HCS and TxHmL Waiver Programs

Frequently Asked Questions

This document is produced by TMHP Training Services.
Content is current as of the time of publishing and is subject to change.
Providers should always refer to the TMHP website for current and authoritative information.

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

v2022_0809

Contents

Section 1: TexMedConnect and Electronic Data Interchange (EDI)

1.1 If I have already set up my Texas Medicaid & Healthcare Partnership (TMHP) secure portal account, does that mean I signed the EDI Agreement?

Setting up your TMHP secure portal account does not necessarily mean you have a signed EDI Agreement on file. To confirm you have an EDI Agreement on file, and for all other EDI-related questions, call the TMHP EDI Help Desk at 888-863-3638, Option 4.

1.2 I have three separate contracts numbers (two Home and Community-based Services [HCS] and one Texas Home Living [TxHmL]) in TexMedConnect, but only one is displaying.

If you do not see all of your contract numbers, you will need to link your TMHP secure portal username to the numbers that are not displaying. Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for steps on completing this action.

1.3 Is there any material outlining how to register for an EDI account?

The "HCS and TxHmL Programs: Getting Ready for Submitting Claims to TMHP for Payment" web article, located on the TMHP website, details steps for creating a new EDI account.

1.4 What clearinghouses does TMHP work with?

Providers can view the TMHP Approved Vendor List located on the EDI page of the TMHP website to see the clearinghouses TMHP works with. If a provider is using an existing vendor not on the approved list, the vendor will need to contact the TMHP EDI Help Desk at 888-863-3638, Option 4, to begin testing requirements.

1.5 If we already use TMHP for Electronic Visit Verification (EVV), does that mean we already have a completed EDI on file?

To check if you have an existing EDI agreement on file, contact the TMHP EDI Help Desk at 888-863-3638, Option 4.

1.6 What is TexMedConnect?

TexMedConnect is an online application that lets providers file claims, check claims status, confirm client eligibility, and more. There are two versions of TexMedConnect—Acute-Care and Long-Term Care. HCS and TxHmL providers will utilize the Long-Term Care version.

1.7 When I log into my TexMedConnect account, my only option is Acute Care and not Long-Term Care. What do I need to do?

For assistance with linking to a Long-Term Care account, reference Step 2A to link to the Long-Term Care Online Portal (LTCOP) and Step 2B to link to TexMedConnect (LTC) in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)*.

1.8 Will there be daily or weekly payments for EDI transactions separate from TexMedConnect transactions, or will transactions for both systems be added together for daily or weekly payments?

All claims for each provider number/contract number are combined into one voucher. TexMedConnect and EDI claims are not separated out for voucher creation or electronic funds transfer (EFT)/payment. After a voucher is paid (for the group of claims), TMHP does reconciliation to mark all the claims for that voucher as Paid (status "P"). Until then, the claim status will be Approved (status "A"). Providers can use the Remittance & Status (R&S) Reports or the Claims Status Inquiry (CSI) screen to confirm their claims status.

1.9 Will all the billing reports still be available in Portable Document Format (PDF), or will we be able to export the data to Excel®?

The Claims Data Export is in Excel® format, while all the other data reports within TexMedConnect are PDF.

1.10 If we use a clearinghouse, do we need to complete the EDI Agreement or is the clearinghouse responsible for it?

Providers are required to sign the EDI Agreement. You should work with your clearinghouse to get this done.

1.11 When I try to log into my TMHP secure portal account, I receive an error message stating, "Username must be different than your EDI submitted ID."

If you are unable to log into your account, you can request a password reset as outlined on page seven of the *Basic Tasks for Managing an Account on the TMHP Secure Provider Portal Manual*. Upon completion of the password reset, you will be able to log into your TMHP secure portal account.

1.12 Is the Submitter Identifier (ID) and Login ID the same?

For TMHP EDI File Transfer Protocol (FTP)/Virtual Private Network (VPN), the Submitter ID and Login ID are the same. Users who experience problems with their Submitter IDs or passwords can contact the EDI Help Desk by telephone at 888-863-3638, Option 4.

For TexMedConnect, the Login and Submitter ID are not the same. You can access TexMedConnect from the Long-Term Care home page of the TMHP website. To use TexMedConnect, you must already have an account on the TMHP website. If you do not have an account, you can set one up using the information provided in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)*.

1.13 What is the personal identification number (PIN) used for?

You will need to request a PIN if you are unable to answer the security questions to begin the process of creating a TMHP secure portal account. Follow the steps in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)*, or call the Help Desk at 888-863-3638, Option 4, for assistance.

1.14 Does the administrator create a TMHP Portal User ID for their staff members, or should staff members create their own accounts and somehow link it with the main administrator's account?

The administrator will create a secure portal account for each additional user. Each user will need their own login credentials. Follow the steps in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for further information on creating accounts.

1.15 Is there a location where we enter our Submitter ID in TMHP?

The only location to enter a Submitter ID within TMHP is in the Claims Data Export. This information can be found within the *Long-Term Care (LTC) User Guide for TexMedConnect*.

1.16 Is there a benefit to having a separate LTC Submitter ID for HCS and TxHmL?

The difference for having a separate LTC Submitter ID for HCS and TxHmL is the login credentials for TMHP EDI FTP/VPN, the receipt of the response files, and the 835 Report. The benefit is if you link all contract numbers to one Submitter ID, then you will receive only one 835 file.

1.17 Do I need multiple authorization PINs for all my billing staff?

Only one PIN is needed for creating the initial administrator account. The administrator will then create a secure portal account for each additional user. Each user will need their own login credentials. Follow the steps in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for further information on creating accounts.

1.18 Can we have access to both EDI and TexMedConnect?

Yes, you can use both EDI and TexMedConnect.

1.19 Are clearinghouses assigned a single Submitter ID for all providers using their platform, or is each provider assigned their own Submitter ID?

This depends on each vendor and their requirements.

1.20 What is a loop?

A loop and segment are the location where data can be entered. More information on EDI X12 claims submission can be found in the *837P Long Term Care Companion Guide*.

1.21 I was told by the EDI Help Desk that the Apple® default browser, Safari, is not compatible with TexMedConnect. Is this correct?

This is correct. You will need to download Internet Explorer 11 (preferred) or Google Chrome to your machine to access TexMedConnect.

1.22 If we are using a clearinghouse, do we only need to complete the EDI Agreement, but not testing?

If the clearinghouse you are planning to use is currently submitting with EDI to TMHP, you only need to submit a new agreement for each contract number and coordinate with the clearinghouse. No additional testing will be required.

1.23 Will we be able to pull reports for individual categories such as nursing, Personal Assistance Services/ Habilitation (PAS/HAB), Supervised Living (SL), or day habilitation?

TexMedConnect users utilizing CSI are limited to searches involving a single individual and for no longer than three months at a time.

1.24 When creating a TMHP account, do we choose the option to create a provider enrollment account, or select an option under the section for Creating an Account to Administer an Existing Texas Medicaid and Other State Healthcare Program Provider?

You will choose option "Create Account and link to a Long Term Care provider" to create an LTC TexMedConnect account. You will also choose option "Create Account and link to a Nursing Facility/ Waiver Program provider" to create a Nursing Facility (NF)/Waiver Program account. Follow the steps in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for further information on creating accounts.

1.25 Where do I submit my completed EDI Agreement?

The EDI Agreement can be mailed or uploaded using the information listed on page one of the agreement.

1.26 When I try to log into my TMHP portal account, it says I need to change my password, but I don't know what my current password is or how to get it.

If you are unable to log into your account, you can request a password reset as outlined on page seven of the *Basic Tasks for Managing an Account on the TMHP Secure Provider Portal Manual*. Upon completion of the password reset, you will be able to log into your TMHP secure portal account.

1.27 Do we link the National Provider Identifier (NPI), the contract/provider number, or both to our TexMedConnect account?

You can link both your contracts and associated NPIs to TexMedConnect.

1.28 Does the account number on the Client tab on TexMedConnect need to be entered manually each time we enter claims?

Yes, the Patient Account Number is a number that the provider uses to identify the individual internally. When manually submitting a new claim entry from the beginning, it will require the provider to enter the Patient Account Number each time. The provider can choose to save the Patient Account Number to an individual template to avoid having to manually enter it.

1.29 Is there training material available to learn how to bill a service through TexMedConnect?

Yes, you may refer to the *Long-Term Care (LTC) User Guide for TexMedConnect*, TexMedConnect for Long-Term Care (LTC) Providers CBT, HCS and TxHmL TexMedConnect Claims Submission Webinar, and other trainings on TMHP's Learning Management System (LMS).

1.30 How can I check the status of a submitted EDI Agreement?

Contact the EDI Help Desk at 800-925-9126, Option 4, and let the EDI agent know you want to check the status of your EDI Agreement. You must provide the agent with your contract number(s). The EDI agent can validate receipt of the agreement and inform you of the pending time frame for completion.

Note: *It can take up to 30 days to process an EDI Agreement once it is submitted.*

1.31 I have a TMHP account that I use for a different program (e.g., Community First Choice [CFC], Intermediate Care Facilities [ICF], etc.,). Do I need to setup another account to handle things for HCS?

Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for steps on setting up your accounts and linking multiple accounts and account types.

1.32 After clicking claims submission on TexMedConnect, I received a red message stating that I am not permitted to submit a claim. Will this message disappear on May 2, 2022?

Yes, for HCS and TxHmL programs you will have full account access on May 2, 2022. Certain functions are currently unavailable to deter premature claim submission, and the message will disappear once full functionality is available.

1.33 Where can I check a client's Medicaid status, and can I do it prior to the ineligibility status?

You can view a client's Medicaid Eligibility (ME) at any time through your TexMedConnect account by going to Medicaid Eligibility and Service Authorization Verification (MESAV). Reference the *Long-Term Care (LTC) User Guide for TexMedConnect* for details about MESAV ME.

1.34 If using a clearinghouse to submit claims, are authorization reference numbers required?

TMHP does not require authorization reference numbers. There are state-assigned referral numbers that are used and can be found in the individual's MESAV on TexMedConnect.

1.35 Can we create billing templates before May 2, 2022?

No, billing templates cannot be created until May 2, 2022.

1.36 If I currently have a TMHP portal account, do I need to request additional functions, or will functions be automatically available beginning May 2, 2022?

If you have already set up access for your HCS or TxHmL provider numbers for forms and billing, then the new functionality will automatically be available May 2, 2022. If you have not done this, reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* to ensure you have correctly setup your claims and forms accounts.

1.37 How can I change the PIN for my account to be able to enroll all my contracts on the TMHP portal?

If you are the account administrator, contact the TMHP EDI Help Desk at 888-863-3638, Option 4, for assistance.

1.38 How do I set up a TexMedConnect account if I already have a TMHP portal account?

Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for steps on creating a TexMedConnect account.

1.39 Do HCS and TxHmL program providers that enter data in TMHP's system without using a clearinghouse have to submit an EDI Agreement?

If you are a program provider billing claims through TexMedConnect and not through a clearinghouse, TMHP recommends you complete the EDI Agreement to ensure you have access to 835 Electronic Remittance and Status (ER&S) data that is older than 90 days.

1.40 What name must be entered for the performing provider on TexMedConnect? May the biller's name be used?

The performing provider is the program provider that provides services to the client. It is possible that the billing provider and the performing provider are the same.

1.41 What information will prepopulate on TexMedConnect after the migration to TMHP? If not all client and program provider information is prepopulated, will TMHP give the program provider time prior to May 2, 2022, to create individual templates without filing a claim?

If the claim is entered in TexMedConnect using the member's Medicaid number, most of the member's information will prepopulate. The same occurs with program provider information. Program providers must verify fields with red dots (indicating required fields) in each section tab to make sure information is filled in correctly or to add information, if needed.

1.42 When is the line item control number (LICN) field required?

Refer to the Long-Term Care Bill Code Crosswalks page, located on the Texas Health and Human Services Commission (HHSC) website, for guidance on when the LICN field must be used and which parts of the LICN are required. Generally, the LICN field will be used when the claim is related to EVV and when a staff ID is required.

1.43 If I decide to use TexMedConnect, do I need to submit a completed EDI agreement?

We encourage you to complete the EDI Agreement so that you will have access to the EDI 835 ER&S Report. The 835 is an X12 transaction that will contain remittance advice information. Refer to the *835 Long Term Care Companion Guide* on the TMHP website for additional information and formatting of the 835 ER&S Report.

1.44 What is the difference between billing in EDI and TexMedConnect?

EDI uses standard X12 837 transactions for billing that are generally used by clearinghouses, software vendors, or third-party billing services. For more information on these transactions, visit the EDI web page located on the TMHP website. Billing in TexMedConnect is done through a free, web-based interface that is supported by TMHP.

1.45 How will the LICN field work in TexMedConnect?

TMHP will allow claims to be submitted according to HHSC billing guidelines, where the individual who provided the service delivery must be identified using the LICN field. These services are identified in the HHSC LTC Bill Code Crosswalk as either requiring a Staff ID, a Texas EVV Attendant ID, or, in the case of Nursing and Transportation Services, a label indicating the accumulated units.

Refer to the HHSC LTC Bill Code Crosswalk for guidance on when the LICN field must be used and which segments of the LICN field are required. Proper use of the LICN field will prevent claim mismatches, denials, or rejections.

