



**TexMedConnect User Guide**  
**for Managed Care Organization (MCO) Long-**  
**Term Services and Supports (LTSS) Providers**



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## Overview

TexMedConnect is a free, online claims submission application provided by Texas Medicaid & Healthcare Partnership (TMHP). Managed care organization (MCO) Long-term Services and Supports (LTSS) providers can use TexMedConnect to submit claims, perform Claim Status Inquiries (CSI), and submit appeals.

An MCO LTSS provider is any provider who provides LTSS services under a specific National Provider Identifier (NPI) and taxonomy combination and submits claims through Medicaid Managed Care. An MCO LTSS provider will have to enroll through this process when the NPI combination they bill LTSS services does not have an active, associated Texas Provider Identifier (TPI) through TMHP or an Atypical Provider Identifier (API) through this process.

TexMedConnect:

- Delivers an integrated, web-based application.
- Provides a stable and secure environment for claims submission.
- Is accessible from any computer with Internet access.

TexMedConnect for MCO LTSS providers supports Institutional Outpatient claims (837I) and Professional claims (837P) for Health Insurance Portability and Accountability Act (HIPAA) - compliant transactions. Institutional Outpatient claims are used for services rendered in a hospital. Professional claims are used for services rendered by an individual provider.

Basic knowledge of browsing the web and using other web-based applications is helpful when using TexMedConnect.

## Requirements

TexMedConnect is a web-based application and requires Internet capabilities as follows:

- Internet service provider (ISP)
- Internet browser Microsoft® Internet Explorer® (version 11.0 and later)
- Google Chrome® (version 48 and later)

A broadband connection is recommended but not required.

## Getting Support

This section explains whom at TMHP to contact for assistance with technical issues and claims questions.

## Technical Support

Contact the TMHP Electronic Data Interchange (EDI) Help Desk at 888-863-3638, Option 4, for MCO LTSS provider's technical issues. The TMHP EDI Help Desk provides technical assistance with troubleshooting TexMedConnect and TMHP EDI Gateway system issues.

Contact your system administrator for assistance with modem, hardware, Internet connectivity, or phone line issues.

## Claims Support

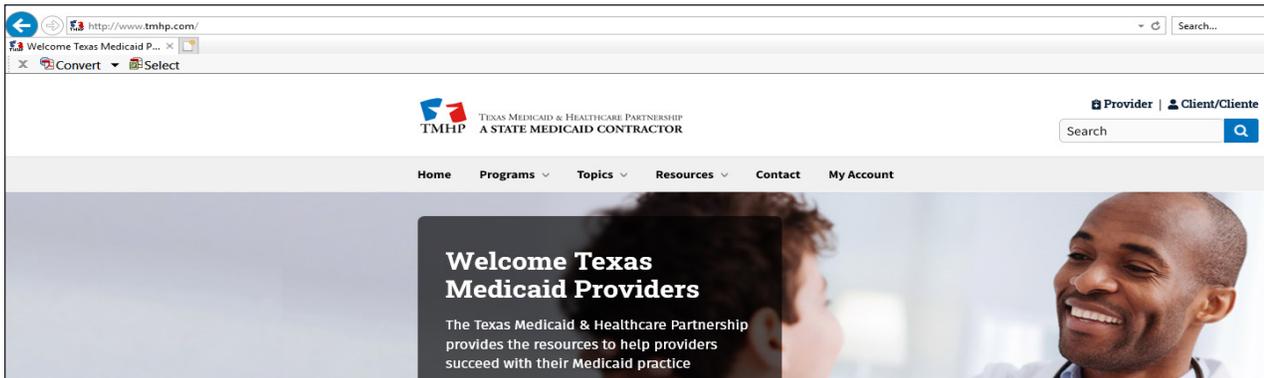
Call the TMHP Contact Center at 800-925-9126 with questions about MCO LTSS electronic claims.

## Accessing TexMedConnect

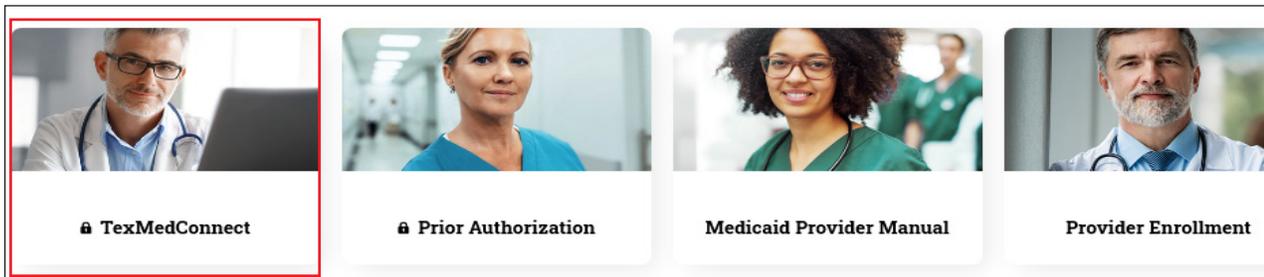
Access TexMedConnect through the TMHP website. To use TexMedConnect, you must already have an account on the TMHP website. If you do not have an account, set one up using the information provided in the [TMHP Website Security Provider Training Manual](#).

Once you have an account for the TMHP website:

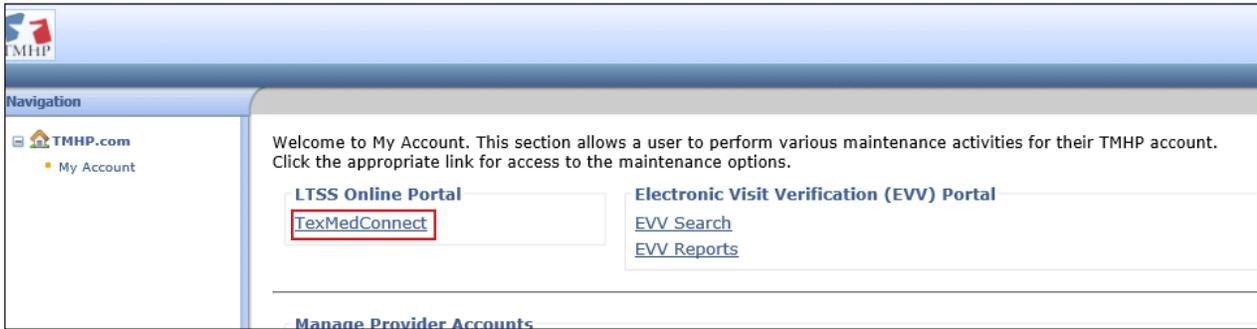
- 1) Access the TMHP website at [tmhp.com](http://tmhp.com).



- 2) Click **TexMedConnect**. Enter your user name and password.



3) The My Account page will open to display website features you have access to. Click **TexMedConnect**.



## Navigation Panel

All of the available menu options for MCO LTSS providers are located under Acute Care in the left navigation panel. A user's access privilege determines which options appear. You can select the activity you would like to perform from the navigation panel.



## Eligibility

You have the ability to verify a client's eligibility, create a list of clients for whom you would like to verify eligibility, and create eligibility batch reports by NPI or API.

## Eligibility Verification (EV)

To verify a client's eligibility, follow these steps:

- 1) Select **Eligibility** from the navigation panel.



- 2) Use the Provider NPI/API drop-down list to select an NPI or API.

### Eligibility Verification

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

Provider NPI/API:  Select a Provider NPI/API

Eligibility From Date:  Format: mm/dd/yyyy

Eligibility Through Date:  Format: mm/dd/yyyy

- 3) Enter an Eligibility From Date and Eligibility Through Date manually, or use the calendar icon.

### Eligibility Verification

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

Provider NPI/API:  Select a Provider NPI/API

Eligibility From Date:  Format: mm/dd/yyyy

Eligibility Through Date:  Format: mm/dd/yyyy

- 4) You must also enter information in the Medicaid/CSHCN ID field or Social Security Number field and either the Date of Birth, Last Name, or First Name fields. Click **Submit**.

Please enter one of the following valid field combinations:

- Medicaid/CSHCN ID and Date of Birth
- Medicaid/CSHCN ID and Last Name
- Medicaid/CSHCN ID and Social Security Number
- Social Security Number and Last Name
- Social Security Number and Date of Birth
- Date of Birth and Last Name and First Name

Medicaid/CSHCN ID:  Format: 123456789  
 Social Security Number:  Format: 123-45-6789 or 123456789  
 Date of Birth:   Format: mm/dd/yyyy  
 Last Name:   
 First Name:

- 5) Eligibility verification results appear. Click the PDF icon in the top right corner of the Eligibility Verification Results page to view and print results.

