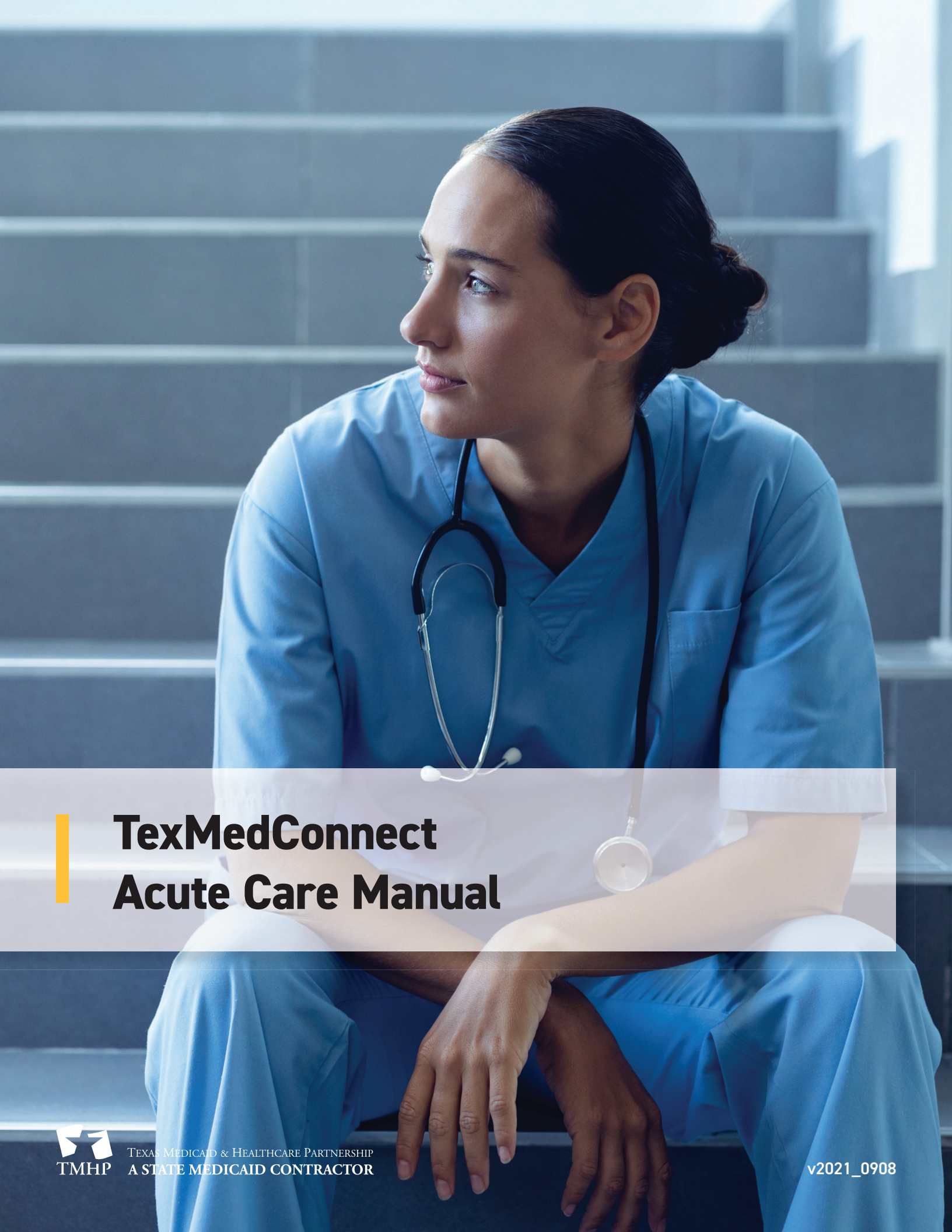


TexMedConnect Acute Care Manual

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

v2021_0908

Contents

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.*

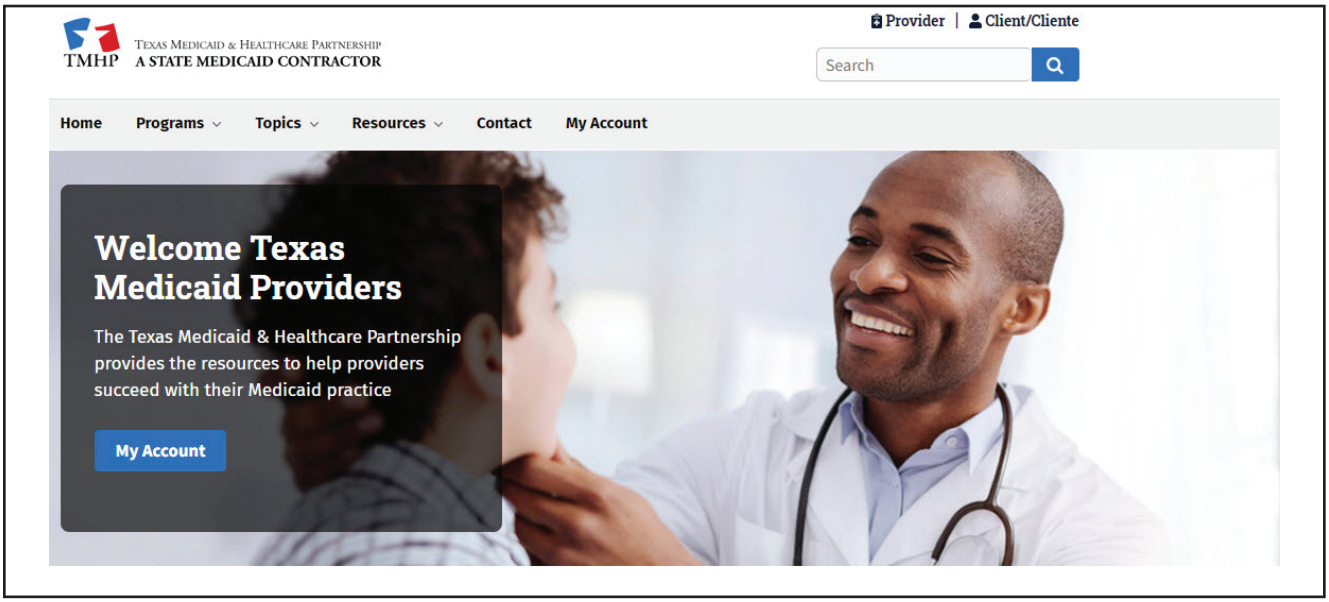
2.0 Accessing TexMedConnect and Internet Requirements

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

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

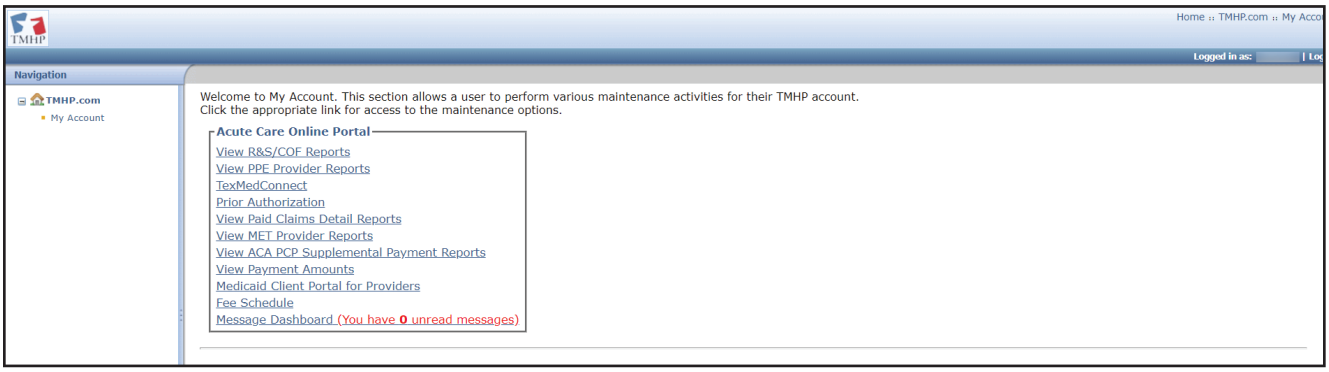
Note: *Broadband connection is recommended but not required*

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.

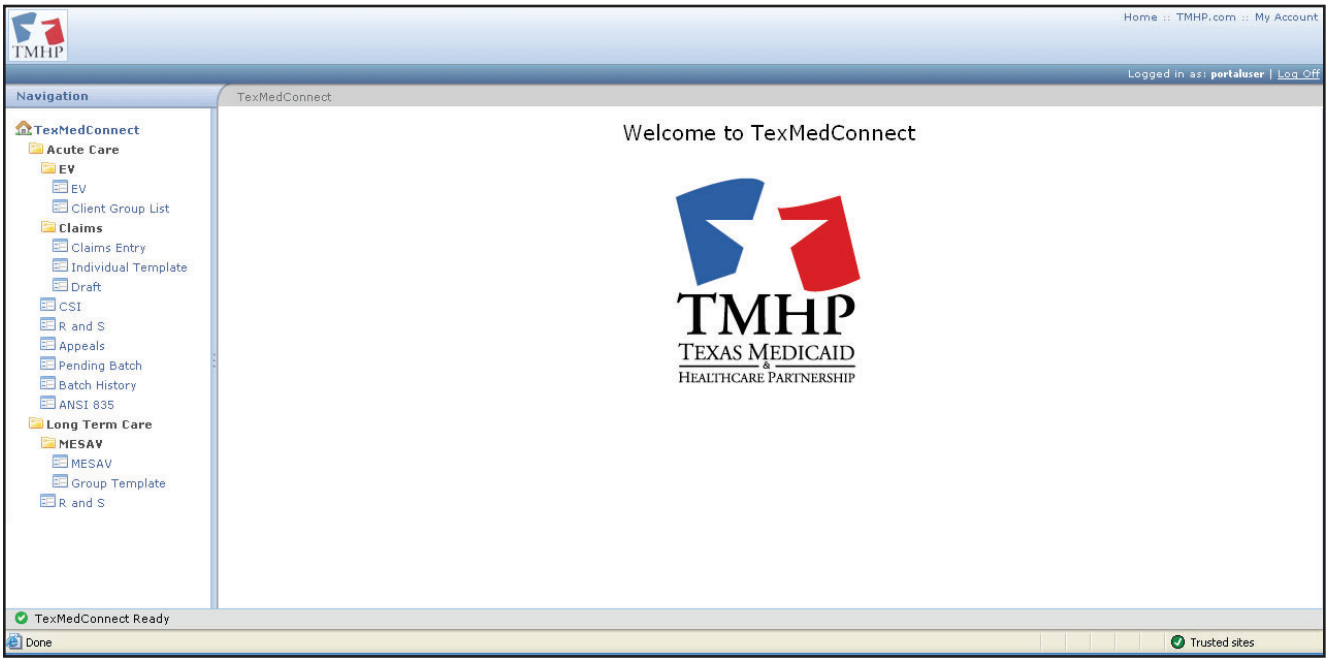
3.3 Getting Claims Assistance

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:

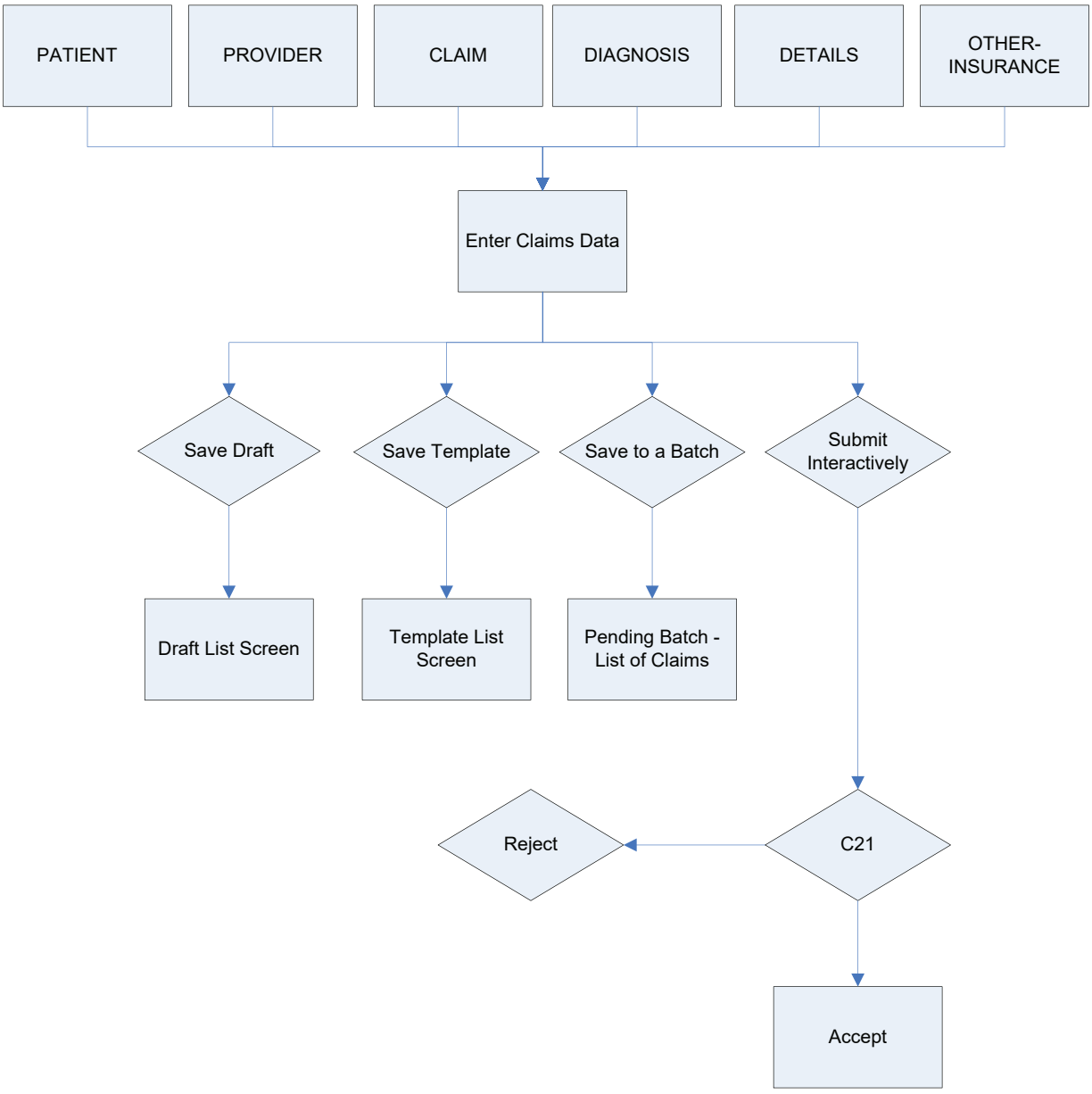
- 020 (Professional, Ambulance, and Vision)
- 021 (Dental)
- 023 (Outpatient)
- 040 (Inpatient)
- 056 (DSHS Family Planning Program [DFPP])
- 058 (Family Planning Title XIX)

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.

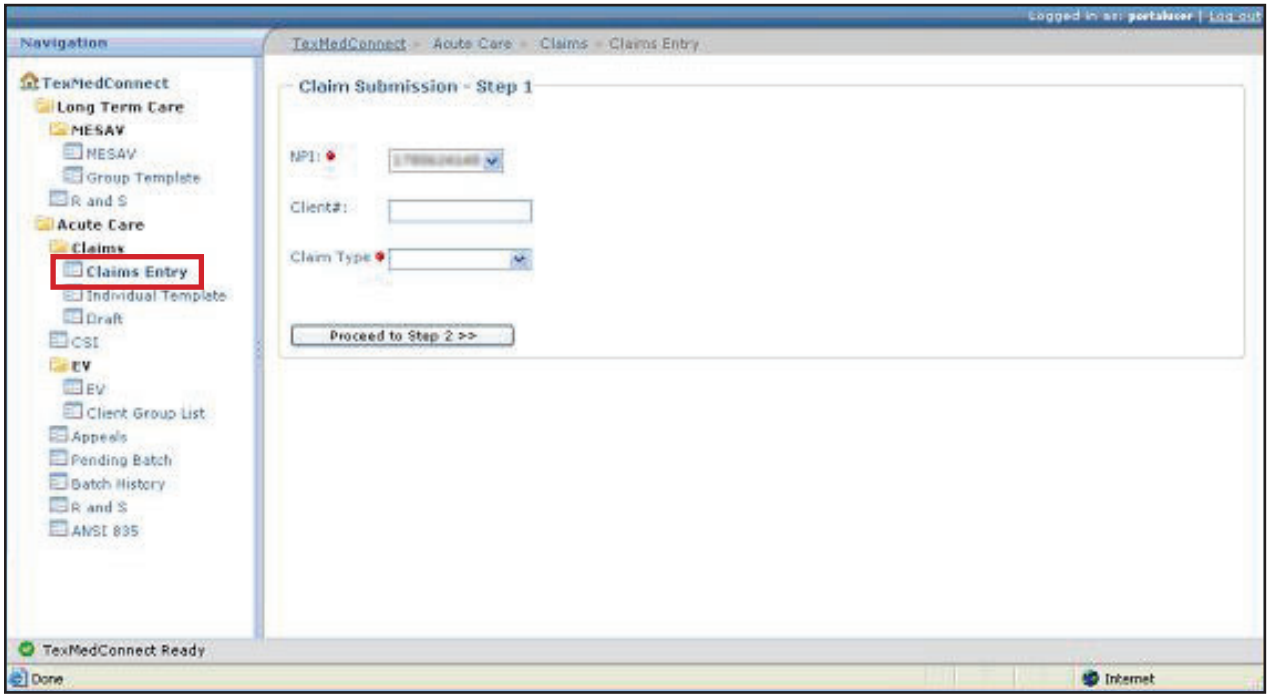
Claims Flow Chart



5.1 Entering Claim Details

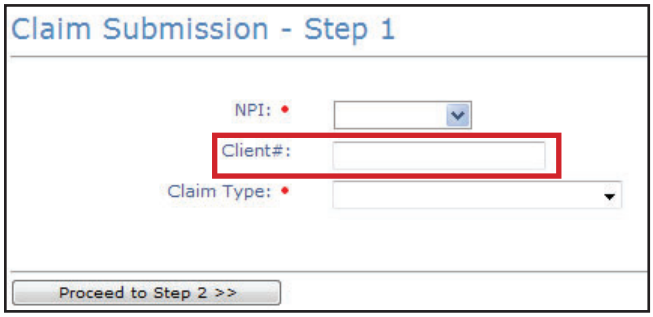
To enter the details of a claim, follow these steps:

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



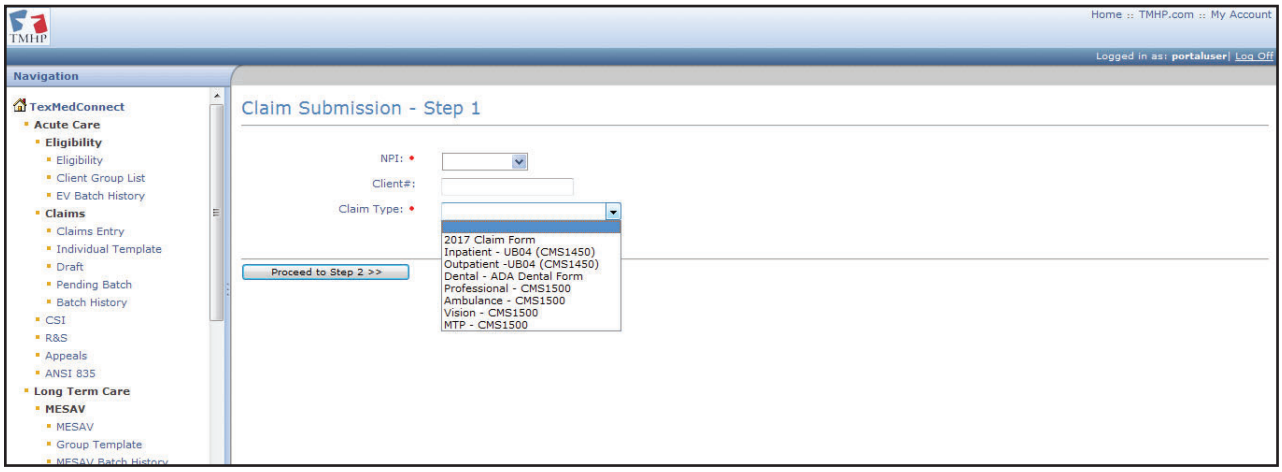
2) Select the appropriate billing provider information.
A list of NPI/API and related data such as taxonomy, physical address, and benefit code selections is displayed based on the user's logon information.

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



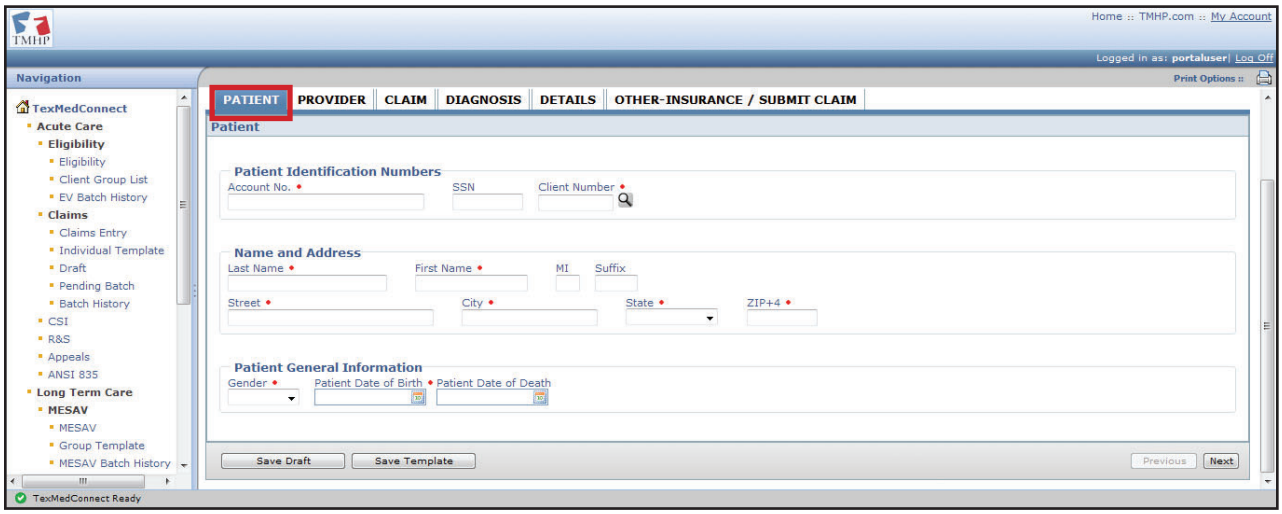
Note: *If you do not enter the client number, you must enter all required fields manually on the Client tab.*

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**

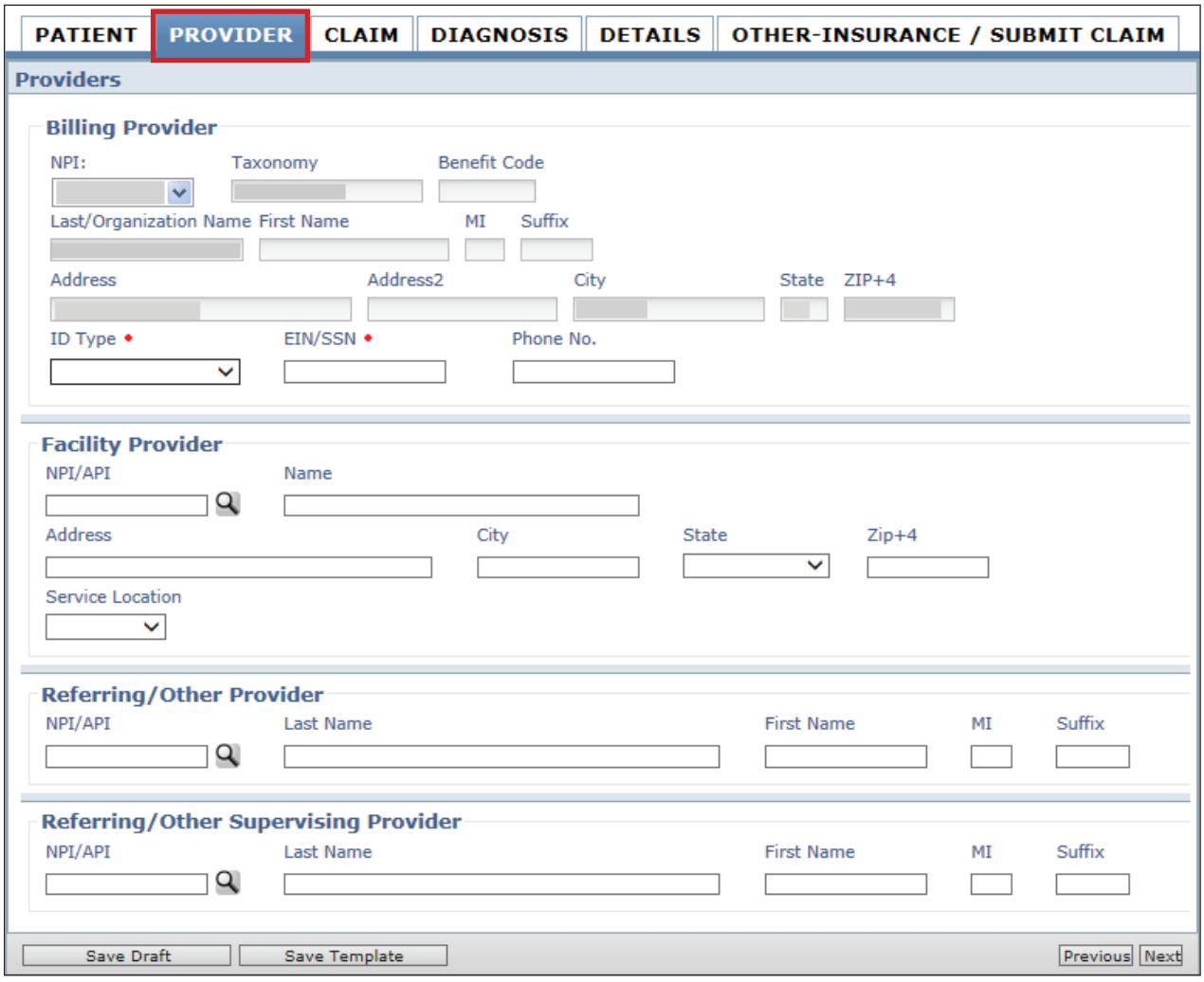


Complete the information on the screen.