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

- Positions 1-4 are in military-time format, are always required, and represent the claim sequence number.
  - Positions 1-2 will range from 00-23.
  - Positions 3-4 will range from 00-59.
  - Format edits apply to certain table-driven SGs and service codes.
  - The claim sequence number must be unique when there are multiple claim details for the same service on the same day.
- Positions 5-20 are for either the Texas EVV Attendant ID, Dummy ID, or Staff ID.
  - For billing an EVV service, use the Texas EVV Attendant ID. EVV visit units may be submitted rolled up by the NPI per existing functionality.
    - For CFC PAS/HAB claims, you must enter the Texas EVV Attendant ID from the visit displayed in the EVV system. If characters not matching the Texas EVV Attendant ID are entered on an EVV Claim, it will be denied.
    - The Texas EVV Attendant ID is not required by HCS and TxHmL programs for in-home respite and in-home day habilitation. Submit information in Positions 1-4 as instructed above in the LICN field to avoid receiving an EVV04 claim mismatch.
    - If positions 5-20 are not used, then the NPI or atypical provider identifier (API) will continue to be used for EVV claim matching. Refer to *HCS and TxHmL Best Practices to Avoid EVV Claim Mismatches* for more information.
  - For billing Nursing and Transportation Services, use one of the following Dummy IDs:
    - ACCUM.NUR
    - ACCUM.NUL
    - ACCUM.NURS
    - ACCUM.NULS
    - ACCUM.TR
  - For billing non-accumulated services, use the Staff ID.
    - “LastName,FirstName” (no spaces)

- Positions 21-30 are for the internal claim ID.
  - The internal claim ID will be used to reconcile the 837 claim to 835 Remittance.

1.46 Are diagnosis codes prepopulated in TexMedConnect?

No, diagnosis codes do not prepopulate in TexMedConnect, but this function could be considered in future enhancements.

1.47 How do we know whether to choose LOC1 or LOC8 in TexMedConnect?

The appropriate level of care (LOC) can be found on the MESAV and is based on an approved 8578 Intellectual Disability (ID)/Related Condition (RC) Assessment. This approved LOC helps providers choose the appropriate bill code and modifier for that service on the HHSC LTC Bill Code Crosswalk, but providers do not select the level itself in TexMedConnect. The LOC is generated based on the MESAV record. If the incorrect combination of bill code and modifier is used, the system may deny the claim.

1.48 Many individuals who receive TxHmL and HCS services have multiple diagnosis codes, but it seems that the field in TexMedConnect allows only one code. Is there a specific diagnosis code that is required, or must all diagnosis codes for the individual be entered?

You must use the Primary Diagnosis Code, found on the individual's 8578 ID/RC Assessment, for claims when the individual has multiple diagnosis codes.

1.49 I printed MESAVs for our HCS clients, but some MESAVs do not appear to be fully set up. Who can I contact to resolve this issue?

The start date of these new systems for HCS and TxHmL is May 2, 2022. During the data migration, it is possible that you will see partial or removed data before May 2. If you find incomplete client data on MESAVs after May 2, call the TMHP LTC Help Desk at 800-626-4117 (select option 1, then option 7).

1.50 Are HCS and TxHmL providers able to see TexMedConnect screens now, or will screen access only be available to providers starting May 2, 2022?

After creating user IDs with permissions set up for TexMedConnect and the LTCOP, HCS and TxHmL providers can log into TexMedConnect and LTCOP screens. However, providers must not enter data or use any buttons on forms or claims before May 2, 2022.

1.51 TexMedConnect is showing our office address instead of the client's address. I checked the Client Assignment and Registration (CARE) system, and all of the addresses are correct there. How can we correct this issue?

Client addresses in TexMedConnect are pulled from the Texas Integrated Eligibility Redesign System (TIERS). Update the client's address in TIERS to resolve the issue.

1.52 Is there a report in TexMedConnect to review the temporary discharge dates submitted for an individual who receives HCS or TxHmL services?

TMHP refers to "temporary discharge" as a Client Hold. Client holds may be viewed on MESAV, and each client hold record has a begin date and end date. The begin date is the "temporary discharge" start date.

1.53 What should I do if our agency already uses TexMedConnect?

If you currently use TexMedConnect, be sure to link your contract numbers or set up accounts for SG 21 for HCS and SG 22 for TxHmL to submit claims to TMHP. Additionally, you must submit a completed EDI Agreement to ensure you have access to the 835 ER&S Report.

Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for more information.

1.54 What environment is used to submit an X12 batch submission for testing?

Refer to the *TMHP EDI Connectivity Guide* for connectivity information for each environment.

1.55 If all we have is the EDI extract, how can we pull our data every week without adding another position?

Providers can submit claims daily using EDI or TexMedConnect. Both of these systems will provide initial claim acceptance or rejection information. Additionally, providers may receive R&S Reports and/or 835 ER&S Reports which contain additional claim status and adjudication information.

R&S Reports are available through TexMedConnect and 835 ER&S Reports are available through EDI. The reports will also list other claims finalized during the reporting period, pending claims from the previous reporting period, system adjustments, and recoupment claims. Providers are also able to submit a CSI on TexMedConnect to obtain claim status information.

1.56 All our crosswalks to the General Ledger (GL) have to be remapped with the new data format, and we are unsure of how to start before the go-live date. Is there a way to preview this information?

Information can be found on the 835 ER&S Report or R&S Report found in TexMedConnect, and by using the reporting dashboard after go-live.

1.57 I only signed up for TexMedConnect, but understand that I can sign and submit an EDI Agreement to have access to certain billing reports. If I have multiple contracts, do I need to sign and submit an EDI Agreement for each contract or do I only need one?

For LTC providers to bill and/or receive their 835s, 837s, 270/271s, or 276/277s using a clearinghouse, third-party vendor, or software company, TMHP must receive a completed EDI Agreement to generate a submitter ID. If you need to add additional contract numbers to the same submitter ID or EDI Agreement, you should complete and submit a Submitter ID Linking Form located on the TMHP website.

1.58 Will batch reporting be available, or do we have to use a third-party vendor and use EDI?

If you choose to use TexMedConnect, TMHP's free web application, you may submit claims and view batches using the batch history.

If you choose to use EDI, you will receive an initial response file for your claims which will indicate whether a claim was initially accepted or rejected. You must work with a third-party billing agency, a clearing house, or use third-party software to create and process X12 transactions.

1.59 Will a straight billing person be able to run basic reports, or will the administrator be the only one to run reports?

The CSI function is available to any users who can access TexMedConnect, while the Claims Data Export function is only available to administrators with a submitter ID.

1.60 What information needs to be entered on the "Other Insurance" tab on TexMedConnect?

You only need to select the attestation check box and select to submit the claim for HCS and TxHmL claims entry. No other entry is required on the "Other Insurance" tab.

1.61 Does the "Details" tab show the Healthcare Common Procedure Codes (HCPCS)?

No, the "Details" tab does not show the HCPCS, but it does show the related billing code which can be verified using the Long-Term Care Bill Code Crosswalks page.

1.62 If you save a group template, do you have to change the service dates every week?

You must update the service dates before you submit. You can update everyone in the template at one time, or you can update person-by-person using the check boxes in the template.

Section 2: Claims

2.1 Should we anticipate that the billing crosswalk for TMHP is going to be different than the crosswalk we are using to bill in the CARE system, which is provided by HHSC?

HHSC will update the Long-Term Care Bill Code Crosswalks to include changes for billing to TMHP. The Long-Term Care Bill Code Crosswalks page, located on the HHSC website, will guide you to the updated bill code crosswalks once they are published. It also provides a link to the EVV bill code crosswalk.

2.2 Does TMHP provide direct payments to the provider?

No, TMHP's Claims Management System runs a daily financial cycle (Monday through Friday) to generate the Payment/Voucher file. The Voucher file is sent to the Centralized Accounting and Payroll/Personnel System (CAPPS), which issues the EFT payments to providers.

Typically, vouchers are paid on the third business day following the TMHP financial cycle (e.g., vouchers generated for the Monday evening financial cycle are paid on Thursday.)

2.3 Will all billing (PAS/HAB, respite, nursing, special therapies, SL, and Host Home) go through TMHP?

Yes, HCS and TxHmL providers will submit claims using TMHP online claim submission tools, TexMedConnect or EDI.

2.4 What is the timeline to correct a claim rejected by TMHP?

Providers have 12 months from the end of the month the date of service (DOS) was performed to successfully submit a clean claim. Claims that were rejected or denied when originally submitted cannot be "corrected;" however, they can be resubmitted as a new claim and are subject to the same timeline as the original claim. For example, a claim submitted in March for a January 1, 2021, DOS rejects. The provider

has the remainder of the 12 months from the original DOS to submit the new, corrected claim and meet the timely filing deadline.

2.5 Does Datalogic/Vesta have the capability to send respite, In-Home Day Habilitation, and PAS/HAB services billing through TMHP?

Yes, Datalogic/Vesta is a TMHP-approved EDI vendor. You will need to submit an EDI Agreement for each contract number to submit claims through EDI. Additionally, you will need to work with Datalogic/Vesta and provide your credentials for TMHP claims submission.

2.6 Since we will be billing in both CARE and the TMHP system, will Individual Plans of Care (IPCs) reflect the change of units in both systems, or will providers need to add the units used in CARE to the units used in TMHP to keep track of how many units are left on the IPCs?

Using the TexMedConnect MESAV system or the EDI X12 Eligibility Verification (EV) transaction, providers will be able to track units used on the IPC service authorization. TMHP will obtain this information for claims processed by CARE when May 1, 2022, falls within the IPC Effective Dates.

2.7 How do we correct a claim?

Claims that have processed successfully can be adjusted. To learn more on the adjustment process, reference the *Long-Term Care (LTC) User Guide for TexMedConnect*.

2.8 Will transfer agreements still be sent to current providers to hold some units for subsequent billing not entered by the transfer date?

There will be no changes to transfer agreements.

2.9 Will we still need to mail forms for Adaptive Aids (AA) and dental reimbursements?

No, Form 4116 is no longer required for billing reimbursement. Providers will be responsible for entering billing for AA, dental, and Minor Home Modifications (MHM) through TMHP.

2.10 Can you explain the referral number?

The referral number is assigned by HHSC to enable the TMHP Claims Management System to differentiate between two contract numbers that share the same NPI. The referral number will appear on the individual's MESAV once the authorization has been granted.

2.11 How long does it take to generate an internal control number (ICN)?

Generation of an ICN for TMHP claims is virtually instantaneous as long as the claim is not rejected at the beginning of the claims process. Rejected claims will not receive ICNs.

2.12 Does TMHP generate R&S Reports every time billing is submitted?

Providers can submit claims daily; however, R&S Reports are generated twice a week and are available every Saturday and Wednesday. R&S Reports generated on Saturday list claims processed from the previous week between the close of business (COB) Tuesday through COB Friday. R&S Reports generated on Wednesday list claims processed from the previous Friday (after COB) through COB Tuesday of the current week.

The R&S Reports also list other claims finalized during the reporting period, pending claims from the previous reporting period, system adjustments, and recoupment claims.

2.13 How can I find out what my Submitter ID is?

Contact the TMHP EDI Help Desk at 888-863-3638, Option 4, for assistance.

2.14 Can we have a separate Submitter ID for a sender and receiver for one provider number?

You can choose to use the same Submitter ID or obtain a different one. Regardless of your choice, you will need to submit a completed EDI Agreement.

2.15 If I have an Intermediate Care Facilities (ICF) Submitter ID, do I also need a separate HCS Submitter ID?

You can use the same ICF Submitter ID, or you can obtain a different one. Regardless of your choice, you will need to submit a completed EDI Agreement.

2.16 Will we be able to separate our contracts for each NPI, or do we have to link all our contracts to the same NPI?

To get an NPI assigned for each contract, you will need to repeat the process for obtaining an NPI that you completed previously. If you decide not to have an NPI assigned for each contract, there are other options available, such as:

- Linking your HCS and TxHmL contracts and associated NPIs to your existing TexMedConnect User ID.
- Creating a new TexMedConnect User ID and linking specific contracts and NPIs to differentiate between contracts and claims.

To update an existing TMHP Portal ID, reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)*.

2.17 Where will the authorization for AA, MHM, and Dental (DE/DEV) services appear in the claims submission at TMHP?

Form 4116 will no longer be required for submission to HHSC on May 2, 2022, and after. Form 4116 for MHM, Pre-Minor Home Modifications (PMHM), AA, and DE/DEV services will be entered into the TMHP system as part of the IPC. Providers will then bill their claims directly in TexMedConnect based upon the IPC and service authorization found on the MESAV screen.

2.18 Will we still need to submit paper claims for AA and DE/DEV for service dates on and after May 1, 2022? Specifically, will the step of having to submit a paper claim, waiting for approval, and then entering claims be removed?

Providers will continue to submit Form 4116 for MHM, PMHM, AA, and DE/DEV for service dates prior to May 1, 2022. Claims for all services with dates prior to May 1, 2022, will continue to be billed into CARE. For service dates on or after May 1, 2022, providers will not submit Form 4116 for MHM, PMHM, AA, and DE/DEV services. These services will be entered into the TMHP system as part of the IPC. Providers will then bill their claim in TexMedConnect.

2.19 Will all billing be done under TMHP? Can we submit claims simultaneously in CARE and TexMedConnect?

Providers must submit HCS and TxHmL claims with DOS on or after May 1, 2022, through TMHP. CARE will continue to be utilized to bill HCS and TxHmL claims with DOS before May 1, 2022.

2.20 Will historical claims data remain available in CARE and for how long?

Historical claim data will remain in CARE for five years, after which the claims are archived.

