

TexMedConnect Acute Care Manual



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

v2021_0908

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1.0 Overview

The TexMedConnect – Acute Care application is accessed online on the Texas Medicaid & Healthcare Partnership (TMHP) website at www.tmhp.com. TexMedConnect will replace TDHconnect. Although TexMedConnect uses similar logic and validation that existed in TDHconnect, TexMedConnect has a new look, feel, and updated navigation. A new left navigation bar makes it easier to move through the application.

Additionally, the application is more efficient due to the improved technology.

TexMedConnect requires a National Provider Identifier (NPI) and does not support the Texas Provider Identifier (TPI).

TexMedConnect:

- Delivers an integrated, web-based application.
- Provides a stable and secure environment for claims submission.
- Provides a comparable solution to most TDHconnect tasks.
- Provides accessibility from any computer with Internet access.

With TexMedConnect – Acute Care, you can administer billing for Medicaid, Family Planning, and Children with Special Health Care Needs (CSHCN) Services Program clients.

TexMedConnect supports the following Health Insurance Portability and Accountability Act (HIPAA) - compliant transaction types:

HIPAA Compliant Transaction Types	
Eligibility Request	270
Eligibility Response	271
Claim Status Inquiry	276
Electronic Remittance and Status (ER&S) Report	835
Dental Claims	837D
Institutional Claims	837I
Professional Claims	837P
Long Term Care Claims	*(See Note)

Note: All transaction types except 276 apply for LTC transactions through TexMedConnect.

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

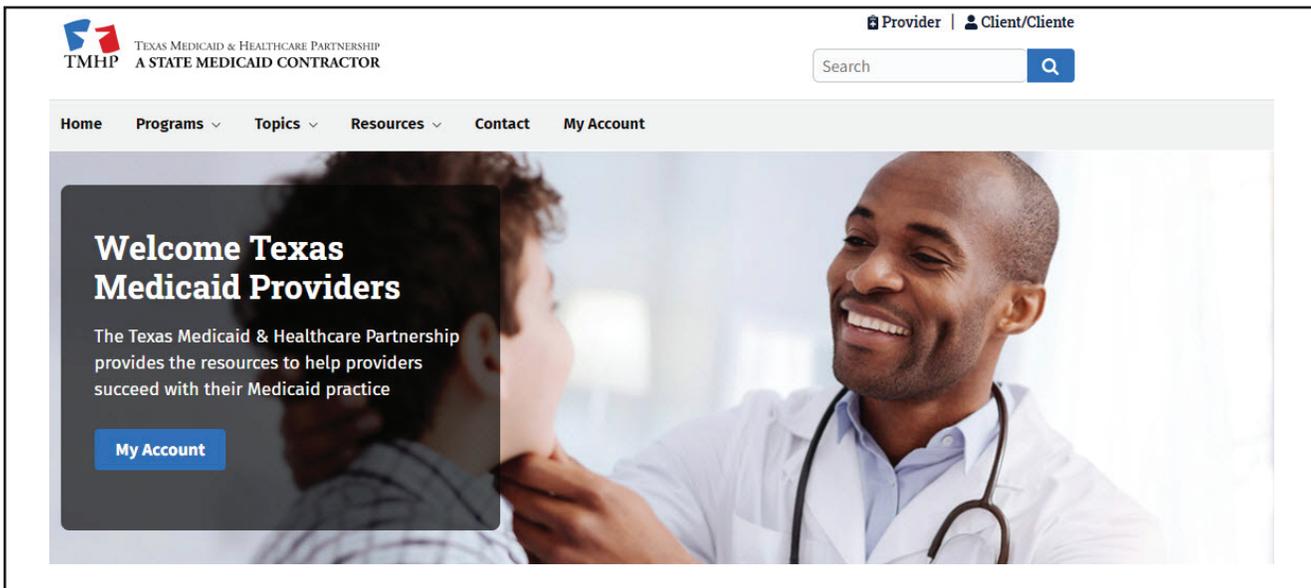
2.0 Accessing TexMedConnect and Internet Requirements

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

- Internet service provider (ISP)
- Internet browser Microsoft® Internet Explorer®
- Google Chrome®

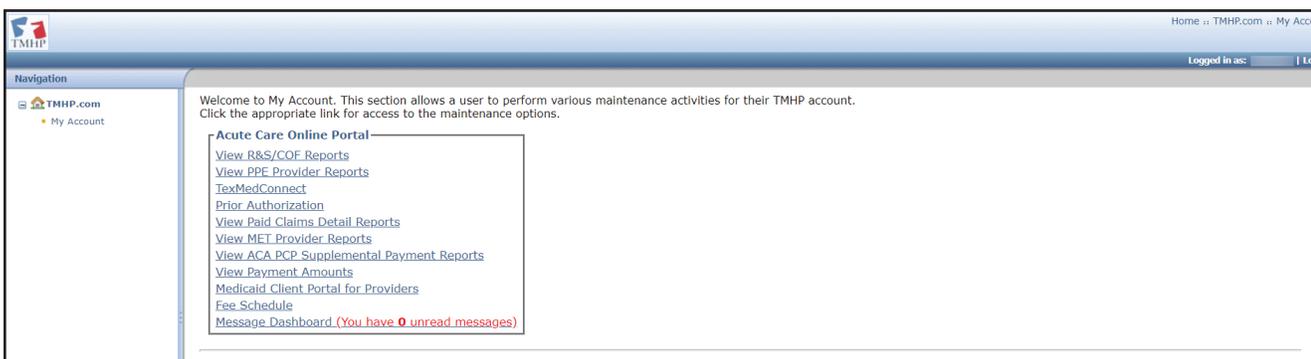
Note: *Broadband connection is recommended but not required*

TexMedConnect is accessed through the TMHP website at tmhp.com. After accessing the website and clicking **TexMedConnect** on the page.



2.1 Logon and Logoff

There is a “Log in to my account” hyperlink located in the upper right hand corner on the homepage of the TMHP website directly above the “Access TexMedConnect” link. Selecting this hyperlink directs the user to the My Account page, as shown below, and not directly to TexMedConnect. The My Account page provides users with another method to access TexMedConnect, and it allows providers to manage their accounts.



3.0 Getting Support

This section explains how to get assistance from TMHP with technical issues, training, and claims questions. This section also shows how to access additional resources on the TMHP website.

3.1 Getting Technical Assistance

For Medicaid, CSHCN Services Program, and Family Planning technical issues, you can call the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638. 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.

3.2 Accessing Training Resources

The TMHP EDI Help Desk does not provide training; however, training is available through your TMHP provider relations representative or one of the training workshops provided by TMHP Provider Relations. You can also find answers to frequently asked questions (FAQs) and Medicaid workshop schedule information on the TMHP website at www.tmhp.com.

TMHP has two contact centers that provide information about your provider relations representative, workshops, or other information:

- For Medicaid and Family Planning information, call the TMHP Contact Center at 800-925-9126.
- For CSHCN Services Program information, call the TMHP-CSHCN Services Program Contact Center, at 800-568-2413.

3.3 Getting Claims Assistance

For answers to questions about Medicaid and Family Planning electronic or paper claims, providers can call the TMHP Contact Center at 800-925-9126.

For answers to questions about CSHCN Services Program electronic or paper claims, providers can call the TMHP-CSHCN Services Program Contact Center, at 800-568-2413.

4.0 Navigation Panel

Available transactions for Medicaid, Family Planning, and the CSHCN Services Program are located under “**Acute Care**” in the sidebar navigation. You can select the activity you would like to perform from the navigation panel:



Note: A user’s access privilege determines which transactions show up in the navigation panel.

5.0 Filing a Claim

To submit an individual claim, you must select a valid NPI and related data before entering the Claims Entry screen.

You have the ability to submit interactively for the following claims:

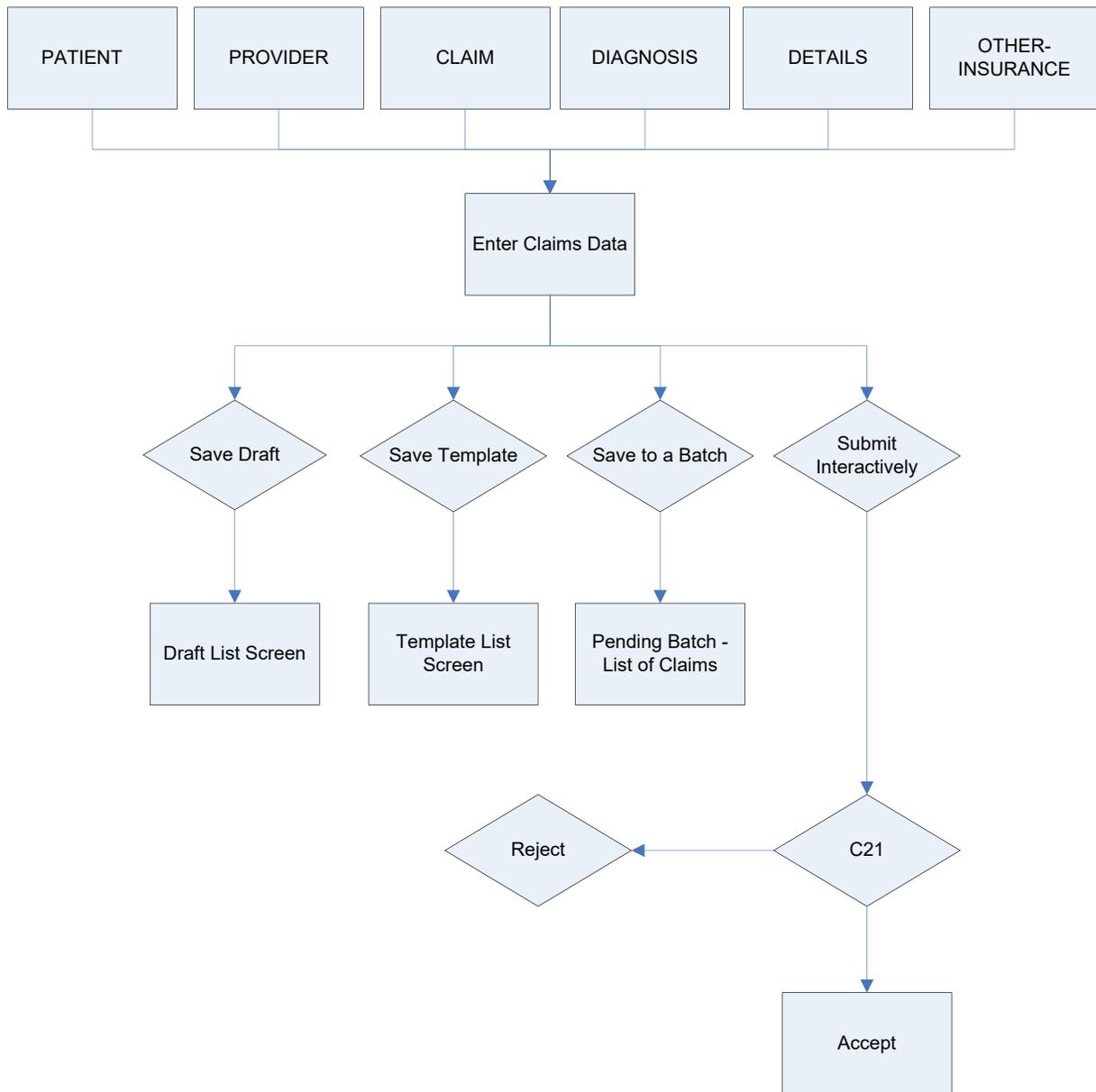
- 020 (Professional, Ambulance, and Vision)
- 021 (Dental)
- 023 (Outpatient)
- 040 (Inpatient)
- 056 (DSHS Family Planning Program [DFPP])
- 058 (Family Planning Title XIX)

After choosing the appropriate claim type, entering the optional client number, and selecting the next appropriate action, you are directed to the Claims Main screen. On the Claims Main screen, the required data can be entered on the available tabs for the selected claim type.

After the claim is completed, you can choose to submit the claim interactively from the Other Insurance tab. After doing so, you receive any Explanation of Benefits (EOBs) that may apply or an Internal Control Number (ICN) if the claim has submitted successfully. You also can save incomplete claims in a draft status or to save the individual claim as a template.

The following flow chart provides an overview of the process.

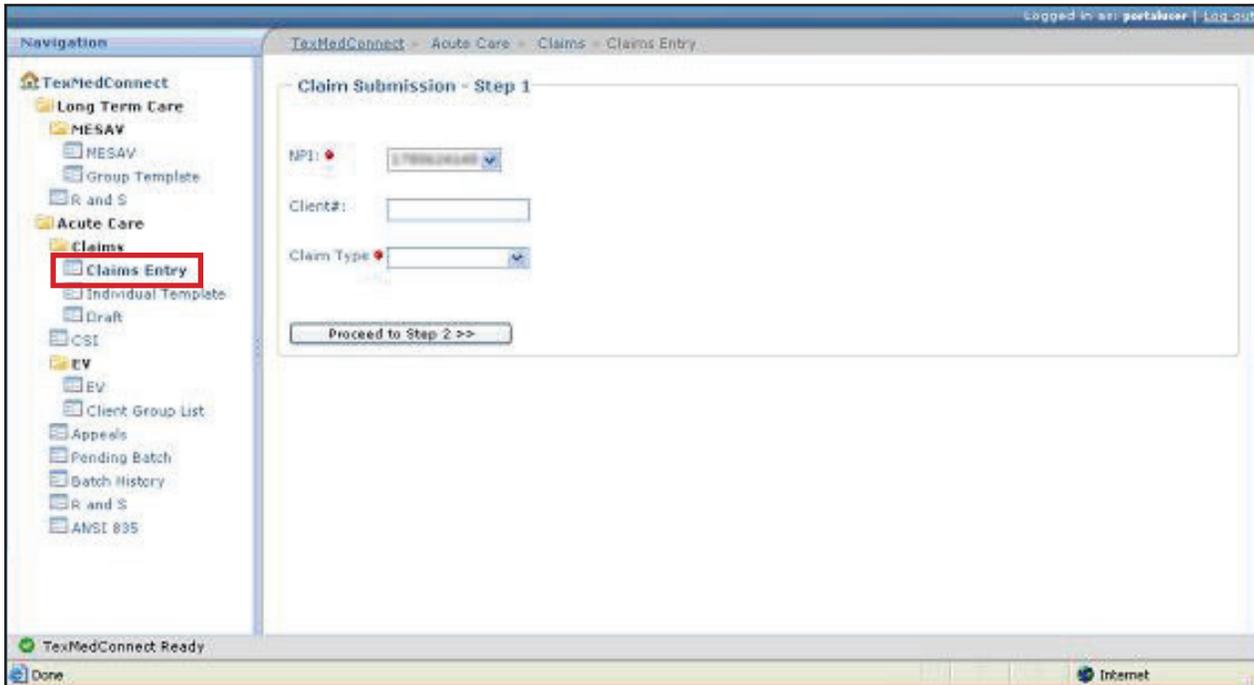
Claims Flow Chart



5.1 Entering Claim Details

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

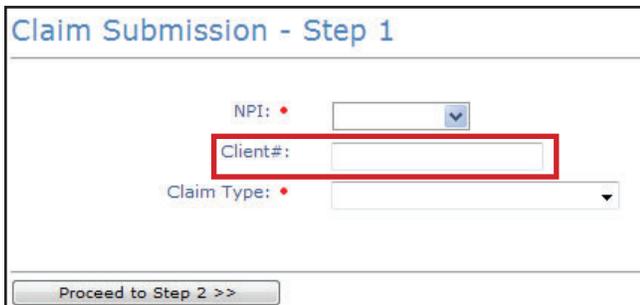
- 1) Select **Claims Entry** from the navigation panel.