Print Options :: 

### Eligibility Verification Results

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

Patient Information		Inquiry Information	
Client No./Trainee SSN		NPI/API	
DOB		Eligibility From	9/1/2019
Gender	F	Eligibility Through	9/30/2019
SSN		Medicaid / Client No.	
Name		Social Security Number	
Address		Date of Birth	
County	Garza	Last Name	
Medicare No.		First Name	
Base Plan	INDIV OUTS		

Eligibility Segments					
Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Spend-down Indicator
EFF : 1/1/2012 TRM : 7/31/2020 ADD : 11/22/2011	R - REGULAR	54 - MQMB (SSI, RECIPIENT)	100 - MEDICAID	140 - MCAID QUAL MEDICARE BENE	Q - MQMB - CATEGORY 01, 03, OR 04 CLIENT WHO IS DUALY ELIGIBLE FOR MAO AND QMB

Medicare Segments				
Segment Dates	Medicare Type	Contract Number	Plan ID	Contract Number Link
EFF : 4/1/1992 TRM : 7/31/2020 ADD : 4/14/1992	A			
EFF : 4/1/1992 TRM : 7/31/2020 ADD : 4/20/1992	B			

**Lock-In Segments**  
No Lock-In Segments found

**TPR Segments**  
No TPR Segments found

**TPL Segments**  
No TPL Segments found

Managed Care Segments					
Segment Dates	Organization	Plan Code	Line Of Business	Name	Phone
EFF : 9/1/2013 TRM : 7/31/2020 ADD : 7/23/2013		58	STAR+PLUS		

Limits Segments				
Dental	Hearing Aid	Eye Exam	Eye Glasses	Medical
		4/26/1990	1/16/2012	

- 6) Click **New Lookup** to return to the Eligibility Verification screen. Click **Return with Search Criteria** to return to the Eligibility Verification screen with the last search criteria in the fields.



## Client Group List

The client group list allows you to create a list of clients for whom you would like to verify eligibility. You can create up to 100 groups for each NPI or API. Each client group can contain up to 250 clients.

To verify eligibility through the client group list, follow these steps:

- 1) Select **Client Group List** from the navigation panel.



- 2) Select the NPI or API on the EV Client Group List screen. Click **Continue**.

**EV Client Group List**

Select NPI/API and related data

NPI	Taxonomy	Address	Zip	Benefit Code
<input checked="" type="radio"/>			77642	LTSS
<input type="radio"/>			77642	LTSS
<input type="radio"/>			77642	LTSS

Continue >>

- 3) Click the name of the group to view the client list. Click **Delete** to remove an existing client group list. You can also type a group name and click **Add Group** to create a new client group list.

**Client Group List**

NPI/API

Add Group

Name of the group	User ID	Created Date	Last Updated Date	
<a href="#">TEST</a>	TESTING_USER	08/04/2020	08/04/2020	<a href="#">Delete</a>
<a href="#">TEST 4</a>	TESTING_USER	08/04/2020	08/04/2020	<a href="#">Delete</a>
<a href="#">LTSS client Group Test_0805</a>	TESTING_USER	08/05/2020	08/05/2020	<a href="#">Delete</a>
<a href="#">New LTSS Group 2_0805</a>	TESTING_USER	08/05/2020	08/05/2020	<a href="#">Delete</a>

- d) To create a group, enter a Client number or social security number and date of birth, last name, or first name. Click **Lookup**. Then, click **Add to Group**.

## Add Client

Client #:

SSN:

DOB:

Last Name:

First Name:

**Lookup**

**Lookup Criteria**

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

Go Back
Add To Group

- 5) You can click **Add Client** to add more clients to the group.

## Client List

Go Back
**Add Client**

- 6) Enter a date range in the From Date of Service and To Date of Service fields manually, or use the calendar icon. Click **Eligibility** to view the Eligibility Verification Results.

Print Options ::

## Client List

Go Back
Add Client

NPI/API L245468727

From Date of Service

To Date of Service

Format mm/dd/yyyy

Format mm/dd/yyyy

Select All <input type="checkbox"/>	First Name	Last Name	Client #	SSN		
<input type="checkbox"/>	JOHN	SMITH	123456789	***-**-****	<b>Eligibility</b>	<a href="#">Delete</a>
<input type="checkbox"/>	JANE	DOE	987654321	***-**-****	<b>Eligibility</b>	<a href="#">Delete</a>

Submit EV Batch

- 7) Eligibility verification results appear. Click the PDF icon in the top right corner of the Eligibility Verification results page to view and print results. Click **Return to List** to return to the Client List screen.

**Return to List**

Patient Information		Inquiry Information	
Client No./Trainee SSN		NPI/API	
DOB		Eligibility From	9/1/2019
Gender	M	Eligibility Through	9/30/2019
SSN		Medicaid /Client No.	
Name		Social Security Number	
Address		Date of Birth	
County	Dallas	Last Name	
Medicare No.		First Name	
Base Plan	INDIV OUTS		

Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Spend-down Indicator
EFF : 12/1/2011 TRM : R - REGULAR 7/31/2020 ADD : 10/25/2011		54 - MQMB (SSI, RECIPIENT)	100 - MEDICAID	140 - MCAID QUAL MEDICARE BENE	Q - MQMB - CATEGORY 01, 03, OR 04 CLIENT WHO IS DUALY ELIGIBLE FOR MAO AND QMB

Segment Dates	Medicare Type	Contract Number	Plan ID	Contract Number Link
EFF : 5/1/2011 TRM : A 7/31/2020 ADD : 4/6/2011				
EFF : 2/1/2011 TRM : B 7/31/2020 ADD : 5/24/2011				
EFF : 4/1/2011 TRM : C				<a href="#">CMS ID Info</a>

- 8) To submit an eligibility report for one or more clients in a client group list to batch, enter a date range in the From Date of Service and To Date of Service fields manually, or use the calendar icon. Click individual check boxes to select clients for a batch report, or click **Select All** to create a batch report for all members of the client group list. Click **Submit EV Batch**.

**Client List**

Go Back Add Client

NPI/API

From Date of Service  Format mm/dd/yyyy

To Date of Service  Format mm/dd/yyyy

Select All	First Name	Last Name	Client #	SSN	Eligibility	Delete
<input type="checkbox"/>				***-**-****	Eligibility	Delete
<input type="checkbox"/>				***-**-****	Eligibility	Delete

**Submit EV Batch**

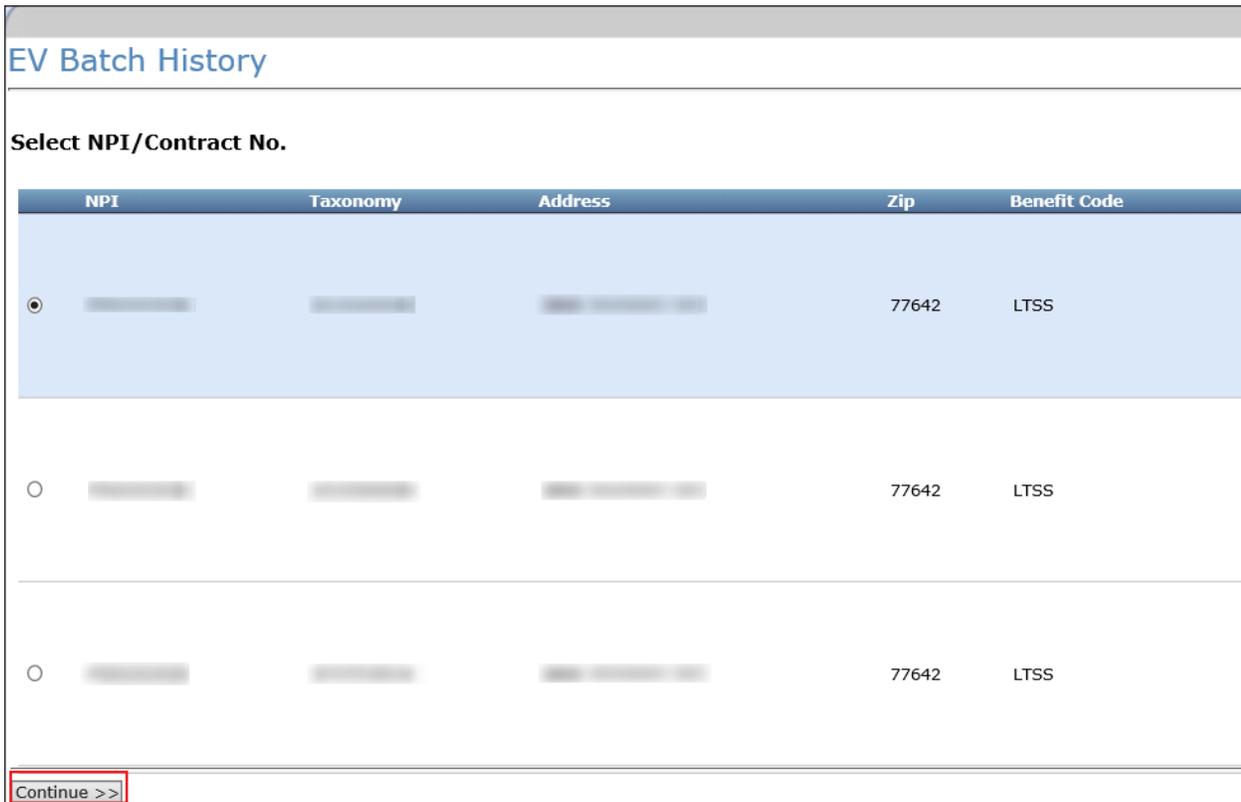
## EV Batch History

To view eligibility batch reports, follow these steps:

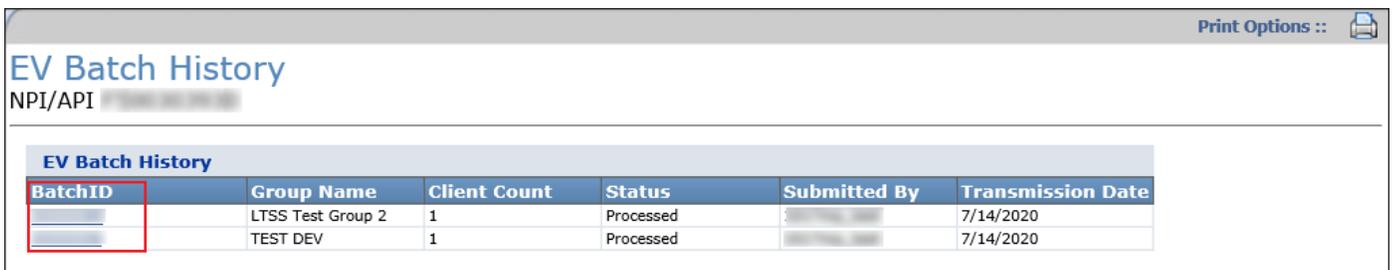
1) Select **EV Batch History** from the navigation panel.