2.21 How long should providers expect to have a delay in payment after May 2, 2022?

HHSC does not anticipate a delay in provider payment due to the migration to TMHP.

2.22 Is there a time cut-off to submit billing like there is in CARE (i.e. 6:00 p.m.), or can you submit billing 24/7?

TexMedConnect allows for billing 24 hours a day, 7 days a week, except for times of scheduled system maintenance and/or service outages.

2.23 In CARE, we have longer than 365 days to bill. Per rule, we have until the last day of the month that the service was delivered one year later. For example, if the service was provided on April 1, 2021, we have until April 30, 2022, to bill it into CARE. Will this be the same with TMHP?

The HCS and TxHmL transition is not altering the claims filing deadline as outlined in the Texas Administrative Code (TAC). HCS and TxHmL providers will continue to submit claims within 12 months after one of the following, whichever is later:

- The last day of the month in which the service was provided, the AA or medical supply was delivered, or the MHM was completed.
- The date the individual's eligibility for the service was determined.

2.24 Will TMHP require the individual's diagnosis code when submitting claims? Will it be required when submitting claims via 837 electronically? Will this diagnosis code need to match what is on the individual's 8578 ID/RC Assessment?

The individual's diagnosis code is required on the claim. At least the Principal Diagnosis code is expected to be submitted on the claim. TMHP does not match the diagnosis code with the individual's 8578 ID/RC Assessment.

2.25 Will an authorization number be required to bill HCS services through TMHP electronically via 837?

All providers must use the claim information along with the individual's service authorization information. The Claims Management System derives the service group (SG), service code, and bill code.

2.26 When will the referral number be available in TMHP MESAV for HCS and TxHmL?

The referral number is found on the client service authorization record(s). Historical service authorization records that span May 1, 2022, will be available on day one in MESAV. IPC forms submitted will be available through MESAV once they are approved by HHSC staff and authorization records are received at TMHP.

2.27 Is there a way to report the contract number instead of the referral number for each service on a claim?

If there is more than one contract associated with an NPI number, you must include a referral number on the claim, or the claim will be denied. You can access the referral number by searching an individual's eligibility within MESAV.

2.28 Do we submit HCPCS or bill codes on a claim?

Providers are required to submit claims using National Codes: Revenue (REV), Current Procedure Terminology (CPT), and HCPCS using the HHSC LTC Bill Code Crosswalk. The HHSC LTC Bill Code Crosswalk is a code set used to match the National Codes to the Texas LTC local codes (bill codes).

2.29 Will responses be 999 or TA1?

999 responses are Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard rejections and TA1 refers to files that are incorrectly formatted. Providers will receive these two types of rejections, if applicable.

2.30 How do we set up templates for billing?

For information on setting up templates, refer to the *Long-Term Care (LTC) User Guide for TexMedConnect* and the TexMedConnect for Long-Term Care (LTC) Providers CBT.

2.31 Will TMHP require the attending physician NPI be different from the billing provider NPI (like in ICF)? If so, does TMHP require the primary care provider (PCP) NPI for all of our HCS clients?

An attending provider is not applicable for professional claims. You can submit the performing provider NPI and name and the referring provider NPI and name on these claims, but these are optional fields. Only the billing provider information is required to pay these claims.

2.32 Is the Texas Provider Identifier (TPI) needed on submitted claims?

No, TMHP uses the NPI, physical address, and service authorization number to crosswalk to the contract number.

2.33 What should we do when submitting a claim and the place of service is home, but there is another claim by the same provider on the same day; however, the place of service is office?

TMHP has created multiple service codes since there will be multiple authorizations.

2.34 If a claim is denied, do we have to rebill or will it pay once the individual is no longer on hold? Currently if an individual shows on the HCS Denied Report, it gets paid once the issue is resolved.

All claims that have been denied will remain in that status unless rebilled by the provider.

2.35 Where can I learn more about submitting multiple claims at once?

You can learn more about batch claims by referencing the *Long-Term Care (LTC) User Guide for TexMedConnect*.

2.36 We would like clarification on the procedure for billing Registered Nursing (RN). In a scenario where we have eight nurses who saw an individual on the same day for varying lengths of time, can we add those times together and enter it on one line? Or do we combine visits less than eight minutes and bill those together under the one Provider ID and then bill visits that were over eight minutes on eight separate lines of nursing under eight separate Provider IDs?

Accumulation of service time cannot be done per day in either scenario noted above. Accumulation of the RN service times can be done on *a single calendar month on the last day of the month*. The time does not have to be less than eight minutes to accumulate the time on a single calendar month.

Example 1: An RN provides registered nursing services to one individual three times during a single calendar month: July 1, 2021, 8:30-8:55 a.m. (25 minutes); July 6, 2021, 4:15-4:20 p.m. (5 minutes); and July 25, 2021, 8:00-8:05 p.m. (5 minutes).

Without accumulating service times, two units of service for registered nursing are billable for the service time of 25 minutes. The service times of five minutes are not billable because they are less than eight minutes each. If all three service times are accumulated into one service time of 35 minutes (25 + 5 + 5), two units of service for registered nursing are billable.

If the first service time of 25 minutes is billed as two units of service on the day it was provided, and the second and third service times are accumulated into one service time of 10 minutes (5 + 5), which is billable as one unit of service on the last day of the month, July 31, 2021, three units of service for registered nursing are billable (2 + 1).

Example 2: Nurse A provides seven minutes of registered nursing to an individual. During the same month, Nurse B provides seven minutes of licensed vocational nursing to the same individual. You could not accumulate the time and neither service would meet the minimum requirements for billing a unit of their respective nursing component.

To learn more about the accumulation process, reference Sections 4460 and 3610(b) of the *Home and Community-based Services (HCS) Program Billing Guidelines*.

2.37 Will there be a test period to input claims that will not be paid prior to May 2, 2022?

Providers can refer to the article, "Trading Partner Testing and Claims Submission Practice Now Available for TxHmL and HCS Programs," for information about completing the EDI account creation process and practicing submitting claims using EDI.

2.38 Which claim file indicator should be selected when billing through TexMedConnect?

Providers should use the professional claim form and use "MC" (Medicaid) as the claim file indicator.

2.39 How will TMHP know the rate from the group since it may vary?

TMHP uses the rate(s) already determined by HHSC.

2.40 What is the difference between the individual template and group template?

The individual template is used to enter claims for one specific individual, while the group template can be used to store up to 250 individuals.

2.41 Does the referral number remain the same as long as the individual is in the same SG (SG 21 for HCS and SG 22 for TxHmL)?

Yes, the referral number remains the same for the contract/individual combination. The referral number is a unique number that associates one contract to one individual.

2.42 CARE currently selects the claim type based on the provider. What claim type should be used for the CARE-related services that are billed through TMHP?

Providers must select the claim type during the claim entry process. All claims for HCS and TxHmL services must be billed as professional claims.

2.43 What service codes should we use for HCS and TxHmL?

Providers will use SG 21 for HCS and SG 22 for TxHmL. You can reference the Long-Term Care Bill Code Crosswalks page.

2.44 Has the new 837 Long-Term Care Companion Guide been released for migrating claim submissions to TMHP?

Yes, the new *837P Long Term Care Companion Guide* is now available on the TMHP website.

2.45 What happens if a provider submits a claim to TMHP that undercharges or overcharges?

Billing codes are set as fixed rates in the Claims Management System to ensure claims are paid at the approved rate based on the units of service that have been submitted for payment.

2.46 How do I coordinate professional and dental claim types?

Providers can use the 837P for professional claim types, and the 837D for dental claim types.

2.47 What is the difference between codes LC1 and LN1?

LC1 is for LOC and LN1 is for Level of Need (LON).

2.48 Residential support services use the same HCPCS code and modifier for all LONs. If I submit an 837P for these services, how will TMHP know which LON is being billed?

TMHP uses the approved LON on the individual's current 8578 ID/RC Assessment to determine the unique bill code and bill rate.

2.49 Exactly what services will be billed through TMHP?

Services billed through TMHP include HCS services, TxHmL services, and CFC services for HCS and TxHmL clients. Reference the Long-Term Care Bill Code Crosswalks page to view a list of services.

2.50 What information will be required on a claim submitted through TMHP?

Reference the *Long-Term Care (LTC) User Guide for TexMedConnect* and the TexMedConnect for Long-Term Care (LTC) Providers CBT located on TMHP's LMS for detailed information on claim submission.

2.51 If an individual is admitted during the 180-day wait time for approval of Medicaid Identification (MI) and ME, will the provider not get paid during that time?

As soon as eligibility is verified, the provider can begin billing.

2.52 Do level and service authorizations need to be in the LTCOP before we can bill?

Yes, HCS and TxHmL assessments and forms used to create service authorizations and level records must have been successfully submitted and approved in the LTCOP before they can be used for billing.

2.53 Will we still need to mail forms for AA and dental reimbursements?

No, Form 4116 is no longer required for billing reimbursement. Providers will be responsible for entering billing for AA, dental, and MHM through TMHP.

2.54 Can we submit paper claims to TMHP?

No, all claims must be submitted electronically using EDI or TexMedConnect.

2.55 In the HCS program, we are instructed to return someone to services on the last day they are out of the program so that services will be paid on the date that they return to the program. How is the return-to-service date affected with the migration to TMHP, and will we be able to bill for services on the return date?

The program provider can bill for services as long as the dates entered on the claim match the service authorization date from MESAV, which is found on TexMedConnect, and there is not an active client hold for any of the billed dates.

2.56 How do I set up claim entry and payment?

HCS and TxHmL program providers will submit claims using TMHP's online claim submission tools: TexMedConnect or EDI.

Reference the *Long-Term Care (LTC) User Guide for TexMedConnect* and the TexMedConnect for Long-Term Care (LTC) Providers CBT located on the TMHP LMS for detailed information on claim submission. You can also reference the EDI web page located on the TMHP website.

2.57 How do you process billing for dental, nursing, day habilitation, and SL/foster services?

All claims will be billed using the professional claim type. Dental service codes starting with "5A" and HCPCS starting with "D" will be billed using the dental claim type. Claims that go through EDI or a third-party biller will use 837P for professional claims and 837D for dental claims.

2.58 If I have billing from last year, will I be able to bill using the TMHP portal after May 1, 2022?

TMHP's TexMedConnect and EDI systems can accept billing with a DOS starting from May 1, 2022. Billing with DOS prior to May 1, 2022, should be billed in the CARE system.

2.59 Will there be a Paid Claim Status Report or a Services Provided by IPC Report?

Program providers may track units used on the IPC service authorization using MESAV on TexMedConnect or the EDI X12 EV transaction.

Reference the "Remittance and Status (R&S) Reports" section of the *Long-Term Care (LTC) User Guide for TexMedConnect* for an explanation of pending/denied or approved to pay claim statuses.

2.60 How do I bill for Consumer Directed Services (CDS)?

You must bill CDS claims as professional claims.

2.61 When multiple employees are working, can we bill multiple times for the same service on the same day? Do we add together for a daily total?

Yes. The LICN field must be used to identify the staff for whom you are billing. Each line item is used for each day.

2.62 Will we get new authorizations if the amounts in CARE and TMHP will be different?

You will not get new authorizations, as this information will be transferred to TMHP. You will only get new authorizations if the member's services were terminated and a new service was requested. The balance you have in CARE prior to May 1, 2022, will be transferred to TMHP so that on May 2, 2022, you will be able to see the information in MESAV.

2.63 If claims are submitted appropriately, should providers expect two 835 files?

Yes, 835 ER&S Reports are generated twice a week. You will receive one file on Wednesday and one file on Saturday. The 835 ER&S Report will be delivered to the submitter ID that has been linked to your contract number on the EDI Agreement or Linking Form. You may also obtain claim status through TexMedConnect on the CSI screen or by obtaining the R&S Report.

2.64 If we bill claims in CARE, will the amounts we bill be reflected only in CARE? Or will the amounts also be reflected in TMHP?

Claims for DOS prior to May 1, 2022, will be billed in CARE and will only be reflected in CARE. Claims for DOS on or after May 1, 2022, will be billed to TMHP. Some service authorizations for HCS and TxHmL may span the implementation date. CARE claims with DOS prior to May 1, 2022, may be used to update the utilized units on these service authorizations to ensure that claims are not overpaid. Paid claim utilization will be reflected in MESAV on the service authorization. You will not bill for the same DOS in both systems.

2.65 What is the difference between the Staff ID and EVV Attendant ID?

Certain claims that are submitted for payment must identify the service provider that is delivering the specific service. Use the Staff ID for non-EVV required services that need service provider identification. Use the EVV Attendant ID for EVV required services. The Staff ID is the service provider's LastName,FirstName (no spaces) or a dummy ID for services that are accumulated. The EVV Attendant ID is the last four numbers of the passport or social security number (SSN) plus the last name.

2.66 What happens to a submitted claim that is missing a required Staff ID or EVV Attendant ID?

TexMedConnect will reject claims submitted for services that require a Staff ID or EVV Attendant ID and do not have one entered.

2.67 Which services allow the dummy ID codes to be used for claim submission?

Currently, the two services that allow a dummy ID to be used are Nursing (including all sub-components) and Transportation.

Nursing accumulation that is billed on the last day of the calendar month can use the following dummy ID codes:

- ACCUM.NUR
- ACCUM.NUL
- ACCUM.NURS
- ACCUM.NULS

Transportation accumulated in a single calendar day can use dummy ID code ACCUM.TR.

