
- ID Qual: [Dropdown menu with a red dot indicating a required field]
- Contact Phone: [Text field]
- Other ID: [Text field with a red dot indicating a required field]

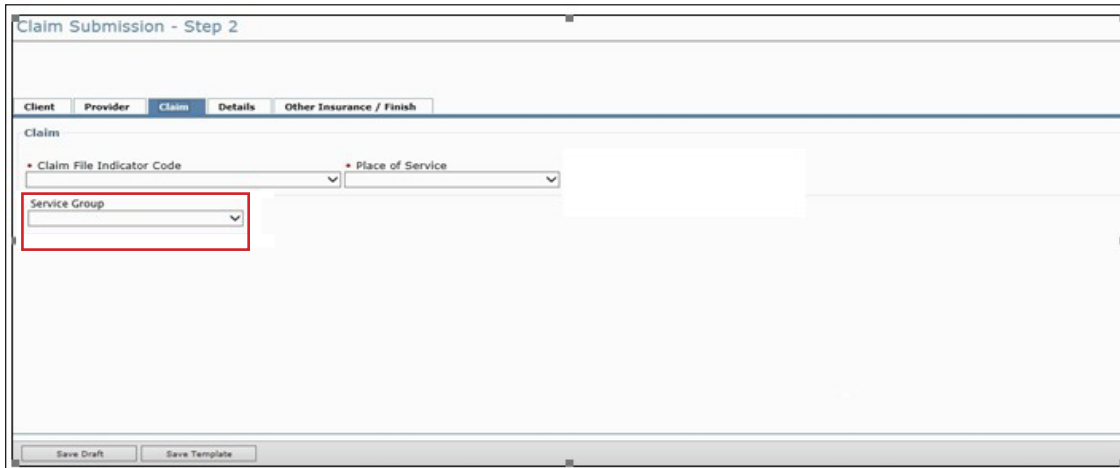
- 3) Click the **Claim** tab. You must complete all required fields that are indicated by a red dot.
- A valid principal diagnosis code is required for professional claims. Inputting an invalid diagnosis code may result in an error message (and not allow a claim to submit) in TexMedConnect.
 - To add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

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

The screenshot displays the 'Claim Submission - Step 2' interface. At the top, there are tabs for 'Claim Type' (Professional), 'Client', 'Provider', 'Status' (New), and 'Claim No.'. Below this, there are tabs for 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The 'Claim' tab is active, showing a 'Claim' section with a 'Claim File Indicator Code' dropdown menu (options: MC Medicaid, VA Veteran Administration Plan Refers to Veteran's Affairs Plans) and a 'Budget Number' dropdown. To the right is a 'Place of Service' dropdown menu with options ranging from 03 School to 99 Other Place of Service. Below these is a 'Diagnosis' section with a 'Qualifier' dropdown and an 'Add New Diagnosis' button. At the bottom, there is a table with columns for 'Code', 'Description', and 'Delete'. The table contains one row with the number '1' in the 'Code' column and a search icon in the 'Description' column.

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

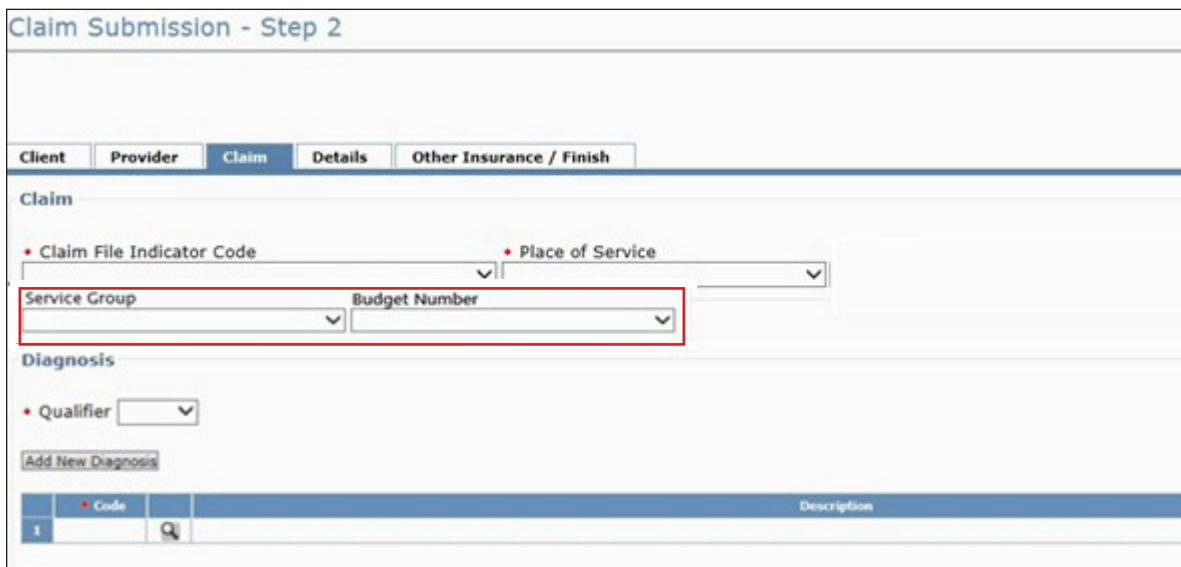
- The Service Group drop-down is to be used on LTC Professional, Institutional, and Dental claims by billing providers with multiple SGs linked to the same LTC Provider Contract number. It will not appear for other providers.



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

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

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 the Budget Number field to display. If the provider is linked only to SG 7 or SG 20, the Service Group field is not displayed.



The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there are tabs for 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The 'Claim' tab is active. Below the tabs, there are two dropdown menus: 'Claim File Indicator Code' and 'Place of Service'. Below these, the 'Service Group' and 'Budget Number' dropdown menus are highlighted with a red box. Below the 'Service Group' and 'Budget Number' fields, there is a 'Diagnosis' section with a 'Qualifier' dropdown menu and an 'Add New Diagnosis' button. At the bottom, there is a table with columns for 'Code' and 'Description'.

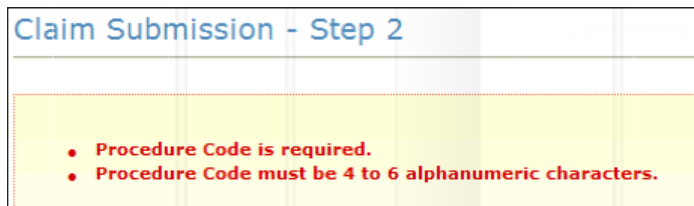
Note: Billing providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC LTC Bill Code Crosswalk. It is important to remember that modifier placements changed as of February 1, 2019, so providers should consult the Crosswalk to update their previously saved claims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

- 4) Click the **Details** tab. You must complete all 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:** OI information is not required on a Professional claim, only an Institutional claim.
- Click either the **Submit** radio button or the **Save to Batch** radio button.
 - Check the **We Agree** box.
 - Click the **Finish** button.
 - If the claim is submitted successfully, an ICN will be displayed at the top of the page.

To save the claim as a draft, click 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. If there is any missing or invalid information, an error message will be displayed. Click the tab that is indicated in the error message. Error fields are indicated with red exclamation marks. After you have made the necessary corrections, click the **Finish** button in the lower right corner of the screen.



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

Entering a Dental Claim

To enter a Dental claim:

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

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Dental			New	

Client	Provider	Claim	Details	Other Insurance / Finish
Client				

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.

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

section, but it is not required.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Dental			New	

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

Billing Provider

NPI: 1699817007 / 000010100

Name: NPI/API: 7

Address:

• ID Qual: Employer/Tax ID

• Other ID: 752735009

Performing Provider

NPI/API First Name Last Name MI Suffix

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

NPI/API First Name Last Name MI Suffix

Save Draft | Save Template | Prev | Next | Finish

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

Claim Submission - Step 2

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

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

Client Identification Numbers

• Client ID • Patient Account No.