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**

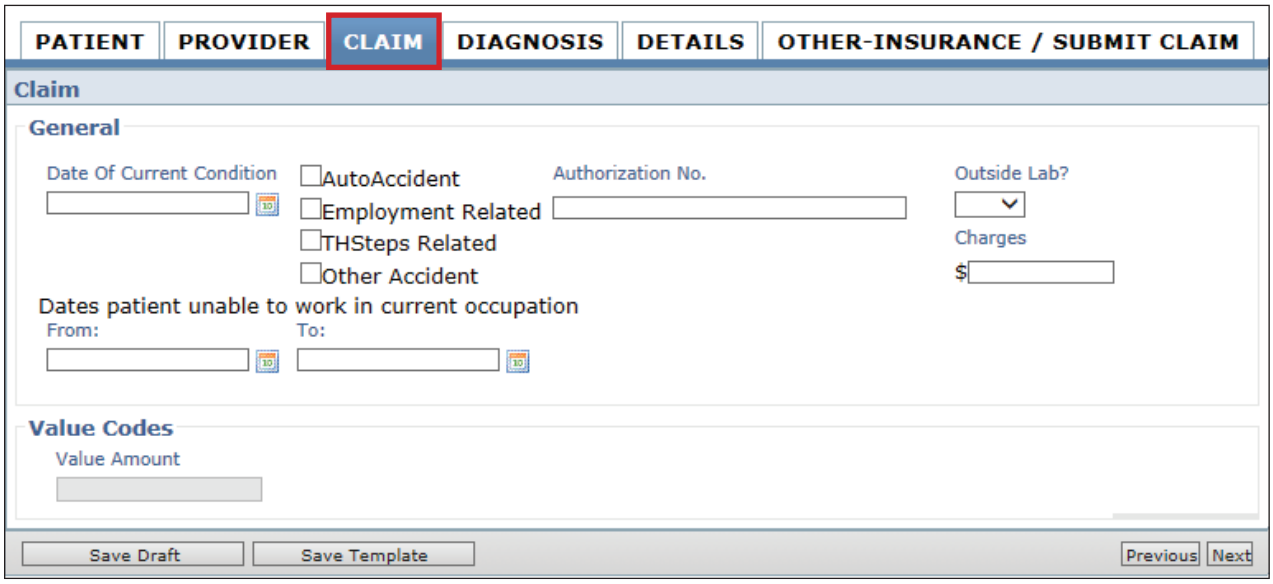


a) Enter provider information into all required fields, which are indicated by a red dot. Many of the fields are populated on this screen from the Billing Provider NPI/Related selected on the Claims Entry screen.

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**

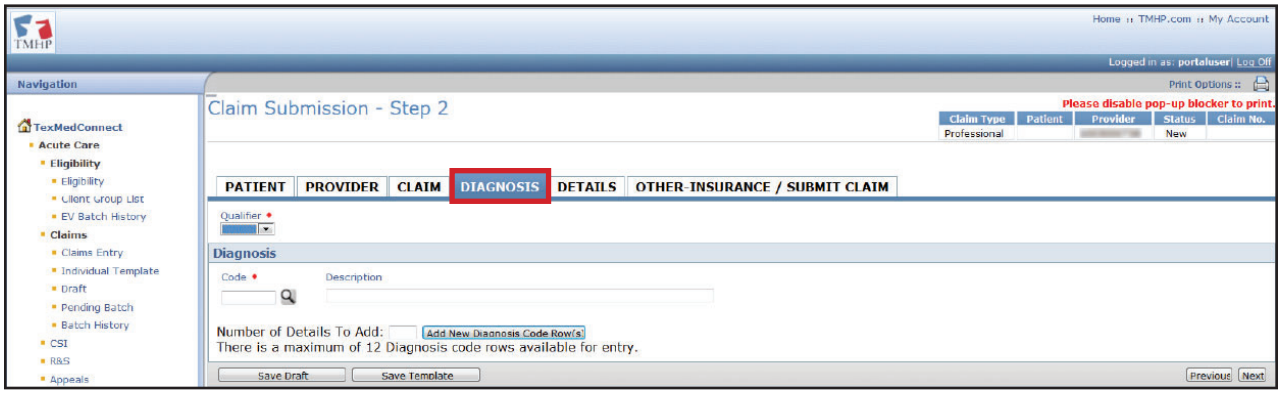


a) Enter claim information into all required fields, which are indicated by a red dot.

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**



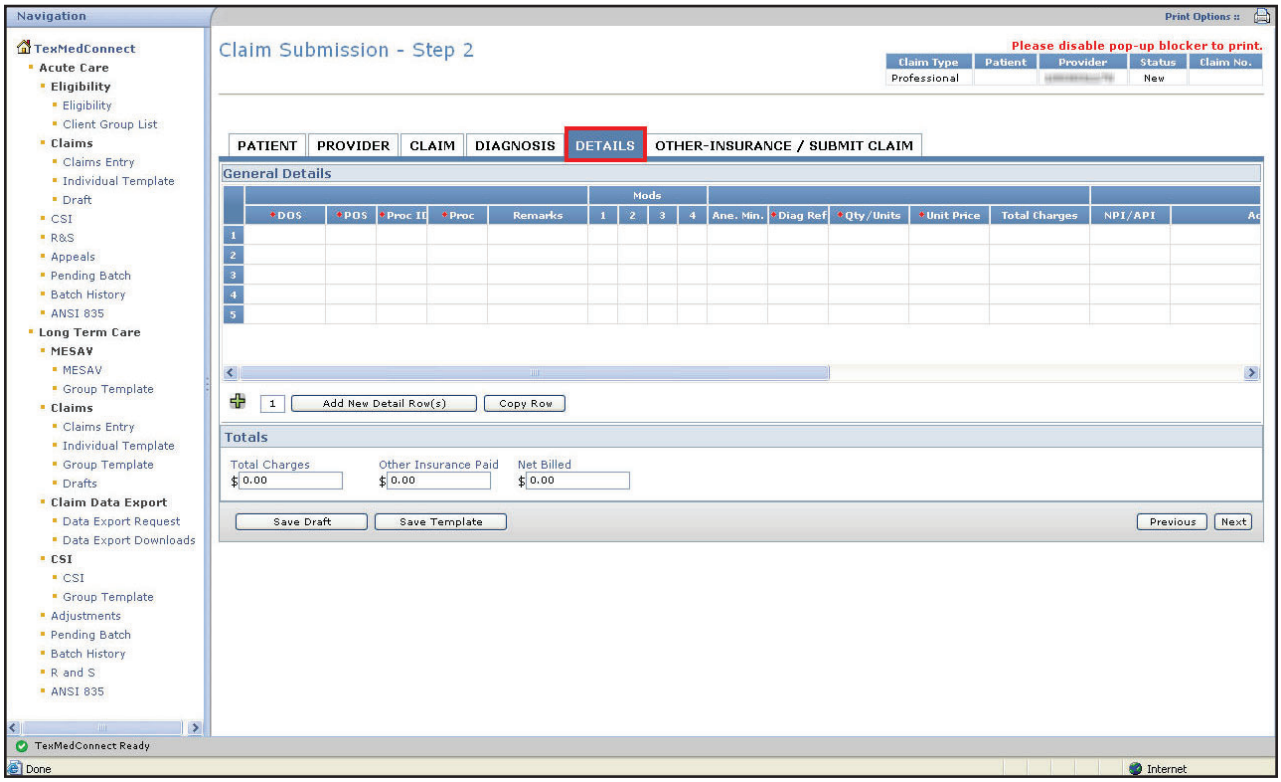
a) Enter diagnosis information into all required fields, which are indicated by a red dot.

b) 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.*

c) 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.

d) 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.

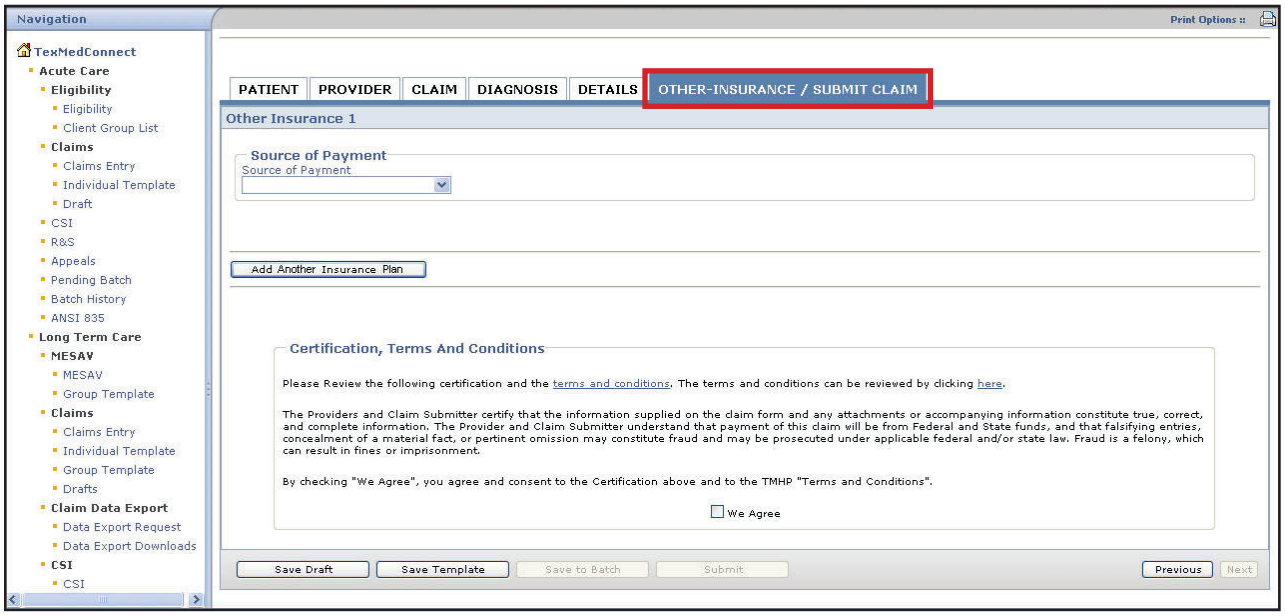
10) **Details Tab**



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

b) 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:

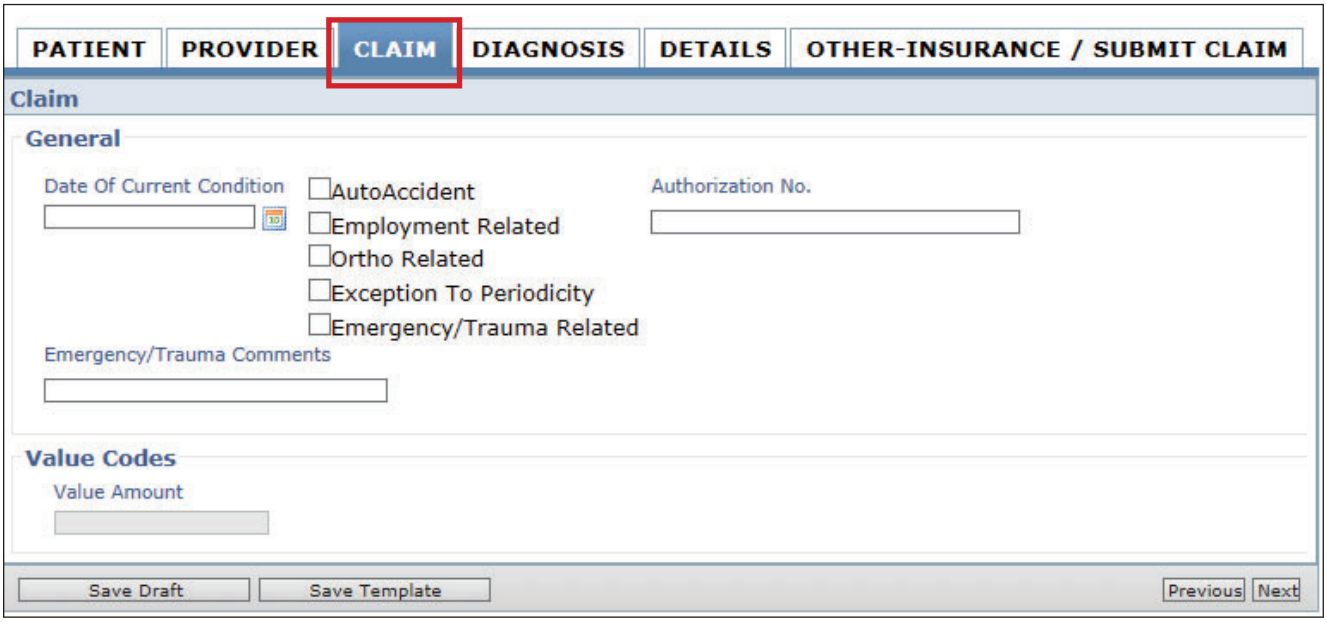
- Dental – Claim tab, Details tab
- Inpatient – Provider tab, Claim tab, Diagnosis tab, Details tab
- Outpatient – Claim tab, Diagnosis tab, Details tab
- Family Planning – Patient tab, Provider tab, Claim tab

- Vision – Claim tab

5.2.1 Dental Claim

To enter a dental claim, follow these steps:

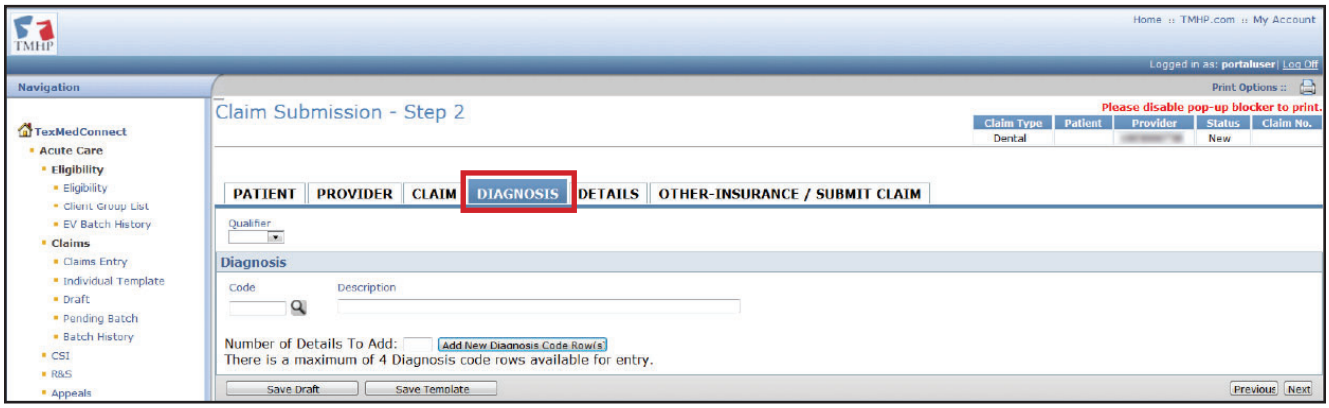
Claim Tab



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

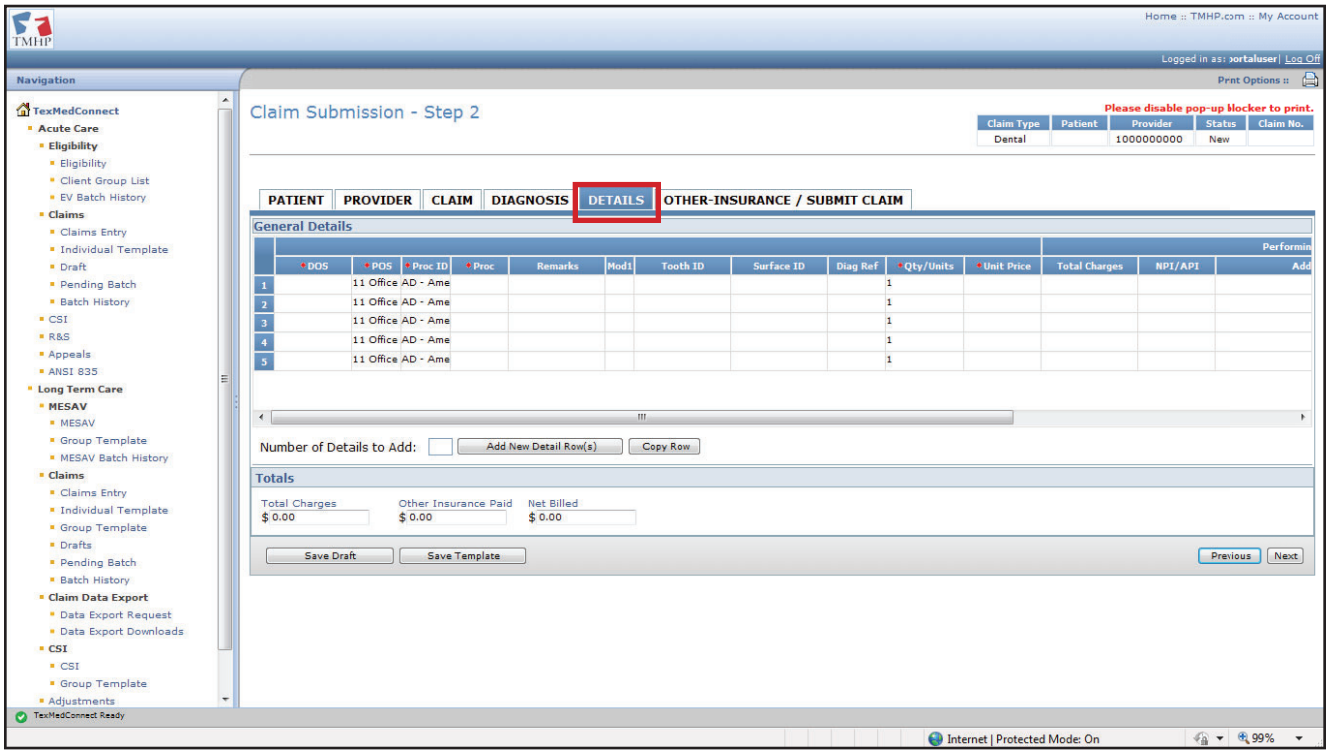
2) Ensure the data entered meet field edit requirements:
Alphanumeric – Authorization No.
Drop-down calendar – Date of Current Condition (no future date allowed)
Drop-down selection – Accident State
Free text – Emergency/Trauma or Exception to Periodicity Comments
Check box – Auto Accident, Employment 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



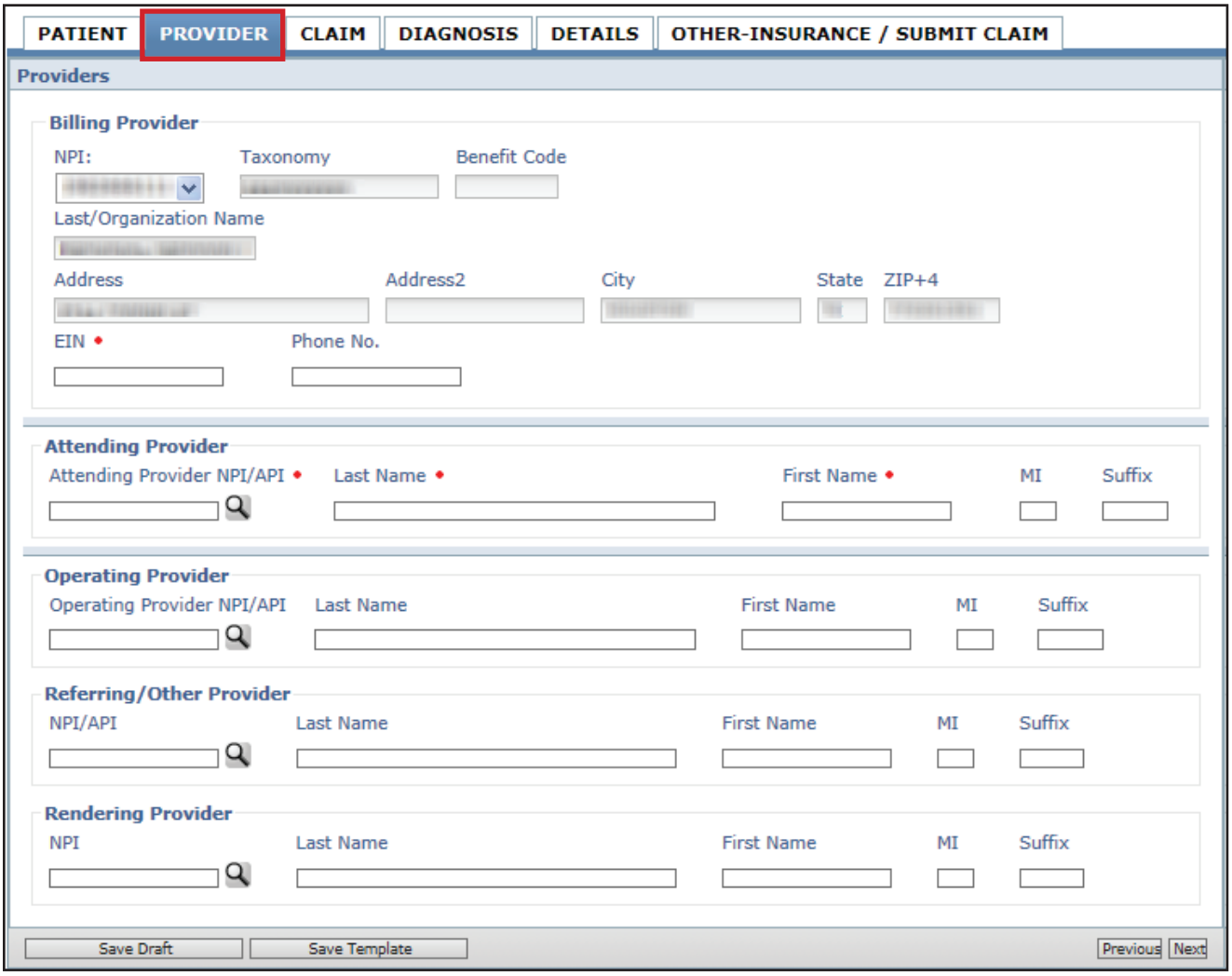
5) Enter dental-specific information into all required fields, which are indicated by a red dot.

