Long-Term Care Programs
Frequently Asked Questions

Q. How do I use the LTC/Nursing Facilities Bill Code Crosswalk Table?

A. The left side of the LTC/Nursing Facilities Bill Code Crosswalk Table provides the Texas LTC/Nursing Facilities Local Codes for the service group, bill code, service code, and bill code description used to bill for services before HIPAA. The right side of the table identifies the National Standard Codes you will use on your claims effective October 16, 2003. Your contract and MESAV information will tell you the service codes and service groups for which you have authorization to provide services. To use the table, follow the guidelines below:

1. Find your service group, service code, and, if possible, the bill code you have used in the past to bill for the service(s) and follow the row across to the National Codes section to find the new codes to use effective October 16, 2003 .
2. If the bill code has been mapped to a national HCPCS code, you will find an entry of “HC” or “AD” in the procedure code qualifier field and information in either the HCPCS or CPT code fields (or, in some cases, in the HCPCS or CPT and the revenue code fields). If the bill code only has a national revenue code shown, no entry will be found in the procedure code qualifier field.
3. If there are entries in the modifier fields, you will need to use those modifiers in the designated fields when completing the detail line for that service.
4. If there is an “ER” in the procedure code qualifier field, you will continue to use the existing bill code for claim reimbursement (ZZ has changed to ER).
5. The table contains a field called “End Date.” If this field has an entry, it means that services provided after the stated end date will not be paid.

Q. What is a Retroactive Adjustment?

A. A Retroactive Adjustment is created when a change in client or provider information is sent to TMHP from HHSC LTC, and this information affects previously paid claims. The change may affect a client's service authorization, number of units, unit rate, applied income or co-payment, level of service or dates of service; or a change to a provider's contract. Retroactive adjustments are made in either the favor of the state or the provider. These adjustments are generated by the Claims Management System, not by providers. When new information is received at TMHP, a "trigger" is created and retroactive adjustments are generated for claims that match certain criteria, such as a specific billing code, dates of service, etc.

Q. Do you have records of services that were never billed?

A. If you are unsure if you were paid or not for past services, you can run Claim Status Inquiry to see paid claims up to three years ago.

Q. What is PASRR and how does if affect entry to a nursing facility?

A. PASRR is the Preadmission Screening and Resident Review that is required by all nursing facilities that accept Medicare or Medicaid. The Medicare/Medicaid nursing facility must screen all new admissions to determine if an individual has a mental illness, intellectual disability, or a related condition.

Q. How do I know if my MDS assessment was successfully transmitted?

A. You may review your Final Validation Report within 24 hours of transmission to verify your file was successfully transmitted. Also, if the line was disconnected, you will get an error window and you will not receive the Initial Feedback Report.

Q. Why submit a 3619 Form?

A. 3619 Forms are submitted to initiate, close or adjust Medicare/Medicaid Co-insurance and to provide information to caseworker about status changes of Medicaid applicant or recipient.

Q. How are the comments from the Long-Term Care Medicaid Information (LTCMI) section used?

A. The comments section of the LTCMI can be used to document additional medical information that is not contained elsewhere in the assessment and that indicates the need for skilled nursing care.

Q. When are Minimum Data Set (MDS) or Medical Necessity and Level of Care (MN/LOC) assessments set to Pending Denial (Need More Information)?

A: An assessment may be set to Pending Denial (Need More Information) when there is conflicting information on the assessment or when there is not enough information contained in the assessment to support approval of medical necessity.