Note: The HHSC-LTC Bill Code Crosswalk requires that modifiers start in position 1, and for any subsequent modifier to be in sequential order and not be duplicated. Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate the SG, residence SG, and budget number. Instead, billing providers will indicate the SG, residence SG, and budget number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect. The Service Group drop-down is to be used by billing providers with multiple SGs that are 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 two dropdown menus: 'Claim File Indicator Code' and 'Place of Service'. Below these, the 'Service Group' dropdown menu is highlighted with a red rectangular box.

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

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

The screenshot shows the 'Claim Submission - Step 2' interface with the 'Details' tab selected. At the top right, there is a table with columns: Claim Type (Dental), Client, Provider (1699817007/000010100), Status (New), and Claim No. Below the tabs, there are buttons for 'Add New Details Row(s)' and 'Copy Row'. A table with the following columns is displayed: Line Item Control N, Service Date, Place of Service, Code, Mods (1, 2, 3, 4), Units, Unit Rate, Line Item Total, Co-Pay, Tooth ID, and Oral Ca. The first row has a value of 0 in the Units column and \$0.00 in the Unit Rate, Line Item Total, and Co-Pay columns. At the bottom, there are radio buttons for 'Co-Pay' (selected) and 'Applied Income'. Below these, it shows 'Claim Total: \$0.00' and 'Total Co-Pay: \$0.00'.

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

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

Note: OI 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 ICN will be displayed at the top of the page.

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there is a header with 'Claim Submission - Step 2' and a table with columns: Claim Type (Dental), Client, Provider (1699817007/000010100), Status (New), and Claim No. Below this is a navigation bar with tabs: Client, Provider, Claim, Details, and Other Insurance / Finish (which is selected). The main content area is divided into two sections. The first section is 'Finish Options', which contains the text 'Please select one of the following and click finish' and two radio buttons: 'Submit' (selected) and 'Save to Batch'. The second section is 'Certification, Terms And Conditions', which contains a paragraph of text and a checked 'We Agree' checkbox. At the bottom of the page, there are buttons for 'Save Draft', 'Save Template', 'Prev', 'Next', and 'Finish' (which is highlighted with a red box).

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 MCOs. These claims can be set to the following statuses:

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

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

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

To enter an Institutional claim:

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

The screenshot shows the 'Claim Submission - Step 2' form. At the top right, 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 'Client' tab is active, and the 'Provider' tab is highlighted with a red box. The form contains several sections: 'Billing Provider' with fields for NPI, Taxonomy, Contact Name, Contact Phone, ID Qual, and Other ID; 'Attending Provider' with fields for NPI/API, First Name, Last Name, MI Suffix, and Taxonomy; 'Rendering Provider' with fields for NPI/API, First Name, Last Name, and MI Suffix; and 'Referring Provider' with fields for NPI/API, First Name, Last Name, and MI Suffix. Red dots are placed above the 'ID Qual' and 'Other ID' fields in the Billing Provider section, and above the 'NPI/API' field in the Attending Provider section. At the bottom right, there are buttons for 'Save Draft', 'Save Template', 'Save To Group', 'Prev', 'Next', and 'Finish'. The 'Next' button is highlighted with a red box.

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

This screenshot is identical to the one above, showing the 'Claim Submission - Step 2' form. In this view, the 'Provider' tab is selected and highlighted with a red box. The 'Next' button at the bottom right remains highlighted with a red box. The red dots indicating required fields are still present in the same locations as in the previous screenshot.

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

According to the Centers for Medicare & Medicaid Services, all healthcare providers must select a taxonomy code(s) when applying for an NPI. The values in the Taxonomy drop-down 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 an NPI. If neither of the two autofilled codes applies, choose **Other**. If you choose **Other**, a text box called Other Taxonomy will be displayed and must be filled in.

The screenshot shows the 'Claim Submission - Step 2' interface. At the top right, there are tabs for 'Claim Type' (Institutional), 'Client', 'Provider', 'Status' (New), and 'Claim No.'. Below this is a navigation bar with 'Client', 'Provider', 'Claim', 'Details', and 'Other Insurance / Finish'. The main form area is titled 'Billing Provider'. It includes an NPI field with a search icon, a 'Taxonomy' dropdown menu (currently showing '314000000X', '313M00000X', and 'Other'), and an 'Other Taxonomy' text field. There are also fields for 'Contact Name', 'Contact Phone', 'ID Qual' (with a dropdown for 'Employer/Tax ID'), and 'Other ID'. Below the Billing Provider section are three sections for 'Attending Provider', 'Rendering Provider', and 'Referring Provider', each with fields for NPI/API, First Name, Last Name, and MI Suffix. At the bottom, there are buttons for 'Save Draft', 'Save Template', 'Save To Group', 'Prev', 'Next', and 'Finish'.

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

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

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 the required fields that are indicated by a red dot. Choose the appropriate indicator from the Claim File Indicator Code drop-down box.

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

The Service Group drop-down is to be used by billing providers with multiple SGs 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.

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

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

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', 'Patient Discharge Status', 'Place of Service', 'Claim Frequency', and 'Residence Service Group'. The 'Residence Service Group' dropdown is highlighted with a red rectangular box. Below these fields, there is a 'Diagnosis' section with a 'Qualifier' dropdown and an 'Add New Diagnosis' button. At the bottom, 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.

Claim Submission - Step 2

Claim Type: Institutional

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

Save Draft Save Template Save To Group Prev Next Finish

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

Claim Submission - Step 2

Claim Type: Institutional

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

Save Draft Save Template Save To Group Prev Next 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 duration of the stay.
 - Choose **2 Interim-First Claim** if this is the first claim billed for the person.
 - Choose **3 Interim-Continuing Claim** for all dates of service between the first and last claims.
 - Choose **4 Interim-Last Claim** if this is the last claim billed for the person.

Claim Submission - Step 2

Claim Type: Institutional

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

Client Provider Claim Details Other Insurance / Finish

Claim

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

Diagnosis

Qualifier

Add New Diagnosis

Code	Description	Delete
1		

Save Draft Save Template Save To Group Prev Next Finish

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

Claim Submission - Step 2

Claim Type: Institutional

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

Client Provider Claim Details Other Insurance / Finish

Claim

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

MC Medicaid 07 Left against medical advice or discontinued care 81 Hospice - Special Facility 1 Admit Through Discharge Claim 11/4/2015

Diagnosis

Qualifier

Add New Diagnosis

Code	Description	Delete
1		

Today: 11/4/2015

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

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

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

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

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional			New	

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		Delete

Save Draft Save Template Save To Group Prev Next Finish

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

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional			New	

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

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

Line Item Control No.	Service Dates		Procedure Code	Mods				Units	Unit Rate	Line Item Total	Co-Pay	Rev Code	OI Paid Amount	Rendering Provider					Delete
	Start	End		1	2	3	4							First Name	Last Name	MI	Suffix		
1								0	\$0.00	\$0.00	\$0.00	\$0.00							Delete

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

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 Details tab should be added only if it is different from

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

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

The screenshot shows the 'Claim Submission - Step 2' interface. At the top, there is a header with 'Claim Submission - Step 2' and a table with columns: Claim Type (Institutional), Client, Provider, Status (New), and Claim No. Below this is a navigation bar with tabs: Client, Provider, Claim, Details, and Other Insurance / Finish (which is highlighted with a red box). The main content area is divided into two sections. The first section is titled 'Finish Options' and contains the text 'Please select one of the following and click finish'. It has two radio buttons: 'Submit' (selected) and 'Save to Batch'. The second section is titled 'Certification, Terms And Conditions' and contains a paragraph of text followed by a checkbox labeled 'We Agree'. At the bottom of the form, there 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 those for a Professional claim unless the person is in SG 1, 6, or 8.
Note: *If your claim will be forwarded to an MCO, it is recommended to submit the OI information directly to the MCO. Otherwise, the claim may be held for manual review by the MCO.*
Note: *For people with Medicare in SG 1, Service Code 3 (Extended Care Facility), enter either the Medicare Part A or Part C amount in the Medicare Information section. The Medicare attestation box must also be checked when billing for SG 1, Service Code 3.*
 - a) 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.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional			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.