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



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 popuated 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.

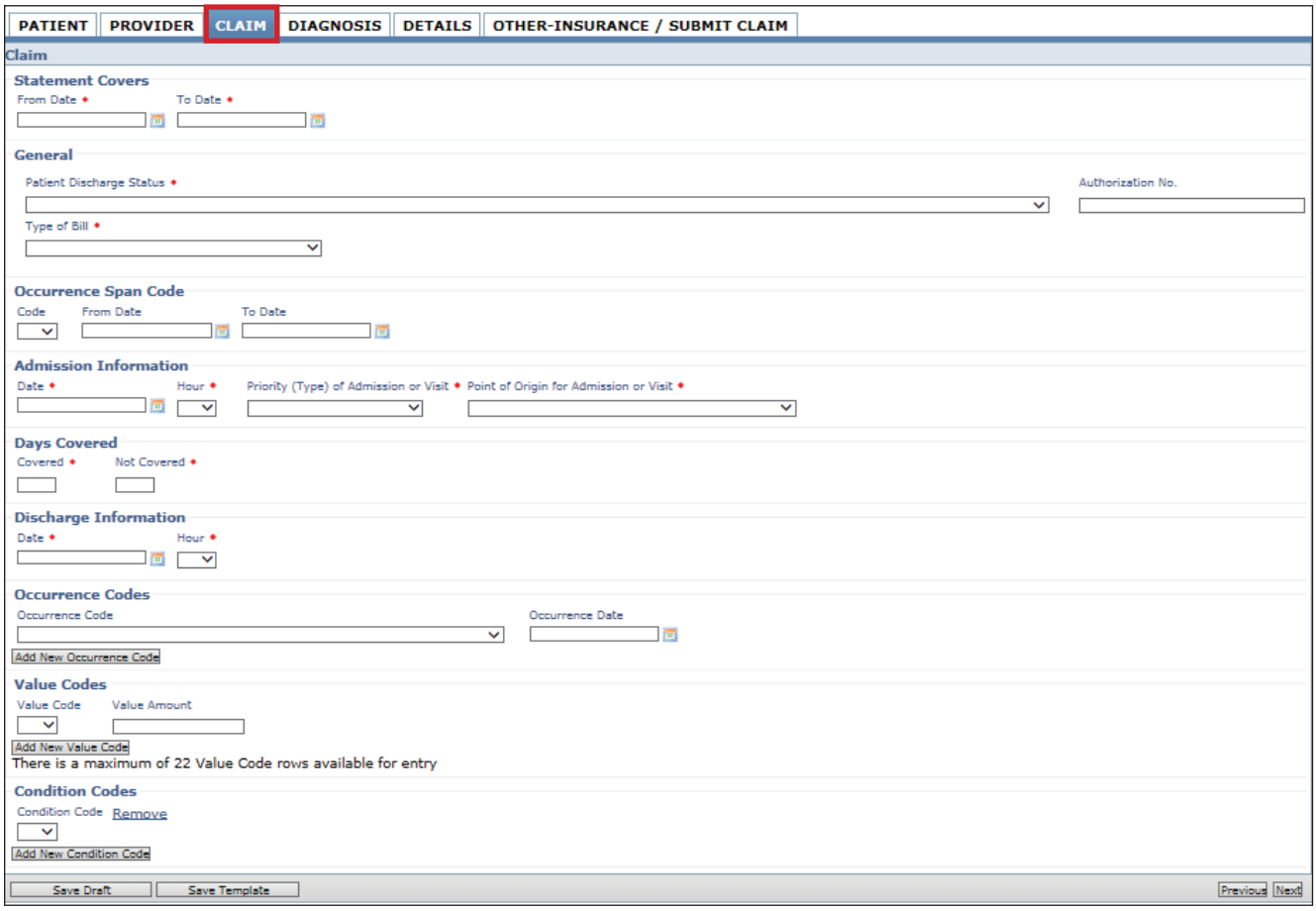
Drop-down selection—ID Type

Rendering Provider

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

Numeric only—NPI

Claim Tab

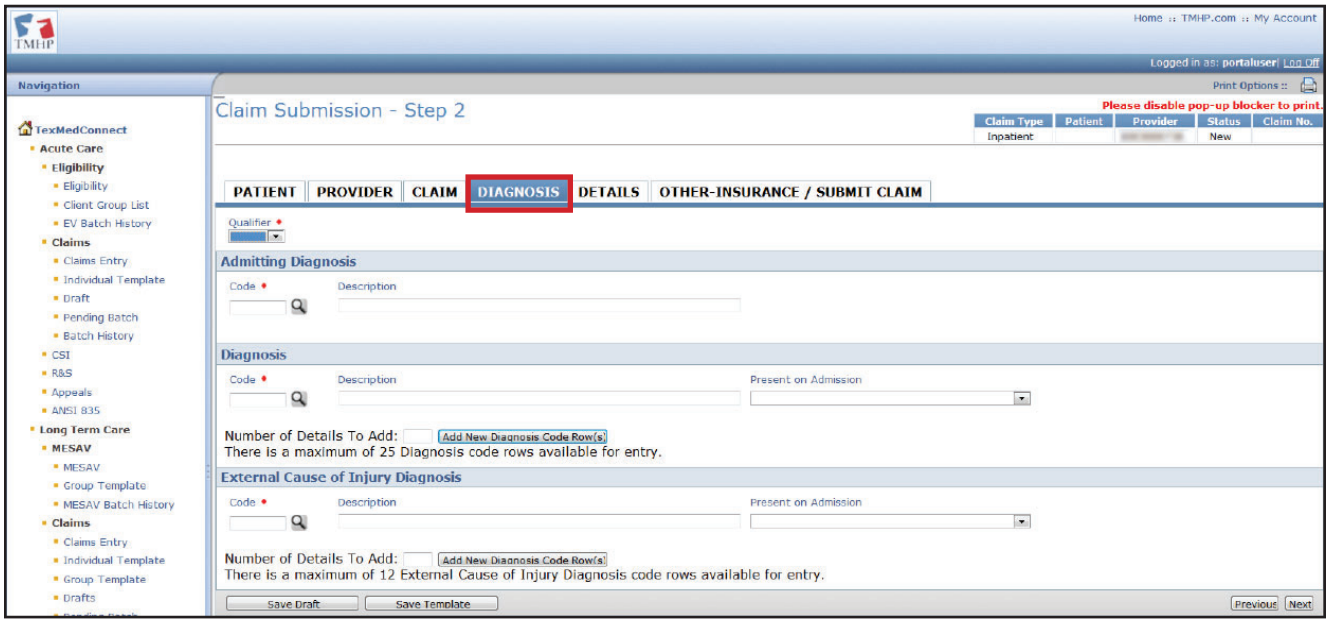


9) Enter the claim information into all of the required fields, which are indicated by a red dot.

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.*

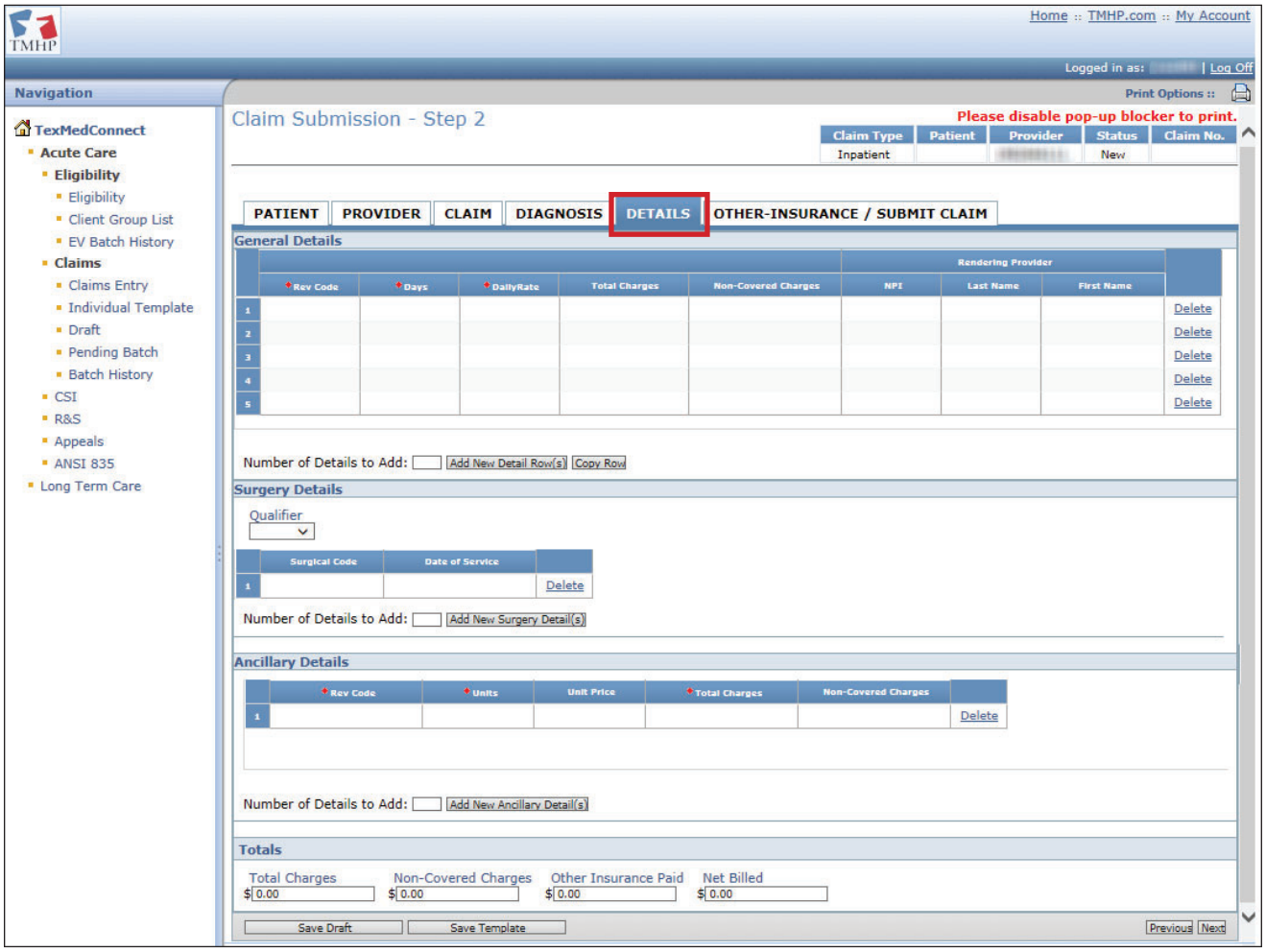
14) Select the Present on Admission (POA) value in the POA field for each diagnosis code entered.

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.

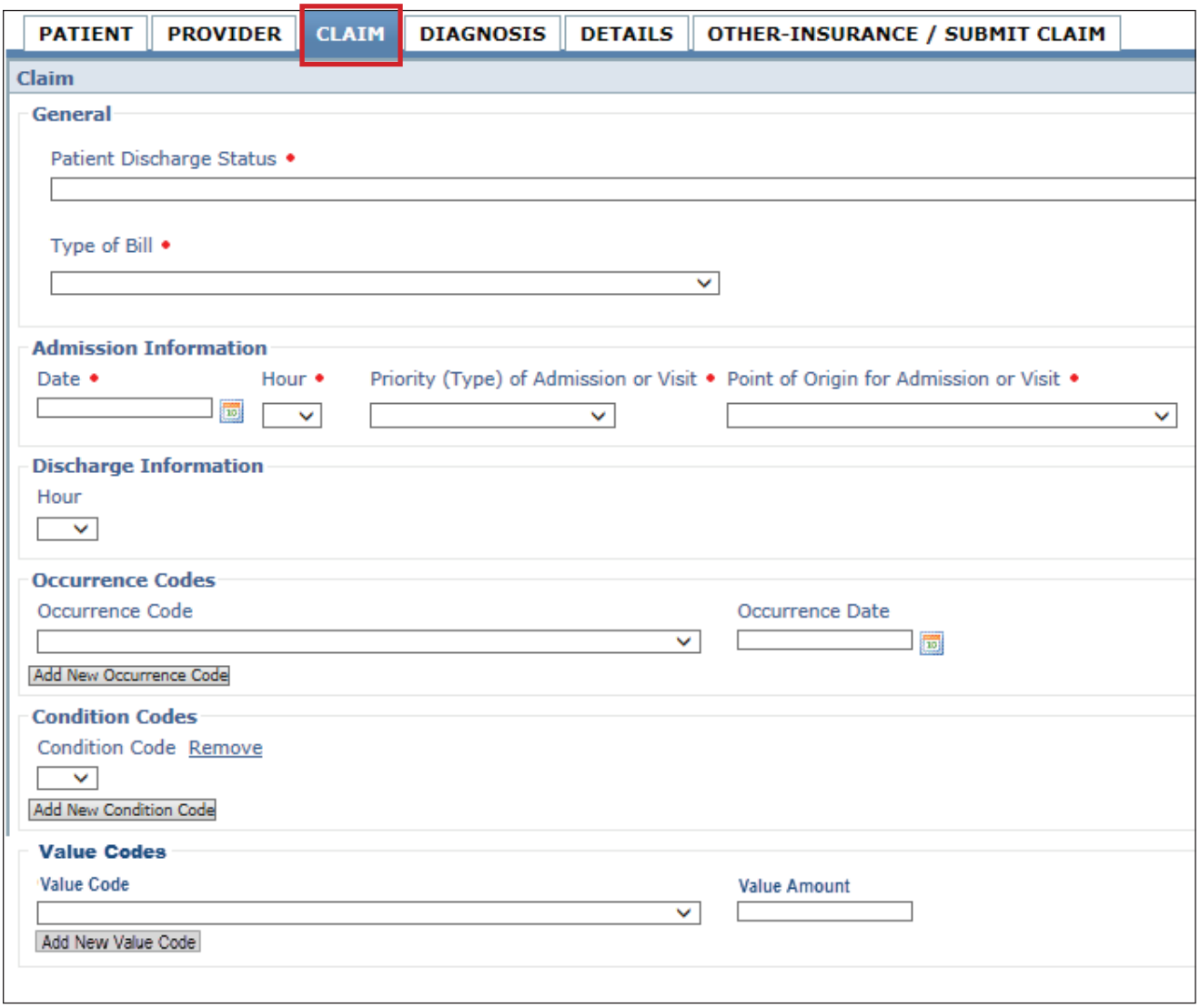
19) Make sure that the data you enter meets the field edit requirements:
Numeric only - Rev Code, Days, Daily Rate, Non-Covered Charges and NPI
Note: *Total Charges are calculated by TMC and are not editable.*
Alphanumeric - Surgical Code, Last Name, and First Name
Select the qualifier field to enter 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

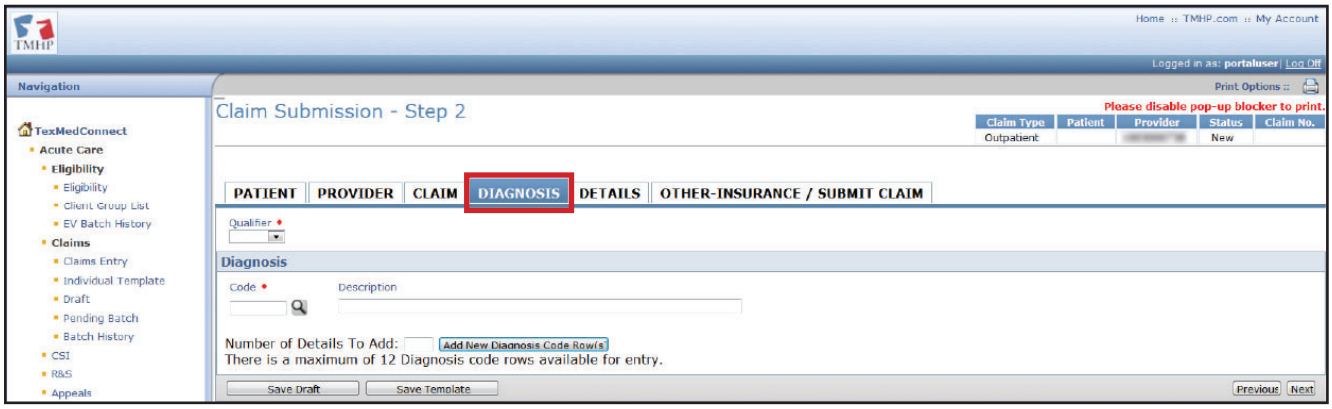
To enter an outpatient claim, follow these steps:

Claim Tab



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



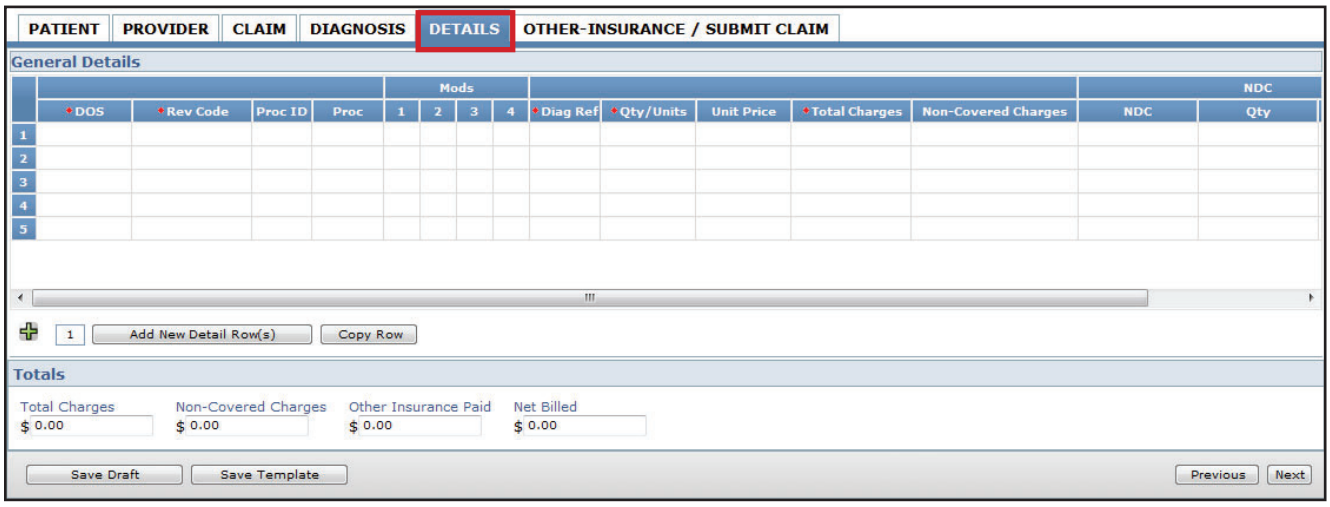
3) Enter diagnosis information into all required fields, which are indicated by a red dot.

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: *Qualifer 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.

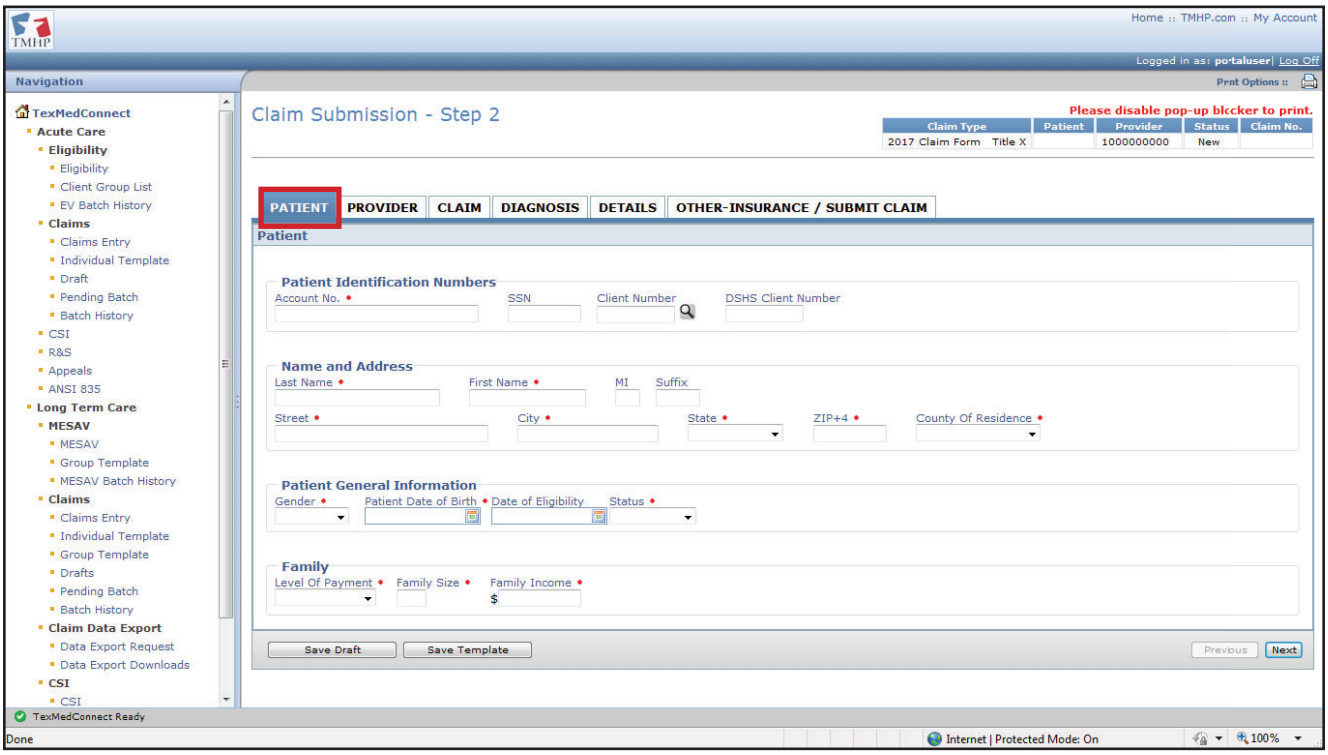
9) Ensure the data entered meet field edit requirements:
Alphanumeric – Mod1–Mod4, Procedure Code, Last Name, and First Name
Drop-down calendar – Date of Service (no future date allowed)
Drop-down selection – Procedure Code ID, Diagnosis Ref
Numeric only – Rev Code, Qty/Units, Unit Price, Other Insurance 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

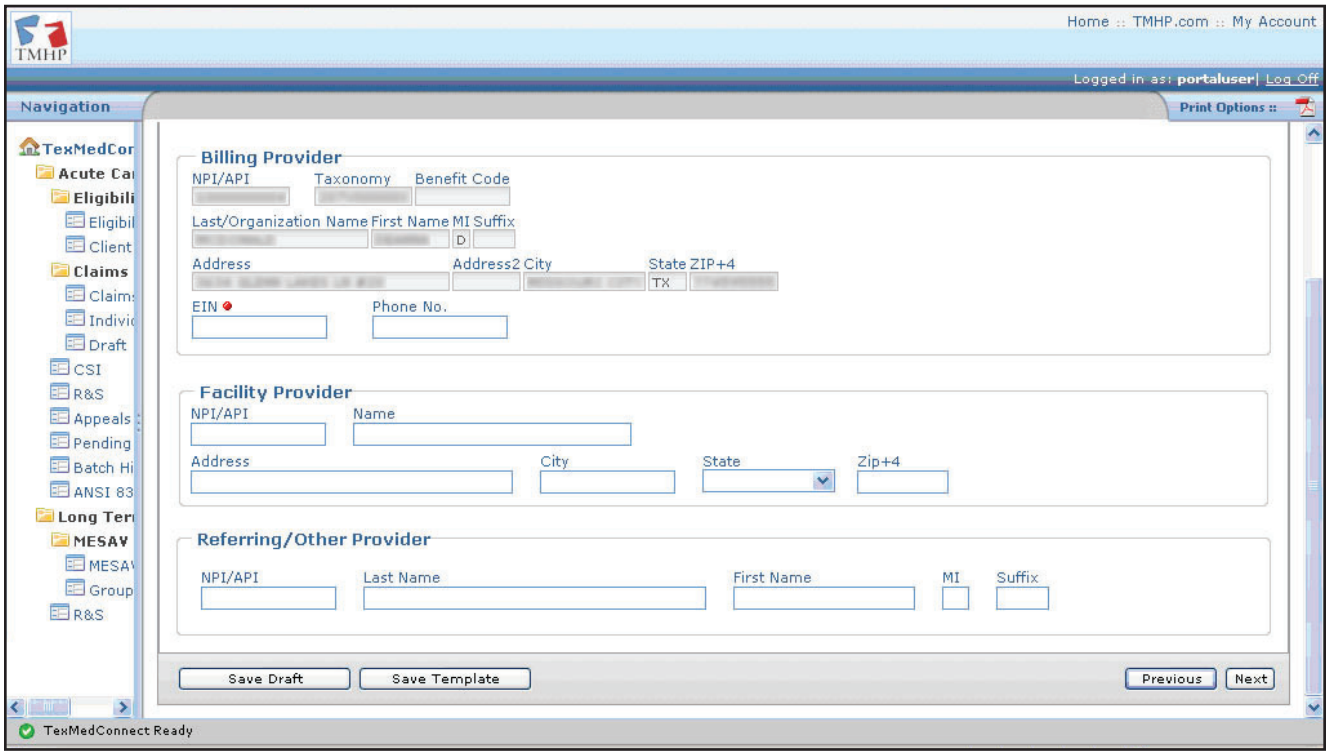


1) Enter patient information into all required fields, which are indicated by a red dot.