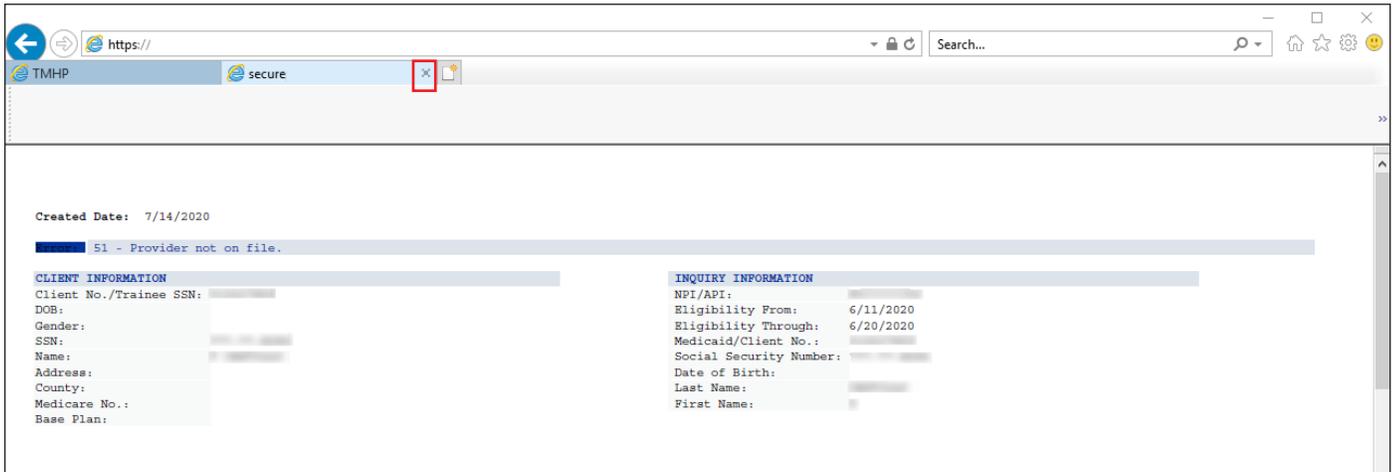
2) Select an NPI or API on the EV Batch History screen. Click **Continue**.



3) Select a **Batch ID** to review the eligibility report results. The report opens in a new browser window in a PDF format.



- 4) Use your browser print functions to print the report results. Click the **X** on the browser tab to close the report and return to the EV Batch History results screen for the selected NPI or API.



## Filing a Claim

You have the ability to submit the following claim types for a selected NPI or API:

- Institutional Outpatient
- Professional

Required data must be entered on each claim submission tab for the selected claim type. Click each tab to navigate through the screens. Ensure the data entered meets field edit requirements (such as social security number [SSN] must be nine digits, and future dates are not allowed for the patient date of birth or date of death).

After the claim information is entered, you can either submit the claim, save a draft, or save the individual claim as a template. Once a claim is submitted successfully, you will receive information about claim routing and a TMHP EDI Transaction Number (ETN).

## Claims Entry

To enter the details of a claim, follow these steps:

- 1) Select **Claims Entry** from the navigation panel.



- 2) Use the NPI drop-down list to select an NPI or API. A list of NPIs or APIs and related data (such as taxonomy, physical address, and benefit code selections) is displayed based on the user's access.

NPI	Taxonomy	Address	Zip	Benefit Code
			77642	LTSS
			77642	LTSS
			77642	LTSS

- 3) Enter the client number for the claim (optional). The client number is the Medicaid ID number. When a client number is entered, the system populates most of the required fields on the Client tab. If you do not enter the client number, you must enter all required fields manually on the Client tab.

- 4) Use the Claim Type drop-down menu to select **Outpatient** or **Professional**. Click **Proceed to Step 2**.

## Professional Claim

The Claims Entry screen appears for the Professional claim type. Required fields (indicated by a red dot) must always be completed on each tab. If you entered the client number on the Claims Entry screen, many of these fields are pre-populated, but can still be edited.

You can use the Next and Previous buttons on each tab to save claim data and move through the claims entry steps.

## Patient Tab

On the Patient tab, complete all required fields. Make sure to enter a nine-digit ZIP code in the ZIP+4 field.

The screenshot shows the 'Patient' tab selected in the 'Claim Submission - Step 2' interface. The interface includes a navigation bar with tabs for PATIENT, PROVIDER, CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The Patient tab is active. Below the tabs, there are three main sections for data entry:

- Patient Identification Numbers:** Fields for Account No., SSN, and Client Number.
- Name and Address:** Fields for Last Name, First Name, MI, Suffix, Street, City, State (dropdown), and ZIP+4.
- Patient General Information:** Fields for Gender (dropdown), Patient Date of Birth, and Patient Date of Death.

At the bottom of the form, there are buttons for 'Save Draft', 'Save Template', 'Previous', and 'Next'. A red notification banner at the top right says 'Please disable pop-up blocker to print.' A table at the top right shows the current claim details:

Claim Type	Patient	Provider	Status	Claim No.
Professional			New	

## Provider Tab

On the Provider tab, complete all required fields. Some billing provider fields pre-populate. All other required data (such as ID Type) must be entered manually.

The screenshot shows the 'Provider' tab selected in the 'Claim Submission - Step 2' interface. The interface includes a navigation bar with tabs for PATIENT, PROVIDER, CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The PROVIDER tab is active. Below the tabs, there are four main sections for data entry:

- Billing Provider:** Fields for NPI, Taxonomy, Benefit Code (pre-populated with LTSS), Last/Organization Name (Last Name, First Name, MI, Suffix), Address (Address, Address2, City, State, ZIP+4), ID Type (dropdown), EIN/SSN, and Phone No.
- Facility Provider:** Fields for NPI/API, Name, Address, City, State, Zip+4, and Service Location (dropdown).
- Referring/Other Provider:** Fields for NPI/API, Last Name, First Name, MI, and Suffix.
- Referring/Other Supervising Provider:** Fields for NPI/API, Last Name, First Name, MI, and Suffix.

At the bottom of the form, there are buttons for 'Save Draft', 'Save Template', 'Previous', and 'Next'. A red notification banner at the top right says 'Please disable pop-up blocker to print.' A table at the top right shows the current claim details:

Claim Type	Patient	Provider	Status	Claim No.
Professional			New	

## Claim Tab

On the Claim tab, complete all required fields when applicable.

Home :: TMHP.com :: My Account  
 Logged in as: [User] | Log Off  
 Print Options :: [Print]

**Claim Submission - Step 2**

Please disable pop-up blocker to print.

Claim Type	Patient	Provider	Status	Claim No.
Professional			New	

**PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM**

**Claim**

**General**

Date Of Current Condition   AutoAccident  Employment Related  THSteps Related  Other Accident

Authorization No.

Outside Lab?

Charges \$

Dates patient unable to work in current occupation  
 From:  To:

**Value Codes**

Value Amount

Save Draft Save Template Previous Next

## Diagnosis Tab

On the Diagnosis tab, complete all required fields.

Home :: TMHP.com :: My Account  
 Logged in as: [User] | Log Off  
 Print Options :: [Print]

**Claim Submission - Step 2**

Please disable pop-up blocker to print.

Claim Type	Patient	Provider	Status	Claim No.
Professional			New	

**PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM**

**Diagnosis**

Qualifier

Code  Description

Number of Details To Add:  Add New Diagnosis Code Row(s)  
 There is a maximum of 12 Diagnosis code rows available for entry.

Save Draft Save Template Previous Next

Use the Qualifier drop-down list to select International Statistical Classification of Diseases and Related Health Problems (ICD-9) or ICD-10 to ensure the correct ICD diagnosis code is found in the Code lookup field. The qualifier selected must be valid for the diagnosis code entered, based on the date of services. Input the diagnosis code to the highest degree of specificity. Click the magnifying glass icon to look up the code description.