- **Scenario 2. Other Insurance/Finish tab (no known OI coverage)** – For providers in SG 1, 6, or 8.

If you are aware of additional OI coverage for the person that is relevant to LTC, you are required to add that coverage to the claim using the **Add Policy** button.

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

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

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

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

Insurance Refresh

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

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

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

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
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

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 OI policy will be validated by TMHP's Third-Party Liability department before it is added to the OI database. However, any amount paid by OI will be taken into consideration on the submission of the claim.
 - a) Complete 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 the 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 OI coverage that is relevant to LTC that is currently on file with TMHP.
 - a) Verify that the OI information is valid and correct.
 - b) Fill in all required OI 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 OI policy, click the **Update Policy** button to display the Other Insurance Policy fields. After the 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 OI policy will be validated by the TMHP Third-Party Liability department before it is added to the OI database.

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 'Other Insurance / Finish' tab is active. Below this, there is a section for 'Other Insurance Policy #1' with an 'Update Policy' button and a note. The form contains several input fields for company and subscriber information, including 'Effective Date', 'Termination Date', 'Company Name', 'Company Address', 'Company City', 'Company State', 'Company ZIP Code', 'Company Phone #', 'Subscriber Relationship to Client', 'Subscriber First Name', 'Subscriber Last Name', 'Subscriber SSN', 'Subscriber DOB', 'Employer Name', 'Subscriber/Policy #', 'Group Number', 'Other Insurance Disposition', 'Other Insurance Billed Date', and 'Other Insurance Disposition Reason'. There is also an 'Add New Policy' button. The 'Attestation' section has a checked checkbox with a warning icon. The 'Medicare Information' section has input fields for 'Medicare Part A Total Amount' and 'Medicare Part C Total Amount'. The 'Finish Options' section has two radio buttons: 'Submit' (selected) and 'Save to Batch'. The 'Certification, Terms And Conditions' section has a 'We Agree' checkbox. At the bottom, there are buttons for 'Save Draft', 'Save Template', 'Save To Group', 'Prev', 'Next', and 'Finish' (highlighted with a red box).

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 NAT Claim

To enter an NAT claim:

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

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

Claim Type	Trainee SSN	Provider	Status	Claim No.
NAT			New	

Header Information
Line Item Information
Other Insurance / Finish

Provider Information

• Service Group
• Provider No.
• NPI/API

• Medicaid Patient Days:
• Medicare Patient Days:
• Private Patient Days:

Trainee Information

• Trainee SSN

• Last Name
• First Name
• MI

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

Claim Submission - Step 2

Claim Type	Trainee SSN	Provider	Status	Claim No.
NAT			New	

Header Information
Line Item Information
Other Insurance / Finish

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

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

Claim Total: \$0.00

If you want to add more rows, click 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: OI information is not required on an NAT 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, the ICN will be displayed in the Claim No. field at the top of the page.

Claim Submission - Step 2

Claim Type	Trainee SSN	Provider	Status	Claim No.
NAT		XXXXXXXXXX-XXXX-XXXX	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, to be completed later.
- 2) Save Template – The claim will be added to the template list for faster claims creation in the future.
- 3) Save To Group – The claim will be added to a group template, which includes templates for many people.
- 4) Save To Batch – The claim will be added to a batch of claims that can be submitted as a group.

The screenshot shows the 'Other Insurance / Finish' tab of a claim submission form. It is divided into three main sections:

- Header Information**: Contains the tab labels 'Header Information', 'Line Item Information', and 'Other Insurance / Finish'.
- Finish Options**: A box containing the instruction 'Please select one of the following and click finish'. It has two radio button options: 'Submit' (selected) and 'Save to Batch'. The 'Save to Batch' option is highlighted with a red box. Below 'Submit' is the text 'Submits the claim interactively'. Below 'Save to Batch' is the text 'Saves the claim to batch for processing later.'.
- Certification, Terms And Conditions**: A box containing a paragraph of text: '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".' Below this text is a checkbox labeled 'We Agree'.

At the bottom of the form, there are six buttons: 'Save Draft', 'Save Template', 'Save To Group', 'Prev', 'Next', and 'Finish'. The 'Save Draft', 'Save Template', and 'Save To Group' buttons are highlighted with red boxes.

Draft Claims

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

- 1) Click 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, any saved drafts are automatically deleted.

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

Client General Information

Gender | Date Of Birth | Referral No.

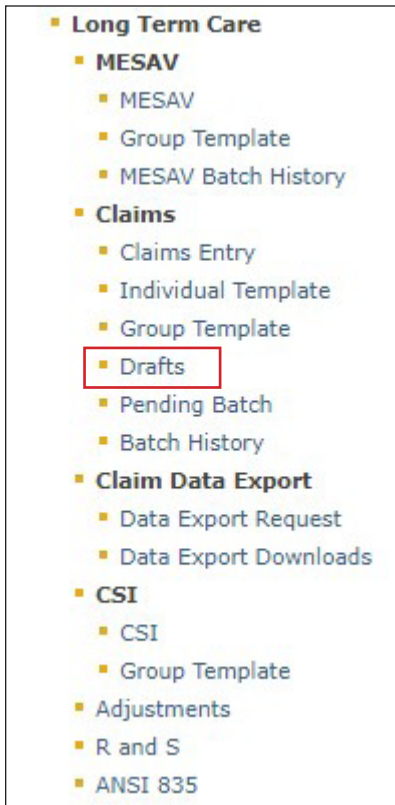
Save Draft | Save Template | Save To Group | Prev | Next | Finish

Name: x **Save** | Cancel

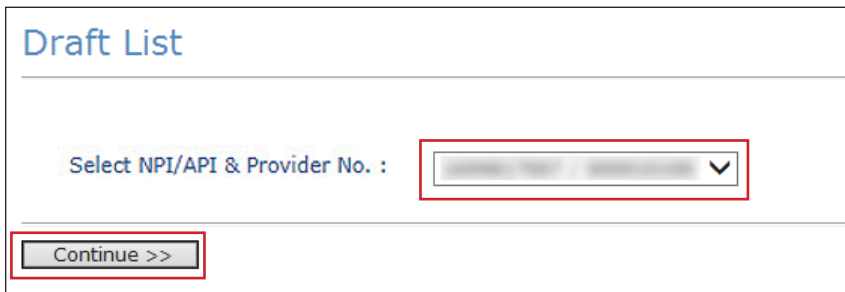
Viewing Draft Claims

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.

- After a claim from the draft list has been submitted, that draft claim is removed from the draft list.
- After 45 days, all drafts will automatically be deleted from the draft list.

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

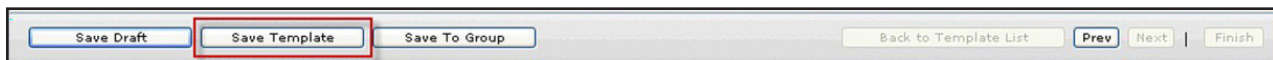
Drafts						
NPI/API [REDACTED] / Provider No. [REDACTED]						
Draft Name	Claim Type	User ID	Created	Last Updated		
[REDACTED]	Expedited	[REDACTED]	07/28/2009	07/28/2009	Delete	