- 2) Select the appropriate billing provider information.
A list of NPI/API and related data such as taxonomy, physical address, and benefit code selections is displayed based on the user's logon information.

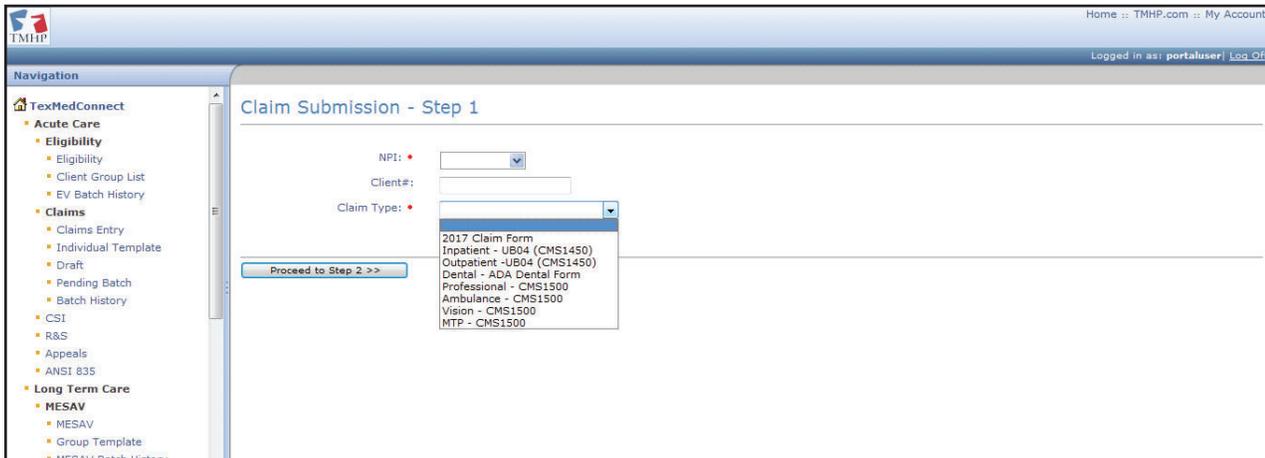


- 3) Enter the client number for the claim (optional).
The system populates most of the required fields on the Client tab.



Note: If you do not enter the client number, you must enter all required fields manually on the Client tab.

4) Select the claim type from the drop-down menu.



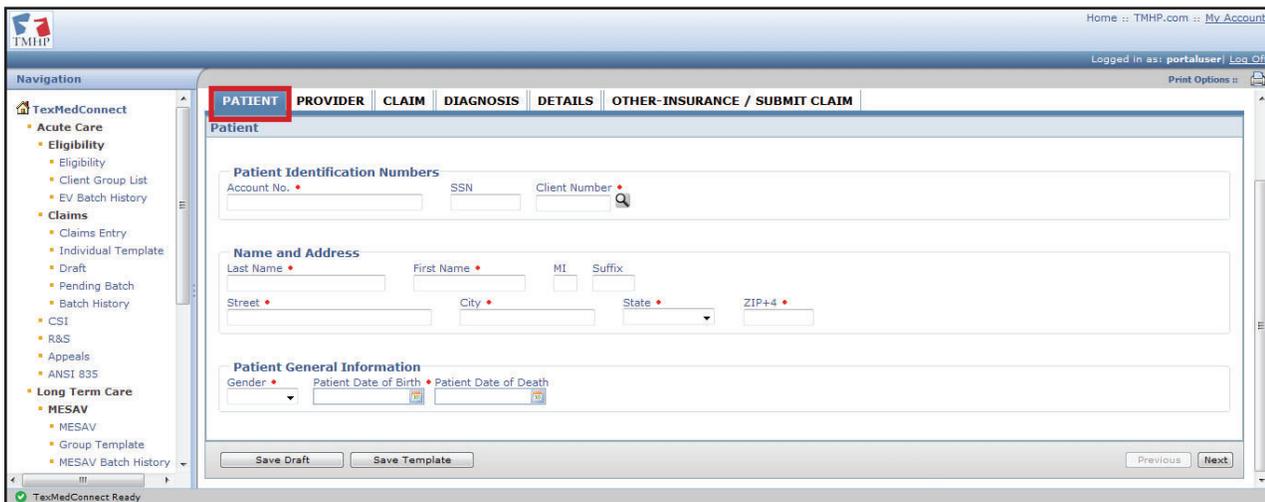
5) Click **Proceed to Step 2**.

The Claims Entry screen appears for the selected claim type.

Note: If you entered the client number on the Claims Entry screen, many of these fields are populated by the system but can still be edited.

The selected claim type (**Professional**) appears.

6) **Patient Tab**



Complete the information on the screen.

a) Enter the required fields, which are indicated by a red dot.

b) Ensure the data entered meet field edit requirements:

Alphanumeric – Account No., First, Last Names, MI, Suffix, Street, City

Drop-down calendar – Patient Date of Birth (no future date allowed), Date of Death (no future date allowed)

Drop-down selection – Gender, State

Numeric only – SSN (9 digits), Client Number (9 digits), ZIP+4 (5+4)

7) **Provider Tab**

The screenshot shows a web interface with a top navigation bar containing tabs: PATIENT, PROVIDER (highlighted with a red box), CLAIM, DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. Below the navigation bar is a section titled "Providers" containing four sub-sections:

- Billing Provider:** Includes fields for NPI (dropdown), Taxonomy, Benefit Code, Last/Organization Name, First Name, MI, Suffix, Address, Address2, City, State, ZIP+4, ID Type (dropdown), EIN/SSN (with a red dot indicating a required field), and Phone No.
- Facility Provider:** Includes fields for NPI/API, Name, Address, City, State (dropdown), Zip+4, and Service Location (dropdown).
- Referring/Other Provider:** Includes fields for NPI/API, Last Name, First Name, MI, and Suffix.
- Referring/Other Supervising Provider:** Includes fields for NPI/API, Last Name, First Name, MI, and Suffix.

At the bottom of the form are buttons for "Save Draft", "Save Template", "Previous", and "Next".

- a) Enter provider information into all required fields, which are indicated by a red dot. Many of the fields are populated on this screen from the Billing Provider NPI/Related selected on the Claims Entry screen.

- b) Ensure the data entered meet field edit requirements:

Billing Provider

Note: The billing provider information on this tab pre-populates only the related data from the NPI that was selected from the initial Claims Entry screen. All other required data (for example, tax ID) must be entered manually.

Alphanumeric – First, Last/Organization Names, MI, Suffix, Address, Address 2, City, Taxonomy, Benefit Code

Drop-down selection – State, ID Type

Numeric only – NPI/API (10 digits), EIN/SSN (9 digits), Phone Number (area code + 7), ZIP+4 (5+4)

Facility Provider

Alphanumeric – Name, Address, City

Drop-down selection – State, Service Location, ID Type

Numeric only – NPI/API (10 digits), EIN/SSN (9 digits), ZIP+4 (5+4)

Referring/Other Provider

Alphanumeric – First, Last Names, MI, Suffix

Drop-down selection – ID Type

Numeric only – NPI/API (10 digits), EIN/SSN (9 digits)

Referring/Other Supervising Provider

Alphanumeric – First, Last Names, MI, Suffix

Drop-down selection – ID Type

Numeric only – NPI/API (10 digits), EIN/SSN (9 digits)

8) **Claim Tab**

a) Enter claim information into all required fields, which are indicated by a red dot.

b) Ensure the data entered meet field edit requirements:

Alphanumeric – Authorization No

Checkbox

Auto Accident – If Auto Accident is checked, the Accident State box appears. The state is required in this field

Employment Related

THSteps Indicator – When the THSteps Indicator is checked, Condition Codes fields appear.

Condition codes are required. Only one condition indicator per detail is allowed.

Other Accident

Drop-down calendar

Date of Current Condition (no future date allowed)

Dates patient unable to work in current occupation

Drop-down selection

Accident State

Outside Lab

Charges

Drop-down selection for Condition Codes

NU – Indicates the patient had a normal screening, an abnormal screen without treatment, an abnormal screen initiated treatment, or was referred to another health agency or to family planning.

S2 – Indicates that the client’s screen was abnormal but the condition is under treatment.

ST – Indicates new services requested, such as when the client was referred to the primary care physician or to a specialist.

9) Diagnosis Tab

- Enter diagnosis information into all required fields, which are indicated by a red dot.
- Select the qualifier dropdown in order to enter the correct ICD diagnosis code qualifier.
Note: *Qualifier selected must be valid for the diagnosis code entered, based on date of services.*
- Input the diagnosis code to the highest degree of specificity. A valid diagnosis must be entered if required for claim. More than one diagnosis code can be entered by clicking **Add New Diagnosis**. There is a maximum of 12 Diagnosis code rows available for entry.
- Ensure the data entered meet field edit requirements:
Alphanumeric – Diagnosis Code, Description populates when a valid diagnosis code is entered.
Note: Clicking the magnifying glass displays the diagnosis description.

10) Details Tab

Navigation

TexMedConnect

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

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

General Details

	DOS	POS	Proc ID	Proc	Remarks	Modes				Ane. Min.	Diag Ref	Qty/Units	Unit Price	Total Charges	NPI/API	Ac
						1	2	3	4							
1																
2																
3																
4																
5																

1 Add New Detail Row(s) Copy Row

Totals

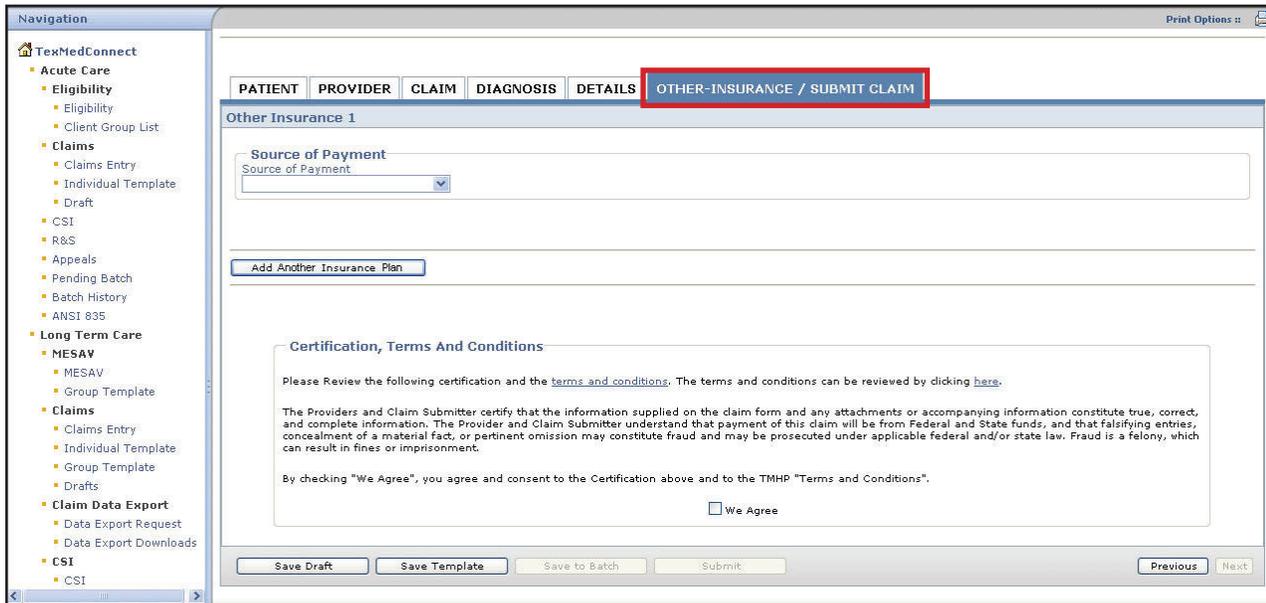
Total Charges	Other Insurance Paid	Net Billed
\$0.00	\$0.00	\$0.00

Save Draft Save Template Previous Next

- Enter claim detailed information into all required fields, which are indicated by a red dot.
- Ensure that the data entered meet field edit requirements:
 - Alphanumeric** – Procedure Code, Mod1–Mod4, Remarks
 - Drop-down calendar** –Date of Service (no future date allowed)
 - Drop-down selection** – Procedure Code ID, POS, Diagnosis Ref
 - Numeric only** – Ane. Min, Other Insurance Paid, Net Billed, Qty/Units, Unit Price, Performing NPI/ API (10 digits), Total Charges are calculated
 Clicking the magnifying glass validates the NPI/API.

Note: To add additional details, click Add New Detail Row(s). Use Copy Row to populate the information from previous detail.

11) Other Insurance / Submit Claim Tab



12) Locate the Source of Payment field and select an option from the drop-down menu.

- a) Enter insurance information into all required fields, which are indicated by a red dot.
- b) Ensure the data entered meet field edit requirements:
 - Alphanumeric** – Company Name, Address, City, Contact Name, Policy Holder First, Last Names, MI, Group/Policy Number, Group/Employer Name
 - Checkbox** – Verbal Denial, Delay Indicator
 - Drop-down calendar** – Bill Date (no future date allowed), Disposition Date (no future date allowed), Verbal Date (no future date allowed)
 - Drop-down selection** – Source of Payment, Adjustment Reason Code, State, Verbal Denial
 - Free text** – Comment
 - Numeric only** – PPO Discount, Paid Amt, ZIP+4 (5+4), Phone Number (area code + 7), Policy Holder ID/SSN (9 digits)
- c) Click the **Add Another Insurance Plan** button to create new insurance that is not on file.
- d) **Save to Batch** and **Submit** buttons are enabled when you accept the Certification, Terms, and Conditions by clicking the **We Agree** button.