2.68 Which services require a Staff ID to be used?

The following HCS and TxHmL service components require a Staff ID in the claim submission:

- Professional Therapies:
  - Occupational Therapy (OT)
  - Physical Therapy (PT)
  - Speech/Language/Pathology Therapy (SP)
  - Dietary (DI)
  - Audiology (AU)
  - Behavioral Support (BES)
  - Social Work (SW) (HCS only)
  - Cognitive Rehabilitation Therapy (CRT) (HCS only)
- Nursing (for claims that are not accumulated on the last day of the calendar month):
  - Licensed Vocational Nursing (NUL)
  - Registered Nursing (NUR)
  - Specialized Licensed Vocational Nursing (NULS)
  - Specialized Registered Nursing (NURS)
- Supported Home Living-Transportation (TR) (HCS only)
- Community Support-Transportation (TR) (TxHmL only)
- Supported Employment (SE)
- Employment Assistance (EA)

2.69 Which services require an EVV Attendant ID to be used?

CFC PAS/HAB requires the EVV Attendant ID of the service provider that delivered the service and appears on the EVV visit.

2.70 Where is the Staff ID or EVV Attendant ID entered on the billing claim?

You must enter the Staff ID or EVV Attendant ID in the LICN field to identify the service provider that delivered the service.

2.71 Where do I find the unit rate for claim submission?

The unit rate of services can be found on the TMHP LTCOP. The 3608 and 8582 IPC Forms have an "IPC Services/Cost" tab that shows the unit rate of each service. The unit rate of the service is prepopulated on the form based on the individual's LON. This unit rate may be used for claims entry.

Refer to the *3608 HCS Individual Plan of Care Item-by-Item Guide* or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for details on the "IPC Services/Cost" tab and unit rate fields.

2.72 Are we required to manually enter all pay rates, including those for Host Home services?

When submitting individual claims, you must enter the number of units and the unit rate for each service delivered, including Host Home services. Unit rates for HCS and TxHmL services are not prepopulated in TexMedConnect, but this function could be considered in future enhancements.

The payment of HCS and TxHmL claims is based on the LON. TMHP's Claims Management System uses the correct unit rate based on the LON to process the claims.

2.73 What do I do if I am submitting a billing claim for a service that does not require a Staff ID or EVV Attendant ID?

There are two scenarios in which a service will not require a Staff ID or EVV Attendant ID:

1. The service does not require an LICN. You may leave the LICN field blank.
2. The service requires an LICN, but does not require a Staff ID or EVV Attendant ID. You may leave positions 5-20 blank on the LICN field. However, positions 1-4 (claim sequence number) are required and must still be entered.

Refer to the HHSC LTC Bill Code Crosswalk for guidance on when the LICN field must be used and which parts of the LICN field are required.

2.74 Can you explain Apply Co-pay, Apply Applied Income, and Apply Neither?

Both Apply Co-pay and Apply Applied Income are individual responsibilities. Applied Income is required for institutional services such as NF, ICF, and Hospice daily care, whereas co-pays are required on select services including assisted living. Not all services will require Apply Applied Income or Apply Co-pay, and both are not required for HCS and TxHmL claims. You will use Apply Neither on the group template.

2.75 How do we apply different dates to a group template? Can we see what information is in a batch set of claims? Can you tell us how this works with a group of claims?

Only one group template can be used for one service date at a time. You can define the start and end date (both should be the same date), the number of units, and the unit rate for all the claims in the group template.

You can select all the individuals that you want to bill for on a certain date by selecting the individual templates under the "Select All" column. Be sure not to check "Select All." Submit and repeat this step for the other individuals with different dates.

To save the claims in a batch from the group template, you will first need to make sure that the individual template has the "Save to Batch" radio button selected. When you submit the claims from the group template, these claims will then go to the Pending Batch section. From there you will select "Pending Batch" under the claims section on the Navigation Panel, select the appropriate NPI or API from the NPI/API drop-down box and the appropriate provider number from the Provider Number drop-down box, and click the "Continue" button. After that, select "Submit Batch."

2.76 For the staff ID, do we need to enter the professional's staff ID for each claim or is there a screen like the one in the CARE system called "Provider ID" where the ID was stored for each professional service?

You must enter the staff ID in the LICN field for each claim that requires a staff ID. You may create a group template and save the staff ID in the template to avoid reentry. If the staff ID changes, you must update it manually. Refer to the Long-Term Care Bill Code Crosswalks page, located on the HHSC website, to identify services that require a staff ID.

2.77 I see that after go-live, we are no longer going to need to submit Form 4116 for MHM, Dental, and AA, and will directly submit to TMHP. What do we do regarding bids or packets? If there is an amount on the plan and we submit the claim, will it be reimbursed?

Form 4116 will no longer be required for submission to HHSC on May 2, 2022, and after. Form 4116 for MHM, PMHM, AA, and DE/DEV services will be entered into the TMHP system as part of the IPC. Providers will then bill their claims directly in TexMedConnect based upon the IPC and service authorization found on the MESAV screen, located on TexMedConnect. Program requirements regarding bids and packets are separate from claims submission. Refer to program billing requirements regarding documentation requirements.

2.78 When looking at the CARE Report Crosswalk, I do not see any HCS weekly reports related to billing. I am specifically looking for how the information from the HC2015, HC2017, and GC2040 Reports will be available after the migration. What will the process look like for these reports?

You can use the R&S Report for reconciling the GC2040 Report. The GC2040 Report is not included as part of this migration to TMHP. The file will not be in the same format as the HC2015 and HC2017 Reports.

2.79 What are the steps to gather cumulative cost report information like we have previously done on the C73 screen in the CARE system?

Refer to the program provider and LIDDA CARE Screen Crosswalk, located on the HHSC website, to see where in the TMHP systems information can be found. Most of the information will be found on TexMedConnect under CSI.

2.80 The R&S EDI extract does not have LON for both HCS and ICF that is critical for billing and cost report information. Will it have the same data as the GC2040 Report?

The R&S Report doesn't report LON, but does report dates of claims, claims paid, and units billed. You can use MESAV to review authorization dates, LON date ranges, and units used. You can also set up a MESAV group template to help automate data entry. This can take up to 24 hours to generate.

Additionally, the GC2040 Report is not included as part of this migration to TMHP.

2.81 Will we bill individually by employee, or can we total all the employee hours for each calendar date to bill as one entry?

Claims may be rolled up by accumulation of services for nursing services and/or transportation services using the approved Dummy IDs. You may also bill individually depending on your specific needs. Refer to program billing requirements to determine if accumulation is allowed.

2.82 Can services be uploaded from my software into a batch and then submitted to TMHP?

Yes, you can submit batch claims. Refer to the *Long-Term Care 837 Professional Companion Guide* and the *TMHP EDI Connectivity Guide* for information on submitting batch claims.

You may also refer to the *Long-Term Care (LTC) User Guide for TexMedConnect* to learn more about submitting batch claims using TexMedConnect.

2.83 Will the start time need to be added for staff ID-required services?

No, a start time of the service event is not required. However, the sequence number is required for all services that require a staff ID. Refer to the HHSC LTC Bill Code Crosswalk for guidance on when the LICN field must be used and which parts of the LICN field are required.

2.84 Can claims for multiple NPIs be submitted under the same 837P?

Yes, you can submit multiple NPIs on an 837P batch file.

2.85 Where can I find detailed information about rates for HCS and TxHmL claims?

Refer to the Rates Tables located on the Provider Finance Department page of the HHSC website. Payment rates are listed on each of the program pages, along with other helpful tools like reporting information and training content.

You can also find rates on a client's IPC Form using the LTCOP after go-live.

2.86 How do I create a group template in MESAV?

Refer to the "MESAV" section of the *Long-Term Care (LTC) User Guide for TexMedConnect* for detailed steps on creating a group template.

2.87 What is the difference between a draft, individual template, group template, and batch?

A draft can occur when trying to submit a single claim, but the user is unable to finalize claim submission. The user can save the data already entered as a draft until claim submission can be completed. Once the draft has been finalized and submitted, the record is deleted.

An individual template can be used when a single client is going to receive ongoing treatment and the treatment is billed on a periodic basis. Once created, an individual template can be reused.

A group template is similar to an individual template, but allows users to add multiple clients and can be used to submit recurring claims for the group of clients. Group templates are grouped by provider number. If a user is authorized to submit claims for multiple vendor/contract numbers, the user cannot use the same group template for multiple provider numbers.

A batch submission is a grouping of individual claims manually entered and saved to a batch. Each individual claim is entered up to the "Other Insurance/Finish" tab, then the user can choose to submit the claim or save it to the batch.

Once the user enters and saves all the claims they want to include in the batch, the batch can be submitted and processed. Future claims for clients included in the batch would have to be re-entered and submitted.

Refer to the *Long-Term Care (LTC) User Guide for TexMedConnect* for more information.

2.88 Where would we enter the provider ID when submitting claims?

The provider ID is the vendor/provider number selected from the drop-down field on the initial claims entry page. Refer to the *Long-Term Care (LTC) User Guide for TexMedConnect* for more information.

2.89 Do we need a claims screen for both CARE and TMHP?

The CARE system and TexMedConnect are two different systems.

2.90 If we bill for 250 consumers, what is the best way to bill?

For this example, you would use the claims group template. The group template allows users to add multiple clients and submit recurring claims for the group of clients.

2.91 What does the service code mean?

The service code is a grouping of services (billing codes, HCPCS, and modifiers). When claims are submitted, the billing codes, HCPCS, and modifiers for the services rendered must be specified. Data is then combined to the appropriate service code.

The system will then determine if the individual is authorized to receive the service specified and if funds are available for the claim to be reimbursed.

Refer to the Long-Term Care Bill Code Crosswalks page for more information on billing codes and HCPCS associated to a service code.

2.92 If a claim is not submitted successfully, will we be redirected to make corrections?

Yes. TexMedConnect will provide error messages letting you know what needs to be corrected for the claim to be submitted successfully.

2.93 Will we know if a submitted claim is approved immediately after submission by clicking the assigned confirmation number?

Yes. When you click the claim ICN, you will be directed to the CSI page and can view the claim status. Claims will be immediately moved to one of the following statuses: Approved, Denied, or Suspended.

2.94 Are we able to do span date billing?

The following services can complete span date billing:

- Day Habilitation
- Host Home/Companion Care
- Residential Support
- Supervised Living

When using span billing for these services, you should enter the first and last dates of service in the Service Dates Start and End fields in the Details tab.

2.95 How many spaces are required in positions 5-20 of the LICN field which includes a provider internal claim ID (positions 21-30)?

The number of spaces is dependent on the number of characters entered in positions 1-20. If values were not entered in the first 20 positions, then 20 spaces would be required.

If the first characters were specified, then the difference between 20 and the number of characters already specified would be the number of required spaces. For example, if a user entered 1130John,Smith (14 characters), then they would need to add six spaces and then add the provider internal claim ID.

2.96 What does it mean that the sequence number should be in military time? Are we entering the time of service, the time of billing, or is it just a unique four digits?

The value must be entered in military time, but it doesn't mean you have to specify the actual time the service was provided.

Services allowed multiple times on the same date of service will be considered a duplicate if the service date, procedure, and LICN values are the same. If the LICN values are different (e.g., 1000 and 2000), then services will be considered unique and the claim service will not be denied as a duplicate.

2.97 If support staff provides CFC and respite, can we submit one claim with multiple lines, or should we submit each one individually?

You can bill multiple claim services on separate detail lines of a single claim.

2.98 How can we access Explanation of Benefits (EOB) codes?

EOB codes can be accessed on the TMHP website by clicking the "Reference Material" section on the Long-Term Care page.

2.99 When creating batches, should we save each batch under LON groups?

Batch claims can be submitted for different clients, claim types, LON, level of service, and so on.

2.100 If I don't have the unit rate, will the system add the dollar amount?

You must enter a unit rate on the "Details" tab for the claim to be successfully submitted. The rate will then be applied to the claim when it is processed, and if an incorrect rate was entered, the claim will be paid based on the HHSC assigned rates.

2.101 How long can templates be saved?

Once created, templates will remain available unless deleted by the user or if not used for 365 days. You can save up to 250 templates.

2.102 If we do not have a dental requisition fee code, do we use the same dental services code for all services submitted by the provider, or should we group all the services under one code?

Dental requisition fees for HCS and TxHmL are defined as service code 41E. Dental requisition fees are considered professional services, and services should be billed using the professional claim option. Refer to the Long-Term Care Bill Code Crosswalks page for associated billing codes, HCPCS, and modifier codes that need to be included in billing.

2.103 Are prior authorizations needed?

Prior authorizations are not required for HCS and TxHmL services. Approved IPC Forms serve as authorization to receive a defined number of approved services.

2.104 Are we required to run a MESAV every time before we enter a claim?

It is not required, but it is recommended as a best practice. We suggest running a MESAV before billing since information on the MESAV may have updated.

2.105 Is the referral number automatically populated each time upon claim entry, or are we required to generate it by running a MESAV?

The referral number will prepopulate once you enter the Medicaid number on TexMedConnect during claim entry.

2.106 Do we need a copy of the MESAV?

No, PDF copies of MESAVs are current at the time of printing, but may not be accurate afterwards. We recommend electronically running MESAVs each time before billing for the most up-to-date information.

2.107 Will MESAV show if an individual has dental coverage?

The "Service Authorization" section in MESAV indicates the billable or allowable service for the individual and will show the service code and the service code description.

2.108 Under the "Levels" section on MESAV, will it show both LOC and LON as it does for the ICF program?

Under the "Levels" section on MESAV, you will see the appropriate levels based on the program the individual is associated with.