Individual Templates

Saving as an Individual Template

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

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

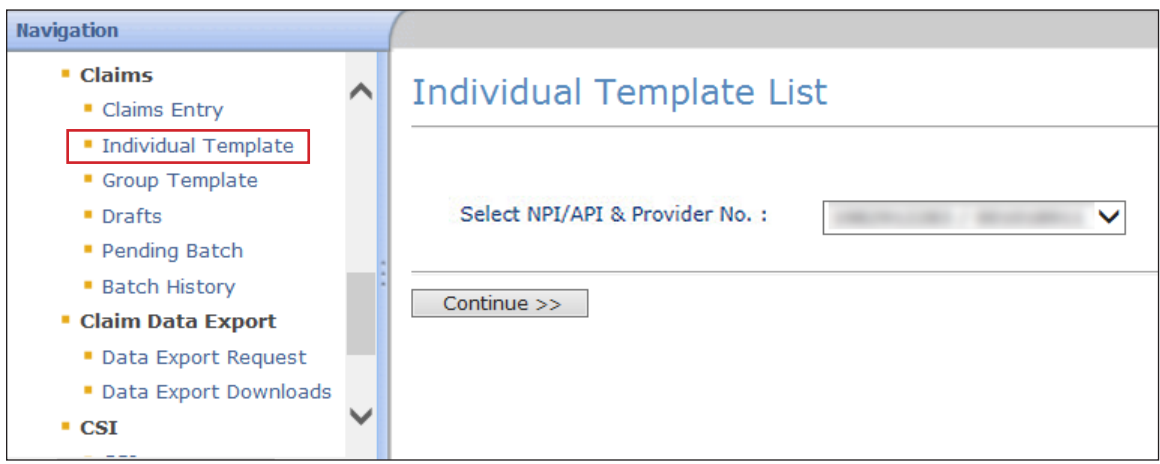


- 2) Enter a template name, and click the **Save** button. The claim will be added to the Individual Template list.
- 3) Templates do not disappear when they are used and can be used an unlimited number of times. However, they will be removed automatically if they have not been used for 365 days.
- 4)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

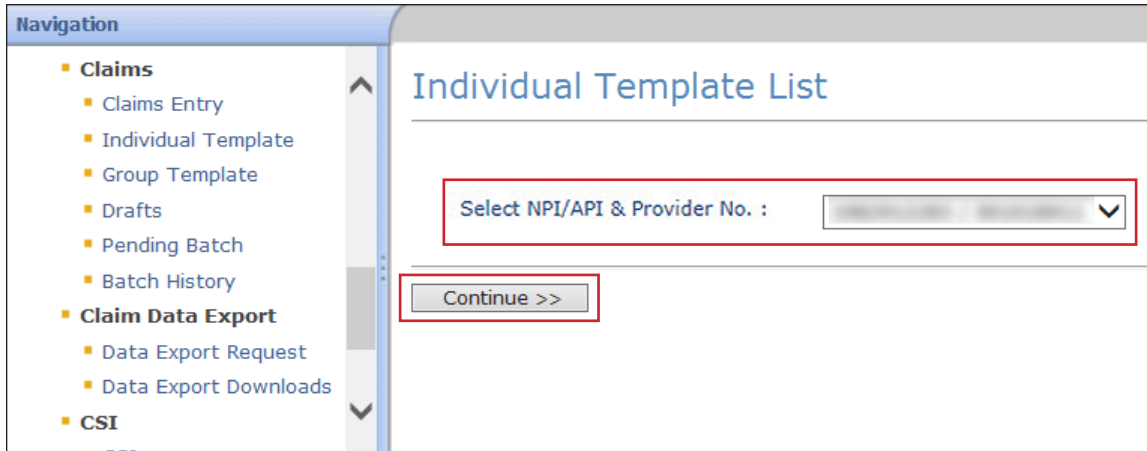
Viewing Individual Templates

To view individual templates:

- 1) Click the **Individual Template** link under the Claims section in 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

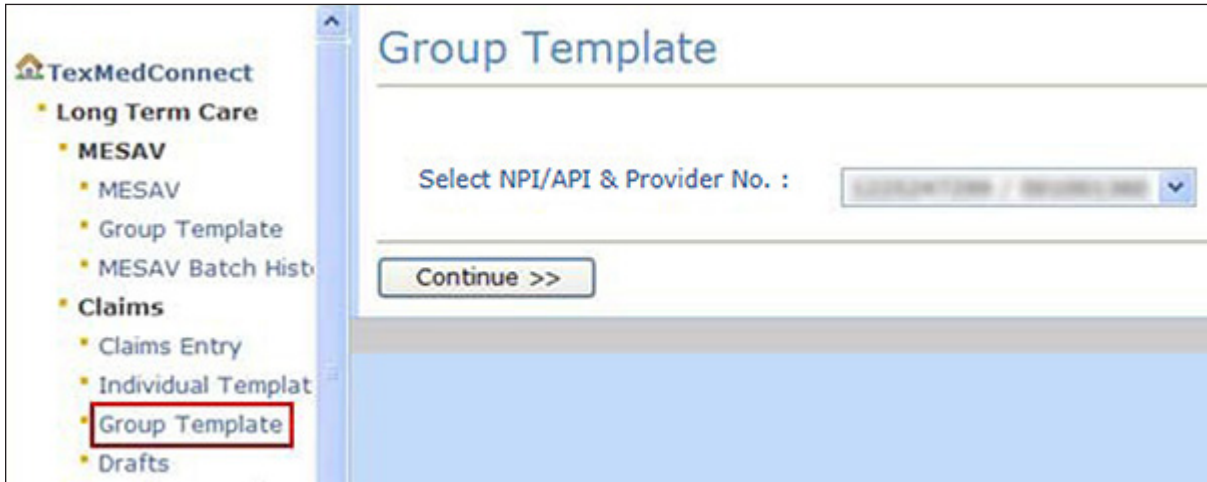
NPI/API / Provider No

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

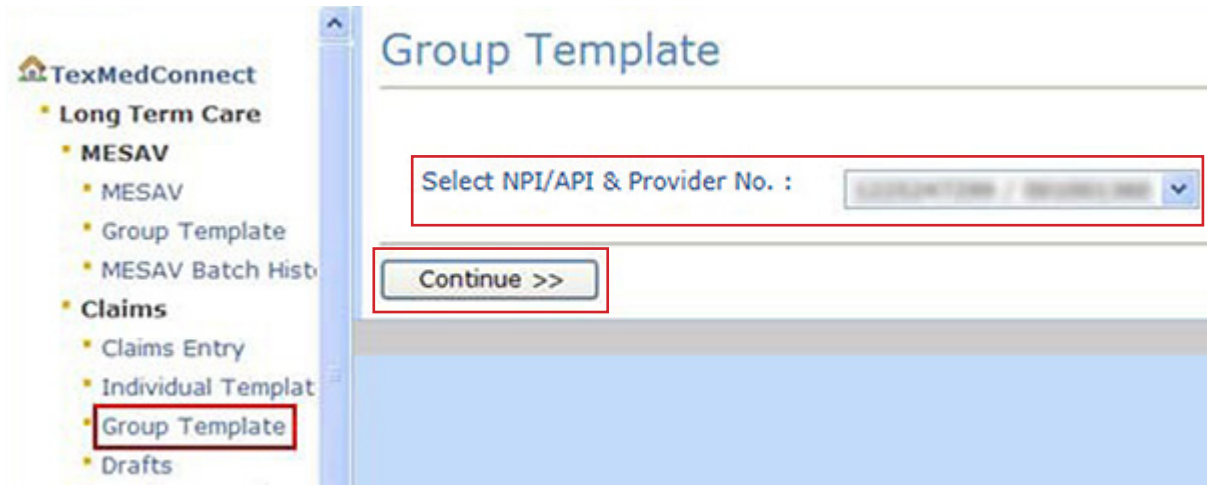
Group Templates

Viewing Existing Group Templates

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



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



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

Group Template List

NPI/API / Provider No.