5.2 Tabs for Other Claim Types

The information required varies by claim type. The following sections provide details for the following claim types:

- Dental – Claim tab, Details tab
- Inpatient – Provider tab, Claim tab, Diagnosis tab, Details tab
- Outpatient – Claim tab, Diagnosis tab, Details tab
- Family Planning – Patient tab, Provider tab, Claim tab

- Vision – Claim tab

5.2.1 Dental Claim

To enter a dental claim, follow these steps:

Claim Tab

- 1) Enter dental-specific information into all required fields, which are indicated by a red dot.
- 2) Ensure the data entered meet field edit requirements:
 - Alphanumeric** – Authorization No.
 - Drop-down calendar** – Date of Current Condition (no future date allowed)
 - Drop-down selection** – Accident State
 - Free text** – Emergency/Trauma or Exception to Periodicity Comments
 - Check box** – Auto Accident, Employment Related, Ortho Related, Exception to Periodicity, Emergency/Trauma Related. If Auto Accident is selected the Accident State field is enabled, which requires a state to be selected.

Diagnosis Tab

- 3) Enter dental-specific information into all required fields, which are indicated by a red dot.

4) Ensure that the data entered meet field edit requirements:

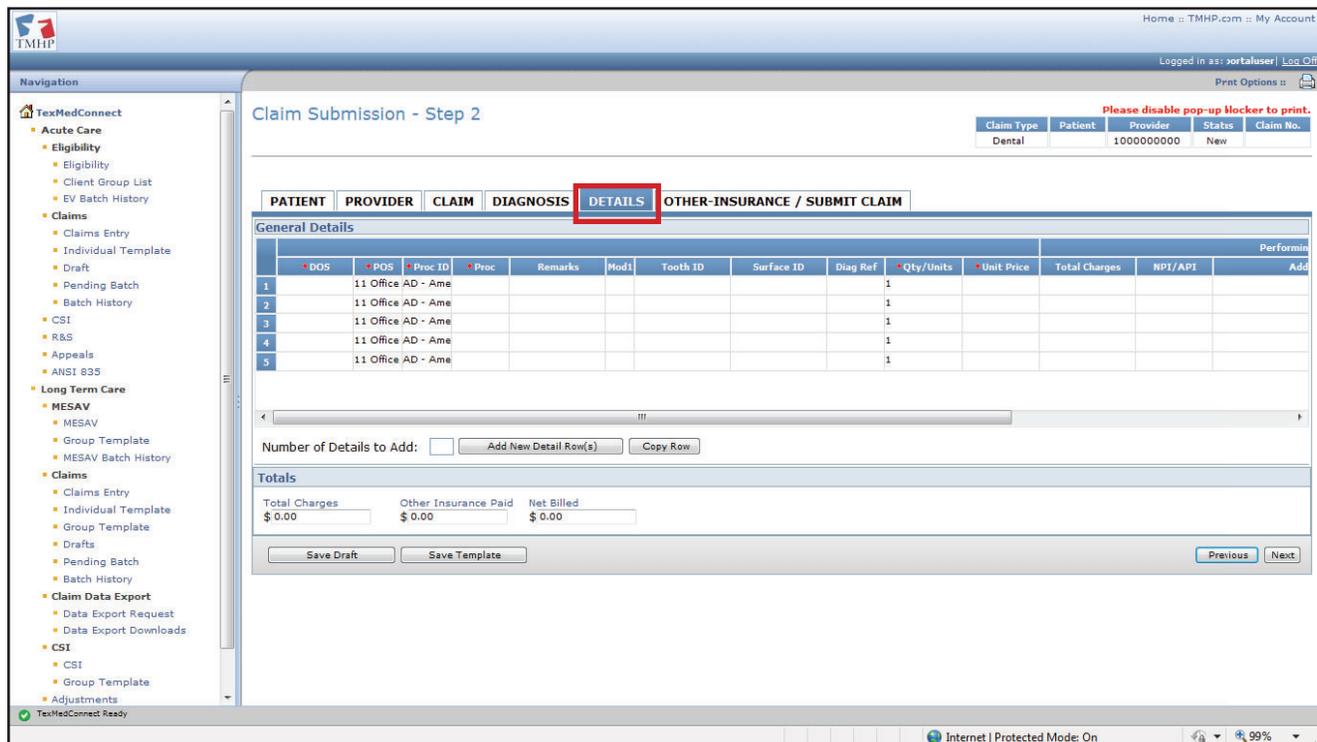
Select the qualifier dropdown in order to enter the correct ICD diagnosis code.

Note: A qualifier selection is required if a diagnosis code is entered. Qualifier selected must be valid for the diagnosis code entered, based on date of services.

Alphanumeric – Code, Number of details to add

There is a maximum of 4 diagnosis code rows available for this entry.

Details Tab



5) Enter dental-specific information into all required fields, which are indicated by a red dot.

6) Ensure the data entered meet field edit requirements:

Alphanumeric – Procedure Code, Remarks, Mod

Alphabet only – Surface ID

Drop-down calendar – Date of Service (no future date allowed)

Drop-down selection – POS, Procedure Code ID (AD), Tooth ID

Numeric only – Qty/Unit, Unit Price, Perf NPI/API (10 digits), ZIP+4 (5+4), Other Insurance Paid, Net Billed

Total charges are calculated.

Note: To add more details, click on **Add New Detail Row(s)**. Use **Copy Row** to copy the information from previous detail.

5.2.2 Inpatient Claim

To enter an inpatient claim:

Provider Tab

The screenshot shows the 'PROVIDER' tab selected in a navigation bar. Below the tab is a 'Providers' section with five sub-sections:

- Billing Provider:** Fields include NPI (with a dropdown arrow), Taxonomy, Benefit Code, Last/Organization Name, Address, Address2, City, State, ZIP+4, EIN (with a red dot), and Phone No.
- Attending Provider:** Fields include Attending Provider NPI/API (with a red dot and magnifying glass), Last Name (with a red dot and magnifying glass), First Name (with a red dot), MI, and Suffix.
- Operating Provider:** Fields include Operating Provider NPI/API (with a magnifying glass), Last Name, First Name, MI, and Suffix.
- Referring/Other Provider:** Fields include NPI/API (with a magnifying glass), Last Name, First Name, MI, and Suffix.
- Rendering Provider:** Fields include NPI (with a magnifying glass), Last Name, First Name, MI, and Suffix.

At the bottom of the form are buttons for 'Save Draft', 'Save Template', 'Previous', and 'Next'.

7) Enter provider information into all of the required fields, which are indicated by a red dot. If the Billing Provider NPI/Related Data is selected on the Claims Entry screen, many of these fields are populated automatically by the system.

8) Make sure that the data you enter meets the field edit requirements:

Billing Provider

Alphanumeric—Last/Organization Name, Address, Address 2, City, Taxonomy, Benefit Code

Drop-down selection—State

Numeric only—NPI/API (10 digits), Tax ID (9 digits), Phone Number (area code + 7), ZIP+4 (5+4)

Attending Provider

Alphanumeric—First, Last Names, MI, Suffix will be populated automatically when the NPI/API is entered and the magnifying glass is clicked.

Drop-down selection—ID Type

Numeric only—NPI/API (10 digits), EIN/SSN (9 digits)

Operating/Referring/Other Provider

Alphanumeric—First, Last Names, MI, Suffix will be populated automatically when the NPI/API is entered and the magnifying glass is clicked.

Drop-down selection—ID Type

Rendering Provider

Alphanumeric—Last Name, First Name, MI, and Suffix

Numeric only—NPI

Claim Tab

9) Enter the claim information into all of the required fields, which are indicated by a red dot.

10) Make sure that the data you enter meets the field edit requirements:

Alphanumeric—Authorization No.

Drop-down calendar—Statement Covers From Date & To Date (no future date allowed), Occurrence Span Code From Date & To Date (no future date allowed), Admission Date (no future date allowed), Discharge Date (no future date allowed), Occurrence Date (no future date allowed)

Drop-down selection—Patient Status, Type of Bill, Occurrence Span Code, Admission Hour, Type & Source, Discharge Hour, Occurrence Code, Condition Code

Numeric only—Days Covered, Not Covered

11) You can also add occurrence, condition and value codes:

To add an occurrence code, click **Add New Occurrence Code**.

To add a condition code, click **Add New Condition Code**.

To add a value code, click **Add New Condition Code**.

To remove an occurrence code, condition or value code, click **Remove**.

Diagnosis Tab

- 12) Enter the diagnosis information into all of the required fields, which are indicated by a red dot.
- 13) A qualifer selection is required from the dropdown.

Note: *Qualifier selected must be valid for the diagnosis code entered, based on the date of discharge.*
- 14) Select the Present on Admission (POA) value in the POA field for each diagnosis code entered.
- 15) Input the admitting diagnosis to the highest degree of specificity. A valid diagnosis must be entered if it is required for claim.
- 16) To enter more than one diagnosis code, click **Add New Diagnosis**.

Note: *There is a maximum of 25 Diagnosis code rows available for entry.*
- 17) Make sure that the data you enter for the Admitting Diagnosis and diagnosis code is all alphanumeric.

Note: *To display the diagnosis description, click the magnifying glass.*

Details Tab

18) Enter the claim detail information into all of the required fields, which are indicated by a red dot.

19) Make sure that the data you enter meets the field edit requirements:

Numeric only - Rev Code, Days, Daily Rate, Non-Covered Charges and NPI

Note: Total Charges are calculated by TMC and are not editable.

Alphanumeric - Surgical Code, Last Name, and First Name

Select the qualifier field to enter the correct ICD surgical procedure code.

Note: A qualifier selection is required if a procedure code is entered. Qualifier selected must be valid for the procedure code entered, based on date of services.

Drop-down calendar—Date of Service (no future date allowed)

Drop-down selection—Procedure Information

Numeric only—Rev Code, Units, Unit Price, Non-Covered Charges

Total Charges are calculated.

Numeric only—Other Insurance Paid, Net Billed

Total Charges—Is calculated using the information you enter.

20) You can also add more details:

To add more rows, click **Add New Detail Row(s)**.

To copy the information from previous detail use **Copy Row**.

5.2.3 Outpatient Claim

To enter an outpatient claim, follow these steps:

Claim Tab

PATIENT	PROVIDER	CLAIM	DIAGNOSIS	DETAILS	OTHER-INSURANCE / SUBMIT CLAIM
Claim					
General					
Patient Discharge Status *					
<input type="text"/>					
Type of Bill *					
<input type="text"/>					
Admission Information					
Date *	Hour *	Priority (Type) of Admission or Visit *	Point of Origin for Admission or Visit *		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Discharge Information					
Hour					
<input type="text"/>					
Occurrence Codes					
Occurrence Code			Occurrence Date		
<input type="text"/>			<input type="text"/>		
<input type="button" value="Add New Occurrence Code"/>					
Condition Codes					
Condition Code Remove					
<input type="text"/>					
<input type="button" value="Add New Condition Code"/>					
Value Codes					
Value Code			Value Amount		
<input type="text"/>			<input type="text"/>		
<input type="button" value="Add New Value Code"/>					

- 1) Enter claim detailed information into all required fields, which are indicated by a red dot.
- 2) Ensure the data entered meet field edit requirements:
 - Alphanumeric** – Authorization No.
 - Drop-down calendar** – Admission Date (no future date allowed), Occurrence Date (no future date allowed)
 - Drop-down selection** – Admission Hour, Type of Bill, Discharge Hour, Occurrence Code, Condition Code, Value Code

Diagnosis Tab

- 3) Enter diagnosis information into all required fields, which are indicated by a red dot.
- 4) A valid diagnosis must be entered if required for claim. More than one diagnosis code can be entered by clicking **Add New Diagnosis**.
- 5) The qualifier dropdown must be selected for the correct ICD diagnosis code entered.
Note: Qualifier selected must be valid for the diagnosis code entered, based on the date of services.
- 6) Ensure the data entered meet field edit requirements:
Alphanumeric – Diagnosis Code
Note: Clicking the magnifying glass displays the diagnosis description.

Details Tab

- 7) Enter claim detailed information into all required fields, which are indicated by a red dot.
- 8) Ensure the data entered meet field edit requirements:
Alphanumeric – Mod1–Mod4, Procedure Code
Drop-down calendar – Date of Service (no future date allowed)
Drop-down selection – Procedure Code ID, Diagnosis Ref
Numeric only – Rev Code, Qty/Units, Unit Price, Other Insurance Paid, Net Billed
Total charges and non-covered charges are calculated.

9) Ensure the data entered meet field edit requirements:

Alphanumeric – Mod1–Mod4, Procedure Code, Last Name, and First Name

Drop-down calendar – Date of Service (no future date allowed)

Drop-down selection – Procedure Code ID, Diagnosis Ref

Numeric only – Rev Code, Qty/Units, Unit Price, Other Insurance Paid, Net Billed and NPI

Note: *Total Charges and non-covered charges are calculated by TMC and are not editable.*

Note: *To add more details, click on **Add New Detail Row(s)**. Use **Copy Row** to copy the information from previous detail.*

5.2.4 Family Planning Claim

To enter a family planning claim, follow these steps:

NOTE: To submit the claim as a Family Planning Program claim using the Professional - CMS1500 claim form, see section on the Professional - CMS1500 claim form after these steps.

Patient Tab

1) Enter patient information into all required fields, which are indicated by a red dot.

If the client number is entered on the Claims Entry screen, many of these fields are populated by the system.

2) Ensure the data entered meet field edit requirements:

Alphanumeric – Account No., DSHS Client Number, First, Last Names, MI, Suffix, Street, City

Drop-down calendar – Patient Date of Birth (no future date allowed), Date of Eligibility (no future date allowed)

Drop-down selection – Level of Payment, Gender, Patient Status, County of Residence, State

Numeric only – SSN (9 digits), Client Number (9 digits), ZIP+4 (5+4), Family Size, Family Income

Provider Tab

- 3) Enter provider information into all required fields, which are indicated by a red dot.
If Billing Provider NPI/Related Data is selected on the Claims Entry screen, many of these fields are populated by the system.
- 4) Ensure the data entered meet field edit requirements:

Billing Provider

Alphanumeric – First, Last/Organization Names, MI, Suffix, Address, Address 2, City, Taxonomy, Benefit Code

Drop-down selection – State

Numeric only – NPI/API (10 digits), EIN (9 digits), Phone No. (area code + 7), ZIP+4 (5+4)

Facility Provider

Alphanumeric – Name, Address, City

Drop-down selection – State

Numeric only – NPI/API (10 digits), ZIP+4 (5+4)

Referring and Other Provider

Alphanumeric – First, Last Names, MI, Suffix

Numeric only – NPI/API (10 digits)

Claim Tab

The screenshot shows a web-based form titled "Claim" with a navigation bar at the top containing tabs: PATIENT, PROVIDER, CLAIM (highlighted with a red box), DIAGNOSIS, DETAILS, and OTHER-INSURANCE / SUBMIT CLAIM. The form is divided into four sections:

- General Demographics:** Includes fields for Marital Status (dropdown menu, value: Married), Race (dropdown menu), and Ethnicity (dropdown menu). Red dots are present next to each label.
- General:** Includes Date Of Occurrence (dropdown calendar), Patient Co-Pay (text input with a dollar sign), Level Of Practitioner (dropdown menu), and Authorization No. (text input). Red dots are present next to Patient Co-Pay and Authorization No.
- Birth Controls:** Includes Primary Before Visit (dropdown menu) and Primary After Visit (dropdown menu). Red dots are present next to each label.
- Reproductive History:** Includes No. Of Times Pregnant, No. Of Live Births, and No. Of Living Children (all text input fields). Red dots are present next to each label.