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

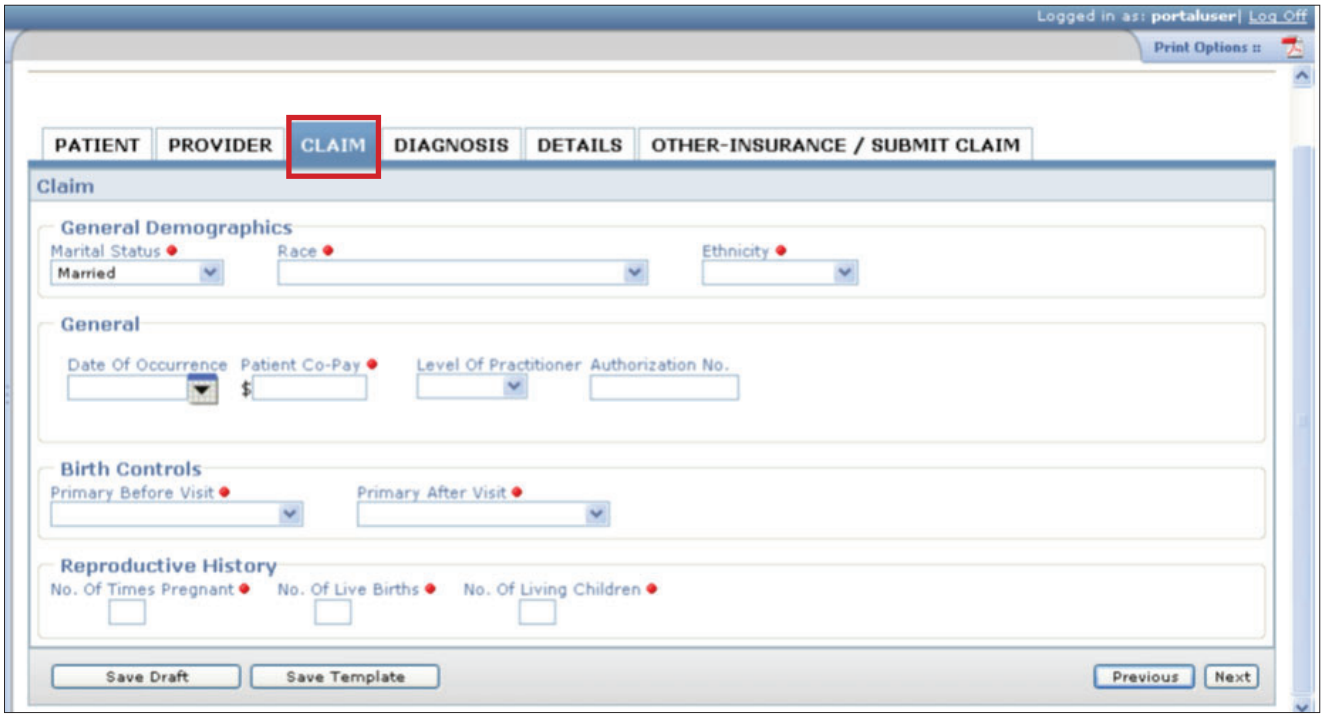
Provider Tab



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



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

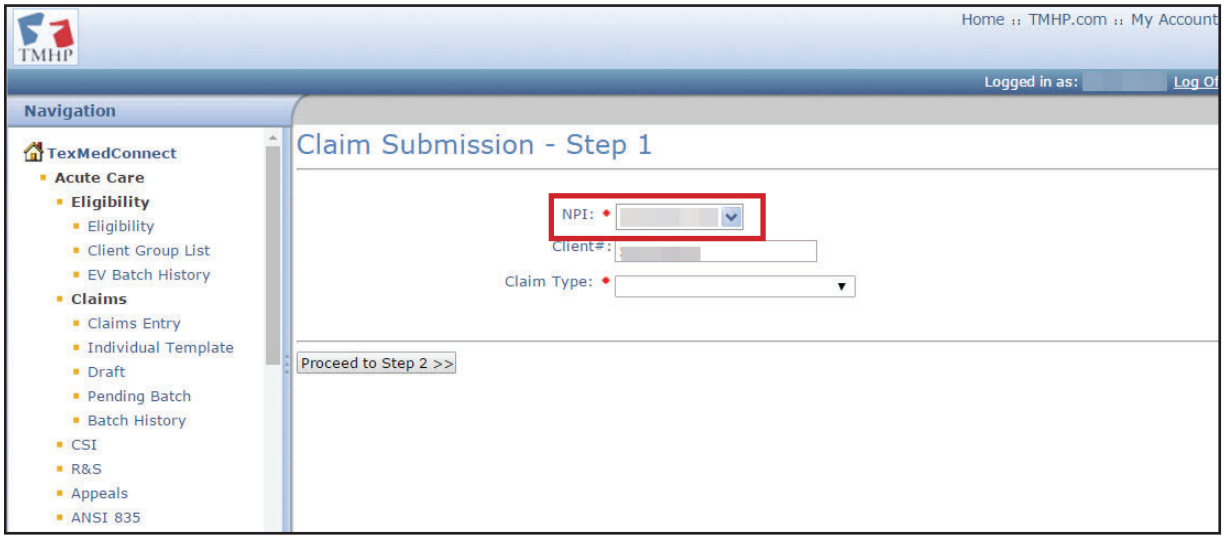
6) Ensure the data entered meet field edit requirements:
Alphanumeric – Authorization No.
Drop-down calendar – Date of Occurrence (no future date allowed)
Drop-down selection – Marital Status, Race, Ethnicity, Level of Practitioner, Primary Before Visit (Birth Control), Primary After Visit (Birth Control)
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

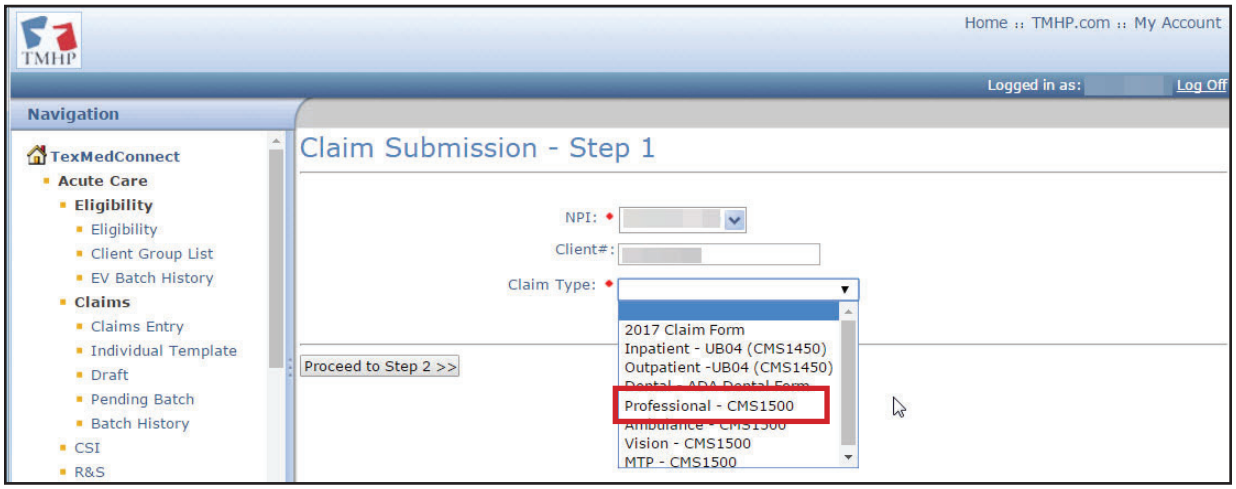
To enter a Family Planning Program claim, follow these steps:

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

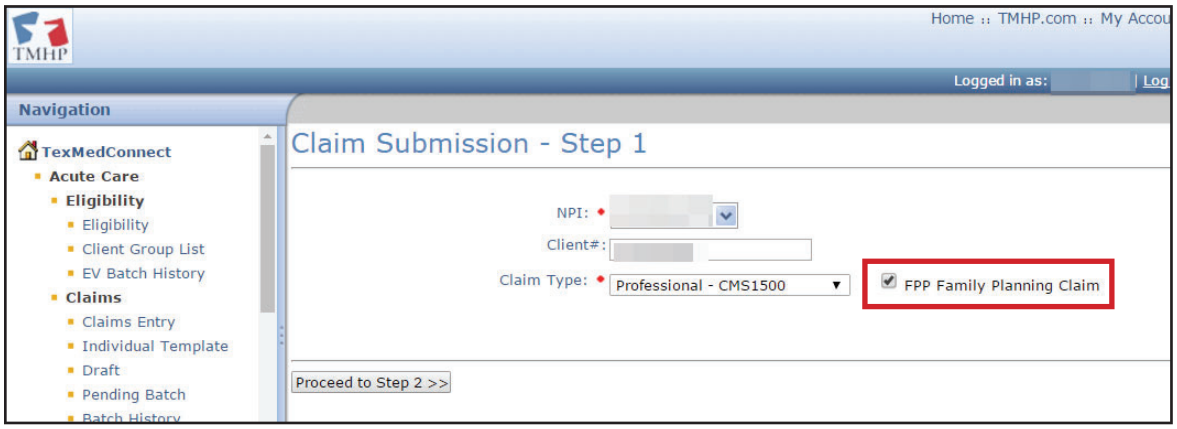
2) Select the appropriate billing provider information. A list of NPI/API and related data such as taxonomy, physical address, and benefit code selections is displayed based on the user's logon information.



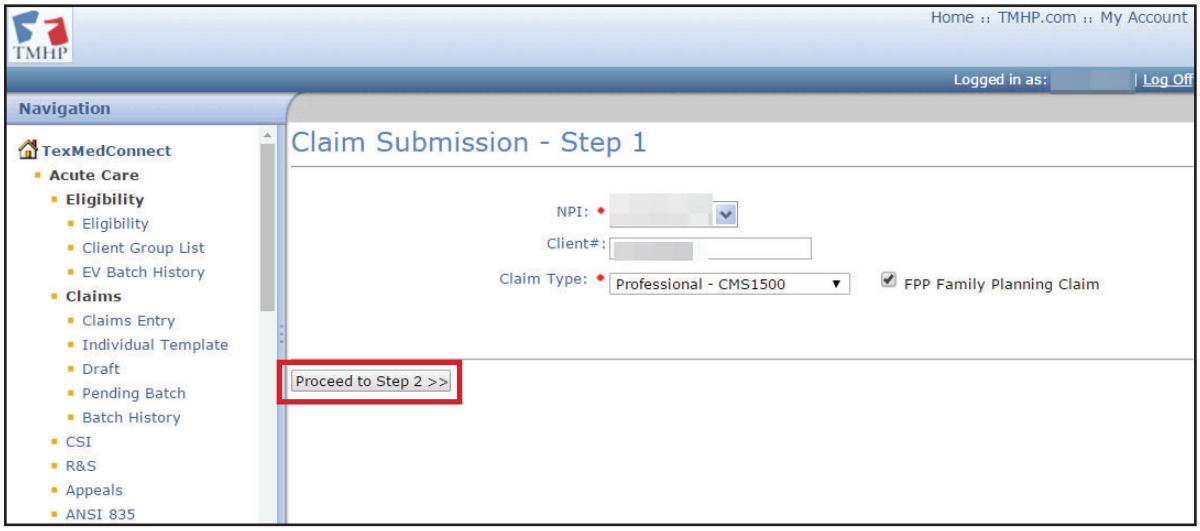
3) Select “Professional – CMS1500” from the Claim Type drop-down menu.



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.

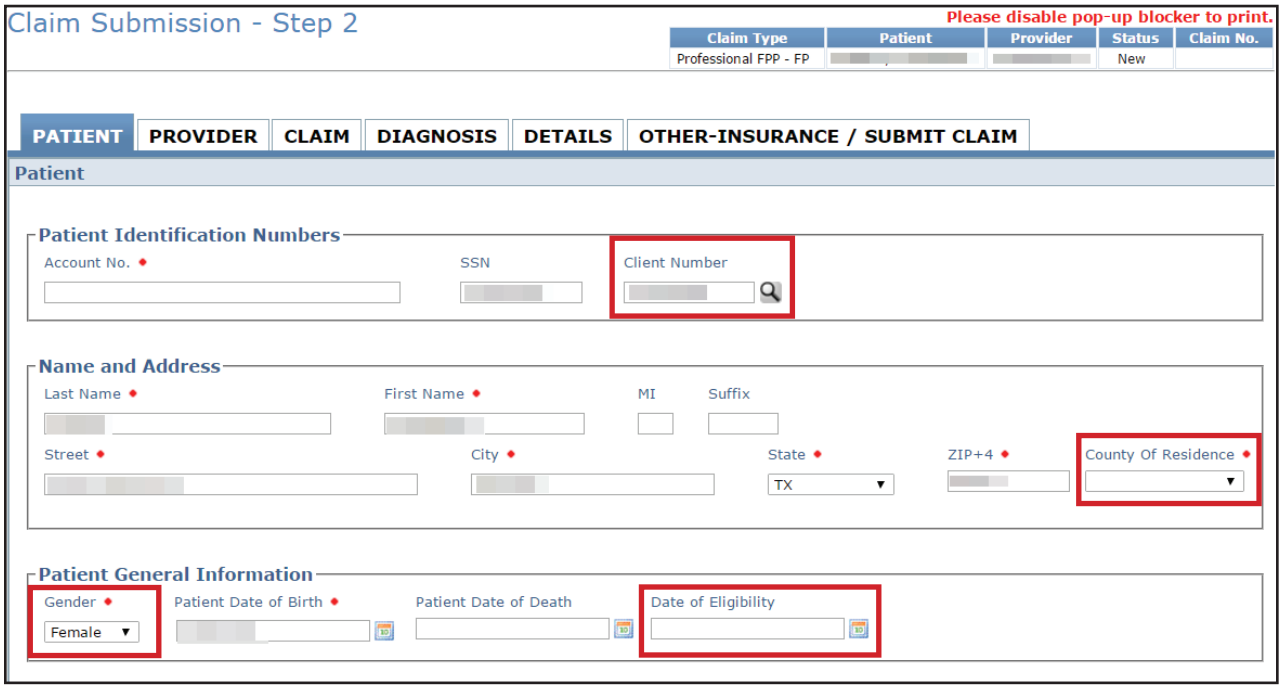


5) Click the **Proceed to Step 2 >>** button.



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

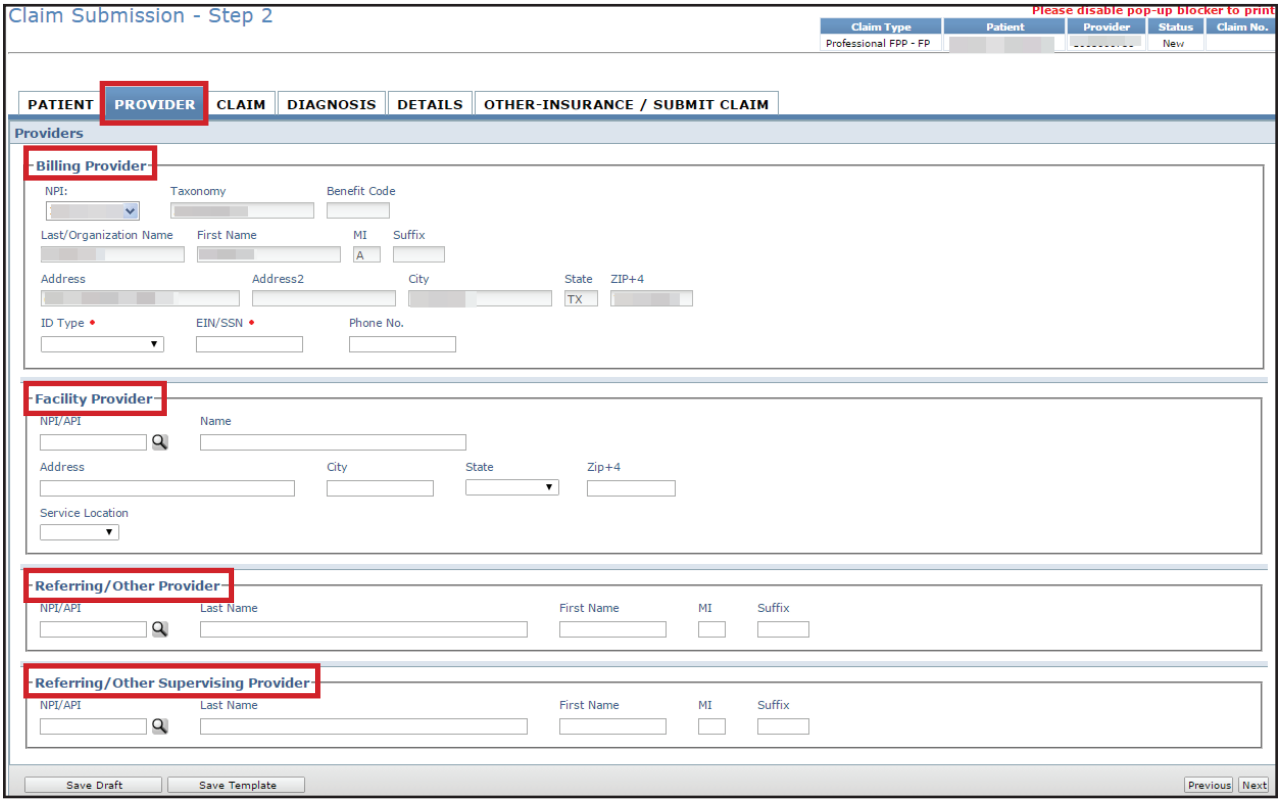
optional.



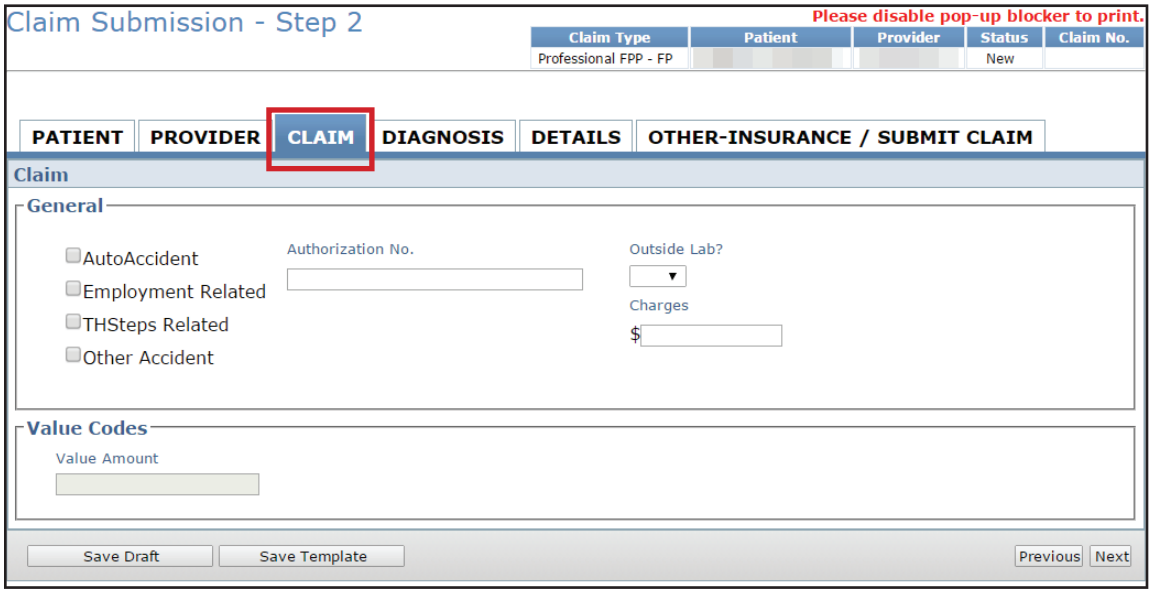
7) The Provider tab is used to enter provider information for the claim. Enter the provider's information into all of the required fields, as indicated by a red dot.

   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.

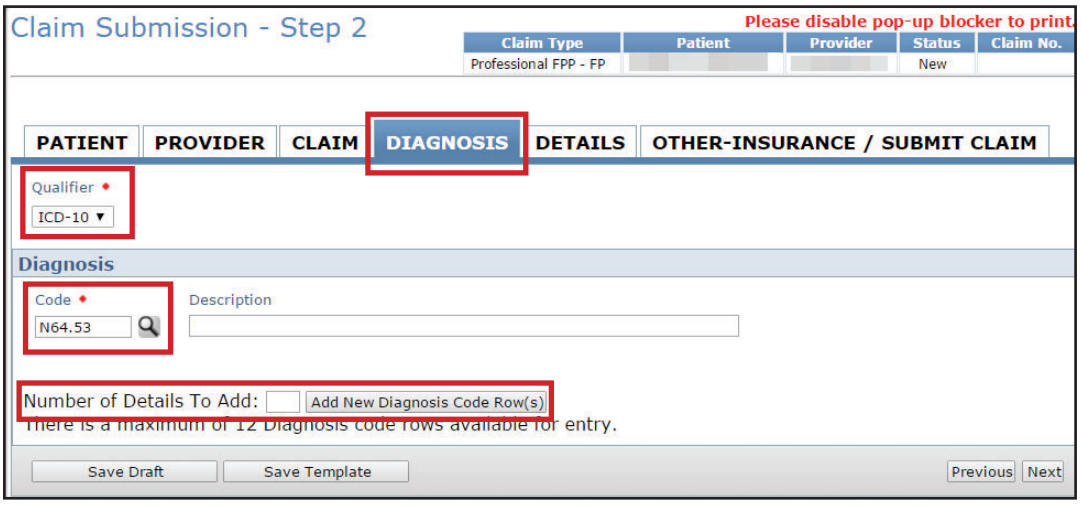
   b) Information about additional providers (facility, referring, supervising) may also be entered.



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.