New Group: Claim Type:

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

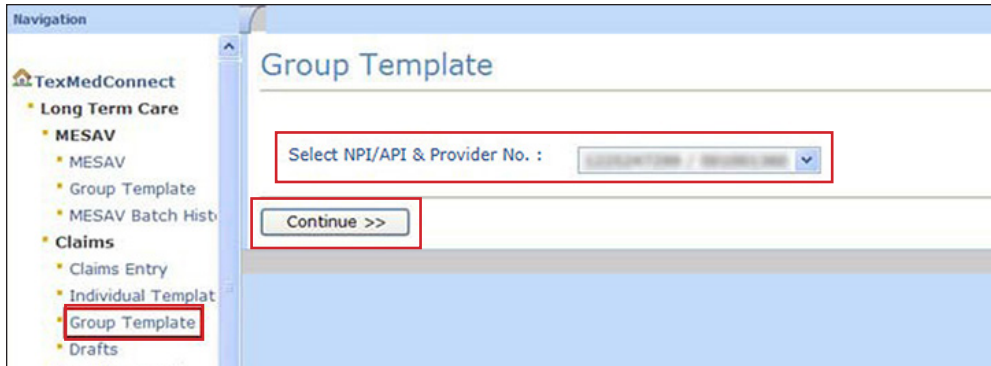
Creating New Group Templates

To create a new Group Template:

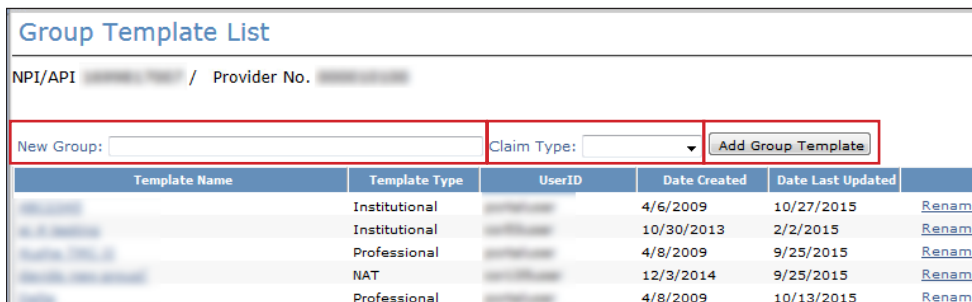
1) Click the **Group Template** link under CSI in the navigation panel.

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

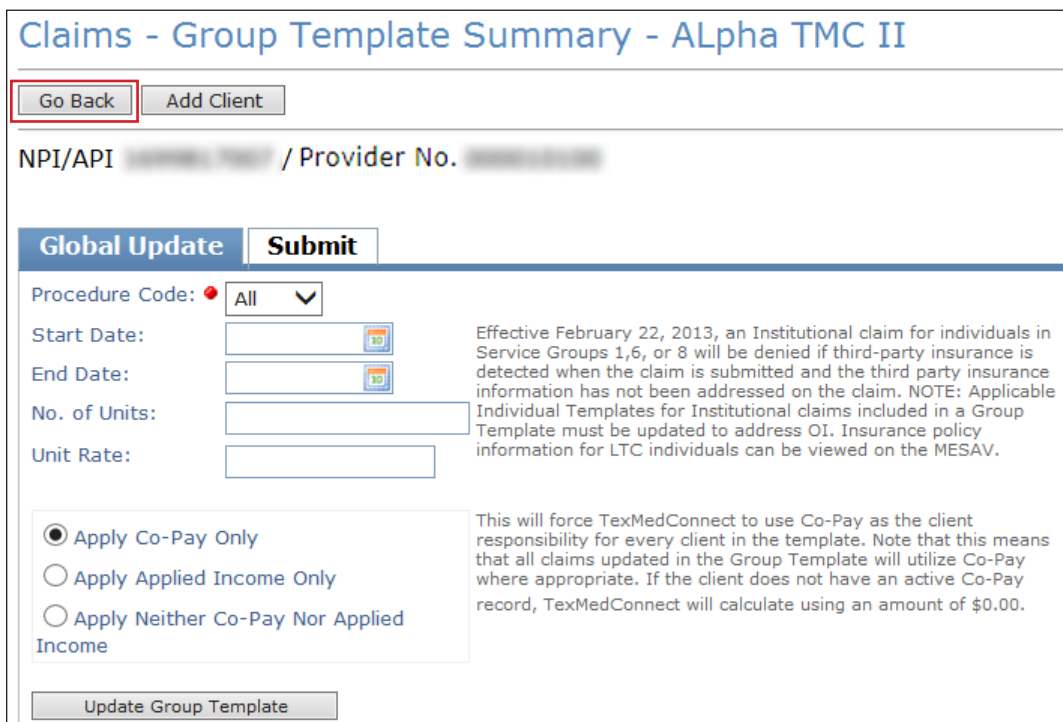
- 2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.



- 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 be displayed. 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 [v]

Start Date: [calendar icon]

End Date: [calendar icon]

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 MESA.V.

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

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

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

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

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

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

individual responsibility deducted.

- 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 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.

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

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

Group Template List

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

New Group: Claim Type:

Template Name	Template Type	UserID	Date Cre	Updated		
	Institutional		04/06/2009	12/09/2014	Rename	Delete

Professional Institutional NAT

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.

Finish Options

Please select one of the following and click finish

Submit
Submits the claim interactively

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

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

Claim Submission - Step 2

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

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

Finish Options

Please select one of the following and click finish

Submit
Submits the claim interactively

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

Certification, Terms And Conditions

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

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

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

We Agree

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

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

Submitting a Batch

To submit a batch:

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



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

- 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 claims in that batch will be submitted, even those created by other users.

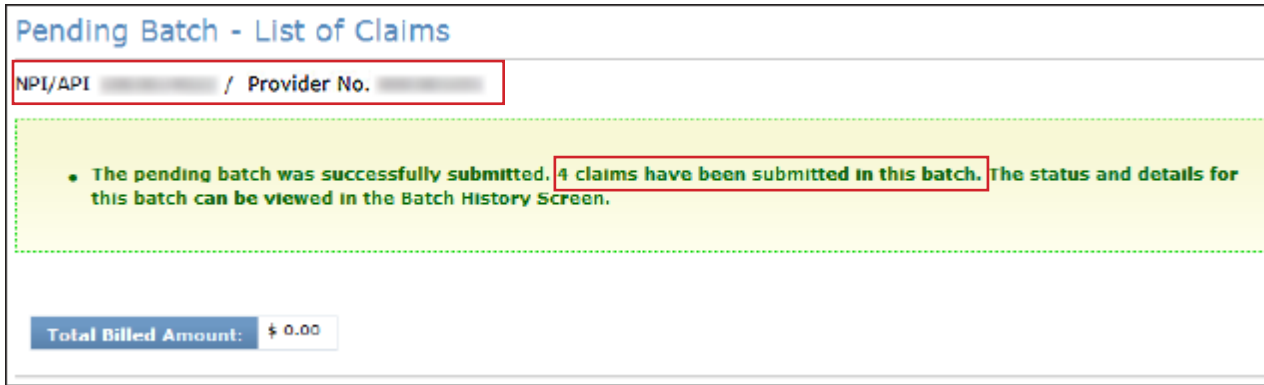
Pending Batch - List of Claims

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

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



View Batch History

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

To view a batch history:

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



- 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 that you clicked. The claims that are listed can be a mix of claims to different MCOs and to TMHP. Claims can be set to the following three statuses:

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

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

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

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

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

Batch History - List of Claims - |

NPI/API [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

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

Batch History - List of Claims - |

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

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

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

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

MCO CSI Search Details

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

ETN

Claim Information

TMHP EDI Trans No	[REDACTED]
Status	Forwarded
Status Date	12/8/2014 4:07:46 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
01745	[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.

This claim has been forwarded 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	\$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 that lists the rejected EOBs. The MCO may choose to list the EOBs with a description. If a description is not present, then only the EOB number will be displayed.

Claim Submission - Step 2

Claim Type	Client	Provider	Status	Claim No.
Institutional	[REDACTED]	[REDACTED]	Rejected	[REDACTED]

- [REDACTED] :EOB from MCO for Rejected Claim.
- Claim Detail# 1: [REDACTED] 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, then the MCO CSI Search Details page will display.

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

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

MCO CSI Search Details

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

Claim Information	
TMHP EDI Trans No	[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 six months.