At the bottom of the form, there are buttons for "Save Draft", "Save Template", "Previous", and "Next". The top right corner shows "Logged in as: portaluser" and "Log Off".

- 5) Enter claim information into all required fields, which are indicated by a red dot.
- 6) Ensure the data entered meet field edit requirements:
 - Alphanumeric** – Authorization No.
 - Drop-down calendar** – Date of Occurrence (no future date allowed)
 - Drop-down selection** – Marital Status, Race, Ethnicity, Level of Practitioner, Primary Before Visit (Birth Control), Primary After Visit (Birth Control)
 - Numeric only** – Patient Co-Pay, Number of Times Pregnant, Number of Live Births, Number of Living Children

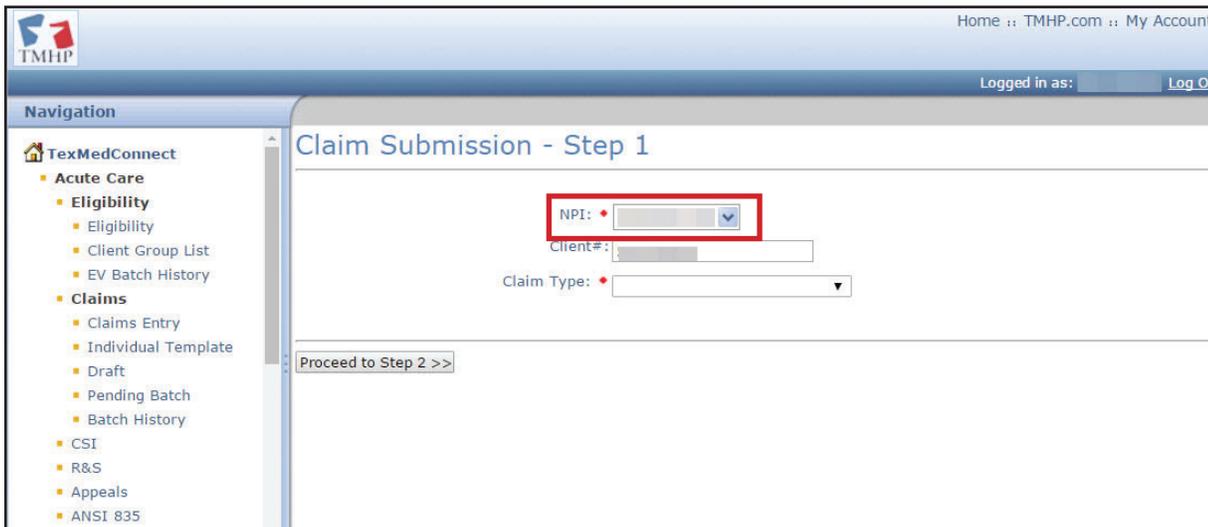
5.2.5 Family Planning Claim Using the Professional - CMS1500 Claim Form

To enter a Family Planning Program claim, follow these steps:

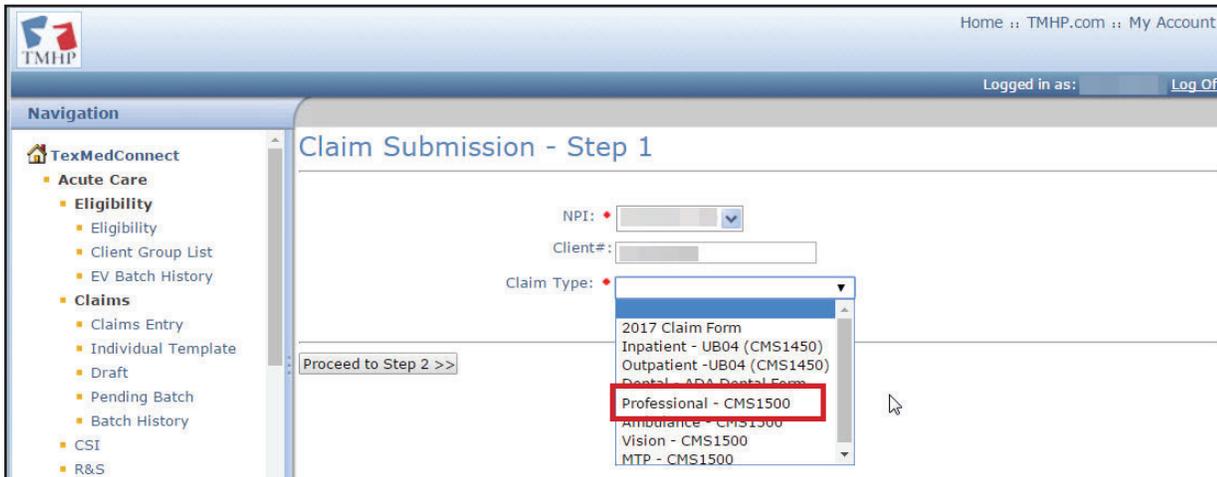
- 1) Select **Claims Entry** in the left navigation panel.



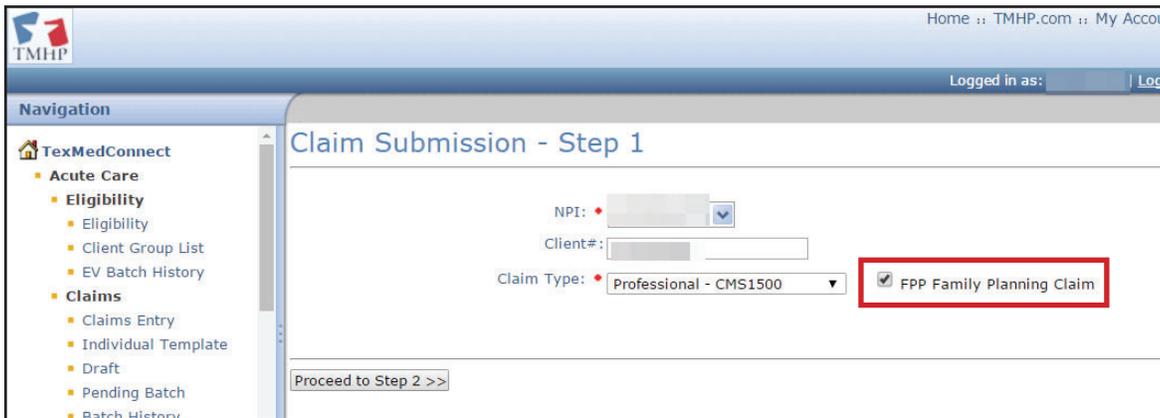
- 2) Select the appropriate billing provider information. A list of NPI/API and related data such as taxonomy, physical address, and benefit code selections is displayed based on the user's logon information.



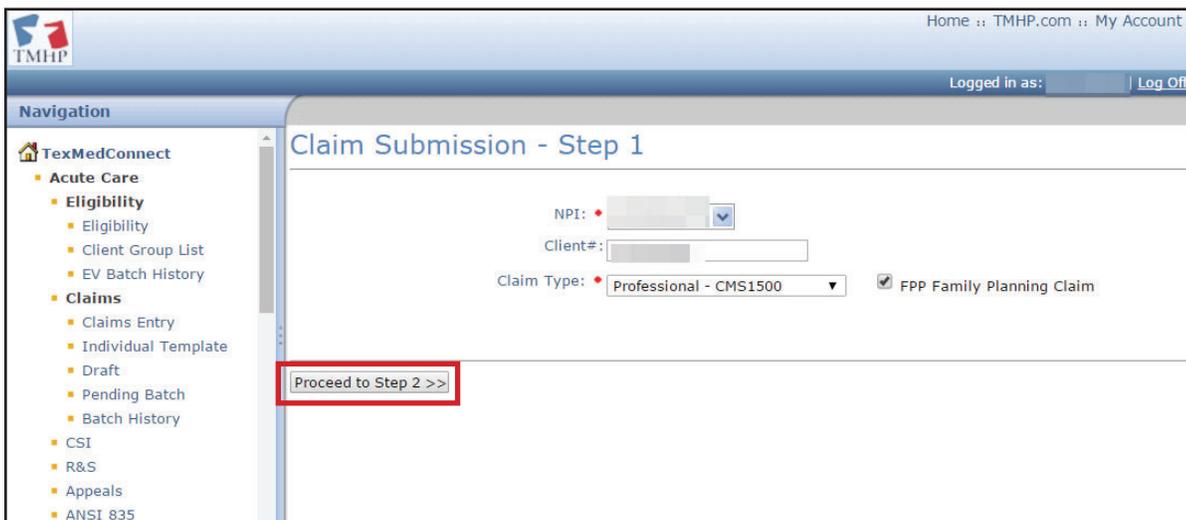
- 3) Select “Professional – CMS1500” from the Claim Type drop-down menu.



- 4) By selecting “Professional – CMS1500” an “FPP Family Planning Claim” check box will display. To submit the claim as a Family Planning Program claim using the Professional - CMS1500 claim form, you must check this box.



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



- 6) Enter information into required fields as indicated by a red dot. For example, the County of Residence and Gender are required fields, but the Client Number and Date of Eligibility fields are

optional.

Claim Submission - Step 2 Please disable pop-up blocker to print.

Claim Type	Patient	Provider	Status	Claim No.
Professional FPP - FP			New	

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM

Patient

Patient Identification Numbers

Account No. * SSN Client Number

Name and Address

Last Name * First Name * MI Suffix
 Street * City * State * ZIP+4 * County Of Residence *

Patient General Information

Gender * Patient Date of Birth * Patient Date of Death Date of Eligibility

- 7) The Provider tab is used to enter provider information for the claim. Enter the provider's information into all of the required fields, as indicated by a red dot.
 - a) Billing provider fields will be auto populated with the information associated with the NPI /API that was entered on the Claim Submission – Step 1 screen.
 - b) Information about additional providers (facility, referring, supervising) may also be entered.

Claim Submission - Step 2 Please disable pop-up blocker to print.

Claim Type	Patient	Provider	Status	Claim No.
Professional FPP - FP			New	

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

Providers

-Billing Provider-

NPI: Taxonomy Benefit Code
 Last/Organization Name First Name MI Suffix
 Address Address2 City State ZIP+4
 ID Type * EIN/SSN * Phone No.

-Facility Provider-

NPI/API Name
 Address City State Zip+4
 Service Location

-Referring/Other Provider-

NPI/API Last Name First Name MI Suffix

-Referring/Other Supervising Provider-

NPI/API Last Name First Name MI Suffix

Save Draft Save Template Previous Next

- 8) The Claim tab is used to provide additional information that may be required on a claim. Each claim type has different requirements. If there is required information, it will be indicated by a red dot.

Claim Submission - Step 2 Please disable pop-up blocker to print.

Claim Type	Patient	Provider	Status	Claim No.
Professional FPP - FP			New	

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM

Claim

General

AutoAccident Authorization No. Outside Lab?

 Employment Related Charges \$

 THSteps Related

 Other Accident

Value Codes

Value Amount

Save Draft Save Template Previous Next

- 9) The Diagnosis tab is used to describe the client’s condition using diagnosis codes.
- Select the qualifier dropdown to enter the correct ICD diagnosis code.
 - Enter the diagnosis code that has the highest degree of specificity.
 - Enter the diagnosis information into all required fields, as indicated by a red dot.
 - To enter more than one diagnosis code, click Add New Diagnosis.
 - To display the description for the entered diagnosis code, click the magnifying glass icon.

Claim Submission - Step 2 Please disable pop-up blocker to print.

Claim Type	Patient	Provider	Status	Claim No.
Professional FPP - FP			New	

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM

Qualifier

Diagnosis

Code Description

Number of Details To Add:

There is a maximum of 12 Diagnosis code rows available for entry.

Save Draft Save Template Previous Next

- 10) The Details tab is used to enter the services that have been rendered to the client.
- Begin by entering data into all of the required fields, as indicated by a red dot.
 - To add additional details, click **Add New Detail Row(s)**.
 - Claims can have up to 28 detail rows. Click **Copy Row** to copy the information from a previous detail.

d) Rows can also be deleted by clicking **Delete** at the end of each row.

Claim Submission - Step 2

Please disable pop-up blocker to print.

Claim Type: Professional FPP - FP | Patient: | Provider: | Status: New | Claim No.:

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

General Details

Proc ID	Proc	Remarks	Mod	1	2	3	4	Am. Min.	DB-Am-In	Diag Ref	Qty/Units	Unit Price	Total Charges	NP/APP	Address	ZIP+4	Taxonomy	Ben Code	NDC	Qty	UOM	Delete

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 Previous Next

11) If there is current, other insurance information that is on file with Texas Medicaid and Healthcare Partnership (TMHP) it will be displayed under the Other-Insurance / Submit Claim tab. If you do not see the other insurance information but there is other insurance information, it should be added.

a) To enter other insurance information, select the applicable Source of Payment drop-down menu.

Claim Submission - Step 2

Please disable pop-up blocker to print.

Claim Type: Professional FPP - FP | Patient: | Provider: | Status: New | Claim No.:

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

Other Insurance 1

Source of Payment

Source of Payment

- CI - Commercial Ins Co
- XX NONE
- 11 Other Non-Federal Programs
- 12 Preferred Provider Org (PPO)
- 13 Point Of Service (POS)
- Ad 14 Exclusive Provider Org (EPO)
- 15 Indemnity Insurance
- 16 - (HMO) Medicare Risk
- AM - Automobile Medical
- BL - Blue Cross/Blue Shield
- CH - Champus
- CI - Commercial Ins Co
- DS - Disability
- HM - HMO
- LM - Liability Medical
- MB - Medicare Part B
- MC - Medicaid
- OF - Other Federal program
- VA - Veteran Admin Plan
- WC - Worker's Compensation

Certification, Terms And Conditions

ification and the [terms and conditions](#). The terms and conditions can be reviewed by clicking [here](#).

er certify that the information supplied on the claim form and any attachments or accompanying information constitute true, and that the Provider and Claim Submitter understand that payment of this claim will be from Federal and State funds, and that if a material fact, or pertinent omission may constitute fraud and may be prosecuted under applicable federal and/or state law. in fines or imprisonment.

- 12) Additional fields will display so that you can enter the Source of Payment information. Enter data into all of the required fields as indicated by a red dot.

Claim Submission - Step 2 Please disable pop-up blocker to print

Claim Type	Patient	Provider	Status	Claim No.
Professional FPP - FP			New	

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

Other Insurance 1

Source of Payment

Source of Payment Other Insurance on File at TMHP

Contact

Verbal Denial Yes

Phone Number

Delay

Indicator Yes

Disposition

Adjustment Reason Code

Other Insurance Company

Company Name Address City State ZIP+4

Insurance Policy Holder

ID/SSN Last name First Name MI

Insurance Policy Information

Group/Policy Number Group/Employer Name

[Add Another Insurance Plan](#)

- 13) If there are additional insurance plans, click the **Add Another Insurance Plan** button to create new insurance that is not on file.