To add additional diagnosis code rows, enter the **Number of Details To Add** (up to 12) and click **Add New Diagnosis Code Row(s)**.

## Details Tab

On the Details tab, complete all required fields.

Home :: TMHP.com :: My Account  
 Logged in as: [ ] Log Off  
 Print Options :: [ ]  
**Please disable pop-up blocker to print.**  
 Claim Type Patient Provider Status Claim No.  
 Professional [ ] [ ] New [ ]  
**DETAILS**  
 General Details  

	DOS	POS	Proc ID	Proc	Remarks	Mods				Ane. Min.	OB.Ane.Units	Diag Ref	Qty/Units	Unit Price	T
						1	2	3	4						
1															
2															
3															
4															
5															

  
 Number of Details to Add: [ ] Add New Detail Row(s) Copy Row  
**Totals**  
 Total Charges: \$0.00 Other Insurance Paid: \$0.00 Net Billed: \$0.00  
 Save Draft Save Template  
 Ben Code NDC Qty UOM Delete  
 [ ] [ ] [ ] [ ] Delete  
 [ ] [ ] [ ] [ ] Delete  
 [ ] [ ] [ ] [ ] Delete  
 [ ] [ ] [ ] [ ] Delete  
 [ ] [ ] [ ] [ ] Delete  
 Previous Next

The Total Charges on each row are automatically calculated based on the Qty/Units x Unit Price. It is important to note that for EVV claims, the units on the EVV claim must match the units on the EVV transactions for the date of service, or the claim will be denied.

Consult the current [HHSC published list of EVV services](#) to know which services are set to bypass the EVV06 claims units match edit. In the list, find your service. Go to the Units Matched During EVV Claims Matching? column to determine if the units on the EVV claim must match the units on the EVV visit transactions for that service.

Additionally, the Total Charges at the bottom of the screen is automatically calculated, based on the Total Charges for each row entered.

To add additional detail rows, enter the **Number of Details To Add** (up to 28) and click **Add New Detail Row(s)**. To duplicate a detail row, click on the row number and click **Copy Row**.

Click **Delete** in the far right column to remove a row.

## Other-Insurance/Submit Claim Tab

On the Other-Insurance/Submit Claim tab, you can select an option from the **Source of Payment** drop-down list. Enter insurance information into all required fields. Click **Add Another Insurance Plan** to create new insurance that is not on file.

Home :: TMHP.com :: My Account  
Logged in as: [User] | Log Off  
Print Options: [Print]

Claim Submission - Step 2

Please disable pop-up blocker to print.

Claim Type	Patient	Provider	Status	Claim No.
Professional			New	

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS **OTHER-INSURANCE / SUBMIT CLAIM**

Other Insurance 1

Source of Payment

Source of Payment:  
[XX NONE]

[Add Another Insurance Plan](#)

**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 Batch **Submit** Previous Next

After reviewing the Certification, Terms, and Conditions, check **We Agree** to enable the Submit button. Click **Submit** for the claim information to be automatically verified by TexMedConnect.

If there is any missing or invalid information, an error message will display the location of the error. Click each tab to view the error message detailing fields that must be corrected and correct them. The claim will not submit until the errors are corrected.

The screenshot shows the 'Claim Submission - Step 2' page. At the top right, it says 'Home :: TMHP.com :: My Account' and 'Logged in as: [Name] | Log Out'. Below that is a 'Print Options' button. A red banner at the top contains the message: 'Please fix these errors. The page will not submit until these are corrected.' Below this banner are four bullet points: 'There are errors in PATIENT tab', 'There are errors in PROVIDER tab', 'There are errors in DIAGNOSIS tab', and 'There are errors in DETAILS tab'. A navigation bar below the banner has tabs for 'PATIENT', 'PROVIDER', 'CLAIM', 'DIAGNOSIS', 'DETAILS', and 'OTHER-INSURANCE / SUBMIT CLAIM'. The 'OTHER-INSURANCE / SUBMIT CLAIM' tab is selected. Under this tab, there is a 'Source of Payment' dropdown menu with 'NONE' selected. Below that is a 'Certification, Terms And Conditions' section with a 'We Agree' checkbox. At the bottom, there are buttons for 'Save Draft', 'Save Template', 'Submit', and 'Previous/Next'.

Once all errors are corrected, return to the Other-Insurance/Submit Claim tab. Read the Terms and Conditions, then check the **We Agree** box. Click **Submit** to submit the claim.

Once a claim is submitted successfully, you can view information about claim routing and a TMHP ETN. Click the ETN number to open the CSI screen to view claim routing information and the status of the claim, such as *Pending, Accepted, or Rejected*.

The screenshot shows the 'Claim Submission - Step 2' page after a successful submission. The page has a yellow background. At the top right, it says 'Home :: TMHP.com :: My Account' and 'Logged in as: [Name] | Log Out'. Below that is a 'Print Options' button. A red banner at the top contains the message: 'Please disable pop-up blocker to print.' Below this banner is a table with columns: 'Claim Type', 'Patient', 'Provider', 'Status', and 'TMHP EDI Trans No.'. The table contains one row: 'Professional', 'Forwarded', 'L1994'. Below the table, the text reads: 'The TMHP EDI Transaction Number is 1994', 'Submitted at 11/15/2019 2:51:53 PM by [Name]', and 'Cigna-HealthSpring has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at 1-877-653-0331 for questions about processing of this claim.' Below this text is a link 'Enter Another Claim'. At the bottom, there is a navigation bar with tabs for 'PATIENT', 'PROVIDER', 'CLAIM', 'DIAGNOSIS', 'DETAILS', and 'OTHER-INSURANCE / SUBMIT CLAIM'.

## Institutional Outpatient Claim

The Claims Entry screen appears for an Outpatient claim type. Required fields (indicated by a red dot) must always be completed on each tab. If you entered the client number on the Claims Entry screen, many of these fields are pre-populated but can still be edited.

Use the Next and Previous buttons at the bottom of each tab to save claim data and move through the claims entry steps.

### Patient Tab

On the Patient tab, complete all required fields.

The screenshot shows the 'Patient' tab selected in the 'Claim Submission - Step 2' interface. The interface includes a navigation bar with tabs: PATIENT, PROVIDER, CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The 'PATIENT' tab is active. Below the navigation bar, there are three main sections: 'Patient Identification Numbers' with fields for Account No., SSN, and Client Number; 'Name and Address' with fields for Last Name, First Name, MI, Suffix, Street, City, State, and ZIP+4; and 'Patient General Information' with fields for Gender and Patient Date of Birth. A 'Please disable pop-up blocker to print.' message is visible at the top right. At the bottom, there are 'Save Draft', 'Save Template', 'Previous', and 'Next' buttons.

### Provider Tab

On the Provider tab, complete all required fields. Some billing provider fields pre-populate. All other required data (such as ID Type) must be entered manually.

The screenshot shows the 'Provider' tab selected in the 'Claim Submission - Step 2' interface. The interface includes a navigation bar with tabs: PATIENT, PROVIDER, CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The 'PROVIDER' tab is active. Below the navigation bar, there are four main sections: 'Billing Provider' with fields for NPI, Taxonomy, Benefit Code, Last/Organization Name, Address, Address2, City, State, ZIP+4, EIN, and Phone No.; 'Attending Provider' with fields for NPI/API, Last Name, First Name, MI, and Suffix; 'Operating Provider' with fields for NPI/API, Last Name, First Name, MI, and Suffix; and 'Referring/Other Provider' with fields for NPI/API, Last Name, First Name, MI, and Suffix. There is also a 'Rendering Provider' section with fields for NPI, Last Name, First Name, MI, and Suffix. A 'Please disable pop-up blocker to print.' message is visible at the top right. At the bottom, there are 'Save Draft', 'Save Template', 'Previous', and 'Next' buttons.

## Claim Tab

On the Claim tab, complete all required fields.

Home :: TMHP.com :: My Account  
 Logged in as: | Log  
 Print Options ::  
**Please disable pop-up blocker to print.**  
 Claim Type Patient Provider Status Claim No.  
 Outpatient New  
**PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM**  
**Claim**  
**General**  
 Patient Discharge Status \* Authorization No.  
 Type of Bill \*  
**Admission Information**  
 Date \* Hour \* Priority (Type) of Admission or Visit \* Point of Origin for Admission or Visit \*  
**Discharge Information**  
 Hour  
**Occurrence Codes**  
 Occurrence Code Occurrence Date  
**Add New Occurrence Code**  
**Value Codes**  
 Value Code Value Amount  
**Add New Value Code**  
 There is a maximum of 24 Value Code rows available for entry  
**Condition Codes**  
 Condition Code **Remove**  
**Add New Condition Code**  
 Save Draft Save Template Previous Next

To add occurrence code rows, click **Add New Occurrence Code**. There is a maximum of four occurrence code rows.

To add value code rows, click **Add New Value Code** (up to 24 rows) and click **Add New Diagnosis Code Row(s)**.

To add condition codes, click **Add New Condition Code**.

To delete any added rows, click **Remove**.

## Diagnosis Tab

On the Diagnosis tab, complete all required fields.