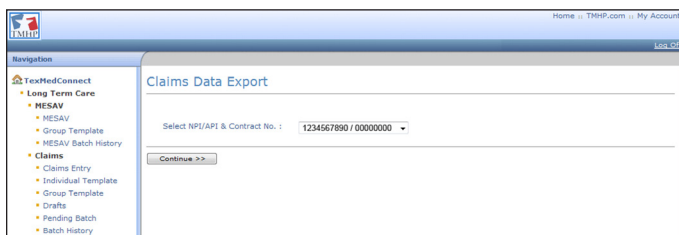
Note: Claims Data Export is available only to users with administrative rights on their account.

To request the claims data to be exported:

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



- 2) Select the NPI or API and provider number from the NPI/API & Provider No. drop-down 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 six months long.

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


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


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

Claims Data Export

Submitter ID:

Password:

Service Begin Date:  Format: mm/dd/yyyy

Service End Date:  Format: mm/dd/yyyy

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

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

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

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

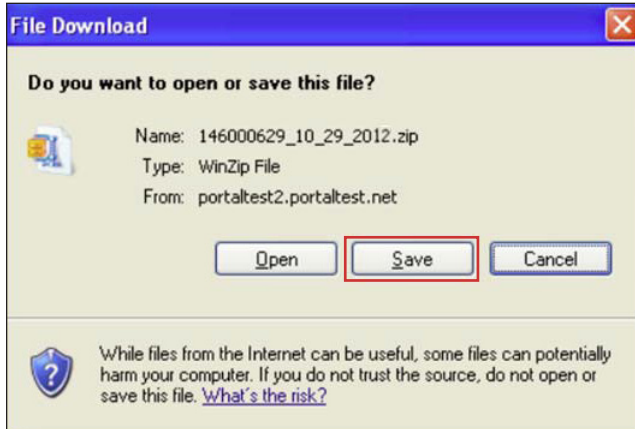
The screenshot shows a web form titled "Claim Data Export Result". It contains two input fields: "Submitter ID:" with a red asterisk and "Password:" with a red asterisk. Both fields contain the placeholder text "Your Submitter ID" and "Your Password" respectively. Below these fields is a "Submit" button, which is highlighted with a red rectangular box.

- 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 "Claim Data Export Result" page with a table of files. The table has two columns: "Select" and "File Name". The "Select" column contains a series of checkboxes, with the first one highlighted by a red box. The "File Name" column lists various CSV files with identifiers and dates. Below the table is a "Download" button, also highlighted with a red box.

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

- 7) A File Download dialog box will be displayed. Click the **Save** button, and save the file to a location on your computer. The requested data will remain available for download for six months.
Note: Your computer must be able to open WinZip® files (zipped files), or you will not be able to open the saved file.



These are some of the data elements you will see:

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

More Information about Claims Data Export

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

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

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

Claims Status Inquiry (CSI)

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

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

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

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

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

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

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

The screenshot displays 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. A note specifies 'Format: 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 'Client Information' (fields for Medicaid No., Last Name, First Name, M.I., and Suffix). It also has a 'Search' button and radio buttons for 'Client' (selected) and 'Trainee'.
- 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

To search for a claim by Claim Request:

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

This close-up view shows the 'Lookup Fee For Service Claim by Claim Request' section. The 'Claim Number' input field and the 'Lookup' button are highlighted with red boxes. The text 'Format: 15 digits with no spaces' is visible to the right of the input field.

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

Amount and Applied OI amount.

CSI Details

[New Lookup](#)

Claim Information		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.
- 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

- You must complete all fields that are indicated by a red dot.
- Click the **Search** button.

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

CSI Details

[New Lookup](#)

Claim Information		Client Information	
Claim No.	██████████	Client/Medicaid No./Trainee SSN	██████████
Dates of Service	8/1/2014 - 8/1/2014	Name	██████████
Status	D	Gender	F
Effective Date	9/10/2014	Date of Birth	8/24/1984
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

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

CSI Search: Lookup Managed Care Claim by Transaction Number

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

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

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

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

Lookup Managed Care Claim by Transaction Number

Transaction Number ◆

Transaction Number Type ◆ ▼

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

MCO CSI Search Details

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

Claim Information

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

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

EOB / EOPS codes messages

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

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

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

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

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

MCO CSI Search Details

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

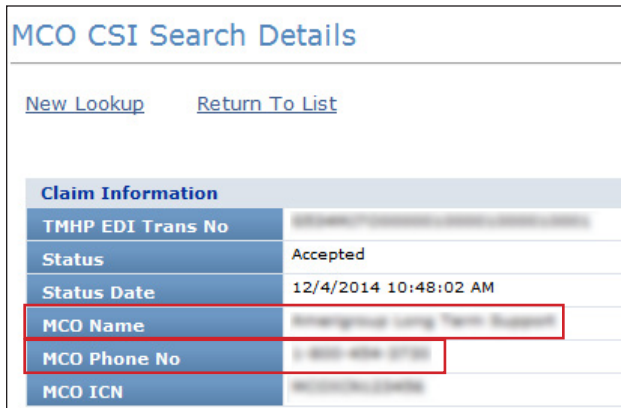
Claim Information

TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	Strategic Long Term Support
MCO Phone No	1-800-456-2726
MCO ICN	

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

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

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



The screenshot shows a web interface titled "MCO CSI Search Details". At the top, there are two links: "New Lookup" and "Return To List". Below this is a table with the following data:

Claim Information	
TMHP EDI Trans No	[REDACTED]
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	Managed Long Term Support
MCO Phone No	1-800-486-2726
MCO ICN	[REDACTED]

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

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

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

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

MCO CSI Search Details

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

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

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

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

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

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

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

CSI Search: Lookup Managed Care Claim by MCO ICN

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

- 1) In the Transaction Number field, enter the **MCO ICN** of the claim for which you are searching, then 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 *	<input type="text"/>	Payer Name *	<div style="border: 1px solid black; padding: 2px;"> Select Amerigroup Long Term Support Cigna Long Term Care Molina Long Term Care Superior Nursing Facility United Healthcare Long Term Care </div>
Transaction Number Type *	MCO ICN		
<input type="button" value="Lookup"/>			

- 2) The MCO CSI Search Details page will be displayed and will autofill with the MCO ICN in the Claim Information section. This MCO CSI Search Details screen will be identical to the one that is generated when searching using an ETN or clicking the hyperlink from the Batch History screen. TMHP will assign an EOB code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB code.

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

MCO CSI Search Details

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

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

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

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

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

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

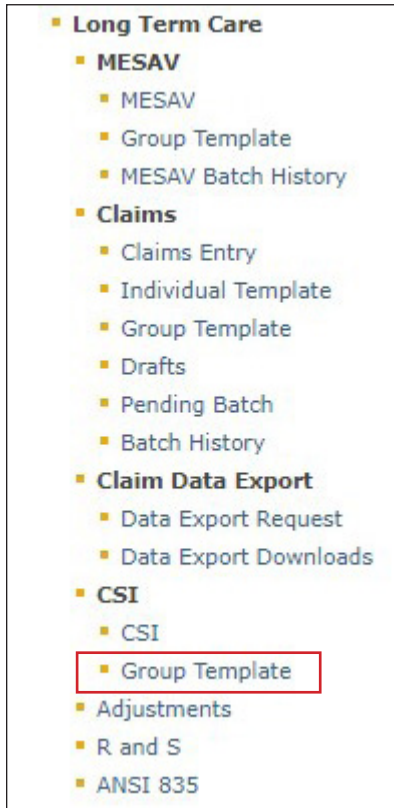
Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	\$159.09	\$0.00	\$0.00	\$0.00	\$169.35

Creating a CSI Group Template

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

To create a CSI group template and add a person:

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



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



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

MESAV/CSI Group Template

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

New Group:

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

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

MESAV/CSI Group Template

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

New Group:

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

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	Delete

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

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

The screenshot shows the 'Add Client' page. At the top, there is a header 'Add Client' in blue. Below it, there is a line for 'NPI/API' and 'Provider No.' with blurred text. The main form area 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 section titled 'Lookup Criteria' with the text: 'Client # or Combination of SSN and DOB or First Name, Last Name and DOB or SSN and Last Name.' A 'Lookup' button is positioned below the input fields. 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' button area.