Other Insurance Company

Company Name Address City State ZIP+4

Insurance Policy Holder

ID/SSN Last name First Name MI

Insurance Policy Information

Group/Policy Number Group/Employer Name

[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

- 14) When the claim is not ready to be submitted, the claim can be saved as a draft, to be completed and submitted later. A claim can also be saved as a template for use with submitting future claims.

- 15) When the claim is ready to be submitted, read the terms and conditions. If you agree, click the **We Agree** box in the Certification, Terms And Conditions section.

- 16) **Save to Batch** and **Submit** buttons are enabled when you accept the Certification, Terms, and Conditions by clicking the **We Agree** box. For more information see the Saving To a Batch section of

this manual.

Other Insurance Company

Company Name • Address • City • State • ZIP+4 •

Insurance Policy Holder

ID/SSN • Last name • First Name • MI

Insurance Policy Information

Group/Policy Number • Group/Employer Name

[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

- 17) When the **Submit** button is clicked, the claim information will be automatically verified by TexMedConnect. If there is any missing or invalid information, an error message will display and indicate the type and location of the error.

Claim Submission - Step 2

Claim Type	Patient	Provider	Status	Claim No.
Professional FPP - FP			New	

⚠ Please fix these errors. The page will not submit until these are corrected.

- Account Number is required
- County is required
- There are errors in PROVIDER tab
- There are errors in DIAGNOSIS tab
- There are errors in DETAILS tab
- There are errors in INSURANCE tab

PATIENT PROVIDER CLAIM DIAGNOSIS DETAILS OTHER-INSURANCE / SUBMIT CLAIM

Patient Identification Numbers

Account No. • SSN • Client Number

Name and Address

Last Name • First Name • MI • Suffix

Street • City • State • ZIP+4 • County Of Residence •

18) Click the tab(s) where the error is located. The field(s) with the error(s) will be highlighted. Correct all the errors. Be sure to check each tab for errors.

Claim Submission - Step 2 Please disable pop-up blocker to print

Claim Type	Patient	Provider	Status	Claim No.
Professional FFP - FP			New	

⚠ Please fix these errors. The page will not submit until these are corrected.

- Account Number is required
- County is required
- There are errors in PROVIDER tab
- There are errors in DIAGNOSIS tab
- There are errors in DETAILS tab
- There are errors in INSURANCE tab

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

Patient

Patient Identification Numbers

Account No. * ⚠ SSN Client Number

Name and Address

Last Name * First Name * MI Suffix

Street * City * State * ZIP+4 * County Of Residence * ⚠

19) Once all errors have been corrected, return to the Other Insurance / Submit Claim tab, read the Terms and Conditions, and click the **We Agree** box. The claim can now be submitted. Click the **Submit** button.

Other Insurance Company

Company Name * Address * City * State * ZIP+4 *

Insurance Policy Holder

ID/SSN * Last name * First Name * MI

Insurance Policy Information

Group/Policy Number * Group/Employer Name

[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

20) Once the claim has been successfully submitted, a message indicating the claim was submitted successfully will display and assign the Internal Control Number (ICN) for the claim. The ICN is a clickable link that will open the Claim Status Inquiry (CSI) screen and display the status of the

claim.

Claim Submission - Step 2

Claim Type	Patient	Provider	Status	Claim No.
Professional			Accepted	123456789012345678901234

Claim was submitted successfully. The ICN for the claim is [123456789012345678901234](#).

Submitted at 12/22/ 12:27:05 PM by provider.

[Enter Another Claim](#)

PATIENTPROVIDERCLAIMDIAGNOSISDETAILSOTHER-INSURANCE / SUBMIT CLAIM

Other Insurance 1

Source of Payment

Source of Payment

[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

5.2.6 Vision Claim

To enter a vision claim, follow these steps:

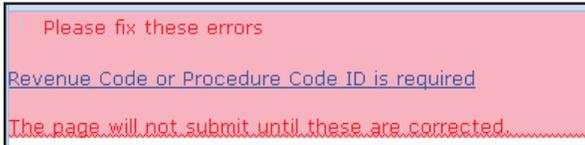
Claim Tab

PATIENT	PROVIDER	CLAIM	DIAGNOSIS	DETAILS	OTHER-INSURANCE / SUBMIT CLAIM
Claim					
General					
Prescription Date <input type="text"/>	<input type="checkbox"/> Auto Accident	Authorization No. <input type="text"/>	Outside Lab? <input type="text"/>		
	<input type="checkbox"/> Employment Related		Charges \$ <input type="text"/>		
	<input type="checkbox"/> Other Accident				
Replacement Indicator <input type="text"/>	Cataract Surgery Date <input type="text"/>				
Dates patient unable to work in current occupation					
From: <input type="text"/>	To: <input type="text"/>				
Value Codes					
Value Amount <input type="text"/>					
New Eye Prescription					
Right Eye Sphere <input type="text"/>	Right Eye Cyl <input type="text"/>	Right Eye Near <input type="text"/>	Right Eye Inter <input type="text"/>		
Left Eye Sphere <input type="text"/>	Left Eye Cyl <input type="text"/>	Left Eye Near <input type="text"/>	Left Eye Inter <input type="text"/>		
Old Eye Prescription					
Right Eye Sphere <input type="text"/>	Right Eye Cyl <input type="text"/>	Right Eye Near <input type="text"/>	Right Eye Inter <input type="text"/>		
Left Eye Sphere <input type="text"/>	Left Eye Cyl <input type="text"/>	Left Eye Near <input type="text"/>	Left Eye Inter <input type="text"/>		
Save Draft		Save Template		Previous Next	

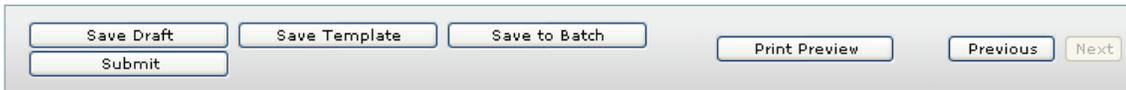
- 1) Enter vision-specific information into all required fields, which are indicated by a red dot.
- 2) Ensure the data entered meet field edit requirements:
 - Alphanumeric** – Authorization Number, Charges, New Rx for Right & Left Eye (Sphere, Cylinder, Near, Intermediate), Old Rx for Right & Left Eye (Sphere, Cylinder, Near, Intermediate)
 - Checkbox** – Auto Accident, Employment Related, and Other Accident
 - Drop-down calendar** – Prescription Date (no future date allowed), Cataract Surgery Date (no future date allowed)
 - Drop-down selection** – Outside Lab?, Replacement Indicator, Accident State

5.3 Saving a Claim

Claims cannot be submitted until all required information has been entered correctly. The following message screen appears if the information has been entered incorrectly. Error fields are indicated with red exclamation marks.



Once all required fields have been completed, four choices are available for processing:



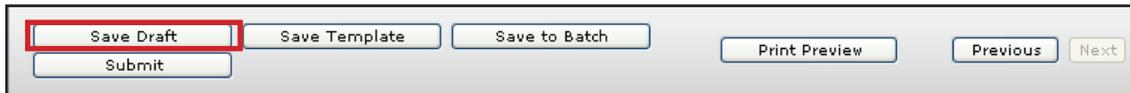
- **Save Draft** – Adds claim to the draft list for completion at a later time.
- **Save Template** – Adds claim to the template list for quicker claims creation in the future.
- **Save to Batch** – Adds claim to the pending claims list for batch submission.
- **Submit** – Submits one claim at a time.

Note: After a claim is submitted, an ICN number is generated.

5.3.1 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 as Draft.



- 2) Enter a draft name.
- 3) Click **Save**.

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

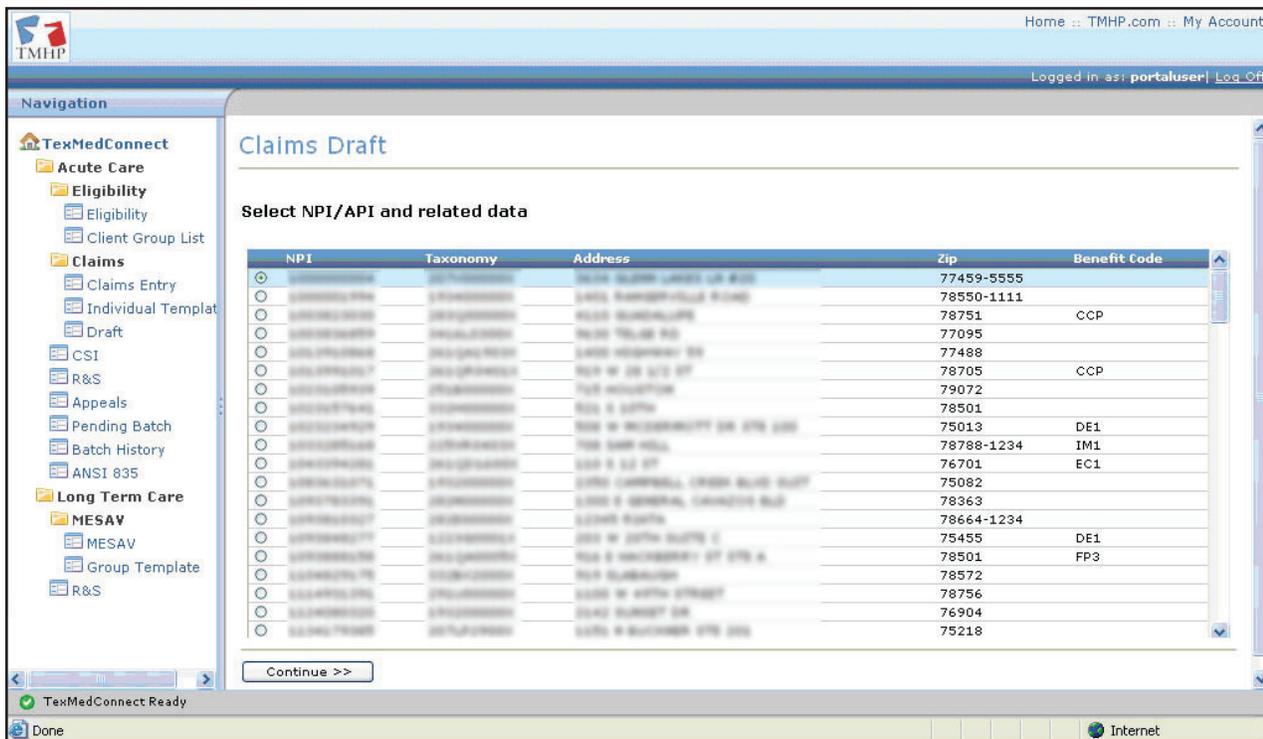
5.3.2 Viewing Draft Claims

When a draft is submitted, it is removed from the draft list. Drafts also are removed if they are not submitted within 45 days. A maximum of 50 drafts can be created for each NPI number. Drafts are displayed by NPI.

To view a list of all your draft claims, follow these steps:

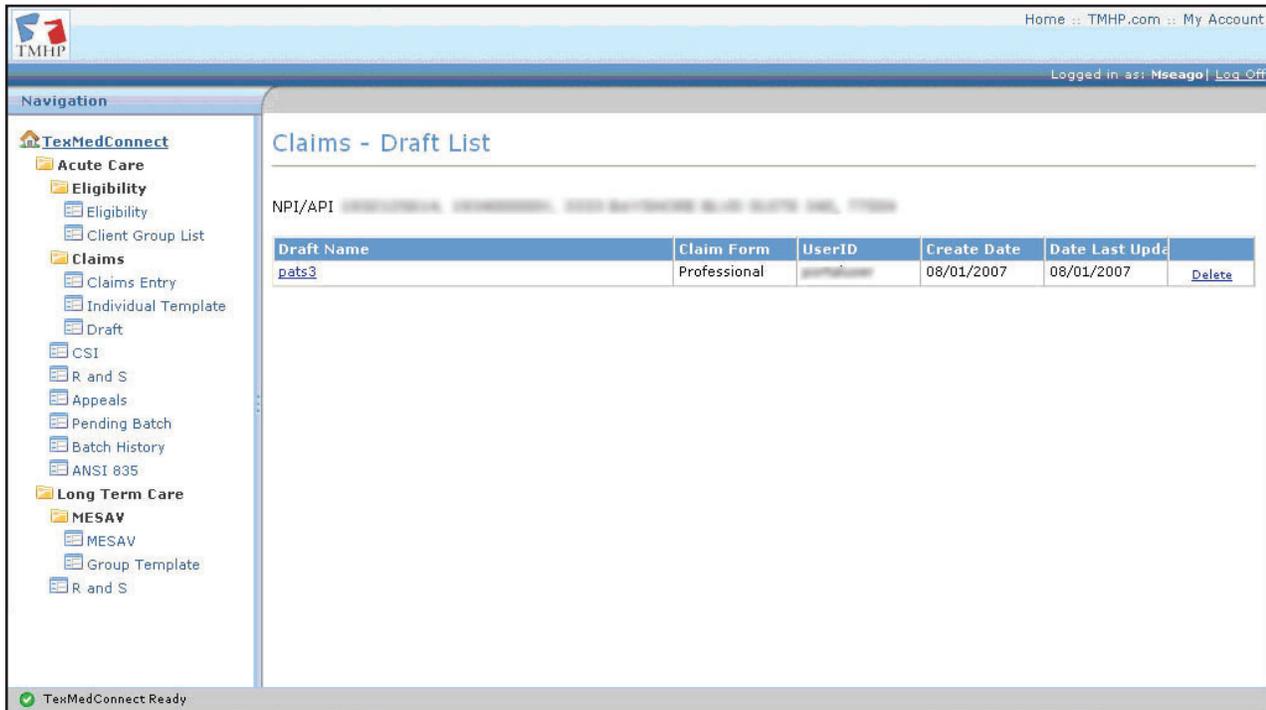
- 1) Click Drafts in the left navigation panel.

A screen appears with a list of the NPIs to which you have access.



- 2) Select the NPI whose drafts you want to view.

3) Click **Continue**.The Claims- Draft List screen appears.



4) Click on a column to sort the list by the data in that column.

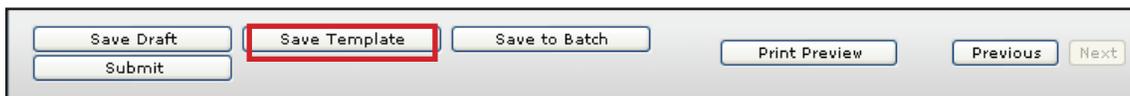
5) Click on a claim to view the details of the claim.