Use the Qualifier drop-down list to select ICD-9 or ICD-10 to ensure the correct ICD diagnosis code is found in the Code lookup field. The qualifier selected must be valid for the diagnosis code entered, based on the date of services.

Input the diagnosis code to the highest degree of specificity. Click the magnifying glass icon to look up the code description.

To add additional diagnosis code rows, enter the **Number of Details To Add** (up to 12) and click **Add New Diagnosis Code Row(s)**.

## Details Tab

On the Details tab, complete all required fields.

The Total Charges on each row are automatically calculated based on the Qty/Units x Unit Price. It's important to note that for EVV claims, the units on the EVV claim must match the units on the EVV transactions for the date of service, or the claim will be denied. Additionally, the Total Charges at the bottom of the screen is automatically calculated, based on the Total Charges for each row entered.

To add additional detail rows, enter the **Number of Details To Add** (up to 28) and click **Add New Detail Row(s)**. To duplicate a detail row, click on the row number and click **Copy Row**.

To remove a row, click **Delete** in the far right column.

## Other-Insurance/Submit Claim Tab

On the Other-Insurance/Submit Claim tab, you can select an option from the **Source of Payment** drop-down list. Enter insurance information into all required fields. Click **Add Another Insurance Plan** to create new insurance that is not on file.

Home :: TMHP.com :: My Account

Logged in as: | Log Off

Print Options ::

Claim Submission - Step 2

Please disable pop-up blocker to print.

Claim Type	Patient	Provider	Status	Claim No.
Outpatient			New	

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS **OTHER-INSURANCE / SUBMIT CLAIM**

Other Insurance 1

Source of Payment

Source of Payment  
XX NONE

Add Another Insurance Plan

**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 Batch **Submit** Previous Next

After reviewing the Certification, Terms, and Conditions, check **We Agree** to enable the Submit button. Click **Submit** for the claim information to be automatically verified by TexMedConnect.

If there is any missing or invalid information, an error message will display the location of the error. Click each tab to view the error message detailing fields that must be corrected. The claim will not submit until the errors are corrected.

The screenshot shows the 'Claim Submission - Step 2' page. At the top right, there is a navigation bar with 'Home :: TMHP.com :: My Account', 'Logged in as:', and 'Log Off'. Below this is a 'Print Options' button. The main header area contains the text 'Please disable pop-up blocker to print.' and a table with columns: Claim Type (Outpatient), Patient, Provider, Status (New), and Claim No. A red-bordered box contains an error message: 'Please fix these errors. The page will not submit until these are corrected.' followed by a bulleted list: 'There are errors in PATIENT tab', 'There are errors in PROVIDER tab', 'There are errors in CLAIMS tab', 'There are errors in DIAGNOSIS tab', and 'There are errors in DETAILS tab'. Below the error message is a tabbed interface with tabs for PATIENT, PROVIDER, CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The 'OTHER-INSURANCE / SUBMIT CLAIM' tab is selected. Under this tab, there is a section for 'Other Insurance 1' with a 'Source of Payment' dropdown menu set to 'XX NONE' and an 'Add Another Insurance Plan' link. Below this is a 'Certification, Terms And Conditions' section with a paragraph of text and a 'We Agree' checkbox. At the bottom of the page are buttons for 'Save Draft', 'Save Template', 'Submit', and 'Previous Next'.

Once all errors are corrected, return to the Other-Insurance/Submit Claim tab. Read the Terms and Conditions, then check the **We Agree** box. Click **Submit** to submit the claim.

Once a claim is submitted successfully, you can view information about claim routing and a TMHP ETN. Click the ETN number to open the CSI screen to view claim routing information and the status of the claim, such as *Pending*, *Accepted*, or *Rejected*.

The screenshot shows the 'Claim Submission - Step 2' page after successful submission. The main content area is highlighted in green and contains the following text: 'The TMHP EDI Transaction Number is 11994', 'Submitted at 11/15/2019 2:51:53 PM by [redacted]', and 'Cigna-HealthSpring has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at 1-877-653-0331 for questions about processing of this claim.' Below this text is a link that says 'Enter Another Claim'. At the bottom of the page is a tabbed interface with tabs for PATIENT, PROVIDER, CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The 'OTHER-INSURANCE / SUBMIT CLAIM' tab is selected. The top right navigation bar is the same as in the previous screenshot, but the 'Status' in the table is now 'Forwarded' and the 'Claim No.' is 'L1994'.

## Saving a Claim

MCO LTSS provider claims can be saved as a draft or saved as a template.

Click **Save Draft** to add the claim to the Draft list for completion at a later time.

Click **Save Template** to add claims to the Individual Template list for quicker claims creation in the future.

## Saving as a Draft

You can save incomplete claims in a draft status for later submission. To save a claim as a draft, follow these steps:

- 1) Click Save Draft.

- 2) Enter a draft name in the blank field that appears. The draft name can include both numbers and letters.

- 3) Click Save to save the draft. Click Cancel to close the draft name field.

The claim is saved to the Draft screen for completion at a later time.

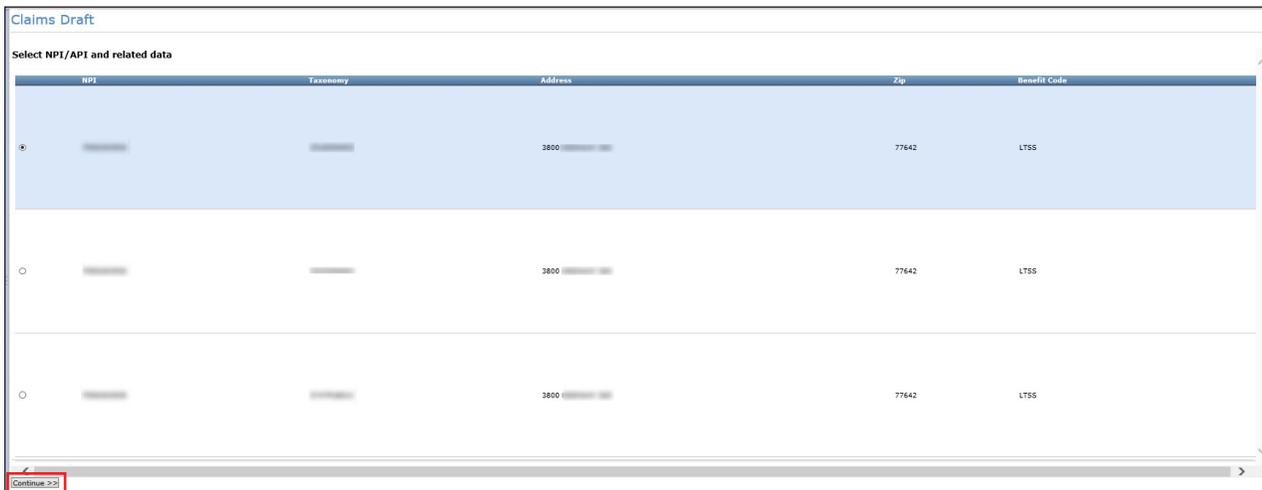
## Viewing Draft Claims

A list of NPIs and APIs and related data appear in the Claims Draft screen. Once a draft is submitted, it is removed from the draft list. **Additionally, drafts are removed if they are not submitted within 45 days.** A maximum of 50 drafts can be created for each NPI or API number. Drafts are displayed by NPI or API. To view a list of draft claims:

- 1) Click **Draft** in the left navigation panel.



- 2) Select the NPI or API on the Claims Draft screen. Click **Continue**.



- 3) Click on a draft name to continue working on it. Drafts can be sorted by clicking column headers.



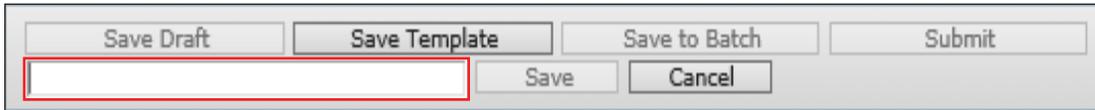
## Saving Individual Claims as Templates

You can save individual claims as a template to save time submitting claims in the future. To save a claim as a template, follow these steps:

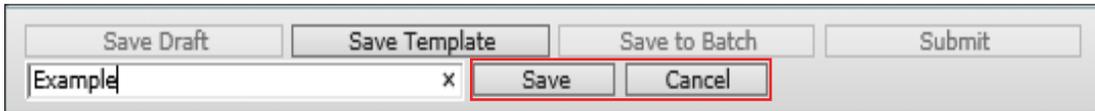
- 1) Click **Save Template**.



- 2) Enter a template name in the blank field that appears.



- 3) Click **Save** to save the template. Click **Cancel** to close the template name field.