7) Click the **Lookup** button.

This screenshot is identical to the previous one, showing the 'Add Client' page. 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 _____ / Provider No. _____

Client Number:

Social Security Number:

Date of birth:

First name:

Last name:

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

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

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

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

Submitting a CSI Group Template

To verify eligibility using a group template:

1) Click the **Group Template** link under the CSI section in 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.

MESAV/CSI Group Template

Select NPI/API & Provider No. : [dropdown menu]

Continue >>

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

MESAV/CSI Group Template

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

New Group: [input] Add Group

Name of the group	User ID	Created Date	Last Updated Date	
[blurred]	[blurred]	10/01/2008	09/02/2014	Delete
[blurred]	[blurred]	10/08/2008	10/14/2015	Delete
[blurred]	[blurred]	10/08/2008	10/08/2008	Delete
[blurred]	[blurred]	10/08/2008	09/09/2015	Delete
[blurred]	[blurred]	04/06/2009	09/09/2015	Delete
[blurred]	[blurred]	04/06/2009	09/09/2015	Delete
[blurred]	[blurred]	07/14/2009	09/17/2015	Delete
[blurred]	[blurred]	07/30/2009	09/25/2015	Delete

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

MESAV/CSI Group Template - [blurred]

Go Back Add Client

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

From Date of Service: [calendar icon] Format mm/dd/yyyy

To Date of Service: [calendar icon] Format mm/dd/yyyy

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

Submit MESAV Batch

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

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

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

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

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

Select All	First Name	Last Name	Client #	SSN	Date of Birth			
<input type="checkbox"/>	RONALD	BARBER	800012345		01/01/1978	MESAV	CSI	Delete
<input type="checkbox"/>	RONALD	BARBER	800012345		01/01/1978	MESAV	CSI	Delete
<input type="checkbox"/>	JOHN	BLAKE	800012345		01/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	ANDREW	BROWN	800012345		01/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	BLAKE	BRUNSON	800012345		11/01/1987	MESAV	CSI	Delete
<input type="checkbox"/>	CLARENCE	BURDET	800012345		01/01/1988	MESAV	CSI	Delete
<input type="checkbox"/>	HORACE	HARRINGTON	800012345		01/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	CAROL	JOHNSON	800012345		11/01/1971	MESAV	CSI	Delete
<input type="checkbox"/>	WILLIAM	LAMBERT	800012345		10/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	LOUIE	LEWIS	800012345		11/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	ISA	MARSHALL	800012345		01/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	DAVID	MCCOY	800012345	400012345	11/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	BENJAMIN	MUIR	800012345		11/01/1988	MESAV	CSI	Delete
<input type="checkbox"/>	ISA	PALAN	800012345		01/01/1988	MESAV	CSI	Delete
<input type="checkbox"/>	MARION	QUITTUMBERG	800012345		01/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	DAVID	WHITE	800012345		01/01/1980	MESAV	CSI	Delete

[Submit MESAV Batch](#)

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

<input type="checkbox"/>	CAROL	JOHNSON	800012345		11/01/1971	MESAV	CSI	Delete
<input type="checkbox"/>	WILLIAM	LAMBERT	800012345		10/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	LOUIE	LEWIS	800012345		11/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	ISA	MARSHALL	800012345		01/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	DAVID	MCCOY	800012345	400012345	11/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	BENJAMIN	MUIR	800012345		11/01/1988	MESAV	CSI	Delete
<input type="checkbox"/>	ISA	PALAN	800012345		01/01/1988	MESAV	CSI	Delete
<input type="checkbox"/>	MARION	QUITTUMBERG	800012345		01/01/1980	MESAV	CSI	Delete
<input type="checkbox"/>	DAVID	WHITE	800012345		01/01/1980	MESAV	CSI	Delete

[Submit MESAV Batch](#)

Adjustments

Creating an Adjustment for an FFS Claim

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

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

To make an adjustment on an FFS claim:

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



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

Adjustment

To proceed, please search for the claim to be adjusted

Lookup Fee For Service Claim by Claim Request

Claim Number: Format: 15 digits with no spaces

Lookup Fee For Service Claim by Client Claim Request

Provider NPI/API:

Service Begin Date: Format: mm/dd/ccyy

Service End Date: Format: mm/dd/ccyy

Select the appropriate Request Type

Client Trainee

Client Information

Medicaid No.

Last Name

First Name

M.I.

Suffix

Lookup Managed Care Claim by Transaction Number

Transaction Number

Transaction Number Type

a) To search by Claim Request, enter the claim number, and click 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

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

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

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

Lookup Fee For Service Claim by Client Claim Request

Provider NPI/API:
Service Begin Date: 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

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

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

CSI Search Results

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

Search Criteria

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

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	000000123456789	P	\$218.60	\$175.00
11/16/2012	11/16/2012	JOHN DOE	0123456789	1234567890000000	P	\$3,324.75	\$3,324.75
11/29/2012	11/29/2012	JOHN DOE	0123456789	000123456789000	P	\$152.75	\$152.75
12/10/2012	12/10/2012	JOHN DOE	0123456789	000001234567890	PZ	\$0.00	\$0.00

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

Select the appropriate Claim Type for this Claim to Adjust

Claim Type: ● Unknown

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 CE
Total Applied Other Insurance Amount \$60.00	Medicare Patient Days % 0
Budget Number	Private Patient Days % 0
	Medicaid Patient Days % 0

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

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

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

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

Claim Submission - Step 2

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

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

Claim Submission - Step 2

Client Provider Claim Details Other Insurance / Finish

Billing Provider

NPI:

Name:

NPI/API:

ID Qual

Employer/Tax ID

Other ID

Performing Provider

NPI/API First Name Last Name MI Suffix

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

NPI/API First Name Last Name MI Suffix

Save Draft Save Template Prev Next Finish

- 7) On the 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. Entering an invalid diagnosis code may result in an error message (and subsequent inability to submit a claim) in TexMedConnect. Use the Qualifier field to indicate whether the diagnosis code is an ICD-9 or ICD-10 code. The correct value is an ICD-10 code.

Claim Submission - Step 2

Claim Type Client Provider Status Claim No.
Professional New

Client Provider Claim Details Other Insurance / Finish

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

Delete

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

- 9) 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 be displayed. The provider should also fill in the OI field on the positive line (if applicable).

Saving and Submitting an Adjustment

All adjustments must be submitted as batches.

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

- 1) 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	121969829/001013238	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 SG 1, 6, and 8, the OI Paid Amount entered in the Details tab must equal the OI Paid Amount in the Other Insurance/Finish Tab.

The screenshot shows the 'Other Insurance / Finish' tab of a claim submission form. At the top, a yellow banner contains a warning: "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." Below this, a navigation bar includes tabs for Client, Provider, Claim, Details, and Other Insurance / Finish (which is selected). The main content area contains several sections:

- Insurance Refresh:** A section with a sub-header and a checkbox. The checkbox is checked and highlighted with a red box.
- Medicare Information:** A section with text and two input fields for Medicare Part A and Part C total amounts.
- Finish Options:** A section with the text "Please select one of the following and click finish". It contains two radio buttons: "Submit" and "Save to Batch". The "Save to Batch" option is selected and highlighted with a red box.
- Certification, Terms And Conditions:** A section with a "We Agree" checkbox, which is also highlighted with a red box.

 At the bottom of the form, there are buttons for "Save Draft", "Save Template", "Save To Group", "Prev", "Next", and "Finish".

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

Remittance and Status (R&S) Reports

R&S Reports are generated on Mondays and Wednesdays.