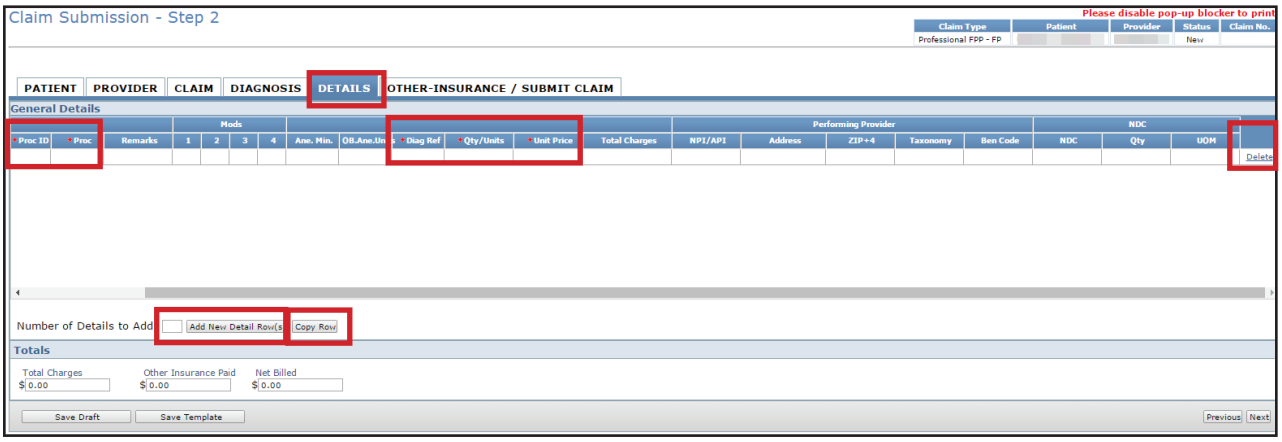


9) The Diagnosis tab is used to describe the client's condition using diagnosis codes.
   a) Select the qualifier dropdown to enter the correct ICD diagnosis code.
   b) Enter the diagnosis code that has the highest degree of specificity.
   c) Enter the diagnosis information into all required fields,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



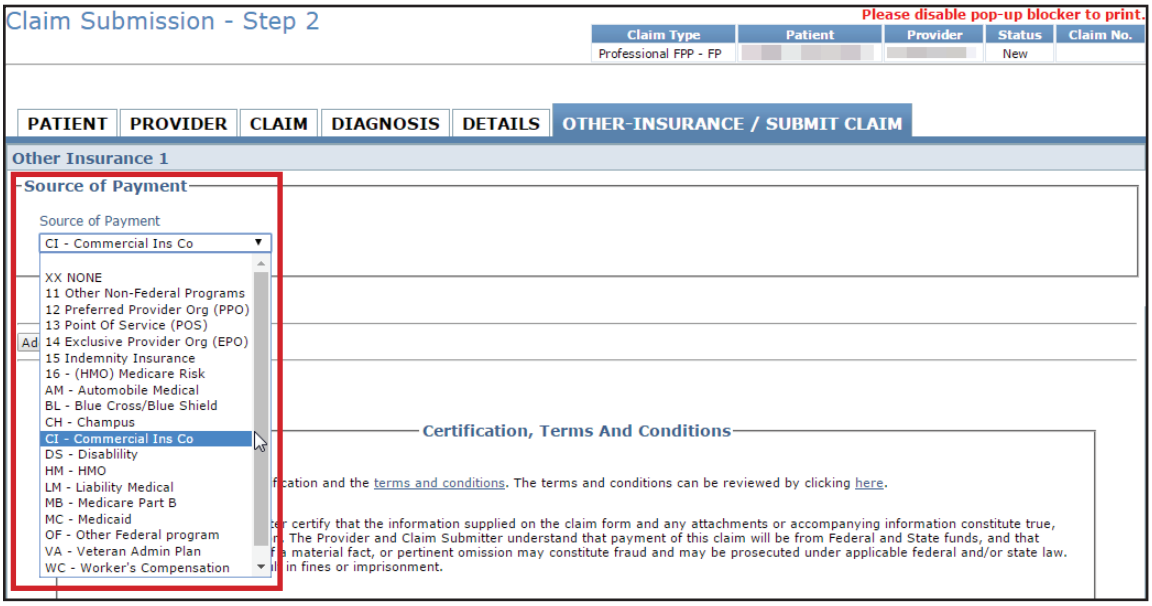
10) The Details tab is used to enter the services that have been rendered to the client.
   a) Begin by entering data into all of the required fields, as indicated by a red dot.
   b) To add additional details, click **Add New Detail Row(s)**.
   c) Claims can have up to 28 detail rows. Click **Copy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

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

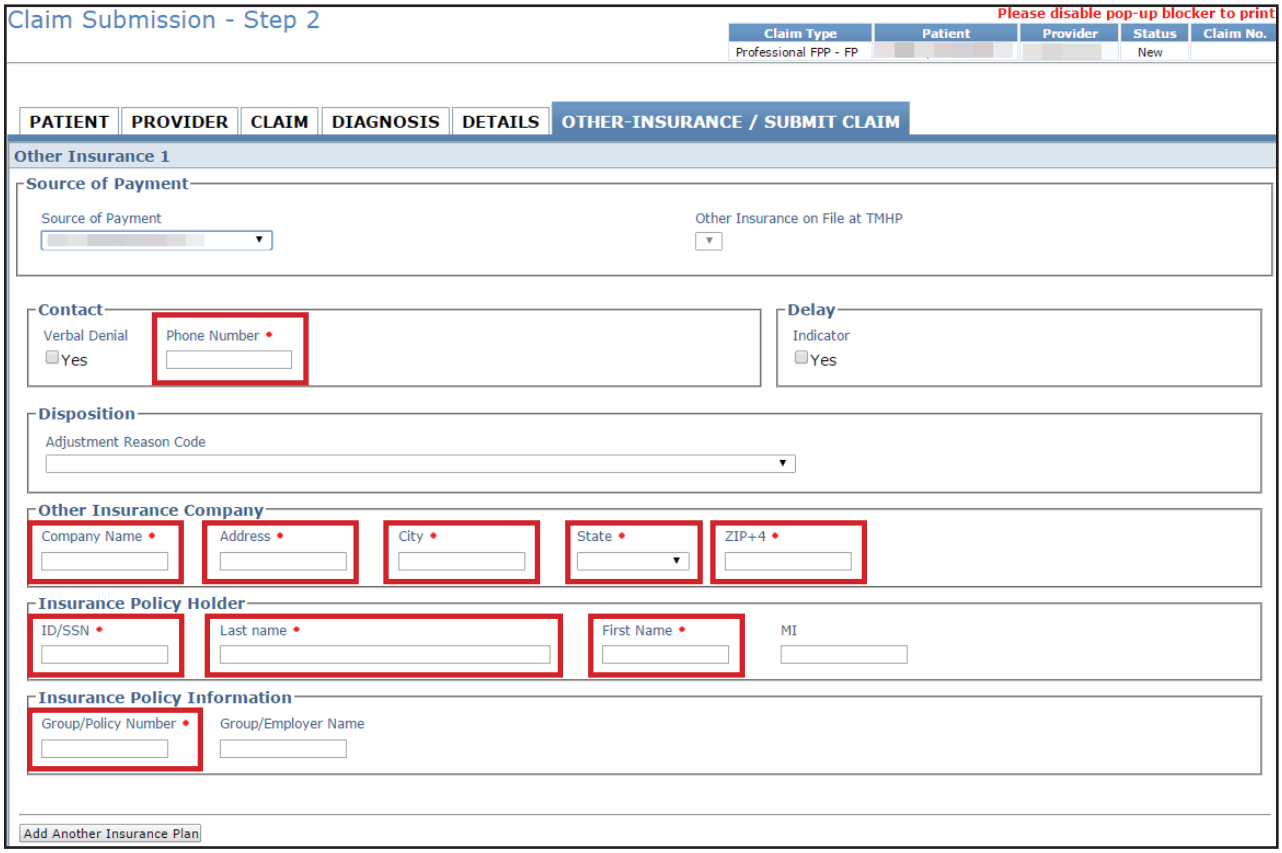


11) If there is current, other insurance information that is on file with Texas Medicaid and Healthcare Partnership (TMHP) it will be displayed under the Other-Insurance / Submit Claim tab. If you do not see the other insurance information but there is other insurance information, it should be added.

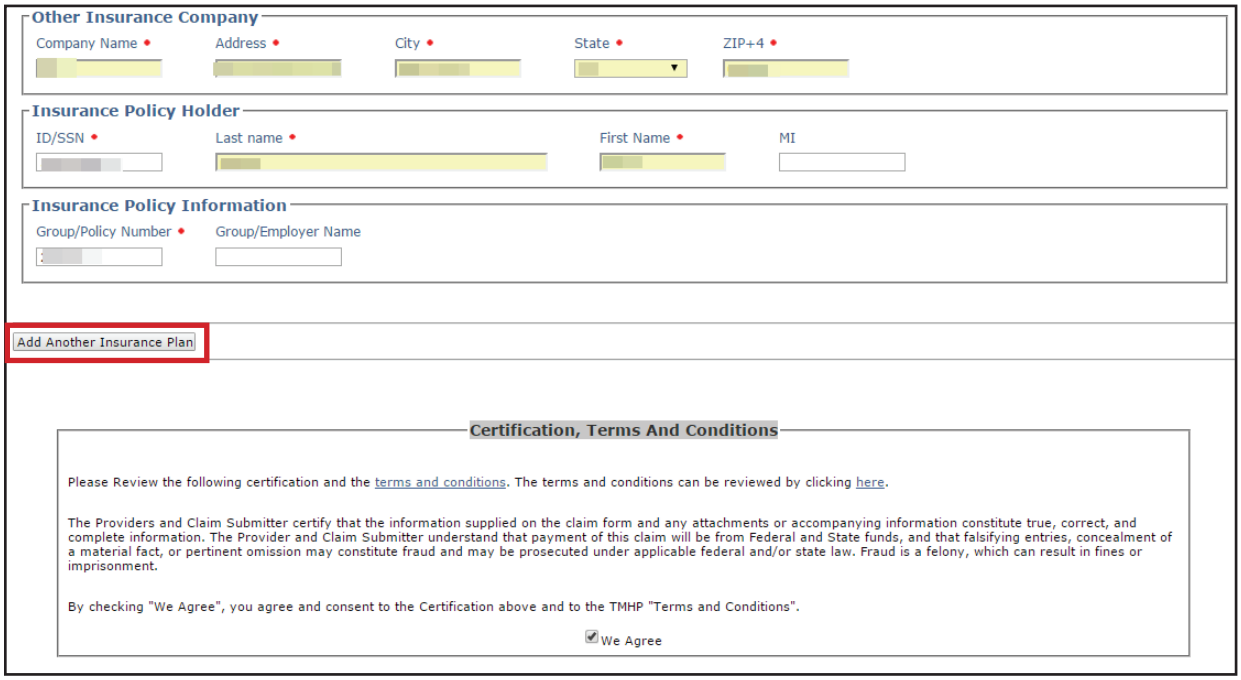
a) To enter other insurance information, select the applicable Source of Payment drop-down menu.



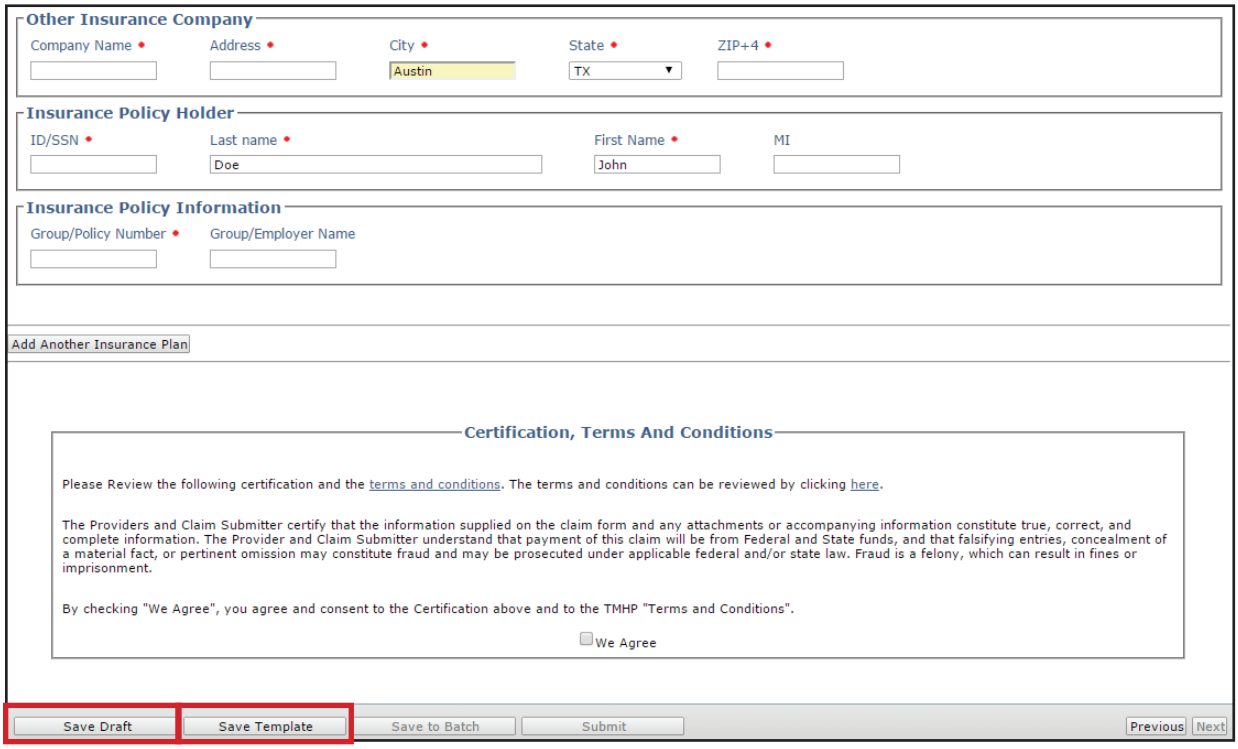
12) Additional fields will display so that you can enter the Source of Payment information. Enter data into all of the required fields as indicated by a red dot.



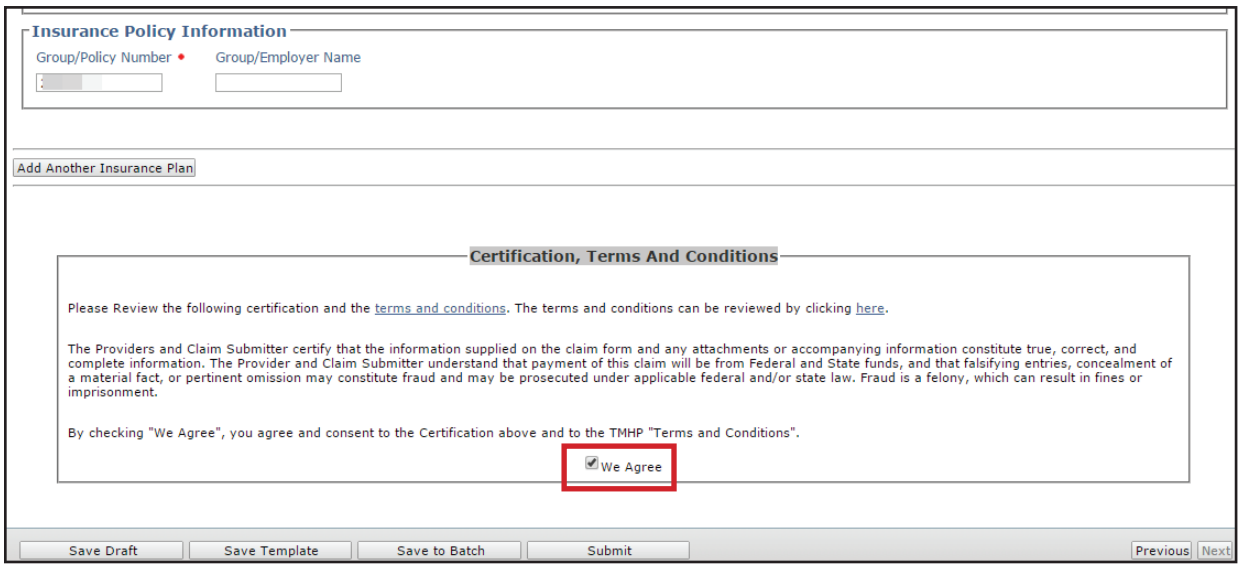
13) If there are additional insurance plans, click the **Add Another Insurance Plan** button to create new insurance that is not on file.



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.

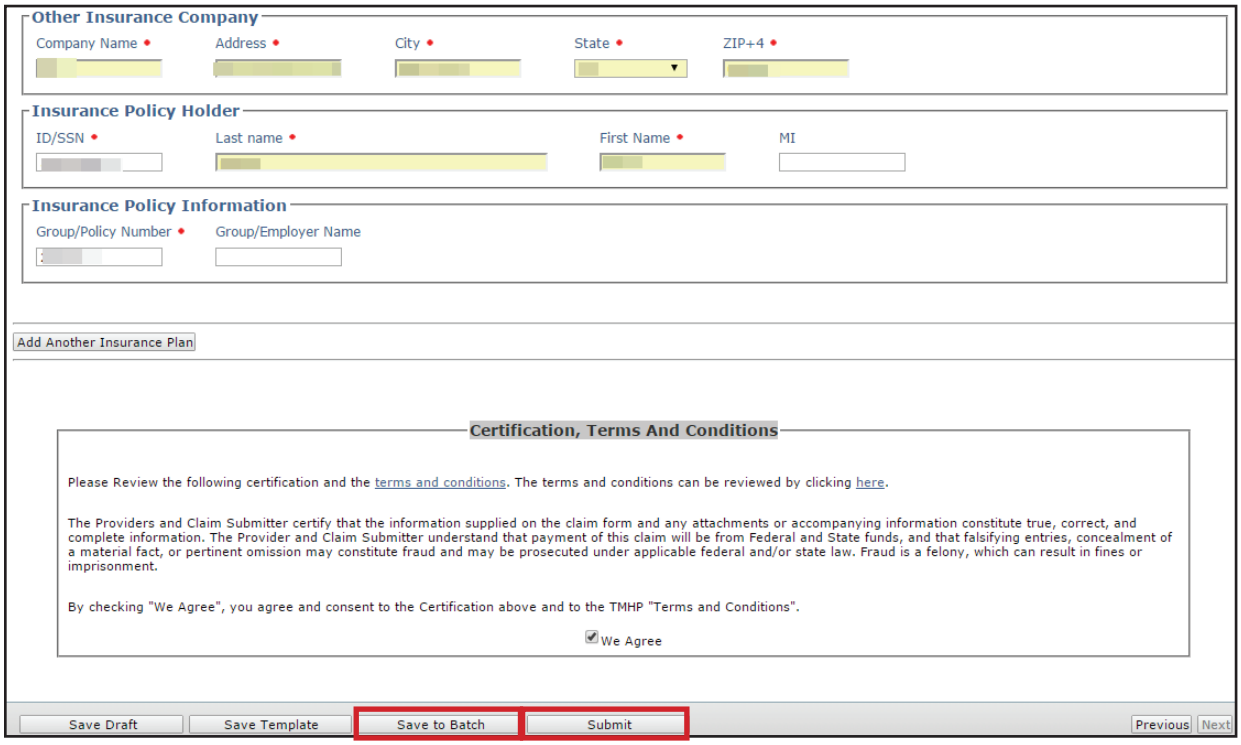


15) When the claim is ready to be submitted, read the terms and conditions. If you agree, click the **We Agree** box in the Certification, Terms And Conditions section.

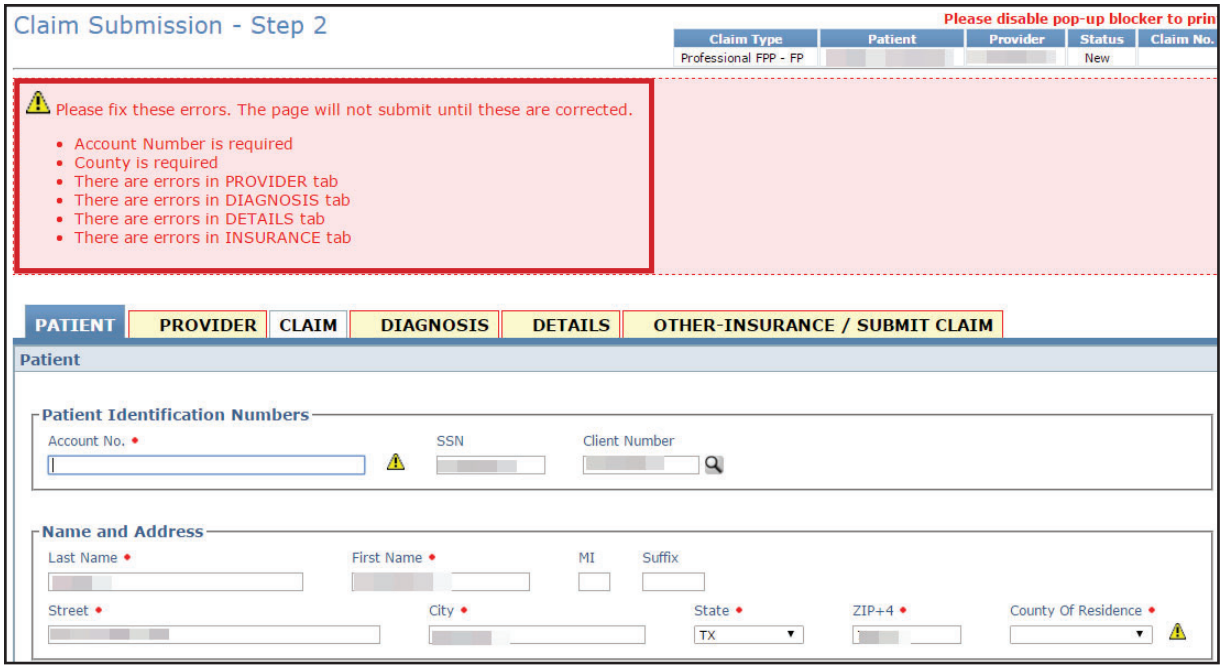


16) **Save to Batch** and **Submit** buttons are enabled when you accept the Certification, Terms, and Conditions by clicking the **We Agree** box. For more information see the Saving To a Batch section of

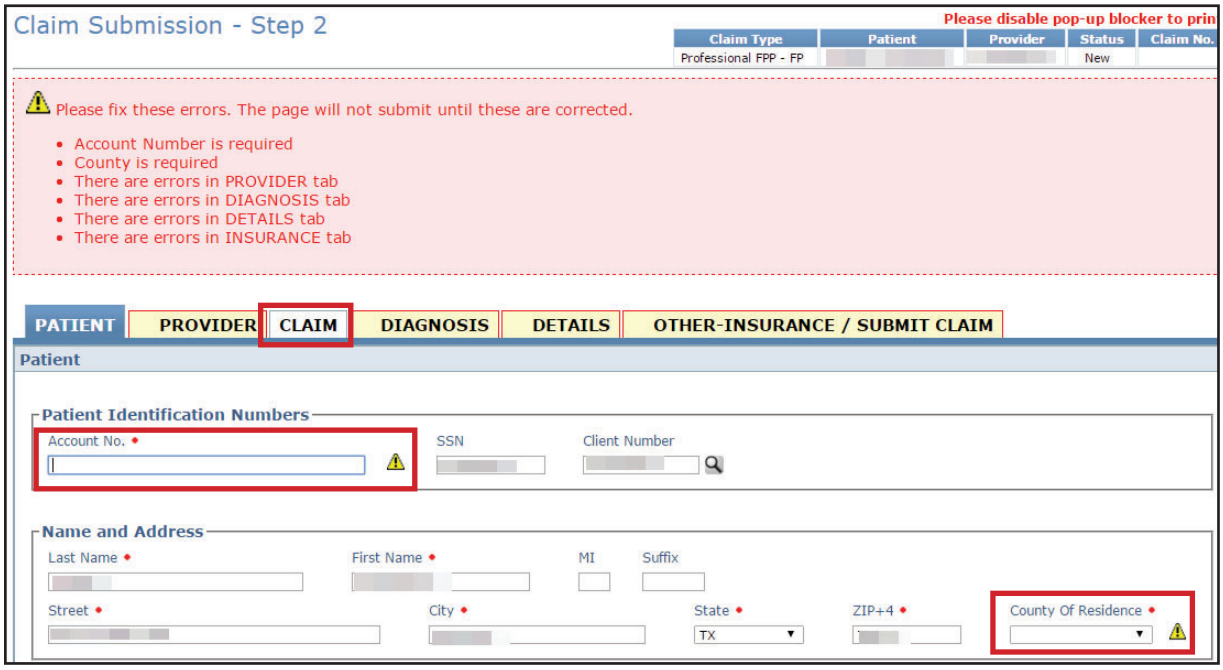
this manual.