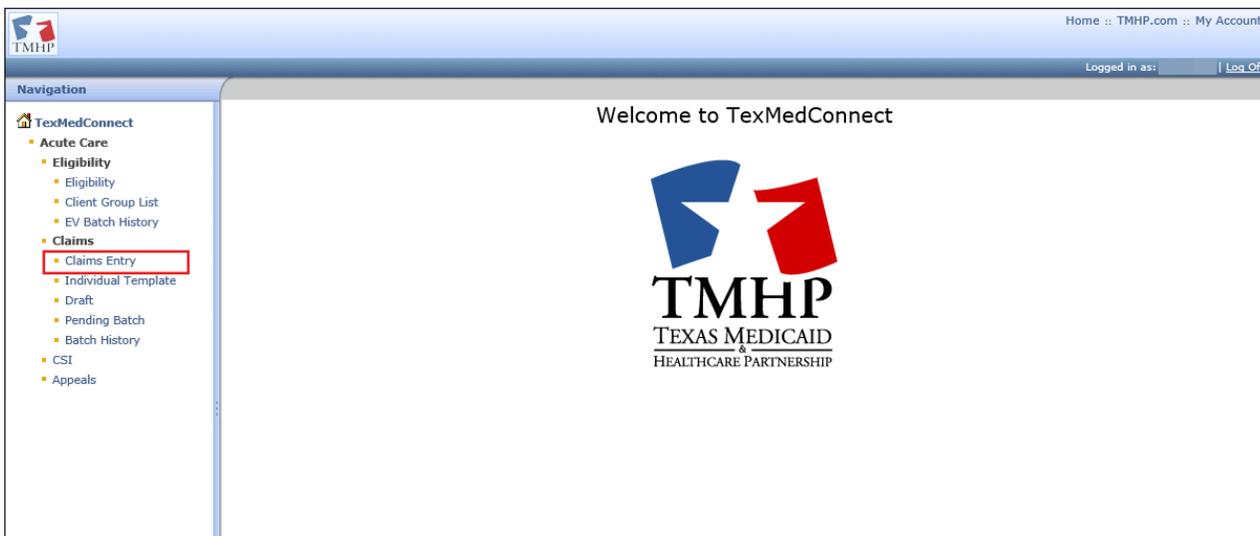


- 4) The claim is saved to the Individual Template screen for completion at a later time.

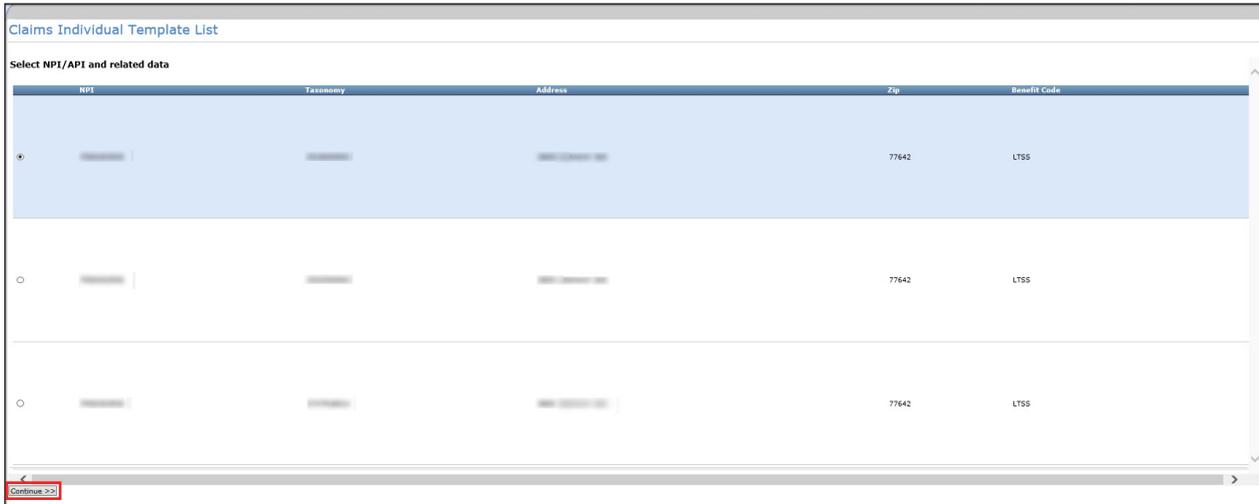
## Viewing Individual Templates

A list of NPIs and APIs and related data appear in the Claims Individual Template List screen. Templates are displayed by NPI or API. **Templates do not disappear when used, but they are removed after 90 days of not being used.** A maximum of 1000 individual claim templates can be created for each NPI or API number. To view a list of individual templates:

- 1) Click **Individual Template** in the left navigation panel.



- 2) Select the NPI or API on the Claims Individual Template List screen. Click **Continue**.



- 3) Click on a template name to continue working on a claim. Templates can be sorted by clicking column headers.



## Saving as Batch

You can save a claim to batch, which creates a pending batch list that is maintained until you submit the batch. One batch can contain up to 250 claims. Claims from Draft, Templates, or claims currently being created can be saved to a pending batch. Pending batches not submitted after 45 days are deleted. To save a claim to batch, follow these steps:

- 1) Click **Save to Batch**.



- 2) After you click **Save to Batch**, the system will take you back to the claims entry screen.

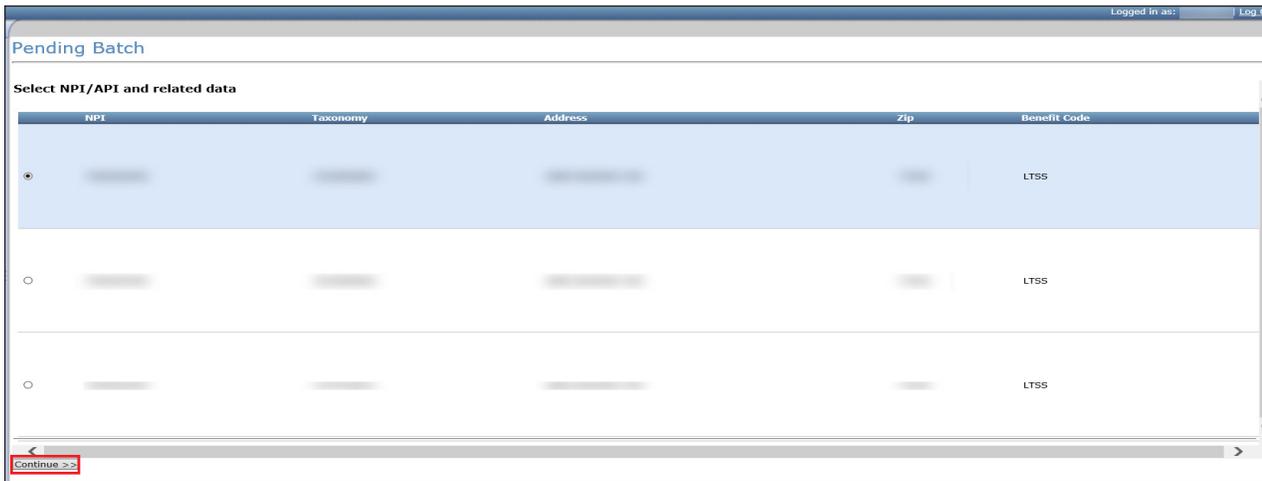
## Pending Batch

The pending batch list displays claims that are ready to be submitted. To submit a batch of pending claims, follow these steps:

- 1) Click **Pending Batch** in the left navigation panel.



- 2) Select the NPI or API in the Select NPI/API and related data list, then click **Continue**.



- 3) Click **View** to view pending claim detail. Click **Edit** to make changes to the pending claim. Click **Delete** to delete the pending claim.

Click **Submit Batch** when all pending claims displayed are ready to be submitted. All claims in the batch will be submitted, even if they were created by other users under the same NPI.

Pending Batch - List of Claims

NPI/API [redacted]

Client #	Account No	Last Name	First Name	Start Date Of Service	Billed Amt	Claim Form	User ID	View	Edit	Delete
[redacted]	[redacted]	[redacted]	[redacted]	12/03/2019	\$5,336.00	Professional	[redacted]	<a href="#">View</a>	<a href="#">Edit</a>	<a href="#">Delete</a>
[redacted]	[redacted]	[redacted]	[redacted]	12/10/2019	\$5,336.00	Professional	[redacted]	<a href="#">View</a>	<a href="#">Edit</a>	<a href="#">Delete</a>
[redacted]	[redacted]	[redacted]	[redacted]	12/11/2019	\$5,336.00	Professional	[redacted]	<a href="#">View</a>	<a href="#">Edit</a>	<a href="#">Delete</a>
[redacted]	[redacted]	[redacted]	[redacted]	12/12/2019	\$5,336.00	Professional	[redacted]	<a href="#">View</a>	<a href="#">Edit</a>	<a href="#">Delete</a>

Total Billed Amount: \$ 21344.00

[Submit Batch](#)

- 4) A confirmation appears when the batch is submitted.