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

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

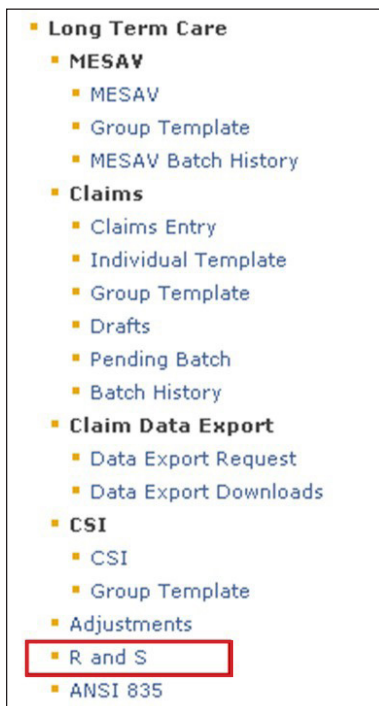
- PDF: Displays the R&S in a PDF version of the paper R&S.
- ANSI 835: Allows you to download the American National Standards Institute (ANSI) 835 version of the R&S Report. This file is for providers that use third-party billing software or third-party billing agents.

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

Viewing the PDF Version

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

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



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

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

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

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

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

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

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

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

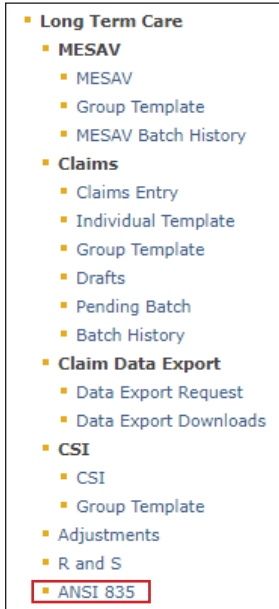
For more information or for problems, please contact the **EDI Helpdesk at 1-888-863-3638, Option 4.**

Downloading the ANSI 835 Version

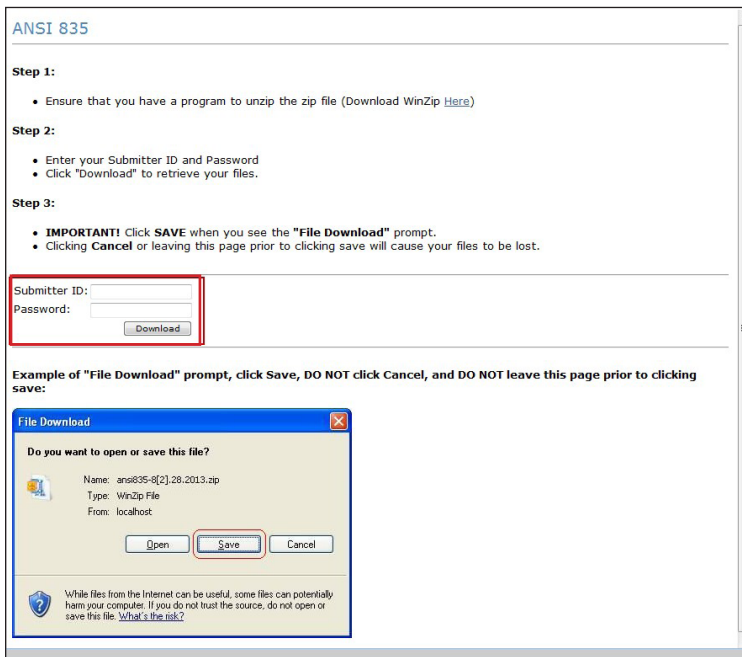
You can access the 835 non-pending Electronic Remittance and Status (ER&S) Report and the pending ER&S Report through TexMedConnect.

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

- 1) Click the **ANSI 835** link in 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/or password, contact the EDI Help Desk at 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 a location on your computer.



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

Claims Identified for Potential Recoupment (CIPR) Reports

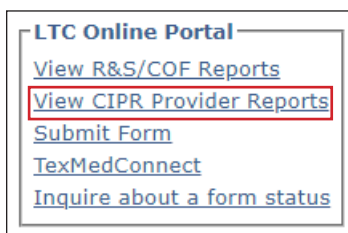
TMHP provides CIPR Provider Reports to LTC providers that can be downloaded and viewed. When TMHP learns of a person's third-party insurance policies with retroactive dates of coverage, claims previously reimbursed by Medicaid will be identified if the claim would have been processed differently based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

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

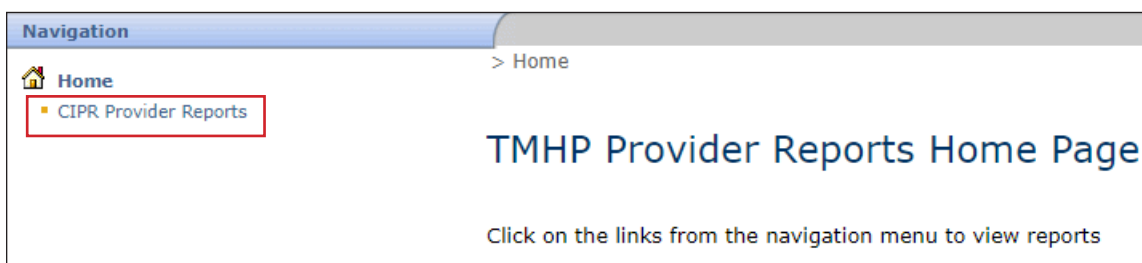
- 1) Click the **My Account** link in the top right corner of the TexMedConnect web page.



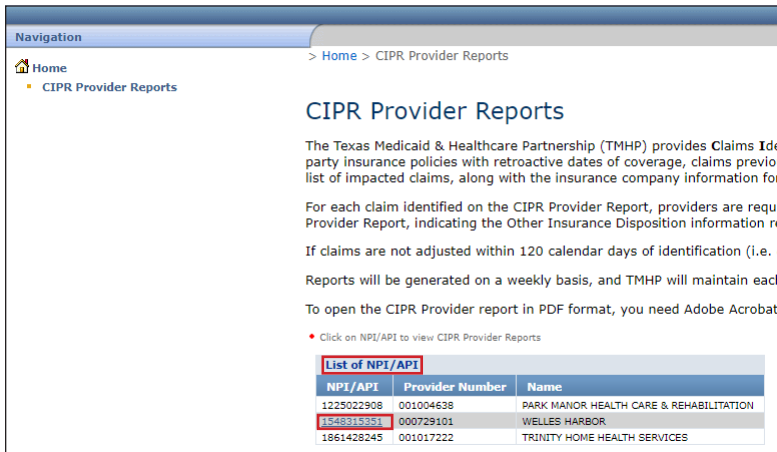
- 2) Click the **View CIPR Provider Reports** link under the LTC Online Portal section.



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



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



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

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

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

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

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

- Positions 1–4 are in military-time format, are always required, and represent the claim sequence number.
 - Positions 1_2 will range from 00–23.
 - Positions 3–4 will range from 00–59.
 - Format edits apply to certain table-driven SGs and service codes.
 - The claim sequence number must be unique when there are multiple claim details for the same service on the same day.
- Positions 5–20 are for either the Texas EVV Attendant ID, the Dummy ID, or the Staff ID.
 - For billing an EVV service, use the Texas EVV Attendant ID. EVV visit units may be submitted rolled up by the NPI per existing functionality.
 - For CFC PAS/HAB claims, you must enter the Texas EVV Attendant ID from the visit displayed in the EVV system. If characters not matching the Texas EVV Attendant ID are entered on an EVV Claim, it will be denied.
 - The Texas EVV Attendant ID is not required by HCS and TxHmL programs for in-home respite and in-home day habilitation. Submit information in Positions 1–4 as instructed above in the LICN field to avoid receiving an EVV04 claim mismatch.
 - If positions 5–20 are not used, then the NPI or API will continue to be used for EVV claim matching. Refer to [HCS and TxHmL Best Practices to Avoid EVV Claim Mismatches](#) for more information.
 - For billing Nursing and Transportation Services, use one of the following Dummy IDs:
 - ACCUM.NUR
 - ACCUM.NUL
 - ACCUM.NURS
 - ACCUM.NULS

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