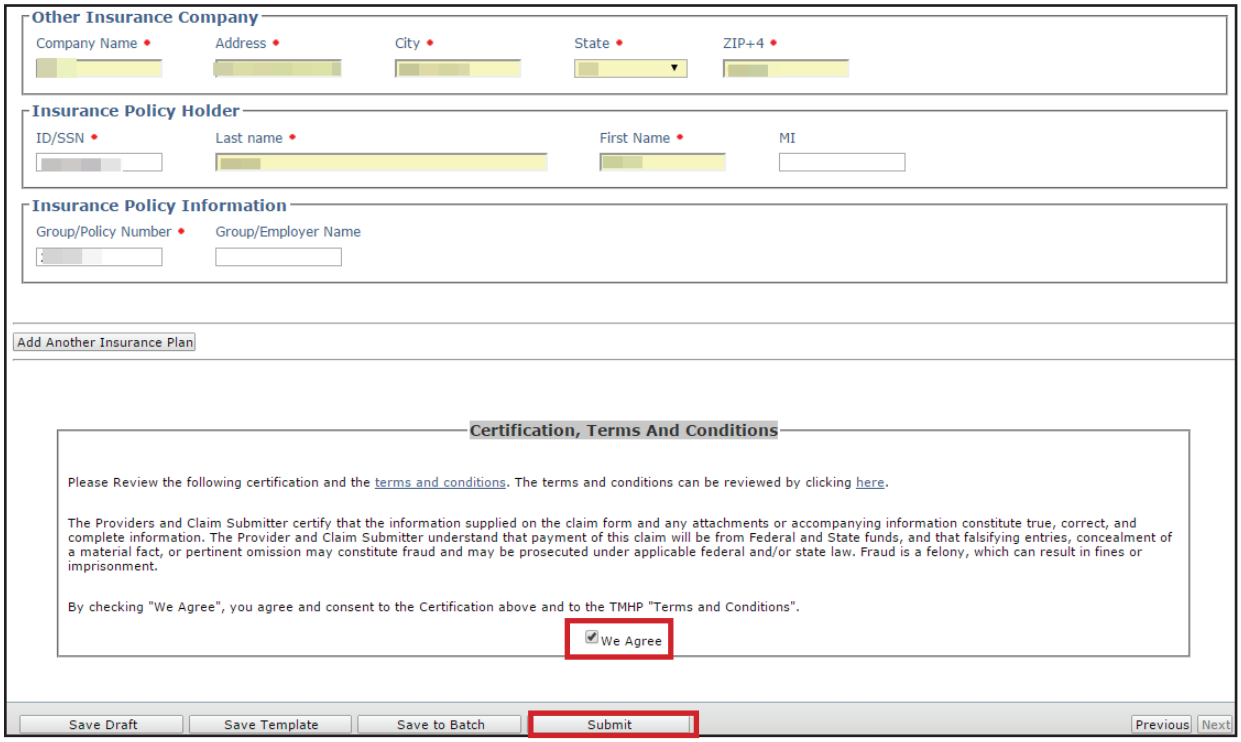
17) When the **Submit** button is clicked, the claim information will be automatically verified by TexMedConnect. If there is any missing or invalid information, an error message will display and indicate the type and location of the error.



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.

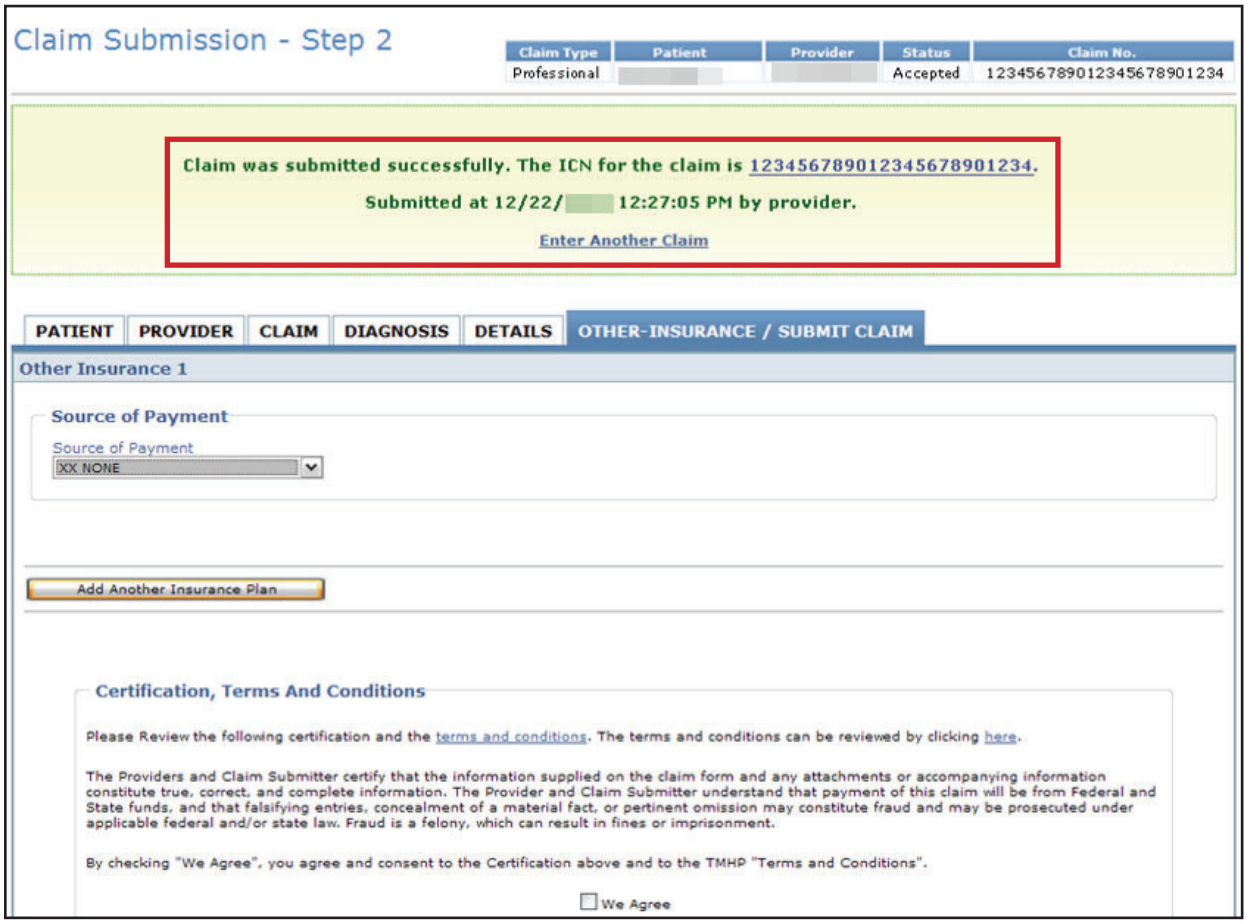


19) Once all errors have been corrected, return to the Other Insurance / Submit Claim tab, read the Terms and Conditions, and click the **We Agree** box. The claim can now be submitted. Click the **Submit** button.



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

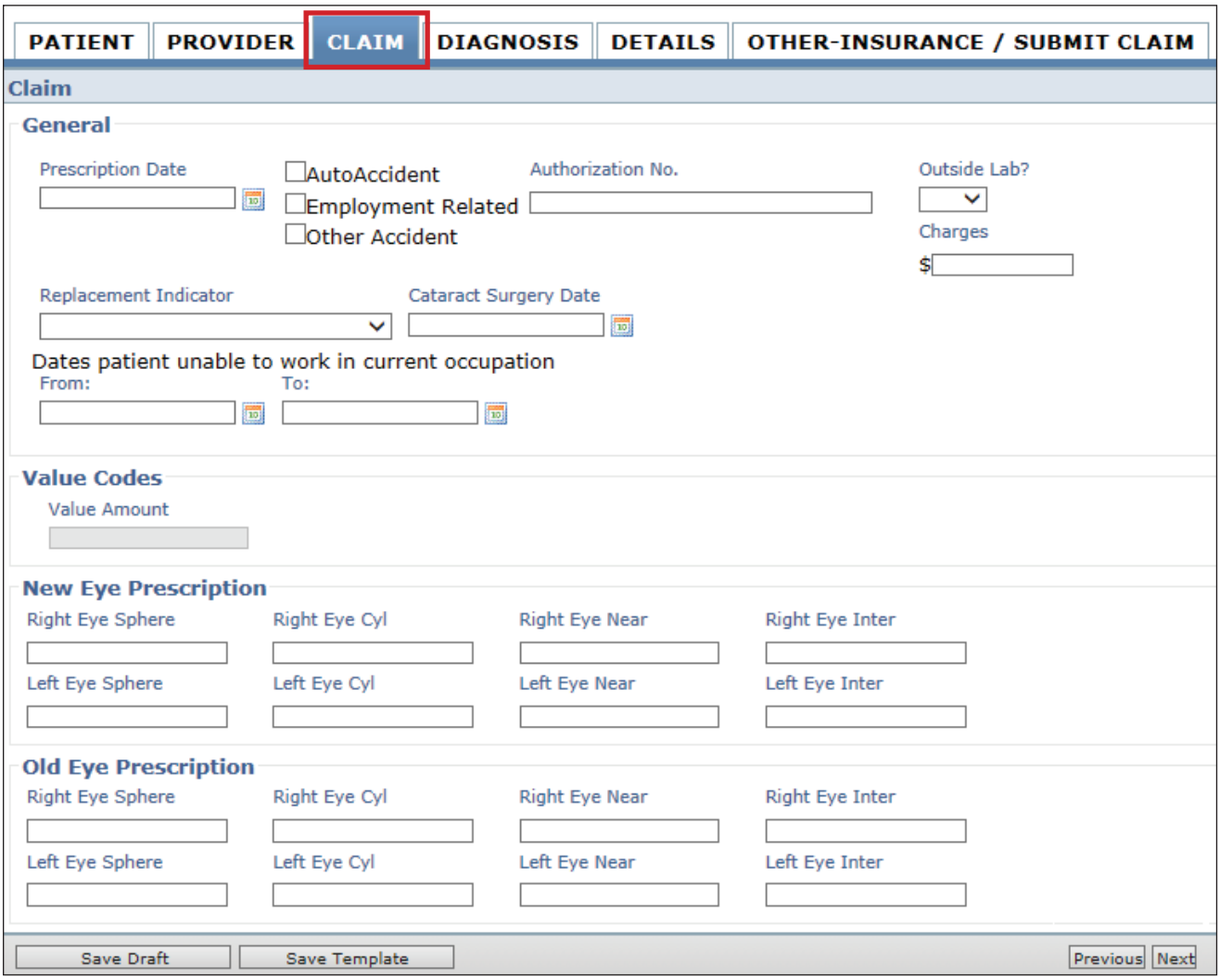
claim.


Claim Submission - Step 2
Claim Type
Patient
Provider
Status
Claim No.
Professional
Accepted
12345678901234567890 1234
Claim was submitted successfully. The ICN for the claim is 12345678901234567890 1234.
Submitted at 12/22/ 12:27:05 PM by provider.
Enter Another Claim
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

5.2.6 Vision Claim

To enter a vision claim, follow these steps:

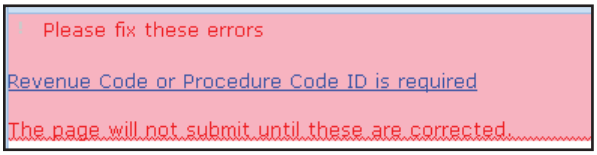
Claim Tab



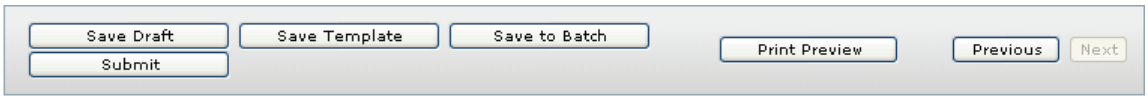
1) Enter vision-specific information into all required fields, which are indicated by a red dot.
2) Ensure the data entered meet field edit requirements:
   Alphanumeric – Authorization Number, Charges, New Rx for Right & Left Eye (Sphere, Cylinder, Near, Intermediate), Old Rx for Right & Left Eye (Sphere, 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:



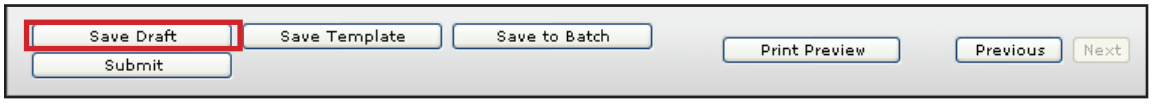
- **Save Draft** – Adds claim to the draft list for completion at a later time.
- **Save Template** – Adds claim to the template list for quicker claims creation in the future.
- **Save to Batch** – Adds claim to the pending claims list for batch submission.
- **Submit** – Submits one claim at a time.

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.**

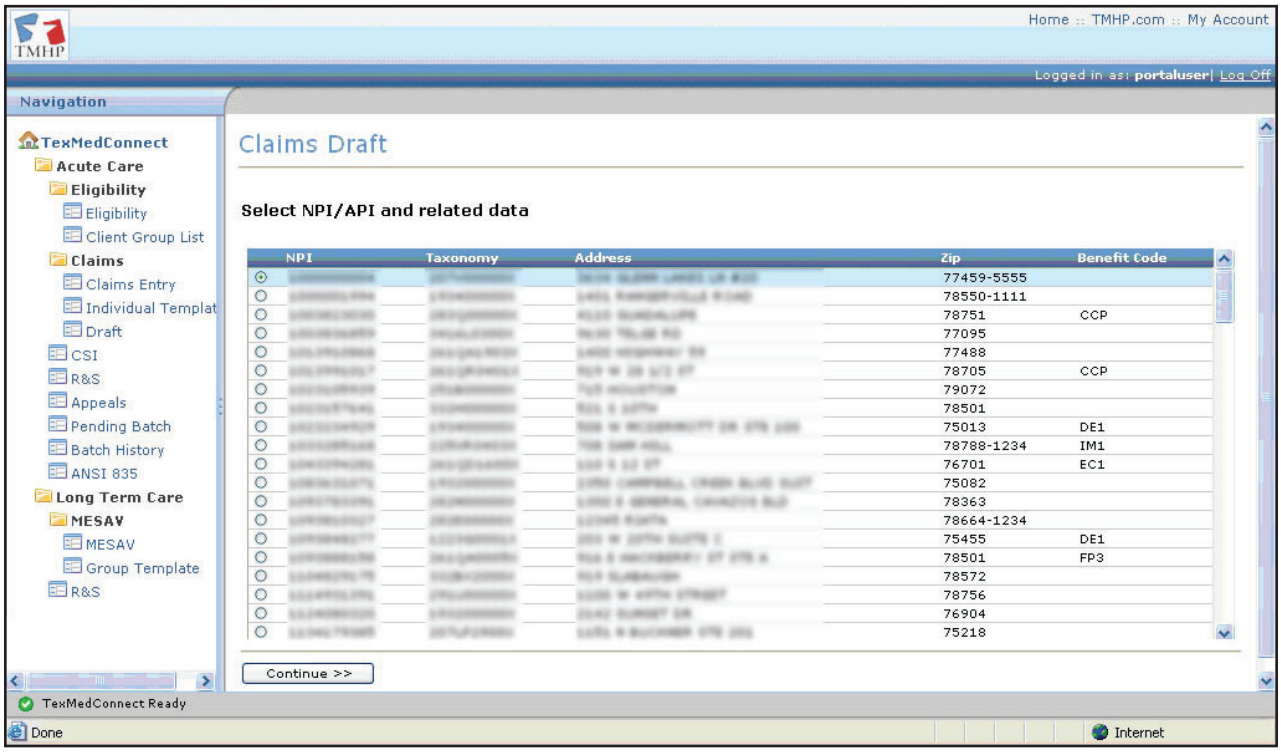
The claim is added to the Draft List screen for completion at a later time.

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.

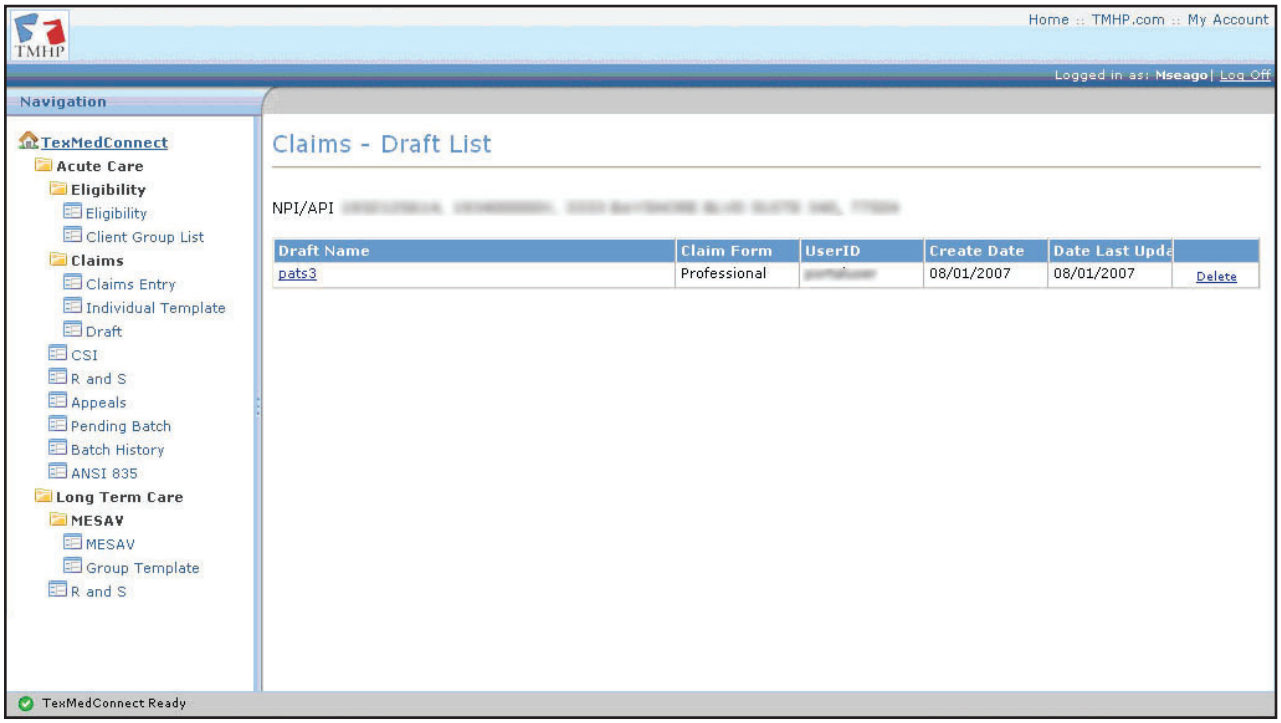
To view a list of all your draft claims, follow these steps:

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.

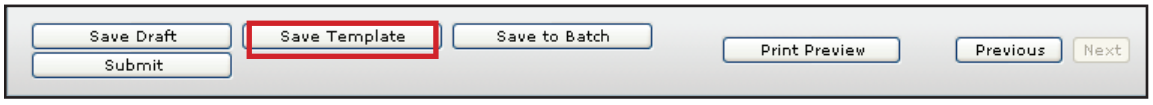
5) Click on a claim to view the details of the claim.

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:

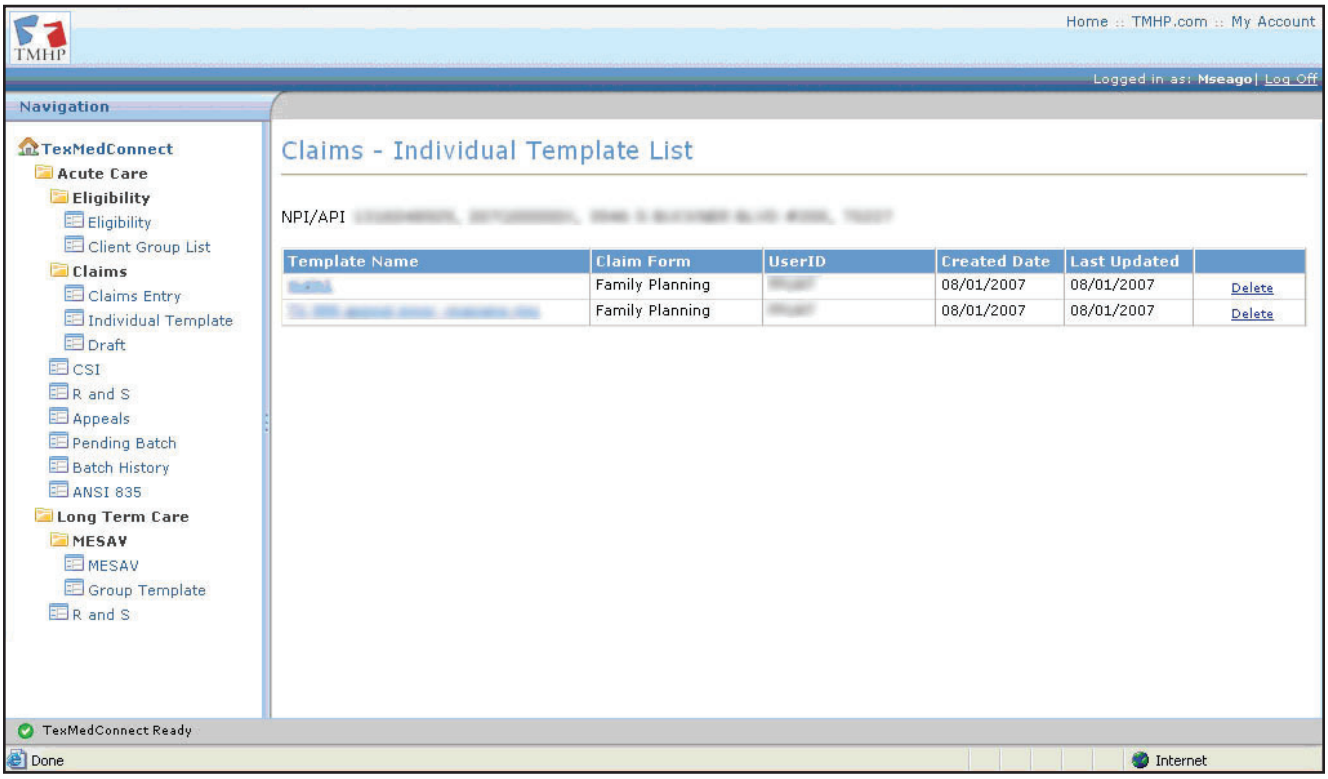
1) Click the **Save as Template** button



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.

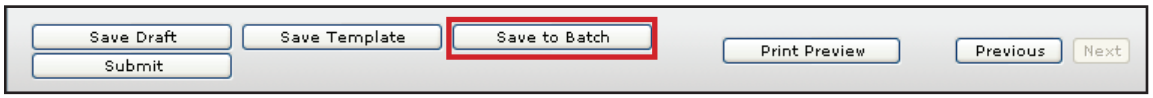


5.3.3 Saving To a Batch

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.