2.109 You mentioned that in step 2 of claims submission we could use the client ID in both boxes. Does that include the client ID and patient account number? Are they the same exact number if we do not have a patient account number?

The patient account number is used by the facility to identify the individual. If you do not have one, you can enter the individual's Medicaid number or SSN in the field.

2.110 What's the difference between LICN type 4 and the blanks on the Long-Term Care Bill Code Crosswalks?

On the Long-Term Care Bill Code Crosswalk, column E is for the LICN field. Numbers from 1 to 4 indicate that these services will need LICN information added to the claim, while services without a number in the LICN field do not need LICN information on the claim.

2.111 There are some codes on the Long-Term Care Bill Code Crosswalk without a CPT/HCPCS. Which one should be used?

On the "Claims Detail" tab, services that do not have both the HCPCS and CPT codes will use the bill code in the field that is for the procedure code (not the procedure qualifier).

2.112 Can you have professional and dental claims on the same batch?

Yes, professional and dental claims can be added to the same batch.

2.113 Can multiple services be billed on one claim, such as residential and periodic?

Yes, you can bill multiple services on one claim as each service will have its own service authorization as long as the claim type is the same. You cannot bill dental services and professional services on one claim.

2.114 Do I submit claims for HCS and TxHmL services at $1 per unit or at the rate given in dollars for the service type?

Claims regarding MHM, AA, taxes, fees, etc., will be authorized and billed with the units as dollars (1 unit = $1).

Other services, such as Supported Employment, will be billed in 15-minute units, meaning you cannot bill for less than 15 minutes or as a partial unit.

Some services, such as day habilitation, will be billed as one unit per day, with partial units possible (billed as .25, .50, or .75, depending on the number of hours performed).

You must enter a unit rate on the "Details" tab for the claim to be successfully submitted. The rate will then be applied to the claim when it is processed, and if an incorrect rate was entered, the claim will be paid based on the HHSC assigned rates.

The unit rate of services can be found on the "IPC Services/Cost" tab of the 3608 and 8582 IPC Forms. The unit rate of the service is prepopulated on the form based on the approved LON on the individual's current 8578 ID/RC Assessment.

For help on how to bill units versus dollar amount for different services, contact the Provider Finance department at rad-ltss@hhsc.state.tx.us or at 512-424-6637. You may also refer to the *Texas Fee-for-Service HCS Rates* and the *TxHmL Rates*.

2.115 According to my billing personnel, a Host Home/Companion Care program provider needs to have an NPI number. We have never been required to do that for HCS. Is that template going to be revised?

If you are a non-medical provider, you can use an API that is based on your contract number in place of an NPI.

2.116 Do we have to submit a location in both the "Details" tab and in the "Claims" tab? What do we do if we perform the same service at multiple locations on the same day?

You must submit a location on both the "Claims" tab and the "Details" tab. The Details data is what TexMedConnect uses when processing the claim. You can use separate detail rows for each location if you perform the same service on the same day.

2.117 What is the difference between a Professional Dental Claim and a Non-Professional Dental Claim?

All dental claims are billed as the Dental claim type. There are no "Professional" or "Non-Professional" dental claims.

2.118 Where does the qualifier "AD" go on the Dental claim submission?

You do not need to enter the "AD" qualifier on dental claims. When you select "Dental" as the claim type, the qualifier is inserted automatically.

2.119 Every September, rates change, but the new rates aren't announced for a while. Are claims corrected retroactively?

If a claim has already been paid at the old rate, the system automatically adjusts the claim when the new rates are updated in the system. Claims that are submitted after the system has been updated are paid at the new rate.

2.120 Do we have to submit claims every day, since we can't submit claims for date ranges?

You don't have to submit a claim on the same day that you perform a service, and you can submit claims as often as you want. However, you must submit one date per claim line for services that don't allow span dates.

2.121 What happens if I put the wrong diagnosis code on a claim? For example, "mild" in entered instead of "moderate". Will the claim successfully process or be re-couped in the future for not matching?

TMHP requires a valid diagnosis code for the claim to process, but does not validate it other than to determine that it is a valid code. The diagnosis code is not checked against the code on the individual's 8578 ID/RC Assessment, for example. The diagnosis code entered on a claim does not effect the claims amount calculation, so there will not be any recoupment due to an incorrect code that is entered.

2.122 Dental is not listed by units, and dentists bill in dollar amounts. How are the units decided?

Dental continues to be entered in dollar amounts.

Section 3: Long-Term Care Online Portal (LTCOP)

3.1 What is the LTCOP?

LTCOP is an acronym for the Long-Term Care Online Portal. The LTCOP is a web-based, user-friendly system that houses many forms including HCS and TxHmL forms many providers are already familiar with and is managed by TMHP.

The portal can be used for the administration of LTC programs. For more information on what the LTCOP is used for, reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and the *Long-Term Care (LTC) User Guide for Online Portal Basics, General Information, and Program Resources*.

3.2 Will we need to enter 8578 ID/RC Assessments and IPCs through TMHP?

Yes, the 8578 ID/RC Assessment and 3608/8582 IPC, along with the HCS or TxHmL Pre-enrollment Form, the Individual Movement (IMT) Form, the 3615 Request to Continue Suspension of Waiver Program Services Form, the 3616 Request for Termination of Services Form, and the Provider Location Update (PLU) Form will be submitted and managed through TMHP's LTCOP beginning May 2, 2022.

3.3 Do I need to have an NF/Waiver Program account if I am an HCS provider?

Yes, you will need to select the **NF/Waiver Program** option when creating your LTCOP account so that you may submit, manage, and print forms from the LTCOP. Follow the steps in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for assistance with creating your LTCOP account.

3.4 Will there be webinars that review the assessments and forms we will be managing in the LTCOP?

Yes. The live webinars have ended, but a recording of the webinars will be published to TMHP's LMS at a later date. Providers will be notified through a notification once the recordings are available.

3.5 Is the LTCOP the same as the Intellectual and Developmental Disability (IDD) Operations Portal?

No, the LTCOP is not the same as the IDD Operations Portal. The LTCOP will allow providers to submit, manage, and print HCS and TxHmL forms.

3.6 Will the LTCOP be user-friendly?

The LTCOP is a web-based, user-friendly system that houses HCS and TxHmL forms many providers are already familiar with. Additionally, training materials including Item-by-Item Guides and a Provider User Guide will be available on the TMHP LMS.

3.7 Will there be a way to do "hands on training" before the LTCOP goes live on May 2, 2022?

HHSC will not be having "hands on training" prior to May 2, 2022. HHSC recommends visiting the TMHP website frequently for updates, which will include quarterly bulletins, articles, and FAQs; as well as quick reference tools which will assist in determining what data will remain in CARE and what data will be found in TMHP.

Providers are encouraged to view the HCS and TxHmL webinars once they are published to TMHP's LMS.

3.8 Currently, we use CARE to pull information for the Cost Report. How will the LTCOP provide information such as units provided?

Using either TexMedConnect MESAV or EDI X12 EV transaction, providers will be able to track the units used on the 3608/8582 IPC service authorization. TMHP's process will be to obtain this information for claims processed by CARE when May 1, 2022, falls within the IPC Effective Dates.

For example, if the 3608/8582 IPC Effective Dates are June 01, 2021 through May 31, 2022, TMHP will account for all the units billed for the individual before the DOS on or after May 1, 2022, on the service authorization record.

3.9 We set up our LTCOP account, but we are unable to see the forms our staff needs to access. How do we access the forms?

The additional HCS and TxHmL forms are not accessible through the LTCOP yet. You will be able to view them once deployment occurs on May 2, 2022.

3.10 Is the account administrator the only one who can submit claims and forms? Should they set up a TMHP Portal account to access these functions?

The administrator is the first individual who creates and activates a TMHP Portal account. Once the administrator links themselves to a contract number, they can create users and set permissions based on the user's responsibilities. The original administrator can also create users with administrative permissions for the same contract number.

3.11 Our account administrator set up all our TMHP accounts and assigned us as users. Do I need to request a PIN by mail to have access to the TMHP accounts?

No, you do not need to request a PIN. The account administrator is the one who requests a PIN to activate the TMHP Portal account. Once the administrator has access, they set up any additional user accounts and grant permissions based on the user's responsibilities.

3.12 When we try to create our TMHP account, we get the following message: "The reCAPTCHA field is required." We can't see a "reCAPTCHA" field. How do we fix this?

TMHP strongly recommends creating your accounts using Internet Explorer (IE) 11®. This will ensure that the "reCAPTCHA" field is accessible.

3.13 Will existing 8578 ID/RC assessments migrate to TMHP for us to review before creating a new IPC form?

TMHP will have current and future dated, or the latest (if a current assessment does not exist), 8578 ID/RC assessments to cover all selected IPC forms. Older 8578 ID/RC assessments will remain in the CARE system.

3.14 How do we add the option to view the HCS and TxHmL forms on our administrator account?

Reference Step 2A: Link Your TexMedConnect Administrator Account to the LTC Online Portal in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for assistance with creating your LTCOP account to view HCS and TxHmL forms.

3.15 As an account administrator, which form permission boxes do I need to check during the LTCOP account setup so users can access HCS and TxHmL forms?

Refer to pages 13 and 14 of the *Managing Your Long-Term Care Online Portal Account: A Step-by-Step Guide* to determine permissions based on the services your organization is contracted to provide and the related tasks the user is responsible for.

3.16 After assessments and forms have been completed on the LTCOP, will we be able to print hard copies?

Yes, all forms that are available for submission through the LTCOP can be printed, including those migrated from the CARE system.

3.17 Is there anything we need to enter ourselves when we have access to the LTCOP, or will everything be available on May 2, 2022?

No, beginning May 2, 2022, the following will be available through the LTCOP:

- Historical forms for clients from the current year
- Demographics from HHSC systems

After the migration to TMHP, beginning May 2, 2022, all actions for HCS and TxHmL clients must be taken in the LTCOP for ongoing administration of your clients.

3.18 How long does it take to correct a form entered in error?

Users can access the LTCOP at any time, and once a form is corrected, the workflow is processed. You will know a form has been corrected if it is in status ***Processed/Complete***.

To correct a form entered in error, you can use the "Correct This Form" button to update data on a form, or you can use the "Inactivate" button to void the form, and then submit a new one.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

3.19 If the MI check fails, are we to assume there was an issue with the migration of CARE data to the LTCOP?

The MI check is part of the regular process of a form being submitted. This is to ensure an individual's Medicaid data is active when a form is being processed and most likely will not indicate an error in the initial migration of data from the CARE system.

MI checks, on forms submitted through the LTCOP, are verified through HHSC's Service Authorization System (SAS) system, not the CARE system.

3.20 Will Local Intellectual and Developmental Disability Authorities (LIDDAs) be notified by the LTCOP when a 3616 Request for Termination of Waiver Program Services Form has been entered?

When a 3616 Request for Termination of Waiver Program Services Form is submitted by the provider, the form will move to status ***Pending LA Review***. The LIDDA can utilize the Form Status Inquiry (FSI) function to search for forms in status ***Pending LA Review***.

3.21 Will the program provider be required to follow and monitor each entry in the History trail until completion?

While it is not required to follow the History trail of each form as it passes through the workflow, it is considered a best practice and will enable you to stay aware of any changes in the form's status that may require submitter intervention.

3.22 What should I do if I don't see the 8578 ID/RC Assessment as a Type of Form option on my LTCOP account?

Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* to learn how to update your form permissions.

3.23 Will information that is entered into an 8578 ID/RC Assessment and 3608 or 8582 IPC Form, using the LTCOP, auto populate when the IPC Revision or Renewal is completed for each one?

An IPC Revision is prepopulated from the previous 3608 or 8582 IPC Form from which the IPC Revision is generated. Use the FSI function on the LTCOP to locate an existing 3608 or 8582 IPC Form.

To submit an IPC Renewal, use the Submit Form page on the LTCOP and enter the information manually or use the "Use as template" button located at the top of the form on the yellow "Form Actions" bar. Clicking the "Use as template" button will prepopulate most of the information from the previous 3608 or 8582 IPC Form. Once populated, you can edit any of the information.

3.24 Do I use the LTCOP to renew or change a client's level and service authorization records?

Yes, you must use the LTCOP to renew or change a client's level and service authorization records.

3.25 Will all Individual Movement (IMT) Forms be entered and managed on the LTCOP for HCS clients?

Yes, all IMT Forms must be entered and managed in the LTCOP for both HCS and TxHmL.

IMT Forms are used to document an individual's suspension, change in county, change in address, change of LIDDA, or change of Service Coordinator (SC). Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and the *Individual Movement Form Item-by-Item Guide* for more information.

3.26 If an assessment or form is denied or if additional information is needed, will I be notified through email or do I have to look in the LTCOP?

To locate an assessment or form that is denied or needs your attention, use the FSI function on the LTCOP to search by form status (e.g., ***Denied*** or ***Remanded***). You can also search by the form's assigned Document Locater Number (DLN).

Forms that have been submitted through the LTCOP can be tracked by the assigned DLN, and may also be searched by form type or by individual. Forms may also appear in the "Current Activity" section of your LTCOP account. This ensures you are always able to check the status of forms and be aware if any updates or changes need to be made to aid in processing and submission.

3.27 Will the LTCOP replace the IDD Portal to enter 8578 ID/RC Assessments and IPC Forms?

8578 ID/RC Assessments and IPC Forms will be submitted using the LTCOP, including authorizations. Supporting documentation must be submitted through the IDD Operations Portal or by fax.