5.3.2 Saving As a Template

You can save an individual claim as a template. Templates are displayed by NPI. 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 number. You can view a list of templates by selecting **Individual Template** in the Claims section of the left navigation panel.

To save a claim as a template, follow these steps:

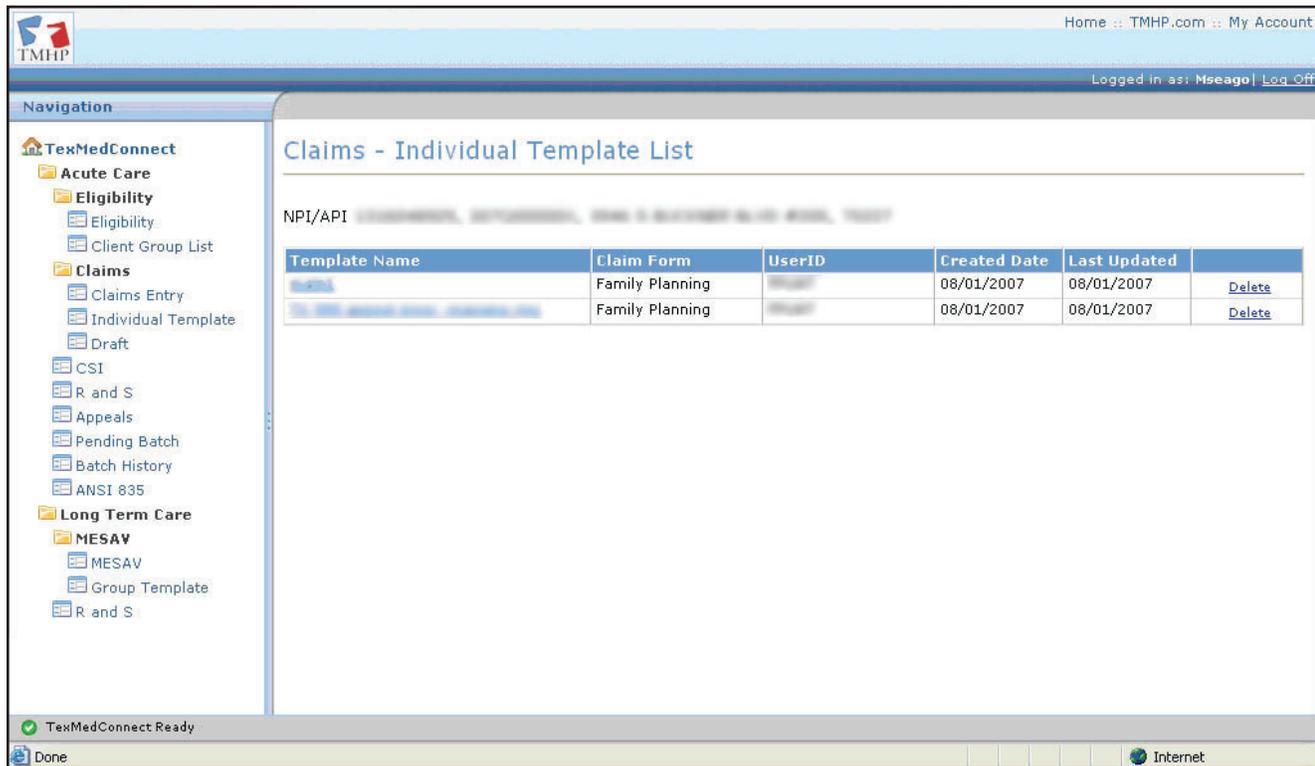
1) Click the **Save as Template** button



2) Enter a template name

3) Click **Save**

The claim is added to the Template List screen to be used later for quicker claims creation.

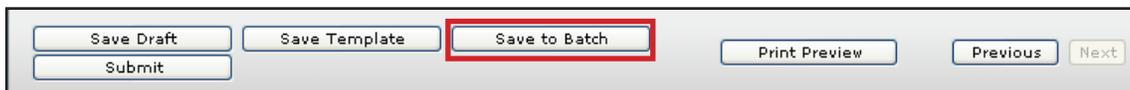


5.3.3 Saving To a Batch

You can select to save the claim to a batch by using the Save to Pending Batch function, which creates a pending batch list that is maintained until you submit the batch. One batch can contain up to 250 claims. Claims that are from Draft, Templates, or claims that are currently being created can be saved to a pending batch. Clicking **Save to Pending Batch** returns you to the claims entry screen where you can continue claims entry. Pending batches that are not submitted after 45 days are purged from the system. You can view or edit claims in a pending batch before submission.

To save a claim as part of a batch, follow these steps:

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



- 2) Click **Save**

The claim is added to the pending batch list for batch submission.

5.3.4 Submitting a Batch

The pending batch list includes those claims that are ready to be submitted. Clicking on a column sorts the list by the data in that column. The Submit Batch button appears at the end of the list.

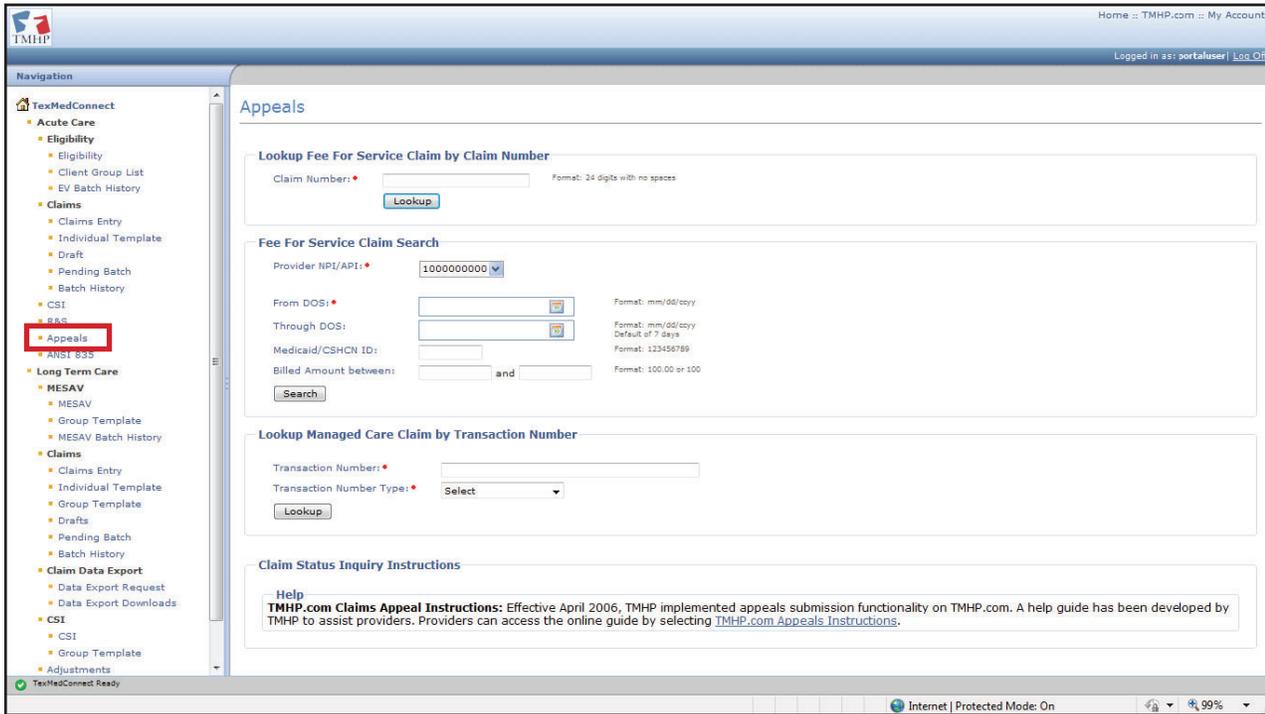
Note: When you Submit Batch, all claims tied to the NPI contained within that batch are submitted, even those created by other users.

5.4 Fee-for-Service Claims Appeals

Claims with a finalized status, such as Denied or Paid, can be appealed directly from TexMedConnect using the TMHP ICN. You can appeal all finalized claims.

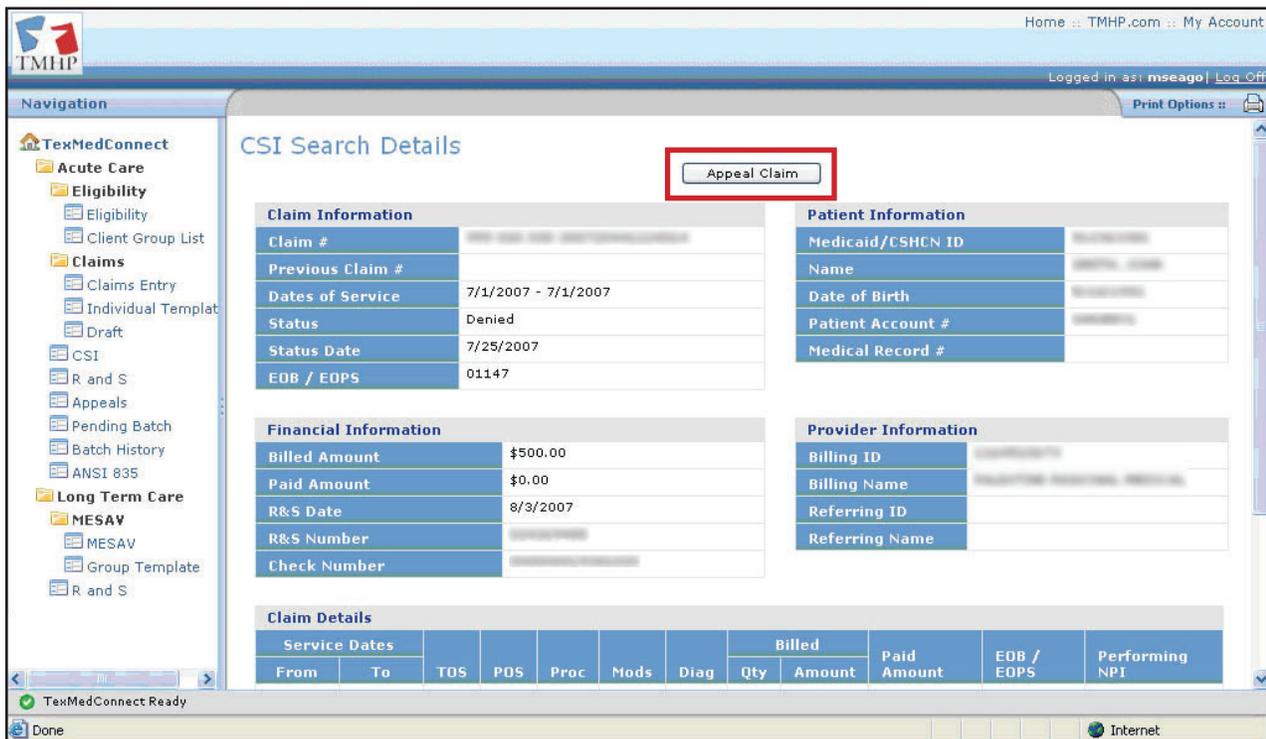
To appeal a claim, follow these steps:

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



- 2) Enter the claim number you want to appeal

- 3) If you do not know the claim number, enter information about the claim and click **Search**. CSI Search Details appears if a match is found.



- 4) Click **Appeal Claim** to continue the appeal process
- 5) Most fields populate with the claim information. You can modify the claim information for the appeals.

5.4.1 Other Pathways for Fee-for-Service Claims Appeals

Instead of using the Appeals function, you can appeal claims by locating the claim on a CSI Search page or from an R&S Report.

5.4.2 Other Pathways for MCO Claims Appeals

Providers may only appeal MCO claims that were submitted to TMHP and forwarded to the MCO, with a claim acknowledgement response from the MCO indicating that the claim was “accepted” by the MCO system for processing. Submitting the appeal creates an adjustment claim that is forwarded to the MCO. **NOTE:** Your MCO may refer to Appeals as “Corrections,” “Adjustments,” or “Updates.

For MCO claims, use the “Lookup Managed Care Claim by Transaction Number” section of CSI and enter either a TMHP-assigned EDI Transaction Number (ETN) or the MCO-assigned ICN.

The screenshot shows the TexMedConnect web application interface. On the left is a navigation menu with categories: Acute Care, Eligibility, Claims, and CSI. The 'CSI' category is highlighted with a red box. The main content area is divided into three sections: 'Lookup Fee For Service Claim by Claim Number', 'Fee For Service Claim Search', and 'Lookup Managed Care Claim by Transaction Number'. The 'Lookup Managed Care Claim by Transaction Number' section is highlighted with a red box. It contains a 'Transaction Number' input field, a 'Transaction Number Type' dropdown menu, and a 'Lookup' button.

5.4.3 Other Pathways for Long Term Services and Supports (LTSS) MCO Claims Appeals

LTSS MCO providers should reference the *TexMedConnect User Guide for MCO LTSS Providers* for additional details about claim appeals and adjustments.

NOTE: Your MCO may refer to Appeals as “Corrections,” “Adjustments,” or “Updates.

6.0 Verifying Client Eligibility

To verify a client’s eligibility interactively, follow these steps:

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

The screenshot shows the 'Eligibility Verification' interface. On the left, the navigation menu is expanded to 'Eligibility'. The main area has a heading 'Eligibility Verification' and a sub-heading 'Please enter the required information and click "Submit" to view the eligibility of the client.' Below this, there are several input fields: 'Provider NPI/API' (a dropdown menu), 'Eligibility From Date' and 'Eligibility Through Date' (date pickers), and a section for 'Please enter one of the following valid field combinations:' which includes 'Medicaid/CSHCN ID', 'Social Security Number', 'Date of Birth', 'Last Name', and 'First Name'. Each of these fields has a corresponding input box and a format instruction. A 'Submit' button is located at the bottom of the form.

- 2) Enter the following required fields:

- Provider NPI/API and related data
- Eligibility Dates

This is a close-up view of the top portion of the eligibility verification form. It shows the 'Provider NPI/API' dropdown menu with the text 'Select a Provider NPI/API' to its right. Below it are the 'Eligibility From Date' and 'Eligibility Through Date' date pickers, each with a calendar icon and the format instruction 'Format: mm/dd/yyyy'.

- 3) If necessary, narrow your search by entering additional information in any of the following combinations:

- Medicaid/CSHCN ID and DOB
- Medicaid/CSHCN ID and Last Name
- Medicaid/CSHCN ID and SSN
- SSN & Last Name
- SSN & DOB
- Last Name, First Name & DOB

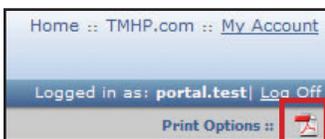
The screenshot shows a form titled "Patient Information" with the following fields and instructions:

Medicaid/CSHCN ID:	<input type="text"/>	Format: 123456789
Social Security Number:	<input type="text"/>	Format: 123-45-6789 or 123456789
Date of Birth:	<input type="text"/> <input type="text"/>	Format: mm/dd/ccyy
Last Name:	<input type="text"/>	
First Name:	<input type="text"/>	

At the bottom of the form is a "Submit" button.