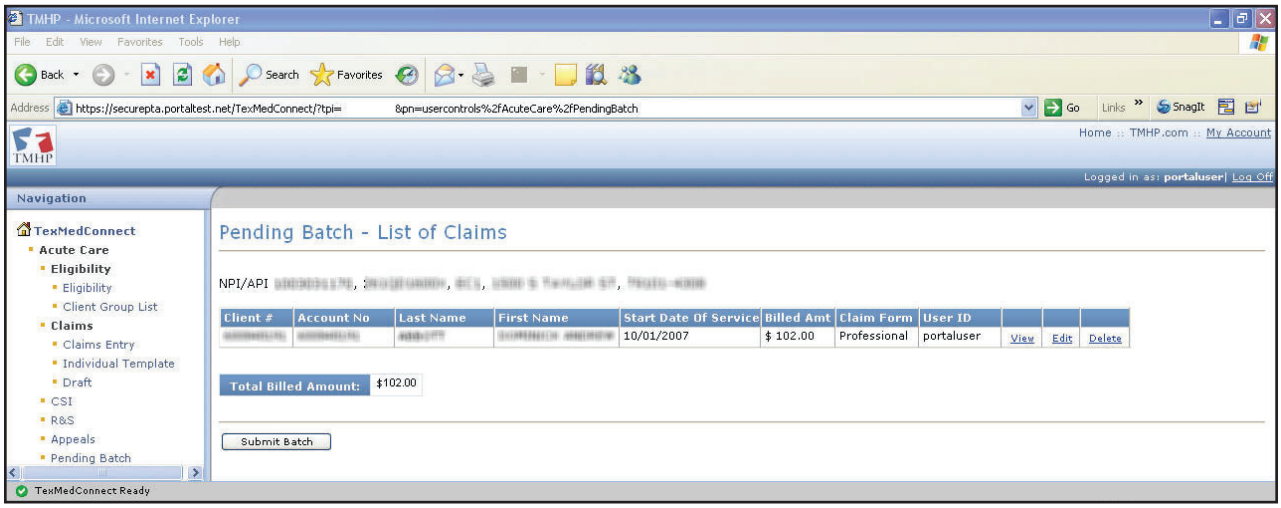
5.3.4 Submitting a Batch

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.*

To submit a batch, follow these steps:

1) Select **Pending Batch** from the left navigation bar
   The Pending Batch screen appears.



2) If there are more claims than can fit on one screen, click **Continue** at the bottom of the screen. To look at the listing on a previous page, use the internet browser back-arrow button.

3) Click **Submit Batch** on the last screen

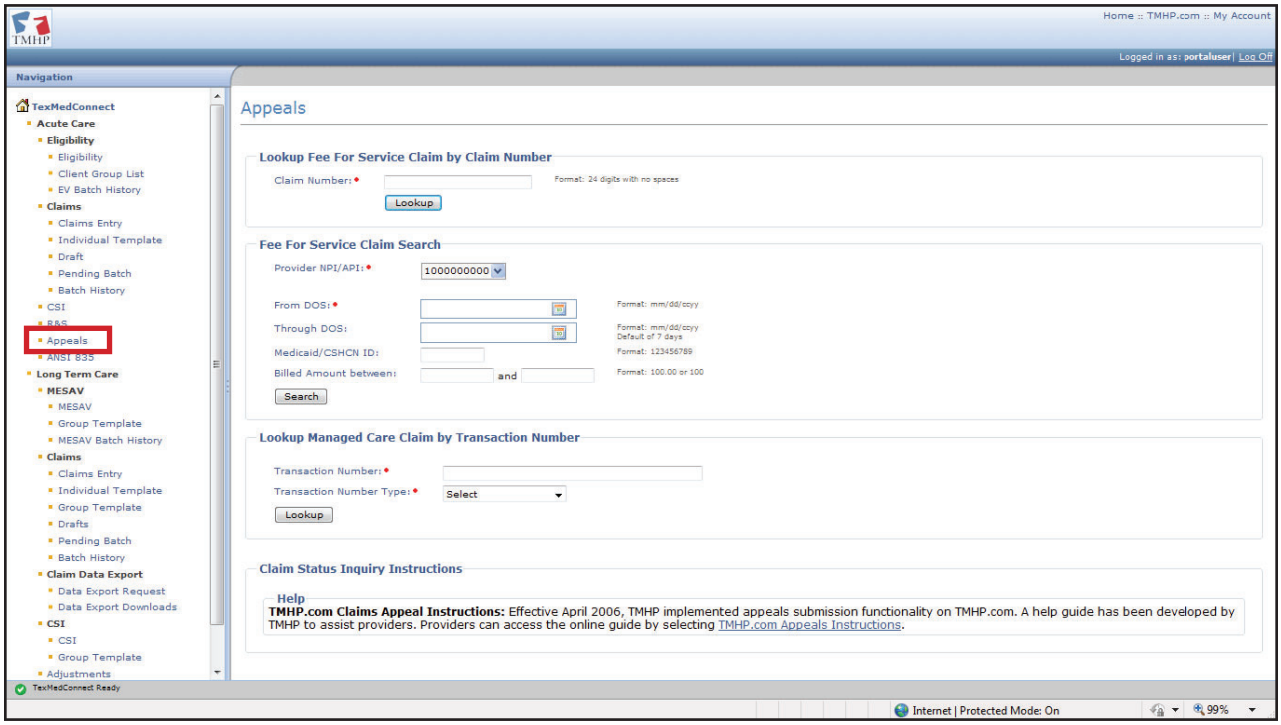
The system displays a confirmation screen when the batch is submitted.

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.

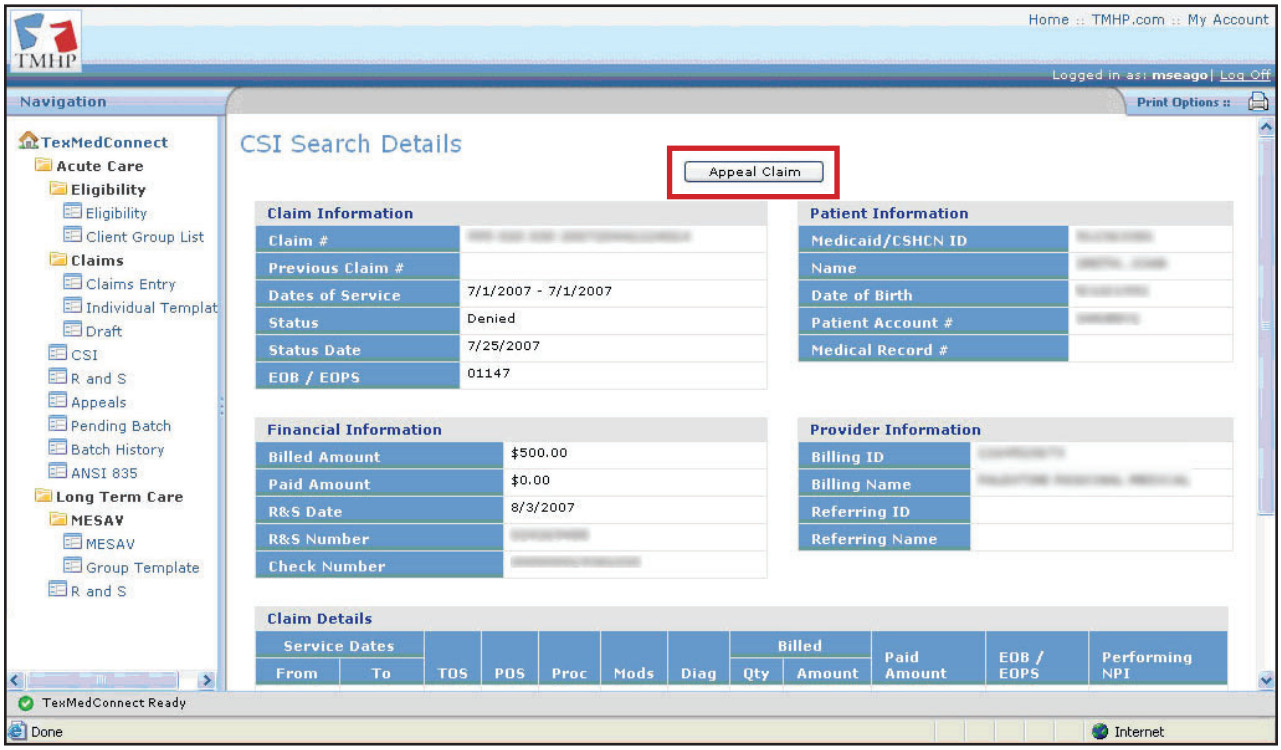
To appeal a claim, follow these steps:

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.

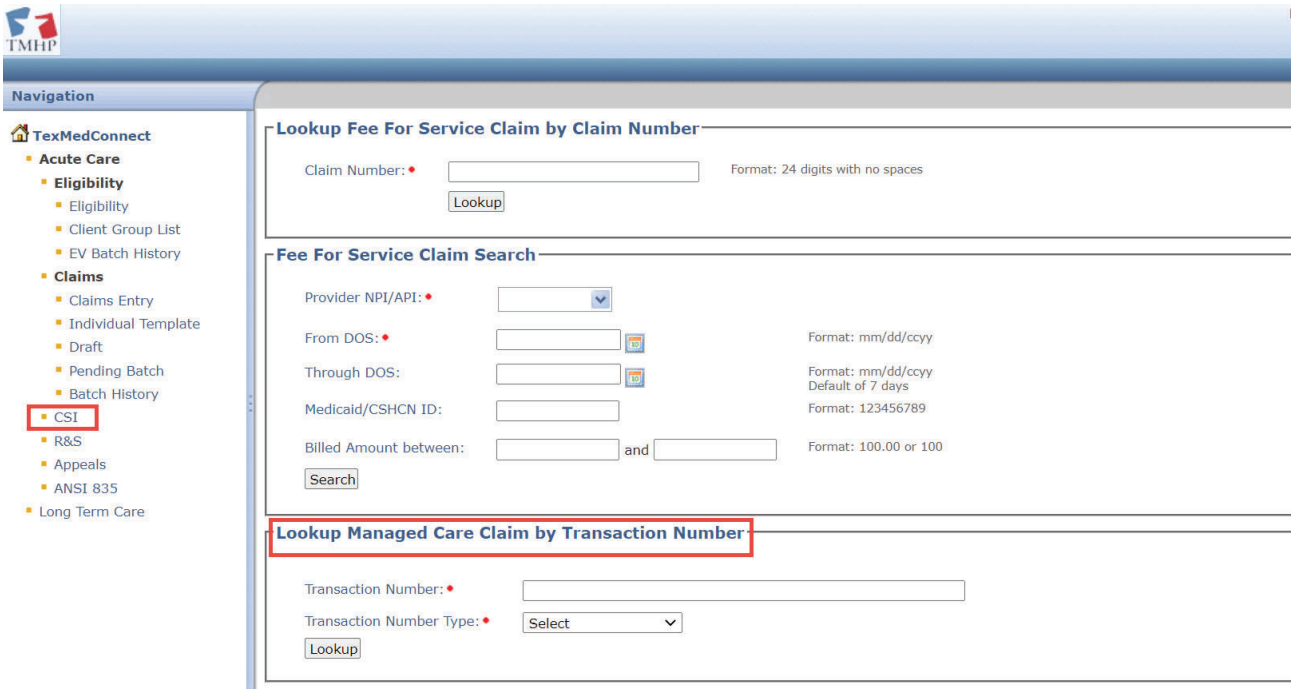
5.4.1 Other Pathways for Fee-for-Service Claims Appeals

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.



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

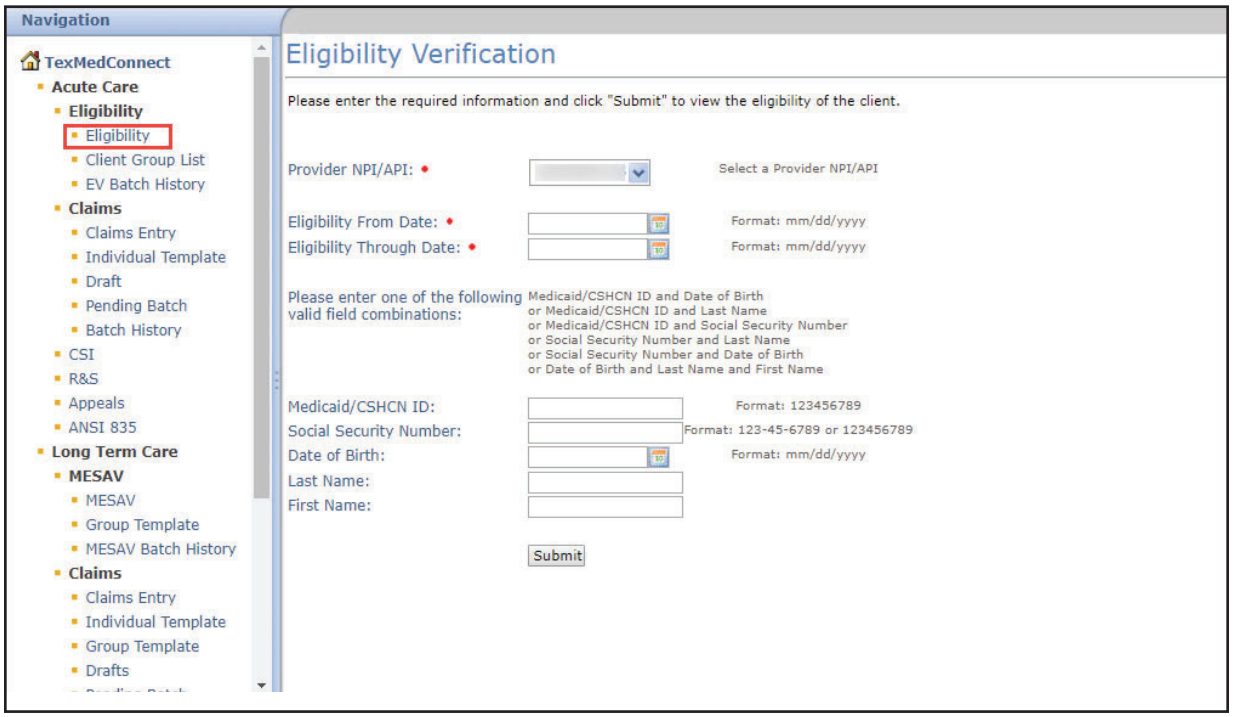
LTSS MCO providers should reference the *TexMedConnect User Guide for MCO LTSS Providers* for additional details about claim appeals and adjustments.

NOTE: *Your MCO may refer to Appeals as "Corrections," "Adjustments," or "Updates.*

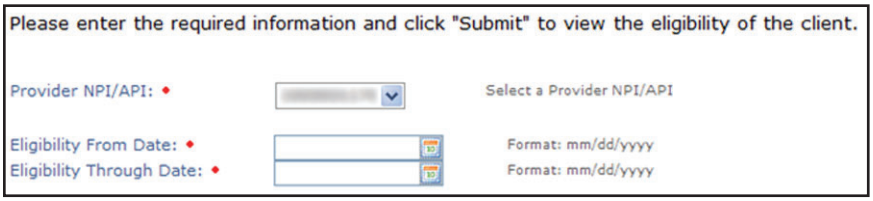
6.0 Verifying Client Eligibility

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

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

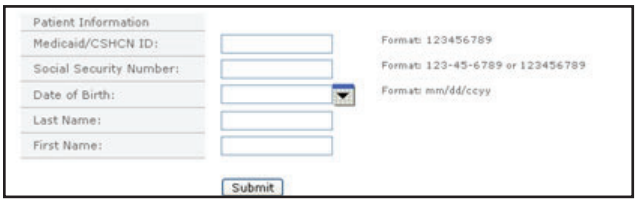


2) Enter the following required fields:
   - Provider NPI/API and related data
   - Eligibility Dates



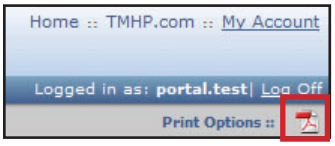
3) If necessary, narrow your search by entering additional information in any of the following combinations:

- 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



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.*

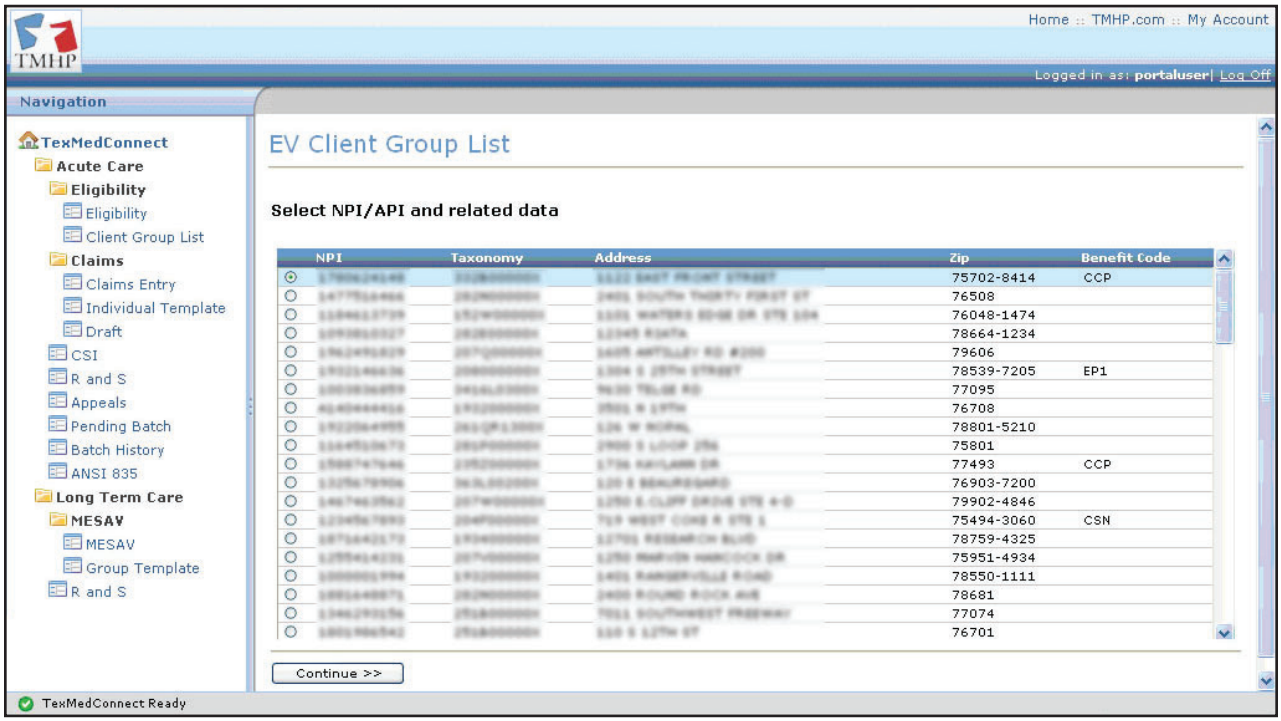
6.1 Client Group List

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.

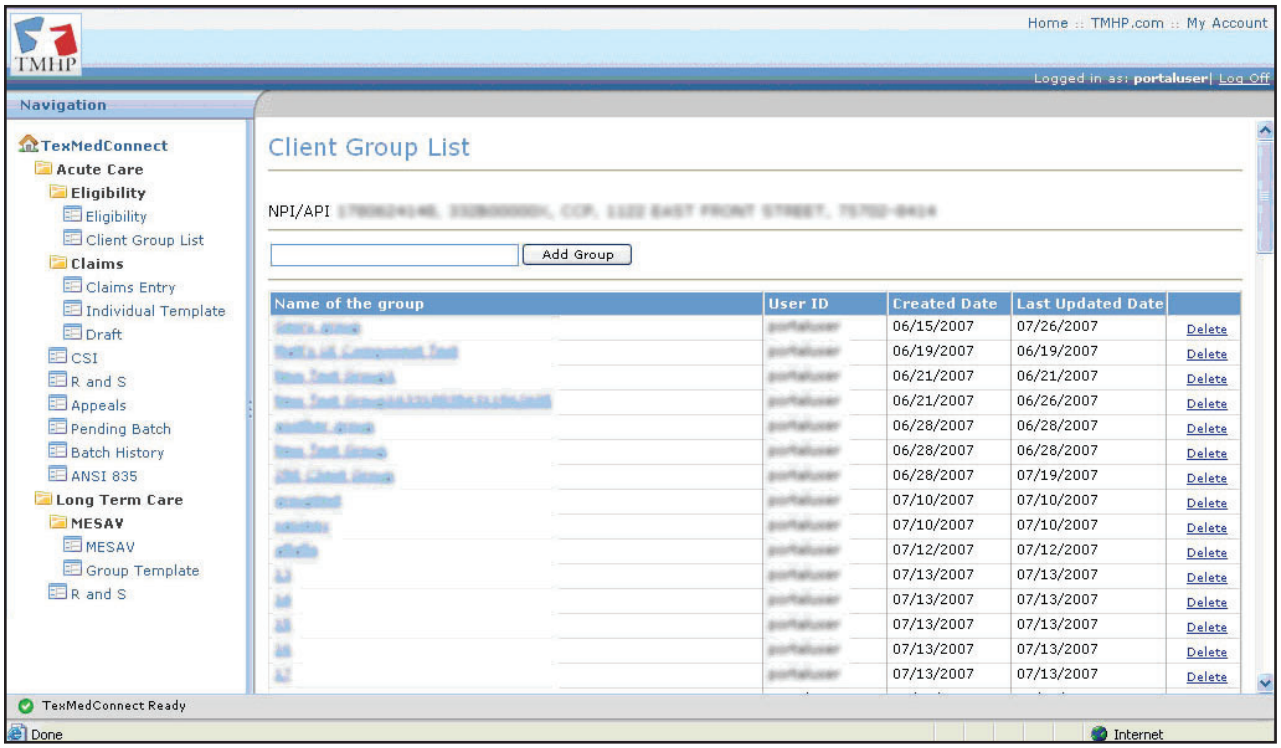
To verify eligibility through the Client Group list, follow these steps:

1) Select **Client Group List** from the left navigation panel. The Client Group List appears.

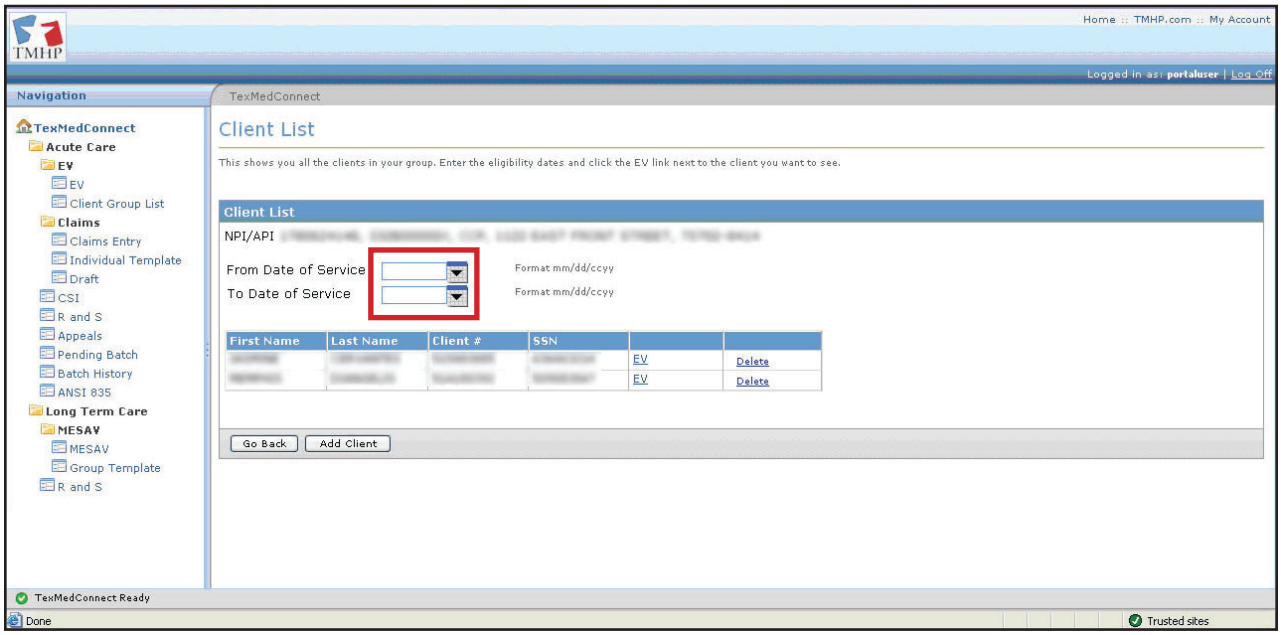
2) Select NPI/API and related data by checking the radio button.