3.28 Will the LTCOP generate reports that will let us know which 8578 ID/RC Assessments are close to expiring?

LIDDAs and providers can use the Dashboard in the LTCOP to determine which 8578 ID/RC Assessments and IPC Forms are expiring within 60 days.

3.29 Is there training on how to create a LIDDA profile in the LTCOP with the correct permissions?

Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* to learn how to create accounts and assign permissions.

3.30 As a Financial Management Services Agency (FMSA), is the LTCOP the best place to get a copy of a client's 8578 ID/RC Assessment and IPC Form?

Yes, you can locate these forms by using the FSI function of the LTCOP.

3.31 Will letters generated by the LTCOP replace enrollment and denial letters that LIDDAs currently send for enrollment?

Enrollment and denial letters that would typically be sent directly to the LIDDA from HHSC will now be available in the LTCOP.

3.32 Is the LTCOP replacing the IDD Operations Portal and the HCS Waiver Survey & Certifications Portal?

No, the LTCOP is replacing the CARE system as the primary data system. However, the IDD Operations Portal will still be used to submit supporting documentation.

3.33 We've created our TMHP portal account. Can we use the same username to access the LTCOP?

If you have already established your TMHP Portal Account login information, you can use the same username on the LTCOP. Reference steps in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* to ensure successful creation of TMHP accounts.

3.34 Does the LTCOP generate a letter for each 3608 or 8582 IPC Renewal, or are they only generated if a change was made by HHSC during the approval process?

For 3608 or 8582 IPC Forms, letters will be generated whenever HHSC-LTC modifies the services requested on the IPC Form during the approval process. For example, a letter is generated when certain services requested within the IPC Form are denied or reduced by HHSC-LTC during their approval process.

If all the services are approved, a letter will not be generated.

3.35 Will we be able to see IPC costs when entering 3608 or 8582 IPC Revisions into the LTCOP, or will the LTCOP only display over-cost warnings?

IPC costs for current 3608 or 8582 IPC Revisions will be displayed on the form.

3.36 When submitting an 8578 ID/RC Purpose Code (PC) 3 Continued Stay Assessment in the LTCOP, do I enter the LIDDA's vendor number or the program provider's vendor number?

LIDDAs will use their vendor number when entering 8578 ID/RC PC 3 Continued Stay Assessments for TxHmL and HCS consumers self-directing their services. Program providers will enter their program vendor number when entering 8578 ID/RC PC 3 Continued Stay Assessments for all other HCS consumers.

3.37 When do we submit a request for permissions to submit enrollment forms through the LTCOP?

Your LTCOP account needs to be ready before May 2, 2022. Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* to learn how to create your LTCOP account and assign permissions.

3.38 Are there step-by-step instructions on how to enter assessments and forms on the LTCOP?

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for step-by-step instructions on how to enter each assessment and form.

3.39 Do you have to enter something in the "Text to be added to form history" field on the LTCOP's Status Change Confirmation page?

No, you are not required to enter information in this field as part of the submission process, but we do recommend entering anything needed for future reference for your agency or HHSC.

3.40 The LTCOP is showing ICF options. Will this be updated or changed in any way?

When HCS and TxHmL options are added to the LTCOP, existing LTCOP functions for ICF will continue to be available.

3.41 On our LTCOP account, we only see Forms 3074 and 3071, but we don't see the 8578 ID/RC Assessment or IPC Form. Do we have to wait until May 2, 2022, or is there something that we are missing?

This could be a result of not having both the LTC (billing) and NF/Waiver (forms) options added during your account setup. Both of these options are required if you intend to submit claims and forms.

If you do have these options added to your account, you may not have the correct permissions assigned. Follow the steps in the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for further information on setting up accounts. You may also need to contact your account administrator for help determining if you have the correct permissions assigned.

3.42 Do program providers need to add an individual's information to the LTCOP?

An individual's information can be auto populated on forms. When submitting a form through the Submit Form page on the LTCOP, make sure that you enter the individual's Medicaid ID or name and date of birth (DOB) before you click the **Enter Form** button. The system will retrieve the individual's information and prepopulate it on the form you are entering.
Note: *If data does not prepopulate, you must enter information manually on the form.*

3.43 I am a program provider, but I do not see the Dashboard function on my LTCOP account. How can I get it added?

The Dashboard function will not appear on your LTCOP account until May 2, 2022. You should work with your LTCOP account administrator to ensure you have the correct permissions assigned. Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for further information on assigning permissions.

3.44 Will we be able to see a screen like the CARE system's C64 and C65 for a complete list of 8578 ID/RC Assessments and IPC Forms that are about to expire or have expired?

The Dashboard function, available to users with the assigned permissions, will have "Past Due" and "Due" tiles that display the count of 8578 ID/RC Assessments and IPC Forms that have expired or are about to expire. Users can click those counts to view the latest information for individuals who fall into those categories.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the Dashboard function.

3.45 Can we check the C72 screen on the LTCOP?

C72 information can be viewed on the LTCOP using the Dashboard or Individual Search functions. Under the Dashboard function, users can select the **CARE ID** hyperlink under the "Individuals by Program" tile and view the individual's information under the "Estimated Annual Cost" section.

Users can also select the **Individual Search** option under the "Search" drop-down menu located on the blue navigational bar. After search criteria has been entered and the results list appears, click the **CARE ID** hyperlink from the Individual List page and view the individual's information under the "Estimated Annual Cost" section.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the Dashboard and Individual Search functions.

3.46 Is there a person we can speak to for help with entering forms on the LTCOP?

Beginning May 2, 2022, HCS and TxHmL program providers who need assistance with form submittal can call the TMHP LTC Help Desk at 800-626-4117 (select option 1, then option 7). Users can also reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* or Item-by-Item guides located on the TMHP LMS.

3.47 I have two contract numbers: one for HCS and one for TxHmL, but the My Worklist tab only displays the HCS contract number. How can I add the TxHmL contract number?

You can link your TxHmL provider number to the same user ID. Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for further information on adding provider numbers to the LTCOP.

3.48 What capabilities are there for forms to be connected and completed using an electronic system that transfers over from that system so that program providers can enter forms in one place?

Beginning May 2, 2022, the Pre-enrollment Form, 8578 ID/RC Assessment, IPC Form, IMT Form, 3615 Request to Continue Suspension of Services Form, 3616 Request for Termination of Waiver Program Services Form, and the PLU Form will be submitted on the LTCOP.

The LTCOP will communicate with other related systems belonging to HHSC and TMHP to validate data and process forms. Once forms are submitted on the LTCOP, they will be saved with a DLN that program providers and LIDDAs will use to search for forms, monitor form statuses, and view a step-by step history of a form's workflow.

3.49 Who will have access to the Dashboard and Worklist options?

Every HCS and TxHmL program provider and LIDDA will be able to view the Dashboard function. Contact your account administrator to have the necessary permissions added to your account. This functionality will be available to users on May 2, 2022.

The Worklist function is an existing functionality. Once you are assigned the appropriate permissions by your account administrator, this menu should be available to view details on existing forms applicable to your account. Related information for HCS and TxHmL forms will be accessible on May 2, 2022.

Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for details on adding permissions to accounts.

3.50 Will we need to use the LTCOP and CARE system to pull different reports for 8578 ID/RC Assessments and IPC Forms?

CARE reports and data will be available in a few locations. Reference the Provider and LIDDA CARE Report Crosswalk and the Provider and LIDDA CARE Screen Crosswalk posted on HHSC website for details.

3.51 Can forms saved as drafts be located using the FSI function?

Only forms that have been successfully submitted to the LTCOP and assigned a DLN can be searched using the FSI function. Forms saved as drafts are available under "Drafts" in the Worklist drop-down menu on the blue navigational toolbar.

3.52 Can program providers see the LIDDA History trail for consumers and vice versa?

Program providers can see their clients' forms, including information added by LIDDA in the History trail. The same is true for LIDDAs as long as clients are currently with the program provider and the LIDDA.

3.53 Where can I find training on how to use the LTCOP?

Training can be found on TMHP's LMS including the *Long-Term Care (LTC) User Guide for Online Portal Basics, General Information, and Program Resources*, Long-Term Care (LTC) Online Portal Basics CBT, and *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*.

3.54 How do I access the blue navigational bar on my LTCOP account?

After logging into your LTCOP account, the blue navigational bar will display at top of the screen. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the blue navigational bar.

3.55 Are LIDDA vendor numbers prepopulated? If not, how do we obtain this information as a program provider?

Yes, LIDDA information will be prepopulated when program providers submit forms on the LTCOP.

3.56 Will we have to add location codes, submit suspensions, etc., using the LTCOP, or will we still complete those tasks in the CARE system?

All of these functions will be completed in the LTCOP. Reference question 5.2 for a list of functions remaining in CARE beginning May 2, 2022. Tasks must be completed in CARE prior to May 2, 2022.

3.57 Will SCs sign through the LTCOP instead of the CARE system?

SCs will continue to enter HCS and TxHmL forms with effective dates prior to May 1, 2022, in CARE. SCs must submit forms with effective dates on or after May 1, 2022, in the LTCOP, but must wait until May 2, 2022, to submit these forms. The LTCOP will be available beginning May 2, 2022.

3.58 Do changes in LON need to be submitted through the LTCOP before May 2, 2022?

No, you must not enter 8578 ID/RC Assessments through the LTCOP before May 2, 2022. Existing 8578 ID/RC Assessments for the current assessment year will be migrated from the CARE system.

3.59 Do we need to input all current clients into the LTCOP?

No, the LTCOP is not a client database. Only form information is stored on the LTCOP. When a submitter enters a CARE ID or Medicaid number on a form, client data is retrieved from other HHSC systems and populated on the form.

3.60 Will the TMHP system allow us to download a client roster into Microsoft® Excel®?

You will be able to export a client roster through the LTCOP dashboard after go-live.

Section 4: Assessments and Forms

4.1 Will the suspension option only be available to LIDDAs on the "Purpose" drop-down field for the IMT Form?

The "Purpose" drop-down field will be visible to users with access to the IMT Form on the LTCOP.

LIDDAs will only submit IMT—Suspension Forms for CDS, while for HCS and TxHmL, the IMT—Suspension Form is submitted by program providers.

4.2 What are the reasons I would submit a 3616 Request for Termination of Waiver Program Services Form and IMT—Suspension Form?

Termination reasons will be listed on the "Termination Reason" drop-down field on the LTCOP, while suspension reasons will be listed on the "Suspension Reason" drop-down field on the LTCOP.

The 3616 Request for Termination of Waiver Program Services Form can be used for reasons such as death, and the IMT—Suspension Form can be used for reasons such as hospitalization.

Reference the *3616 Request for Termination of Services Form Item-by-Item Guide* and the *Individual Movement Form Item-by-Item Guide* for complete lists of termination and suspension reasons.

4.3 I thought the 3616 Request for Termination of Waiver Program Services Form was initiated by LIDDAs. Are program providers able to enter them now?

The 3616 Request for Termination of Waiver Program Services Form can be entered by LIDDAs for TxHmL and program providers for HCS and TxHmL.

When the LIDDA submits the termination request, the program provider is notified in the LTCOP to review and acknowledge the form. Likewise, if the program provider submits the termination request, the LIDDA must review and acknowledge the form before it is submitted to HHSC-LTC.

All 3616 Request for Termination of Waiver Program Services Forms are sent to HHSC-LTC staff for review.

4.4 Will the following forms be completed by the LIDDA unless otherwise stated: 3608 or 8582 IPC, 3615 Request to Continue Suspension of Services, and the 3616 Request for Termination of Waiver Program Services?

3608 and 8582 IPC Enrollment Forms are entered by LIDDAs, 3608 and 8582 IPC Renewal and Revision Forms are entered by program providers, and 3608 and 8582 Transfer Forms are entered by LIDDAs.

3615 Request to Continue Suspension of Services Forms are entered by LIDDAs.

3616 Request for Termination of Waiver Program Services Forms are entered by LIDDAs for TxHmL and program providers for HCS and TxHmL.

4.5 Is the Pre-enrollment Form replacing the L01 screen in the CARE system?

The HCS or TxHmL Pre-enrollment Form is replacing the CARE L01 and CARE L03 screens in the CARE system.

4.6 Will LIDDAs still have six days to review 8578 ID/RC Assessments?

Yes, this time frame is not changing.

4.7 What is required in the justification packet for an LON increase?

LON justification packets will have the same expectation as outlined on the Level of Need (LON) Resources page.

The 8578 ID/RC Assessment will be completed in the LTCOP, while justification packets will still be submitted through the IDD Operations Portal or by fax.

4.8 What will happen to IPC Forms pending utilization review (UR) for exceeding cost in the CARE system when data is transferred to TMHP?

Forms with an "exceeds" flag will be transferred to TMHP in status ***Pending DADS Review*** or status ***Pending Coach Review***. Supporting documentation must be submitted to UR through the IDD Operations Portal or by fax in these instances.

4.9 How can an incorrect DOB be changed on an 8578 ID/RC Renewal Assessment in the CARE system?

The assessment will need to be inactivated and re-entered with the correct information.

4.10 If an individual's Inventory for Client and Agency Planning (ICAP) Assessment score does not match the LON and the program provider is not seeking LON increase, where do you document this when submitting the 8578 ID/RC Assessment?

Reference the *8578 Intellectual Disability/Related Condition Assessment Item-by-Item Guide* for information related to form fields.

Policy is not changing related to the data required on the 8578 ID/RC Assessment.