Logged in as: [redacted] Log Off

Pending Batch - List of Claims

NPI/API [redacted]

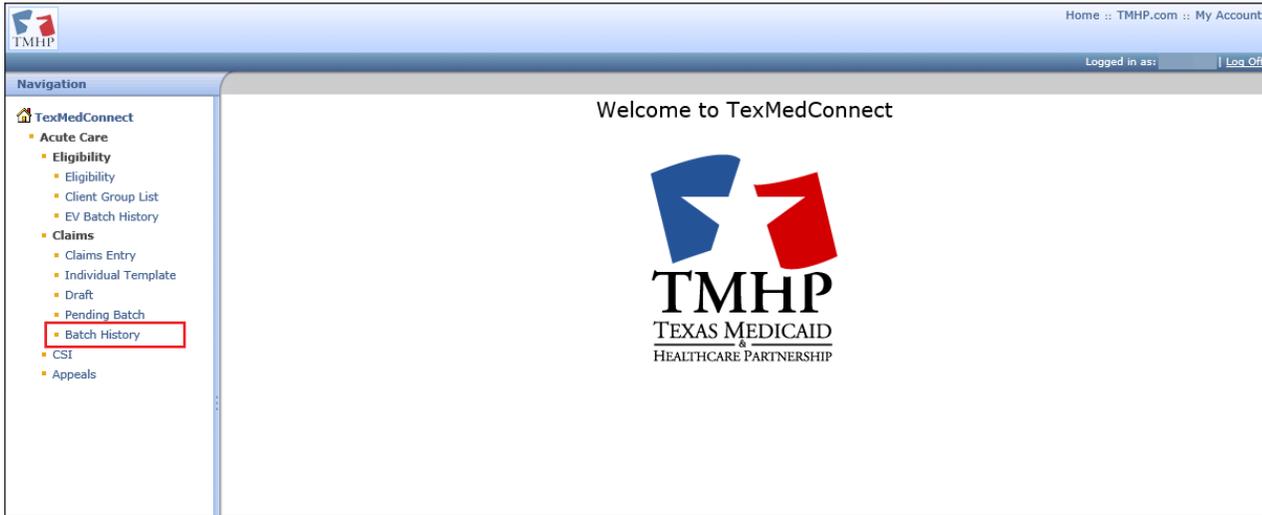
The pending batch was successfully submitted. 4 claims have been submitted in this batch. The status and details for this batch can be viewed in the Batch History Screen.

Total Billed Amount: \$ .00

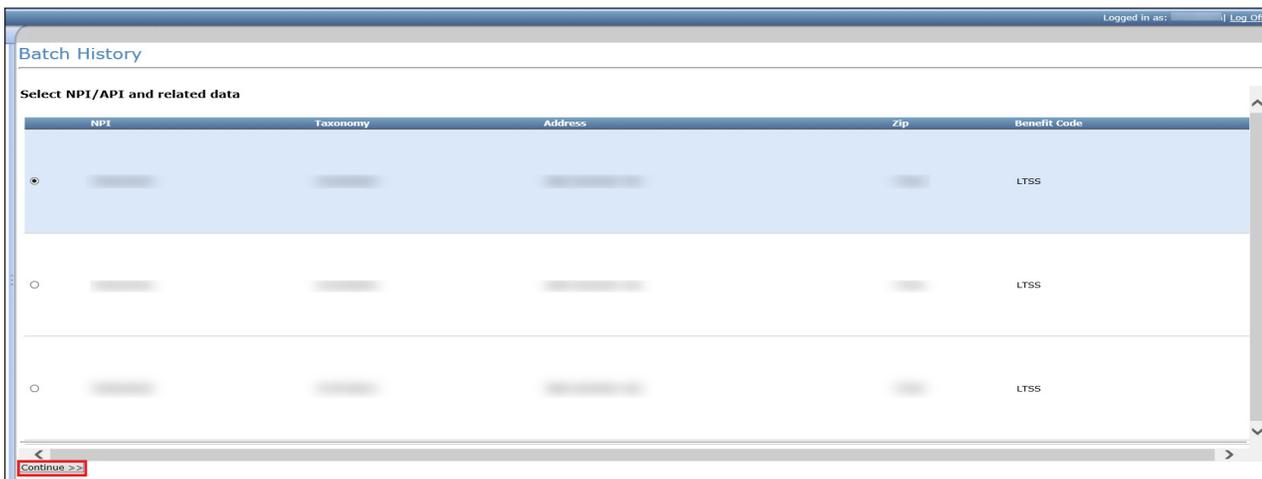
## Batch History

You can view the history of previously submitted claim batches for the previous 120 days. Batches that are more than 120 days old are automatically deleted from the history. To view a batch history, follow these steps:

- 1) Click **Batch History** in the left navigation panel.



- 2) Select the NPI or API in the Select NPI/API and related data list, then click **Continue**.



3) A Batch History list appears. Batch IDs are assigned a **Submitted** status or a **Processed** status.

A **Submitted** status indicates the user has submitted the batch, but it has not been forwarded to the payer. A **Processed** status indicates the batch has been processed by the system and forwarded to the payer. A **Submitted** status will change to a **Processed** status within 24 hours. Contact the EDI Help Desk a 888-863-3638, Option 4, if the batch remains in a **Submitted** status for over 24 hours.

Click a **Batch ID** in **Processed** status to view the list of claims in that batch.

Batch History

NPI/API [Redacted]

Batch ID	Status	Claim Count	Total Billed Amount	Transmission Date	Submitted By
[Redacted]	Submitted	1	\$5,336.00	12/26/2019 03:57:18 PM	[Redacted]
[Redacted]	Submitted	2	\$9,336.00	01/13/2020 12:20:30 PM	[Redacted]
[Redacted]	Submitted	1	\$200.00	01/13/2020 01:12:53 PM	[Redacted]
[Redacted]	Processed	1	\$495.00	01/13/2020 01:23:00 PM	[Redacted]
[Redacted]	Submitted	4	\$21,344.00	01/15/2020 09:24:16 AM	[Redacted]

4) A list of claims for the Batch ID appears. Claims are in a **Forwarded**, **Accepted**, or **Rejected** status. **Forwarded** claims have been sent to the payer, but have not been accepted or rejected. **Accepted** claims have been accepted by the payer. **Rejected** claims have been rejected by the payer.

5) Clicking the **Status** link will take you to additional details on the MCO CSI Search Details screen.

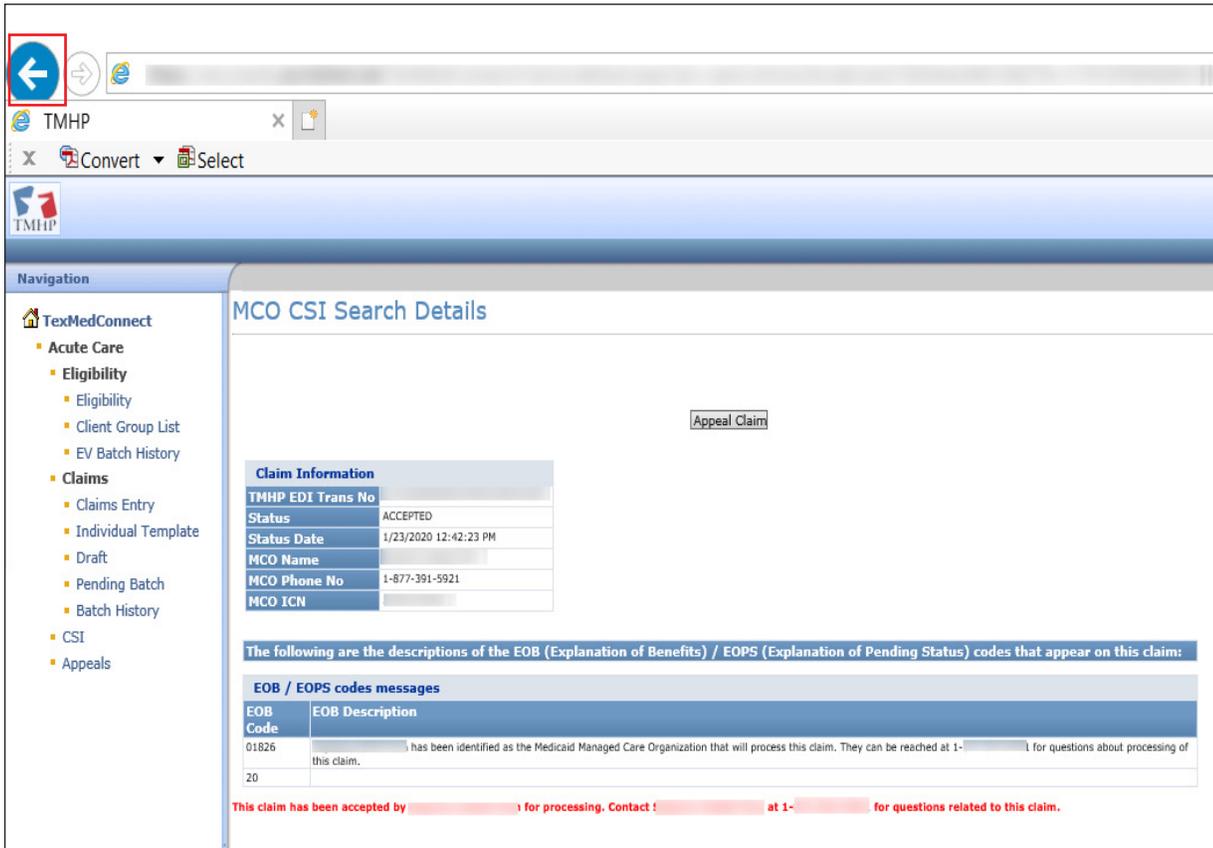
Batch History - List of Claims - [Redacted]