3) Click **Continue.**
The Client Group List appears.

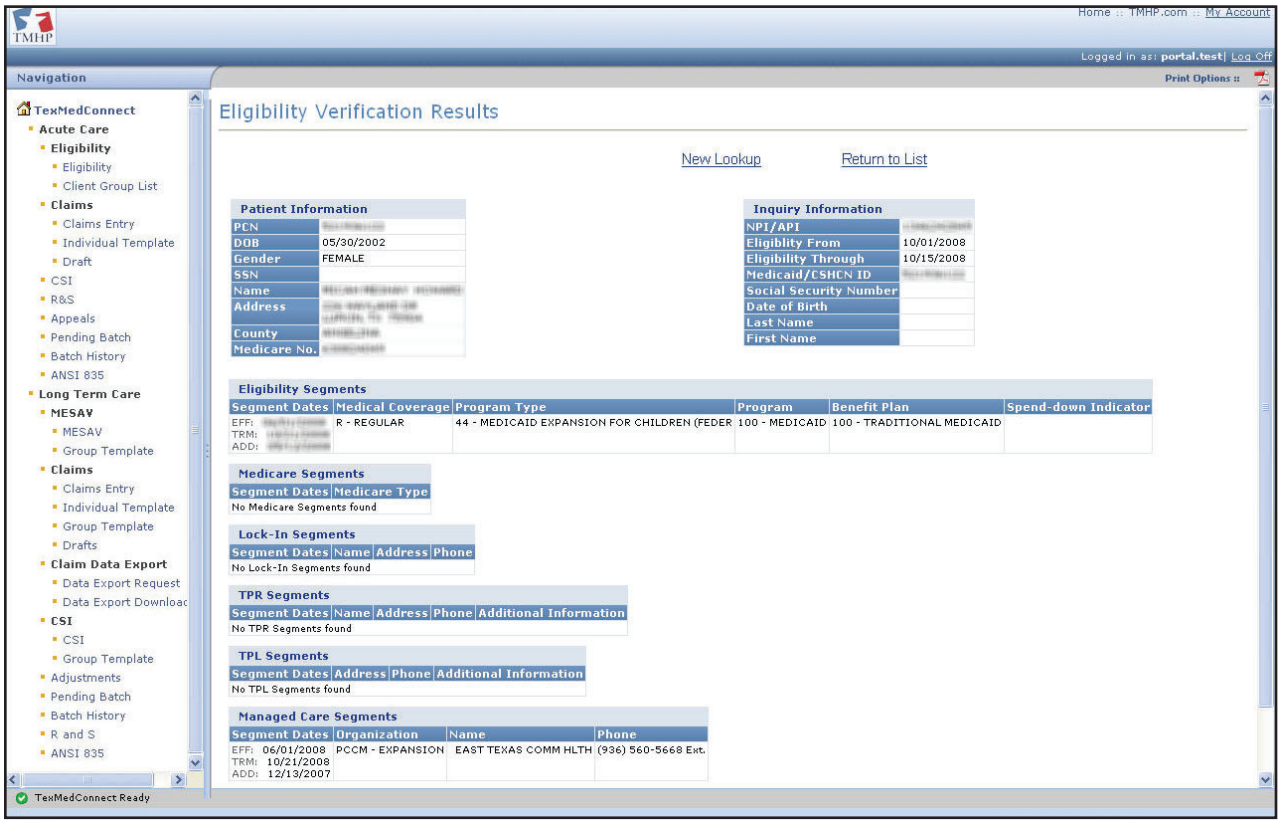


4) Click on the name of a client group. The client list for the client group appears.



5) Enter a date range in the From Date of Service and To Date of Service fields.

6) Click on **EV** on a client row to verify eligibility for that client.
The Client Eligibility screen appears.



7) 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:

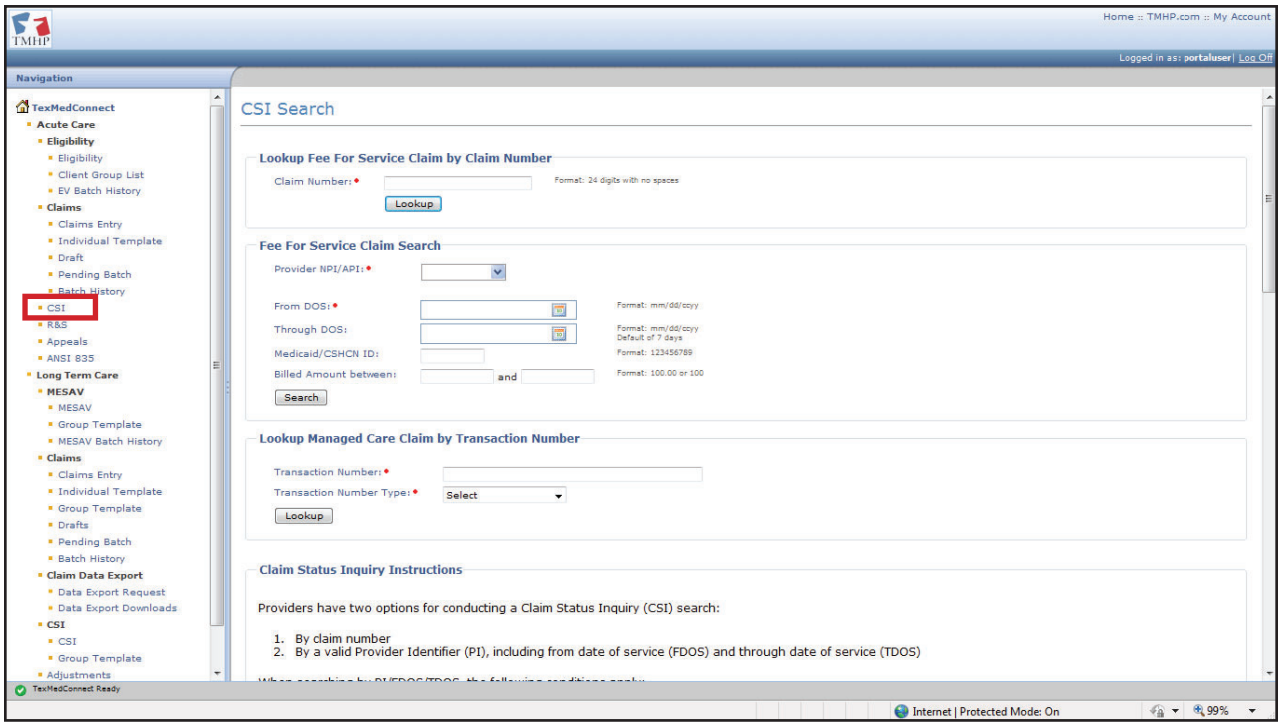
- By claim number.
- By a valid NPI/API and related data, including from date of service (FDOS) and through date of service (TDOS).

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.

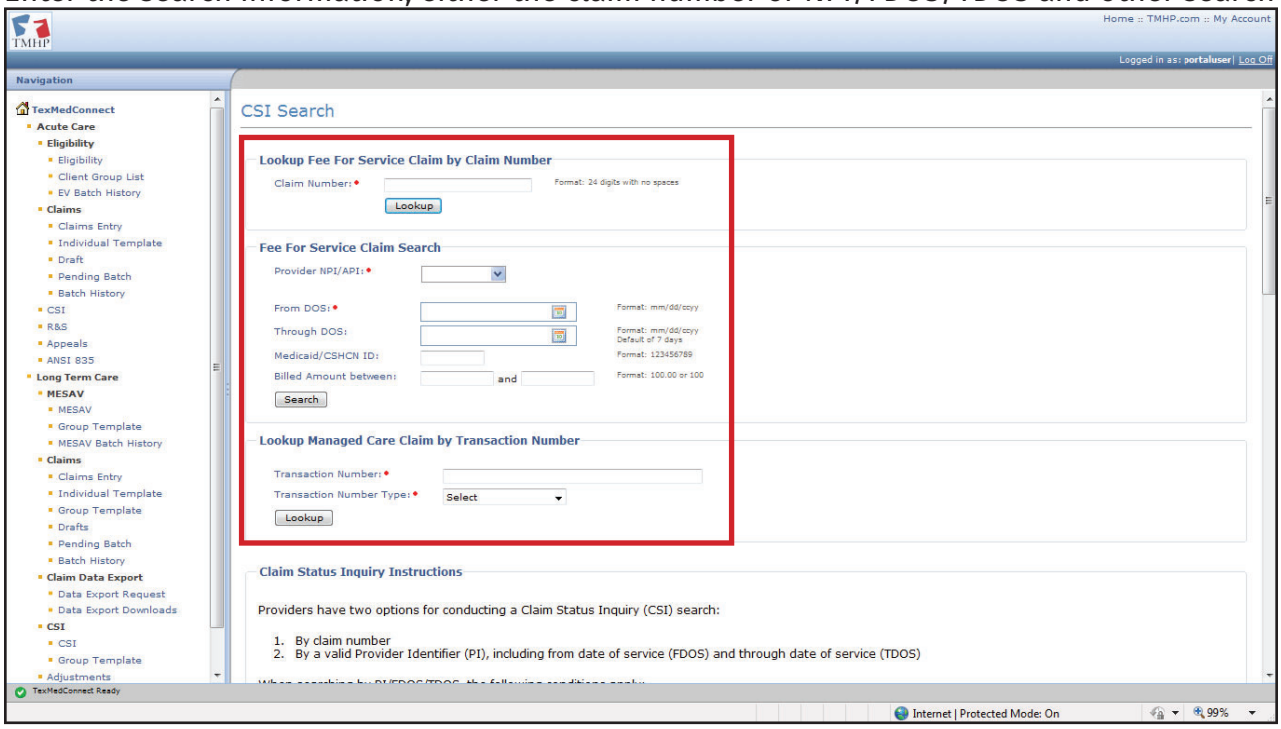
To perform a claim status inquiry, follow these steps:

1) From the navigation panel, select CSI.



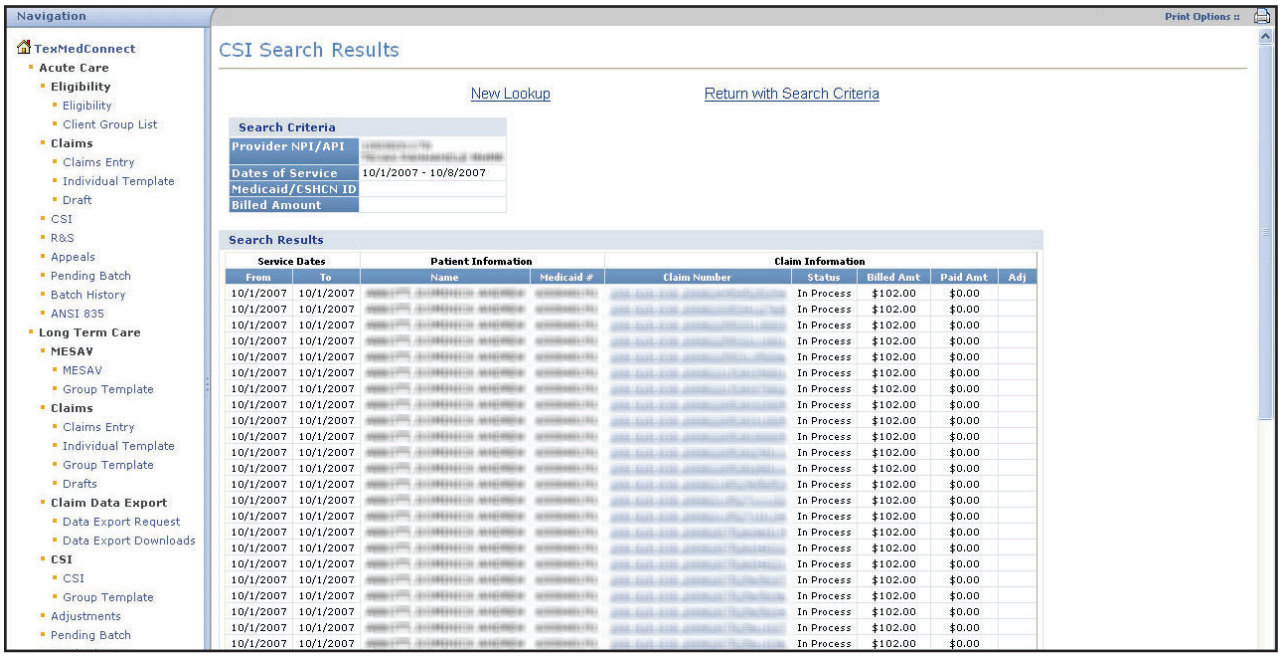
The search criteria screen opens.

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



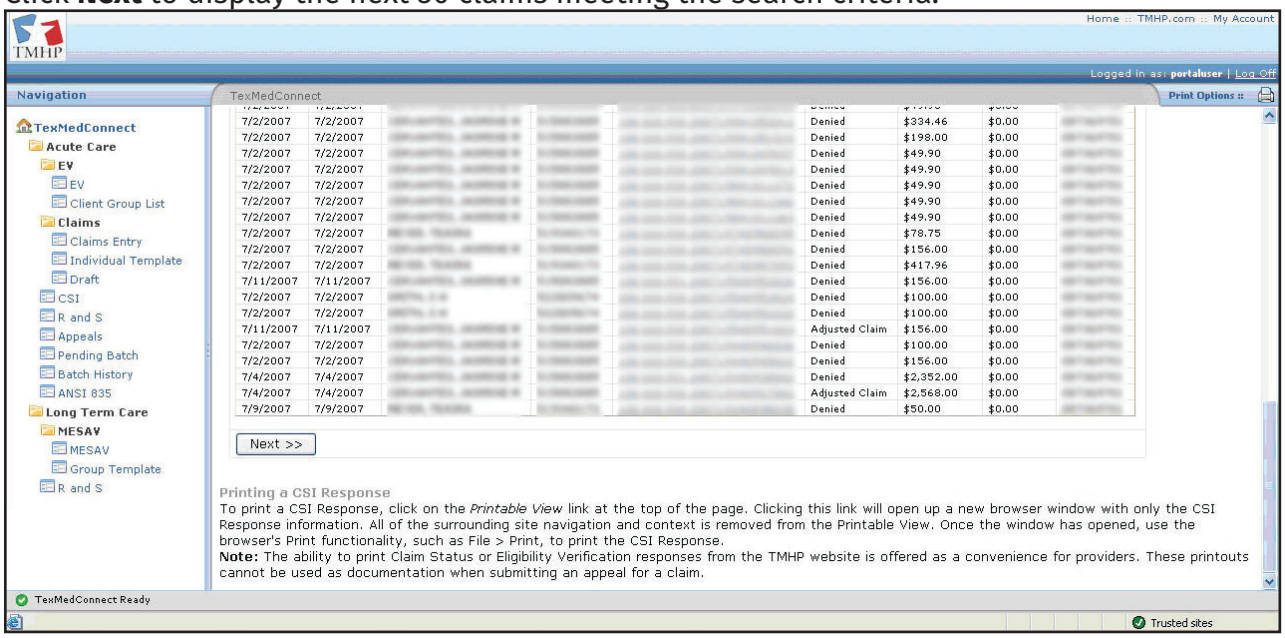
The Search Results screen appears. A maximum of 50 claims can be displayed in the Search Results screen.

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.



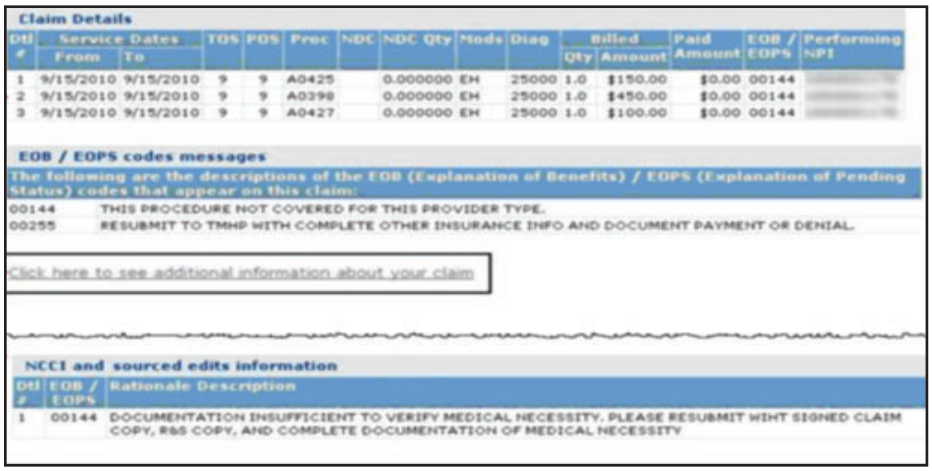
The claim information for the claim selected appears.

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.*

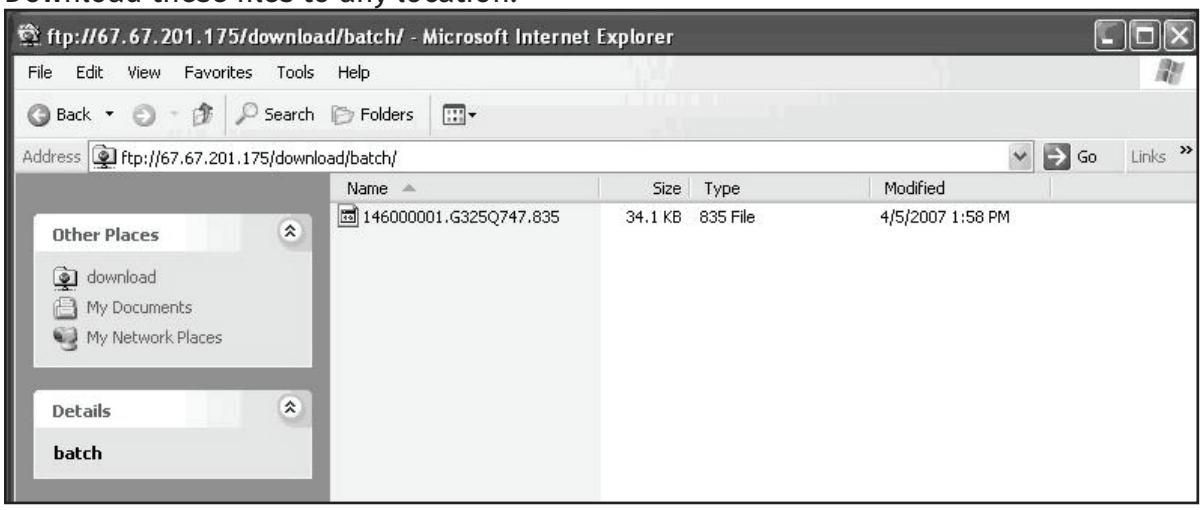
Additional information may become available on the CSI Search Details screen for certain claim denials. If additional information about the claim denials is available, a link that indicates "Click here to see additional information about your claim" will appear.

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.



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.

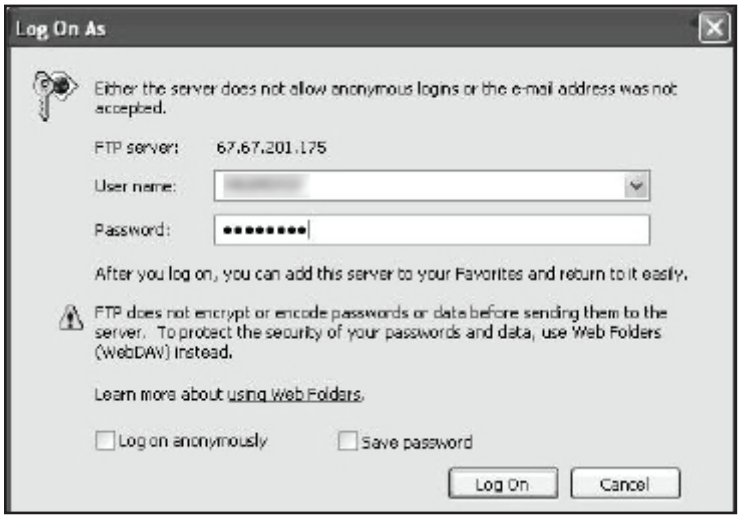
2) Click on the folder number to display the R&S Report

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.

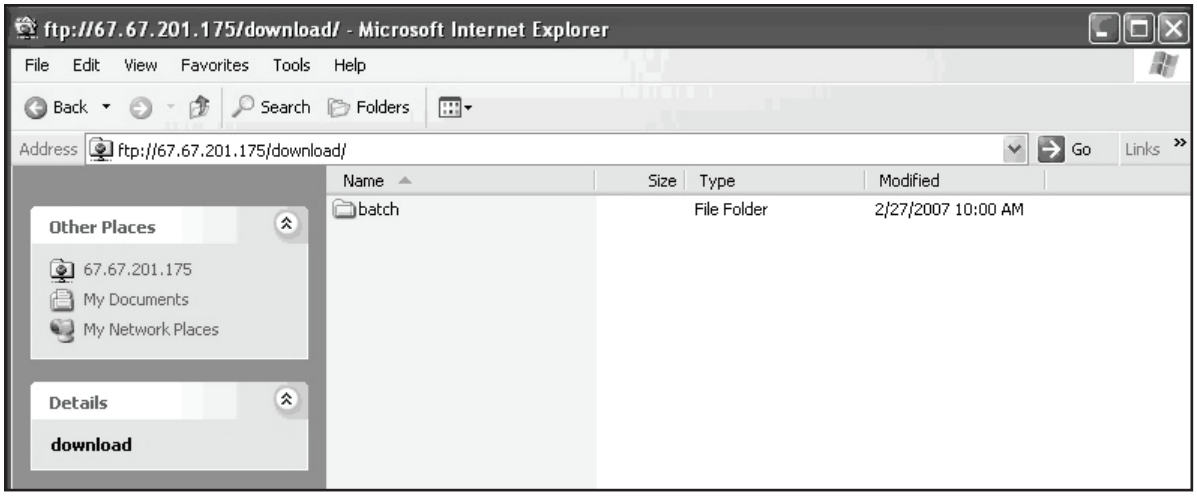
To download the ANSI 835 version of the R&S Report, follow these steps:

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



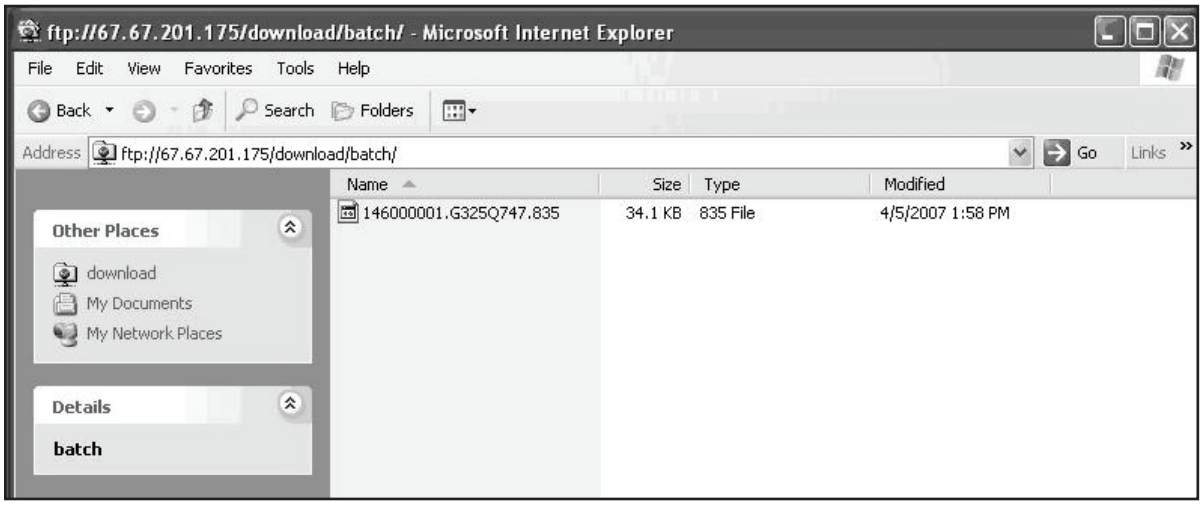
Note: *The Submitter ID can be found in TDHconnect under the Communications file menu by accessing System Settings.*

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.*