Note: If you perform more than one interactive eligibility check, the Provider NPI/API on the Eligibility Search page defaults to the most recently used Provider NPI/API.

The Eligibility Verification (EV) results screen allows you to access the EV results as a PDF. To perform this action, click on the PDF icon at the top of the EV results page.



Note: Printed EV results are considered valid proofs of eligibility.

6.1 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 number. 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 left navigation panel. The Client Group List appears.

2) Select NPI/API and related data by checking the radio button.

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

Navigation

- TexMedConnect
 - Acute Care
 - Eligibility
 - Eligibility
 - Client Group List
 - Claims
 - Claims Entry
 - Individual Template
 - Draft
 - CSI
 - R and S
 - Appeals
 - Pending Batch
 - Batch History
 - ANSI 835
 - Long Term Care
 - MESAV
 - MESAV
 - Group Template
 - R and S

EV Client Group List

Select NPI/API and related data

NPI	Taxonomy	Address	Zip	Benefit Code
<input checked="" type="radio"/> 1786241446	3228000000	1122 EAST FRONT STREET	75702-8414	CCP
<input type="radio"/> 1477751444	2828000000	2402 SOUTH THURTY FIRST ST	76508	
<input type="radio"/> 1194611729	1728000000	1101 WATERS EDGE DR STE 104	76048-1474	
<input type="radio"/> 1092810027	2828000000	11405 RIVITA	78664-1234	
<input type="radio"/> 1962491029	2072000000	1405 ARTISAN RD #100	79606	
<input type="radio"/> 1912144134	2828000000	1104 S 20TH STREET	78539-7205	EP1
<input type="radio"/> 1002810029	3641000000	7630 TOLSON RD	77095	
<input type="radio"/> 4040444134	1728000000	2501 W 19TH	76708	
<input type="radio"/> 1912284135	2828000000	116 W NORAL	78801-5210	
<input type="radio"/> 1104910071	2828000000	2700 S LOOP SW	75801	
<input type="radio"/> 1008747444	2722000000	1736 KILLAM DR	77493	CCP
<input type="radio"/> 110767004	3641000000	110 S BOURBON	76903-7200	
<input type="radio"/> 1407401042	2072000000	1170 S CLIFF DRIVE STE 4-2	79902-4846	
<input type="radio"/> 1104767002	2047000000	719 WEST COME R STE 1	75494-3060	CSN
<input type="radio"/> 1071442171	1728000000	11705 RESEARCH BLVD	78759-4325	
<input type="radio"/> 1109414211	2722000000	11705 RESEARCH BLVD	75951-4934	
<input type="radio"/> 1000001044	1722000000	1401 BARKERVILLE ROAD	78550-1111	
<input type="radio"/> 1001440171	2828000000	2400 ROUND ROCK AVE	78681	
<input type="radio"/> 1146191134	2728000000	7011 SOUTHWEST FREEWAY	77074	
<input type="radio"/> 1001960142	2728000000	110 S 12TH ST	76701	

Continue >>

TexMedConnect Ready

3) Click **Continue**.

The Client Group List appears.

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

Navigation

- TexMedConnect
 - Acute Care
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Client Group List

NPI/API 1786241446, 3228000000, CCP, 1122 EAST FRONT STREET, 75702-8414

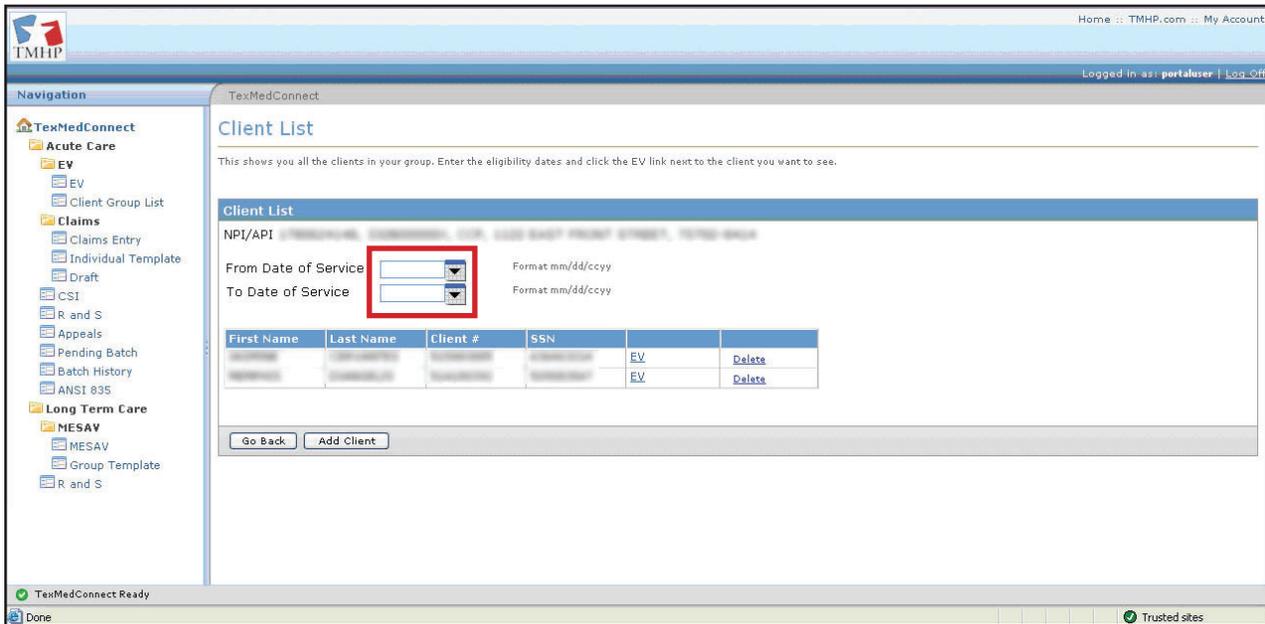
Add Group

Name of the group	User ID	Created Date	Last Updated Date	
New Group	portaluser	06/15/2007	07/26/2007	Delete
New Group	portaluser	06/19/2007	06/19/2007	Delete
New Group	portaluser	06/21/2007	06/21/2007	Delete
New Group	portaluser	06/21/2007	06/26/2007	Delete
New Group	portaluser	06/28/2007	06/28/2007	Delete
New Group	portaluser	06/28/2007	06/28/2007	Delete
New Group	portaluser	06/28/2007	07/19/2007	Delete
New Group	portaluser	07/10/2007	07/10/2007	Delete
New Group	portaluser	07/10/2007	07/10/2007	Delete
New Group	portaluser	07/12/2007	07/12/2007	Delete
New Group	portaluser	07/13/2007	07/13/2007	Delete
New Group	portaluser	07/13/2007	07/13/2007	Delete
New Group	portaluser	07/13/2007	07/13/2007	Delete
New Group	portaluser	07/13/2007	07/13/2007	Delete
New Group	portaluser	07/13/2007	07/13/2007	Delete

TexMedConnect Ready

Done Internet

- Click on the name of a client group. The client list for the client group appears.



- Enter a date range in the From Date of Service and To Date of Service fields.
- Click on **EV** on a client row to verify eligibility for that client. The Client Eligibility screen appears.



- Repeat step 5 for each client whose eligibility you want to verify.

7.0 Claims Status Inquiry (CSI)

The Claim Status Inquiry (CSI) function allows you to determine the status of processed claims. There are three years of claims history available. Claims meeting the search criteria are displayed on the CSI Results Screen. The system returns a maximum of 250 results.

You can determine claim status for all claims.

You have two options for conducting a CSI search:

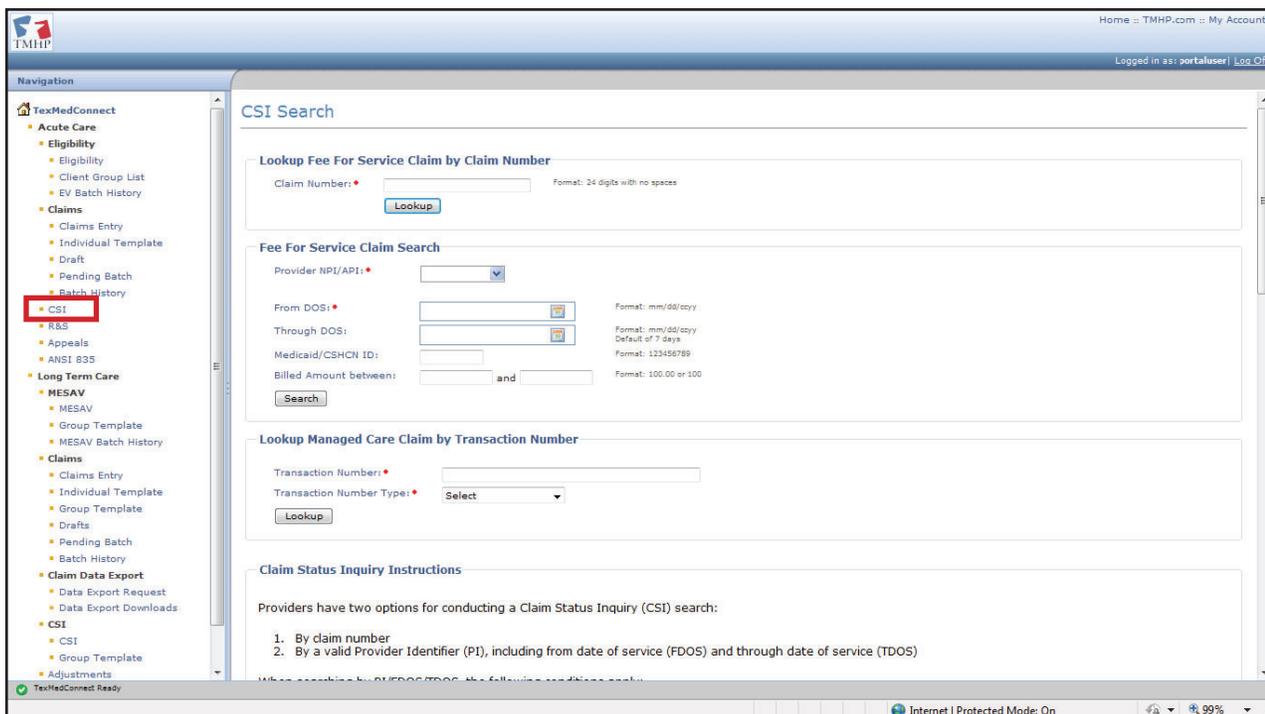
- By claim number.
- By a valid NPI/API and related data, including from date of service (FDOS) and through date of service (TDOS).

When searching by NPI/FDOS/TDOS, the following conditions apply:

- The dates cannot define a length of time greater than 30 days.
- The FDOS cannot go back in time more than 36 months from the current date.
- If the FDOS is entered but the TDOS is not provided, the default value of 7 days (from the FDOS date) auto-populates in the TDOS field.

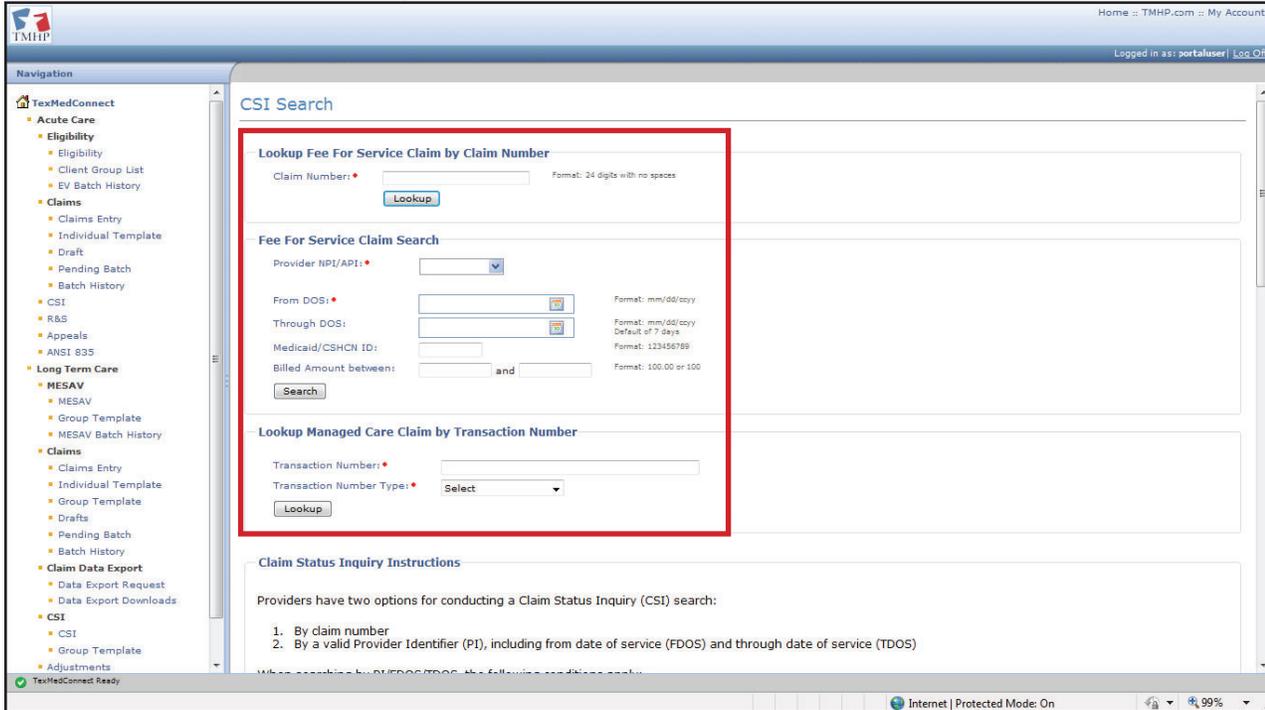
To perform a claim status inquiry, follow these steps:

- 1) From the navigation panel, select CSI.