Status	Client #	Account No	Payer Name	Last Name	First Name	Start Date Of Service	Billed Amt	Claim Form	User ID
Forwarded	[Redacted]	12341234	[Redacted]	[Redacted]	[Redacted]	01/03/2020	\$495.00	Professional	[Redacted]

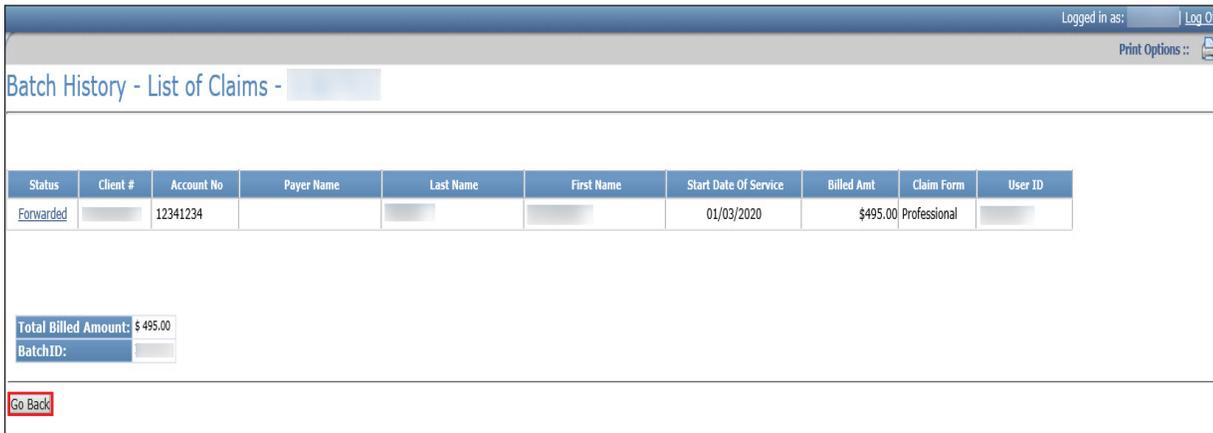
Total Billed Amount: \$ 495.00  
BatchID: [Redacted]

Go Back

- The MCO CSI Search Details screen appears. Use the internet browser back button to return to the previous screen.



- Click **Go Back** to return to the list of claims.



# Claim Status Inquiry (CSI)

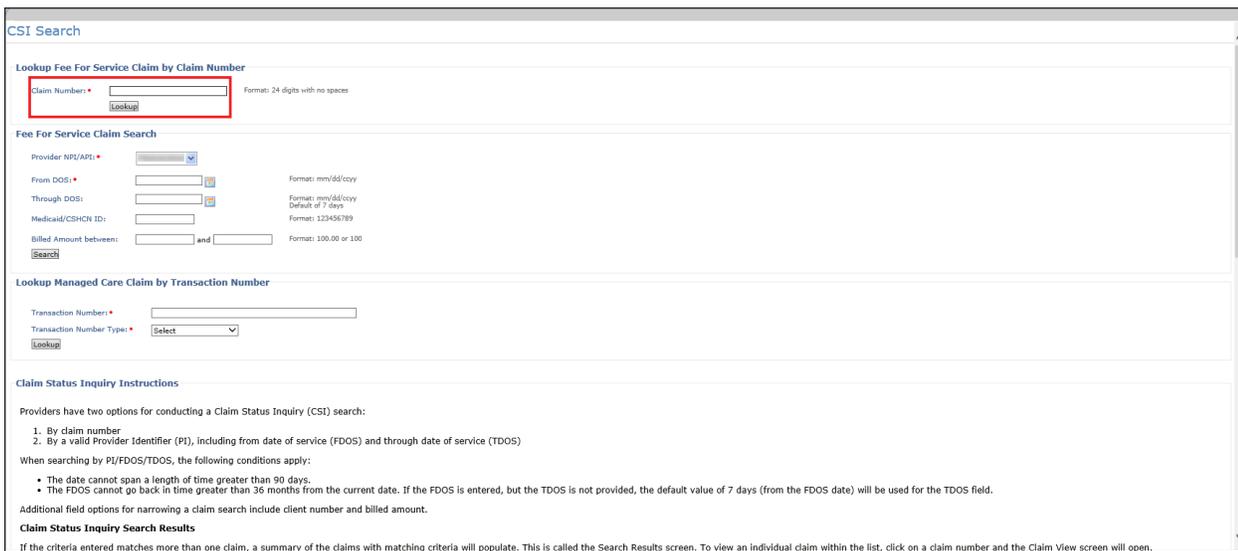
CSI allows you to determine the status of processed claims. The search can be performed using a claim number or a combination of other fields. A summary of claims within the past three years that matches the search criteria appears, and claim detail can be accessed. A maximum of 250 results are returned. To perform a CSI search:

- 1) Click **CSI** in the left navigation panel.



- 2) Enter a claim number. Click **Lookup**. If you do not know the claim number, enter other claim information and click **Search**.

It is important to note that a date range cannot be longer than 30 days, and the From date of service (DOS) field cannot have a date more than 36 months prior to today's date.



- 3) CSI search details appear if a match is found. If the search does not locate the desired claim, narrow the search criteria to produce a more specific match.

## MCO CSI Search Details

Appeal Claim

Claim Information	
TMHP EDI Trans No	L119*
Status	ACCEPTED
Status Date	11/7/2019 4:35:17 PM
MCO Name	Superior Health Plan
MCO Phone No	1-877-391-5921
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
01826	Superior Health Plan has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at 1-877-391-5921 for questions about processing of this claim.

This claim has been accepted by Superior Health Plan for processing. Contact Superior Health Plan at 1-877-391-5921 for questions related to this claim.

# Appeals

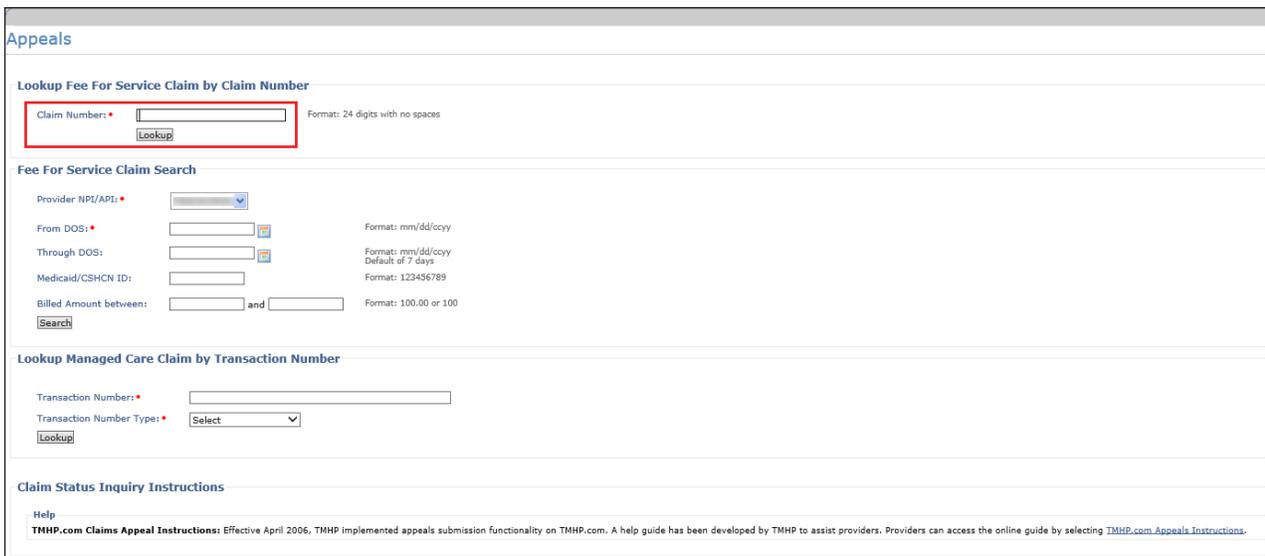
Institutional outpatient claims with a finalized status, such as *Denied* or *Paid*, must be appealed directly with the MCO using the existing appeal process.

Professional claims with a finalized status, such as *Denied* or *Paid*, can be appealed directly from TexMedConnect. You can only appeal finalized claims. To appeal a claim, follow these steps:

- 1) Click **Appeals** in the left navigation panel.



- 2) Enter the claim number. Click **Lookup**. If you do not know the claim number, enter other claim information and click **Search**.



3) CSI search details appear if a match is found. Click **Appeal Claim** to begin the appeal process.

Logged in as: [redacted] Print Opti

### MCO CSI Search Details

Appeal Claim

Claim Information	
TMHP EDI Trans No	[redacted]
Status	ACCEPTED
Status Date	11/7/2019 4:35:17 PM
MCO Name	Superior Health Plan
MCO Phone No	1-877-391-5921
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
01826	Superior Health Plan has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at 1-877-391-5921 for questions about processing of this claim.

This claim has been accepted by Superior Health Plan for processing. Contact Superior Health Plan at 1-877-391-5921 for questions related to this claim.

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