4.11 Will I need to submit a paper hard copy of the IPC Form to the LIDDA when there is a pending IPC Form for approval?

You will continue to work with the LIDDA as you do today. You will not be required to submit the 3608 IPC Form through the IDD Operations Portal or LTCOP unless requested.

4.12 Is the renewal process changing? It seems like there are more steps in the LTCOP.

Data entry for a renewal is comparable in the LTCOP, but instead of multiple screens, information is entered on different tabs.

4.13 Do we print, ask the LIDDA and Legally Authorized Representative (LAR) to sign the form, and then add it to the LTCOP, or do we need signatures in the LTCOP?

Forms are electronically submitted in the LTCOP. Hard copies that need to be printed and signed will still be available from the Health and Human Services (HHS) website.

4.14 Where will HCS providers enter or modify locations?

HCS providers will open, update, and close locations using the Provider Location Update (PLU) Form.

4.15 Has there been a change in the TxHmL 8578 ID/RC Assessment where LON can increase with the move to TMHP?

Per TAC, LON in TxHmL can be changed at any time. This is not changing with the move to TMHP.

4.16 Are providers no longer submitting 8578 ID/RC Assessments for clients using the CDS option beginning May 2, 2022?

8578 ID/RC Assessments are to be entered by LIDDAs if an individual is receiving all CDS services.

4.17 Do we need to monitor submitted 8578 ID/RC Assessments until they are approved?

We encourage you to monitor the assessment workflow to determine if additional information is needed for approval of the 8578 ID/RC Assessment.

4.18 Is the LIDDA required to enter the reason for disagreement on a form during the LIDDA review process?

Yes, the LIDDA is required to enter a reason if they disagree with a request.

4.19 Do we physically sign the 8578 ID/RC Assessment?

Policy related to signature requirements have not changed.

4.20 Which department approves the 8578 ID/RC Assessment?

Program Eligibility and Support (PES) authorizes LOC and Enrollment LON (PC 2); UR authorizes LON requests made at renewal (PC 3) and mid-cycle (PC 4).

All authorizations of the 8578 ID/RC Assessments will be done on the LTCOP.

4.21 For transfers involving two LIDDAs, is the receiving LIDDA required to be involved in the HCS transfer meeting? How much time will the receiving LIDDA be given to submit the IPC Transfer?

The receiving LIDDA will not be involved in the transfer meeting. For more information, see the Transfers and Local Authority Reassignments section of the HCS Handbook.

4.22 Does entering the IPC Transfer Form in the LTCOP eliminate having to upload a hard copy of the documents to the IDD Operations Portal?

No, the same documents will be required through the IDD Operations Portal.

4.23 Is the IMT—Suspension Form replacing the C18 screen when clients go to a hospital or another facility?

Yes, you will use the IMT Form to enter a suspension instead of the C18 screen in the CARE system.

4.24 Will 8578 ID/RC PC E Assessments be required?

Yes, the 8578 ID/RC PC E Assessment will be used to remove a billing hold for an 8578 ID/RC Assessment entered more than 180 days past the expiration of the previous assessment. 8578 ID/RC PC E Assessments only need to be entered if you are requesting a billing hold be removed.

4.25 Currently LIDDAs submit most forms for TxHmL. Will this change?

No, responsible parties for data entry remain the same.

4.26 Do we still need to fax the 8578 ID/RC Assessments and IPC Forms to the person doing data entry?

Data entry is still the responsibility of the program provider.

4.27 Will non-waiver 8578 ID/RC Assessments migrate to TMHP as well?

No, CFC-Non-waiver 8578 ID/RC Assessments will stay in the CARE system with the K screens.

4.28 For the 3608 IPC Form, do we have the SC and individual or guardian sign before submitting the form?

Policies related to hard copies, signatures, document transmission, and documentation retention are not changing.

4.29 For the 8578 ID/RC PC 3 Assessment, will information auto populate from the CARE system's C23 screen?

Reference the *8578 Intellectual Disability/Related Condition Assessment Item-by-Item Guide* for information on which fields are prepopulated.

4.30 Should we submit IPC Forms 30 days before the expiration date?

You can begin submitting 3608 or 8582 IPC Forms beginning May 2, 2022, using the LTCOP, which supports IPC submissions before the expiration date.

4.31 When do we start the renewal process for the 8578 ID/RC Assessment and the IPC Form?

Both 8578 ID/RC Assessments and 3608 or 8582 IPCs are valid for one year. We recommend you submit the renewal before the current 8578 ID/RC Assessment or 3608 or 8582 IPC Form expires.

You can submit a renewal 60 calendar days before the current form's expiration date through the LTCOP.

4.32 Do LIDDAs still enter 8578 ID/RC PC 2 No Current Assessments for enrollment? Do program providers enter 8578 ID/RC PC 3 Continued Stay Assessments and 8578 ID/RC PC 4 Change Level of Need on Existing Assessments?

LIDDAs will continue to enter all 8578 ID/RC PC 2 No Current Assessments for enrollment.

LIDDAs will submit 8578 ID/RC PC 3 Continued Stay Assessments for TxHmL and for all HCS consumers who are self-directing their services, while program providers will enter 8578 ID/RC PC 3 Assessments for all other HCS consumers.

LIDDAs and HCS program providers can submit 8578 ID/RC PC 4 Change Level of Need on Existing Assessments. LIDDAs will also submit 8578 ID/RC PC 4 Assessments for consumers self-directing all services.

4.33 What should we do if we need to complete a transfer on an annual IPC but also need to update the current IPC before the new annual or transfer effective date?

If the current IPC has an effective date prior to the upcoming annual (renewal) or transfer effective date, submit a correction form of the current IPC Form first. After the correction process is completed, the new transfer will be based on the corrected service data.

4.34 Are there forms located on the LTCOP for CFC?

The 8578 ID/RC Assessment and 3608 or 8582 IPC Form should be used for CFC services. The 8578-CFC Form is not currently available on the LTCOP.

4.35 What is the Transfer process when transferring to a new LIDDA?

The current LIDDA will submit the IMT—LA Reassignment Form to inform the new LIDDA when an individual moves to their contract area, and the newly assigned LIDDA must acknowledge the form. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

4.36 Does the ID/RC Check run automatically on a daily basis?

Yes, the ID/RC Check runs automatically on the 3608 or 8582 IPC Enrollment Form until a matching, authorized 8578 ID/RC PC 2 No Current Assessment is found. The 8578 ID/RC PC 2 No Current Assessment must be approved by HHSC-LTC prior to matching with the 3608 or 8582 IPC Enrollment Form.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

4.37 If the LIDDA does not take action on an 8578 ID/RC PC 3 Continued Stay Assessment within the allowed six-calendar day review period, do we have to resubmit the assessment?

After six-calendar days with no LIDDA review, the 8578 ID/RC PC 3 Continued Stay Assessment will move to the HHSC-LTC review queue.

4.38 In the event the 8578 ID/RC PC 3 Continued Stay Assessment is entered after it has expired, will it automatically be backdated, or will the begin and end dates change?

The LTCOP will automatically prepopulate the 8578 ID/RC PC 3 Continued Stay Assessment begin date to be the previous level expiration date plus one day.

4.39 LON increases will sometimes require us to change the effective date, but TMHP's LTCOP will prepopulate the 8578 ID/RC PC 4 Change Level of Need on Existing Assessment effective date. How can we change this?

You will need to contact HHSC-LTC for assistance with cases where the date needs to be changed on the 8578 ID/RC PC 4 Change Level of Need on Existing Assessment.

4.40 If we need to delete a 3608 IPC Renewal due to an error that must be corrected, do we call Processed Claims Services (PCS) as we normally do for the ICF program?

The same rule applies to HCS and TxHmL programs for deletion or invalidation of an IPC that has been processed.

4.41 Is the initial suspension entered by the program provider?

The IMT—Suspension Form is submitted by program providers for both HCS and TxHmL, unless all services are CDS, in which case the form is submitted by the LIDDA.

4.42 Will program providers be able to access the IMT—LA Reassignment Form workflow, or will we need to follow up with LIDDAs?

Program providers will be able to access forms of individuals who are currently assigned to them. If the IMT—LA Reassignment Form is not associated with a provider transfer, the program provider can view the form.

If a provider transfer is part of the process, since the IMT—LA Reassignment Form happens prior to the provider transfer, the receiving program provider will not be able to view the IMT—LA Reassignment Form, but the transferring program provider can view the IMT—LA Reassignment Form. The receiving program provider should follow up with the LIDDA on the status of an IMT—LA Reassignment Form and provider transfer.

4.43 When a 3615 Request to Continue Suspension of Services Form is set to status *Provider Action Required*, will an explanation be included of what action is needed?

As best practice, the HHSC reviewer will provide the details of information required in the notes section of the respective form whenever forms are moved to status ***Provider Action Required***.

4.44 After 270 days, is it the responsibility of the LIDDA to enter continuation of services or termination of services?

During the final review, 270 days after the original suspension request expires, the LIDDA is required to document the final review and either return the individual to services, terminate the individual, or request a continuation of suspension.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the IMT—Suspension process.

4.45 If an individual is on suspension, how do I proceed to a termination?

This will be handled systematically in the LTCOP. IMT—Suspension Forms will have form action buttons that include a button to terminate services. On click of the button, the user will be directed to enter the end date on the 3616 Request for Termination of Waiver Program Services Form.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

4.46 Will 8578 ID/RC Renewals, IPC Renewals, or IPC Revisions dated prior to May 2, 2022, and not entered into the CARE system prior to the migration to TMHP, need to be entered in both the CARE system and TMHP's LTCOP?

Yes, data entry into both systems will be required.

4.47 Will the 3616 Request for Termination of Waiver Program Services Form still need to be uploaded to the HHS portal for terminations?

Yes, nothing is changing with regard to required documentation for terminations.

4.48 If 8578 ID/RC Assessments and IPC Forms are going to be submitted through the LTCOP, will LIDDAs still be required to keep hard copies in each individual's local electronic health record?

Yes, LIDDAs are required to maintain an individual's records as described in their performance contract and the LIDDA Handbook.

Policy related to hard copies, signatures, and record retention is not changing.

4.49 Are we still sending hard copies of 8578 ID/RC Assessments and IPC Forms to the Mental Health and Mental Retardation (MHMR) Department and submitting them to the LTCOP?

Policy is not changing regarding hard copy requirements.

4.50 Can an individual transfer to another provider or service delivery option on the effective date of their renewal?

On the LTCOP, you can submit an IPC Transfer at Renewal Form. You will select the **IPC Type as Transfer** option, and check the **Transfer at Renewal** checkbox which will prepopulate the IPC begin date and end date. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

4.51 What is the difference between the 3608 IPC Form and the 8582 IPC Form?

The 3608 IPC Form will be used for the HCS Program, and the 8582 IPC Form will be used for the TxHmL Program.

4.52 Is there a way to add a service that is not listed on the Transfer Worksheet?

Yes, LIDDAs can click the **Add Provider Totals Information** button to add a service on the Transfer Worksheet when completing the IPC Transfer Form.

4.53 Does the HCS program provider use the IMT—Form to update an address for Host Home individuals, and does this effectively change the location that the individual is assigned to? For example, an individual receiving Host Home services is moving to another home in the same LIDDA catchment area and staying with the same HCS program provider (with the same vendor number).

If an individual receiving Host Home services is moving to another home, the HCS program provider will need to submit the IMT—Individual Update Form to update the individual's address and location code.

Since the LIDDA catchment area and the HCS program provider remain the same, an IMT—LA Reassignment Form or IPC Transfer Form is not required. In this case, submitting the IMT—Individual Update Form can effectively change the address and location of the individual.

Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* or the *Individual Movement Form Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type.

4.54 Do we need to submit an IMT—Form for every transfer we do as a LIDDA?

The appropriate IMT—Form is required if the individual has a location update or change in LIDDA (LA Reassignment) while a transfer is submitted. Reference Appendix A in the *Long-Term Care Home and*

Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide or the *Individual Movement Form Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type.

4.55 On the IMT—Suspension Form, there are fields to enter the LIDDA's information and required data. Is there a list of provider numbers and other required information?

When entering an IMT—Suspension Form, a list of provider numbers associated to the account is available on the Submit Form page's "Vendor Number" drop-down field. Reference the *Individual Movement Form Item-by-Item Guide* for detailed information on required form fields.

4.56 Can a LIDDA initiate the 3616 Request for Termination of Waiver Program Services Form?

Both the LIDDA and program provider can enter and complete the 3616 Request for Termination of Waiver Program Services Form. In both scenarios, the completed form is sent to HHSC-LTC staff for review and approval after submission.

4.57 For the IMT—Individual Update Form, what is the average amount of time required for the LTCOP to process an address update if there are no errors?

If there are no errors, an IMT—Individual Update Form can be processed within a few minutes after it is submitted on the LTCOP and will move to status ***Processed/Complete***.

4.58 Will the IMT Form only be used by program providers for suspensions and terminations?

The IMT Form is used for four purposes:

- **Suspension**: submitted by program providers for HCS and TxHmL, unless all services are CDS in which case the form is submitted by LIDDAs
- **Individual Update**: submitted by only program providers
- **LA Reassignment**: submitted by only LIDDAs
- **Service Coordinator Update**: submitted by only LIDDAs

The 3616 Request for Termination of Waiver Program Services Form can be submitted by both program providers and LIDDAs.