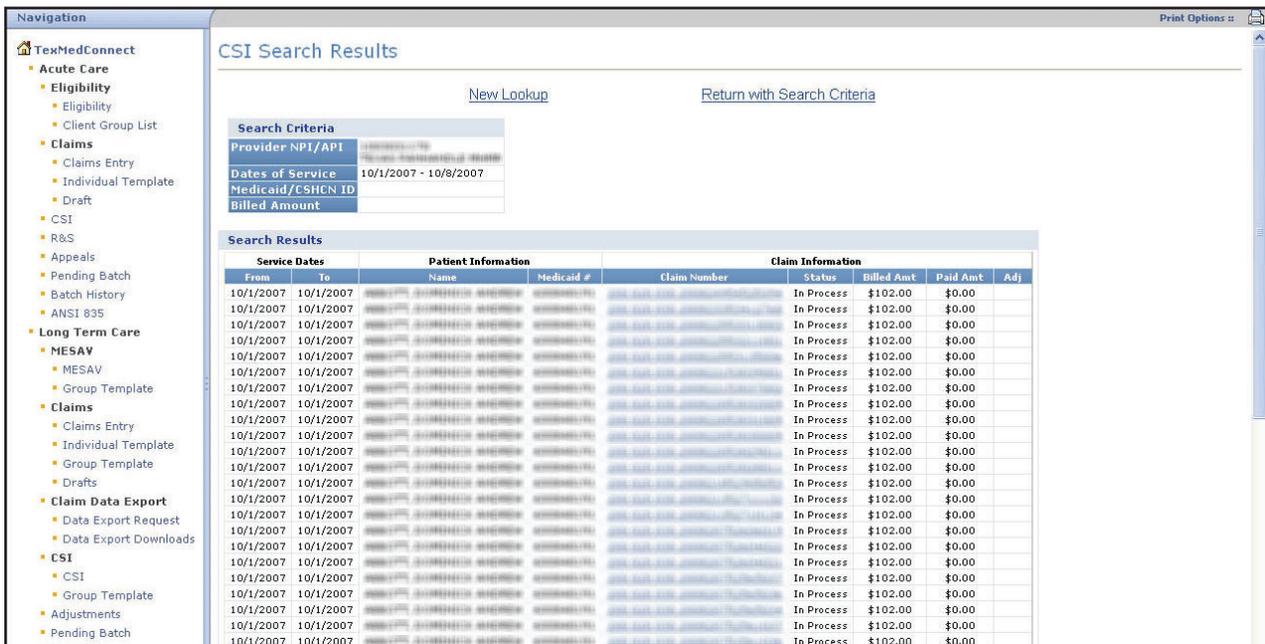
The search criteria screen opens.

2) Enter the search information, either the claim number or NPI/FDOS/TDOS and other search criteria.



The Search Results screen appears. A maximum of 50 claims can be displayed in the Search Results screen.

Note: If search does not locate the desired claim, you can narrow the search criteria to produce a more specific match. Some tips for narrowing a search include using closer span dates, adding the client number, and adding and/or narrowing the total billed amount for the claim.



3) To display the claims status details, click on the claim number on the CSI Claims Results screen.

4) Click **Next** to display the next 50 claims meeting the search criteria.

Printing a CSI Response
 To print a CSI Response, click on the *Printable View* link at the top of the page. Clicking this link will open up a new browser window with only the CSI Response information. All of the surrounding site navigation and context is removed from the Printable View. Once the window has opened, use the browser's Print functionality, such as File > Print, to print the CSI Response.
Note: The ability to print Claim Status or Eligibility Verification responses from the TMHP website is offered as a convenience for providers. These printouts cannot be used as documentation when submitting an appeal for a claim.

The claim information for the claim selected appears.

Claim Information

Claim #	00000000000000000000
Previous Claim #	
Dates of Service	5/29/2007 - 5/29/2007
Status	Denied
Status Date	7/9/2007
EOB / EDPS	01147

Patient Information

Medicaid/CSHCN ID	
Name	
Date of Birth	
Patient Account #	000
Medical Record #	

Financial Information

Billed Amount	\$156.00
Paid Amount	\$0.00
R&S Date	7/13/2007
R&S Number	
Check Number	

Provider Information

Billing ID	
Billing Name	
Referring ID	
Referring Name	

Claim Details

Service Dates		TDS	POS	Proc	Mods	Diag	Qty	Billed		Paid Amount	EOB / EDPS	Performing NPI
From	To							Amount				
5/29/2007	5/29/2007	1	1	99213		0200	1.0	\$156.00		\$0.00	00260, 00144	

Note: The information displayed on the Details screen is the same information available on the R&S Report. Claims in an appealable status contain a link to submit an appeal. In order for the appeal button to be activated, you must have security permissions to appeal.

Additional information may become available on the CSI Search Details screen for certain claim denials. If additional information about the claim denials is available, a link that indicates “Click here to see additional information about your claim” will appear. Click the link to review the rationale for the denial(s). The rationale will appear below the link in the National Correct Coding Initiative (NCCI) and sourced edits information table on the CSI Search

Details screen.

Claim Details												
DTI #	Service Dates		TOS	POS	Proc	NDC	NDC Qty	Mod	Diag	Billed	Paid	EOB / Performing
	From	To								Qty	Amount	
1	9/15/2010	9/15/2010	9	9	A0425	0.000000	EH	25000	1.0	\$150.00	\$0.00	00144
2	9/15/2010	9/15/2010	9	9	A0398	0.000000	EH	25000	1.0	\$450.00	\$0.00	00144
3	9/15/2010	9/15/2010	9	9	A0427	0.000000	EH	25000	1.0	\$100.00	\$0.00	00144

EOB / EOPB codes messages

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

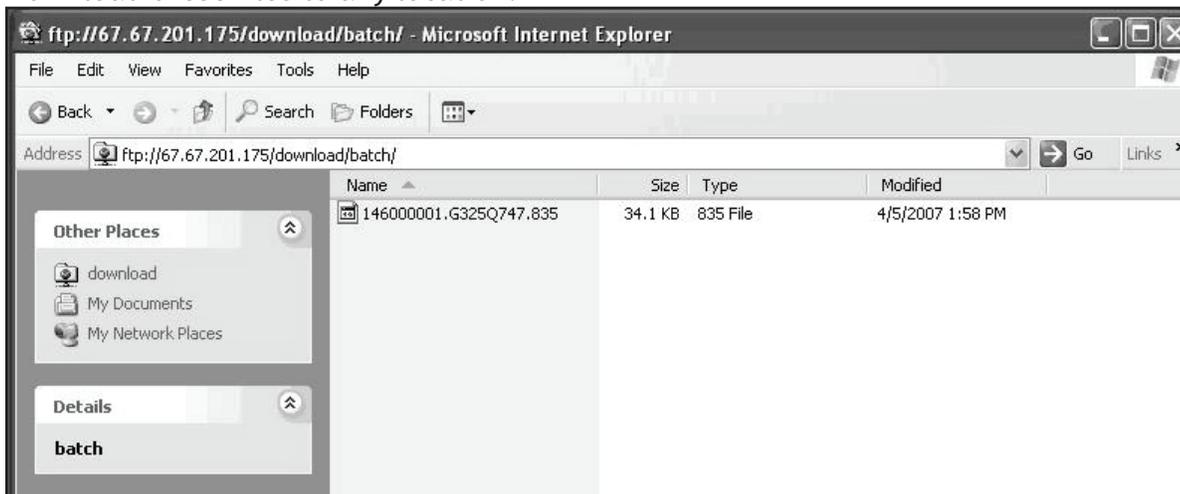
00144 THIS PROCEDURE NOT COVERED FOR THIS PROVIDER TYPE.
 00255 RESUBMIT TO TMHP WITH COMPLETE OTHER INSURANCE INFO AND DOCUMENT PAYMENT OR DENIAL.

[Click here to see additional information about your claim](#)

NCCI and sourced edits information

DTI #	EOB / EOPB	Rationale Description
1	00144	DOCUMENTATION INSUFFICIENT TO VERIFY MEDICAL NECESSITY. PLEASE RESUBMIT WITH SIGNED CLAIM COPY, RBS COPY, AND COMPLETE DOCUMENTATION OF MEDICAL NECESSITY

5) Download these files to any location.



Note: A companion guide that contains information about file formats is available on the TMHP website under EDI Technical Information.

8.0 Remittance and Status (R&S) Reports

The R&S function on the navigation panel has two options:

- PDF – Displays the Portable Document Format (PDF) version of the R&S Report.
- 835 – Accesses TMHP’s secure FTP server to download the ANSI 835 version of the electronic R&S Report.

8.1 Viewing the PDF Version

To view the PDF version of the R&S Report, follow these steps:

- 1) Select the **R and S** option from the navigation panel



The following screen appears.

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	Name	Address	Taxonomy Code	Benefit Code	Description	Modified	File Size
Folder	00000000	00000000000000000000			NPI/API/Provider Number	4/12/2007 10:52:12 PM	
Folder	00000000	00000000000000000000		EP1	NPI/API/Provider Number	6/22/2007 3:18:09 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	6/11/2007 5:36:51 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	6/20/2007 3:10:14 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	6/28/2007 10:27:59 PM	
Folder	00000000	00000000000000000000		CCP	NPI/API/Provider Number	7/18/2007 12:29:52 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	6/22/2007 3:19:48 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	4/12/2007 10:47:15 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	6/11/2007 5:37:17 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	6/11/2007 5:37:09 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	4/12/2007 10:30:00 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	4/12/2007 10:31:51 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	4/12/2007 10:31:53 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	6/22/2007 3:20:26 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	4/12/2007 10:32:59 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	4/12/2007 10:37:57 PM	
Folder	00000000	00000000000000000000		FP3	NPI/API/Provider Number	12/14/2006 6:14:03 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	12/14/2006 6:14:04 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	6/22/2007 3:21:21 PM	
Folder	00000000	00000000000000000000			NPI/API/Provider Number	4/12/2007 10:45:20 PM	

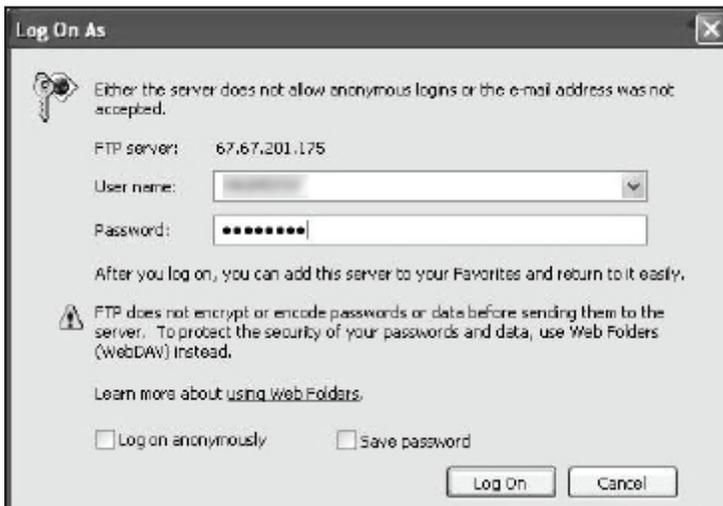
- 2) Click on the folder number to display the R&S Report

8.2 Downloading the ANSI 835 Version

You can access the 835 non-pending ER&S and the pending ER&S through a web page requiring a submitter ID and password. The submitter ID and password are the same you used for TDHconnect. If you do not have a submitter ID or have forgotten the password, you can call the TMHP EDI Help Desk at 1-888-863-3638.

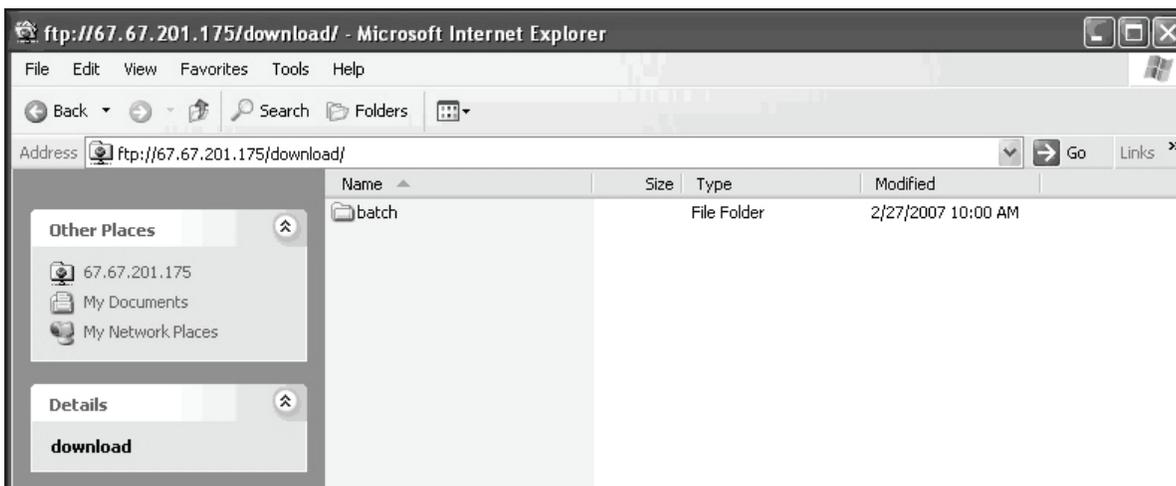
To download the ANSI 835 version of the R&S Report, follow these steps:

- 1) Select the **ANSI 835** option from the navigation panel to access the FTP site
- 2) Enter your submitter ID and password



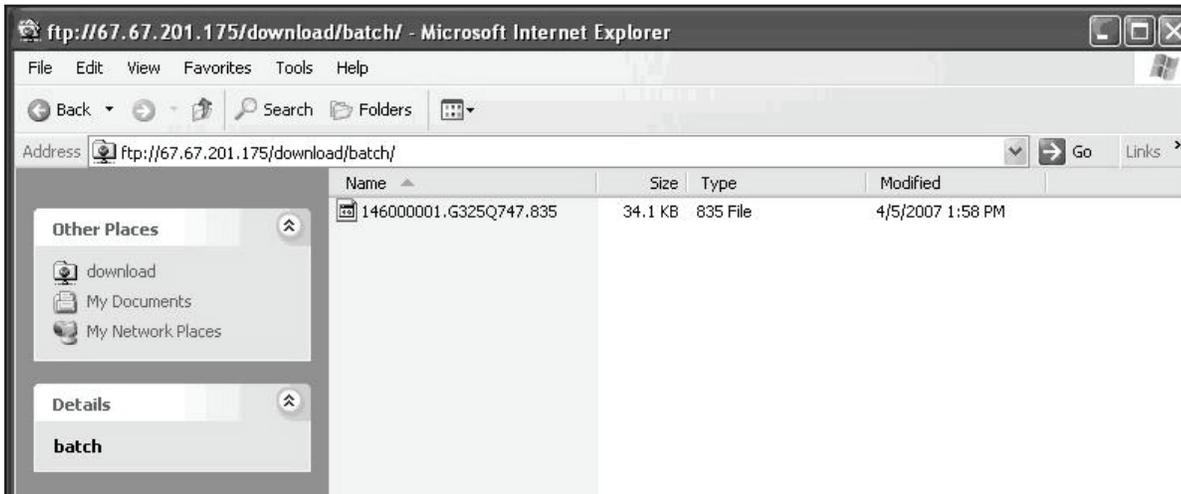
Note: The Submitter ID can be found in TDHconnect under the Communications file menu by accessing System Settings.

- 3) Click **Log On**.
The download window opens.
- 4) Open the Batch folder to access R&S Report files



The list of available ANSI 835 files is displayed.

5) Download these files to any location



Note: A companion guide that contains information about file formats is available on the TMHP website under EDI Technical Information.