4.59 When an individual moves from the TxHmL Program to the HCS Program, we normally have to wait for the HCS IPC Form start date to submit the 3616 Request for Termination of Waiver Program Services Form. We then wait for the program provider to complete their screen in the CARE system, acknowledging that they are no longer going to be the individual's TxHmL program provider before the LIDDA can complete their CARE screen and continue with the enrollment process. Will this process be the same or can we submit the 3616 Request for Termination of Waiver Program Services Form after the enrollment meeting is completed?

To move an individual from the TxHmL Program to the HCS Program, submit the 3616 Request for Termination of Services Form to end TxHmL services. Then, submit the following forms for HCS enrollment:

- Pre-enrollment Form

- 8578 ID/RC PC 2 No Current Assessment
- 3608 IPC Enrollment Form

4.60 Do we submit IPC Forms and revisions on the LTCOP that will need to be approved by UR?

Yes, IPC Forms and revisions will need to be submitted on the LTCOP and will be reviewed by UR based on the data submitted.

4.61 If there is an error on an 8578 ID/RC Assessment or IPC Form that has already gone through the workflow, are we able to correct it, or do we have to "back out" an annual IPC Form to submit the revision to the previous IPC Form and then resubmit the annual IPC Form?

If there is an error on an 8578 ID/RC Assessment or IPC Form, you can click the **Correct this form** button, located on the "Forms Actions" bar, to correct the error.

If there is a need to revise a previous IPC Form after a subsequent annual IPC Form has been submitted, you need to inactivate the subsequent annual IPC Form and then submit the revision of the previous IPC Form. After the IPC Revision Form is in status ***Processed/Complete***, you will need to submit the annual IPC Renewal Form.

4.62 Is the SC agreement or disagreement considered "entering forms" on the LTCOP?

No, "entering forms" is usually referred to as completing a form during the form submission process. There is an "Enter Form" button on the Submit Form page of the LTCOP. 8578 ID/RC Assessments and IPC Forms submitted by program providers through the LTCOP will be moved to status ***Pending LA Review***. When viewing the form on the LTCOP, the LIDDA (SC) will see agreement and disagreement buttons located at the top of the form on the "Forms Actions" bar.

4.63 How will LIDDAs be notified of pending forms that need to be reviewed?

Forms that require a LIDDA's review or acknowledgment will be moved into statuses ***Pending LA Review***, ***Pending New LA Review***, ***Suspension Review Due***, ***Suspension Review Overdue***, ***Suspension Continuation Review Due***, or ***Suspension Continuation Review Overdue***. The form status will depend on the form type and purpose code. LIDDAs can utilize the FSI function on the LTCOP to search for forms in these statuses.

4.64 When a LIDDA reassignment is submitted by the current LIDDA, does the new LIDDA receive an alert on the Alerts page?

Yes, the new LIDDA will receive an alert on the Alerts page letting them know an IMT—LA Reassignment Form has been submitted.

4.65 How do we submit address changes for individuals?

You will need to submit an IMT—Individual Update Form from the Submit Form page on the LTCOP. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and *Individual Movement Form Item-by-Item Guide* for more information.

4.66 Where do we create new location codes?

To create a new location code, HCS program providers can submit the PLU Form and select **Add Location** as the action type. The address of the new location should not be the same as any existing location codes of the program provider.

To assign an individual to the new location, ensure the PLU Form is in status ***Processed/Complete***. You will then need to submit an IMT—Individual Update Form. The new location code will be displayed on the IMT Form in the location code list of the "New Location Code" field.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Home & Community-based Services Provider Location Update Item-by-Item Guide*, and *Individual Movement Form Item-by-Item Guide* for more information.

4.67 Where do we close a location code?

It is important to ensure all individuals who are assigned to the location have been reassigned to other locations before closing a location code. IMT—Individual Update Forms may be submitted to change the location code for the individuals if the individuals' residential type does not need to change. If the residential type needs to change, an IPC revision must be submitted for this change. After reassigning the individuals to new locations, HCS program providers can close the old location code by submitting the PLU Form and selecting "End Location" as the Action Type.

Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type.

4.68 Does a 3615 Request to Continue Suspension of Services Form have to be initiated to terminate an individual from the program before the 3616 Request for Termination of Waiver Program Services Form can be initiated?

A 3616 Request for Termination of Waiver Program Services Form can be initiated in three ways depending on the business scenario:

- If an individual has been on suspension between 265 and 270 days, there should be an IMT—Suspension Form pending for the 270-days suspension review. The LIDDA can initiate a 3616 Request for Termination of Waiver Program Services Form during the process of the 270-days suspension review.
- If an individual has a 3615 Request to Continue Suspension of Services Form in status ***Suspension Continuation Review Due*** or ***Suspension Continuation Review Overdue***, the LIDDA can initiate a termination during the process of the suspension continuation review.
- A 3616 Request for Termination of Waiver Program Services Form can be initiated directly from the Submit Form page on the LTCOP.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on how to submit the 3616 Request for Termination of Waiver Program Services Form.

4.69 I know that I need to open a new location and close the older location if a host home family moves from one home to another home. If they move back to their previous home, can I submit a PLU Form to reopen and use that location again?

If a service location is ended by the program provider, it cannot be reopened. The program provider must submit a PLU Form to add the ended location as a new location to reopen it.

4.70 Will approval of 8578 ID/RC Assessments and IPC Forms occur in the LTCOP after May 2, 2022?

Yes, form entry and form approval for 8578 Assessments and IPC Forms will occur on the LTCOP starting May 2, 2022.

4.71 Can program providers enter the Pre-enrollment Form?

Only LIDDAs can submit Pre-enrollment Forms.

4.72 Are 8578 ID/RC Assessment submission steps the same as ICF?

Yes, the submission steps are the same. However, the form fields are different. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and *8578 Intellectual Disability/Related Condition Assessment Item-by-Item Guide* for more information on submission steps and form fields.

4.73 Can an 8578 ID/RC Assessment start date be changed in the event the IPC effective date is set past the 8578 ID/RC Assessment start date?

For enrollments, the start date of the 8578 ID/RC PC 2 No Current Assessment will prepopulate on the assessment automatically and cannot be changed by the submitter. If the date needs to be changed, contact HHSC.

For renewals, the start date of the 8578 ID/RC PC 3 Continued Stay Assessment will prepopulate based on the cycle of the previous year and cannot be changed if "Yes" is selected in Field **58a. Would you like to renew on the Individual's regular assessment cycle?**.

4.74 Do we still need to terminate an individual from the TxHmL Program before completing the Pre-enrollment Form for the HCS Program?

Yes, you must terminate an individual from the TxHmL Program before submitting the Pre-enrollment Form for the HCS Program.

4.75 Is the functionality to import form field information available? For example, a program provider uses an Electronic Health Record (EHR) system and completes the same form field requirements.

Currently, program providers must enter information in both the EHR system and LTCOP.

4.76 Does the LIDDA or program provider enter the 8578 ID/RC PC E Gaps in Assessment?

8578 ID/RC PC E Gaps in Assessments are submitted by LIDDAs for all TxHmL individuals and HCS individuals using the CDS option. Program providers submit 8578 ID/RC PC E Gaps in Assessments for all HCS individuals not using the CDS option.

4.77 Should LIDDAs enter the 8578 ID/RC Assessment and receive approval before entering the Pre-Enrollment Form?

No, the LIDDA will enter the Pre-enrollment Form prior to submitting the 8578 ID/RC PC 2 No Current Assessment. The Pre-enrollment Form must be in the status ***Pre-enrolled*** before submitting the 8578 ID/RC PC 2 No Current Assessment.

4.78 Where can I find the Community Services Interest List (CSIL) Form number?

IDD Services has created Form 8591, Community Services Interest List (CSIL) Data Entry, to replace the CARE W21 Data Entry Form. IDD Services will notify LIDDAs through an email broadcast when the form is available on the HHSC website.

4.79 Why is the 8578 ID/RC Assessment now tied to the ME status for LON increase and continued stay?

The LON authorization or denial for an increase is not tied to ME. However, the LTCOP does a point-in-time check when processing forms.

4.80 As a program provider, will I still receive a paper format of the IPC Transfer Form to complete, or will only the LIDDA enter the transfer on the LTCOP and then send me an indicator to submit my reserved hours in the LTCOP?

There are no changes to the completion of the transfer paperwork or policies around transfer requirements. The receiving LIDDA will enter the transfer into the LTCOP.

4.81 If we receive a message indicating more documentation is needed on an IPC Form, do we send the documentation to the Operations Portal or is there a way to submit documentation to TMHP?

Documentation supporting an IPC review must be submitted by fax or through the IDD Operations Portal. You may contact EnrollmentTransferDischargeInfo@hhs.texas.gov for additional support.

4.82 Will the 8578 ID/RC Assessment, IPC Form, and other forms be changing? They appear different on the LTCOP.

No, forms will not be changing.
Note: *The PDF version of the 8578 ID/RC Assessment and IMT Form includes fields for all five waiver programs and might look different than the view in the LTCOP.*

4.83 Will we still submit paper copies of completed forms? If so, is there a date that we will be discontinuing paper forms?

There are no changes with regard to paper forms. Only the data entry system is changing.

4.84 Do we still submit supporting documentation for the IPC Transfer Form to the Operations Portal?

Yes. However, the IPC Transfer Form itself will be data entered into TMHP instead of CARE.

4.85 Can you define off-cycle and on-cycle renewals?

For example, an individual's regular cycle (effective period covered by the form in question) is January 1st to December 31st. If the program provider submits an off-cycle renewal, it must be before the established LOC expires, which in this instance is December 31st.

The program provider is not allowed to submit an off-cycle renewal after December 31st. An off-cycle renewal submitted after December 31st is considered an on-cycle renewal. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

4.86 Why is a renewal called off-cycle if it is on time?

An 8578 ID/RC PC 3 Continued Stay Assessment is considered off-cycle if "No" is entered in Field **58a. Would you like to renew on the individual's regular assessment cycle?**. The cycle can only be changed if the assessment is renewed on time and the provider would like to request a begin date that is earlier than the previous level expiration date. This changes the assessment cycle and is considered an off-cycle renewal.

4.87 How will program providers know the SC ID when submitting the IPC Revision Form?

An individual's SC information will prepopulate on the form when the program provider initiates the IPC Revision Form from an existing IPC Form.

4.88 Where can I find Item-by-Item guides for entering each form on the LTCOP?

Item-by-Item guides for each form type can be accessed through the TMHP LMS.

4.89 Will a change in the county of service automatically occur when the IMT—LA Reassignment Form and IPC Transfer Form are submitted?

For a transfer that requires a county change, LIDDA change, and contract change, LIDDAs will complete the following:

- The current LIDDA will submit the IMT—LA Reassignment Form to assign the individual to the new LIDDA and update the individual's county and address. After the IMT—LA Reassignment Form is in status ***Processed/Complete***, the new LIDDA will be reflected in both the TMHP and HHSC systems.
- The new LIDDA will submit the IPC Transfer Form if the contract is being changed.

Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type along with who submits each form.

4.90 Are LIDDAs required to complete an IPC Form when there is a reassignment to a new LIDDA?

This depends on the scenario:

- If there is only a change in LIDDA, only the IMT—LA Reassignment Form is required to be submitted by the current LIDDA.

- If there is a change in program provider along with the LIDDA change, the current LIDDA must submit an IMT—LA Reassignment Form and the receiving LIDDA must submit an IPC Transfer Form.
- If there is a change in the client's residential type along with the LIDDA change, the current program provider must submit an IPC Revision Form and the current LIDDA must submit an IMT—LA Reassignment Form.

You are strongly encouraged to reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type, along with who submits each form.

4.91 You mentioned that an IPC Form may need to be submitted along with the PLU Form. If there is not a change of amount, services, or LIDDA, and there is only a change in location, is there a need for an updated IPC Form?

If there is only a change in location and the residential type did not change, then an IPC Revision Form is not needed. However, if the residential type changed along with the location, you must submit an IPC Revision Form.

Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for more information.

4.92 Do 8578 ID/RC Assessments and IPC Forms that are submitted in the CARE system and not approved need to be submitted in the LTCOP?

Beginning May 2, 2022, program providers and LIDDAs will see 8578 ID/RC Assessments and IPC Forms on the LTCOP. Most of the 8578 ID/RC Assessments and IPC Forms will be in status ***Processed/Complete***, which means those assessments have been fully processed. Some 8578 ID/RC Assessments and IPC Forms could be in status ***Pending DADS Review***, which means those assessments are under HHSC-LTC review. You may also find 8578 ID/RC Assessments and IPC Forms in status ***Remanded to Submitter***, which indicates that the submitter needs to take action to correct an issue, or inactivate the forms and resubmit them on the LTCOP.

If an 8578 ID/RC Assessment or IPC Form was pending review in the CARE system prior to April 6, 2022, but cannot be found in the LTCOP, you must submit the 8578 ID/RC Assessment or IPC Form in the LTCOP on or after May 2, 2022. If the effective date is prior to May 1, 2022, you must submit the forms in CARE.

4.93 If additional hours are added to an IPC form, how will we know the date the hours were added?

The revision date can be found on the IPC Revision Form on the LTCOP. Once the form is in status ***Processed/Complete***, the revision will be reflected in MESAV.

4.94 Are we able to see when an 8578 ID/RC Assessment is up for renewal?

On the LTCOP Dashboard, LIDDAs and providers will see their clients due for renewal in the tile labeled "LOC/LON Assignments due in 60 days." A count will be displayed in the tile. On click of the count, a list of impacted individuals will be displayed.

4.95 What does it mean to remand a form?

If HHSC LTC staff or the LIDDA reviewer believes that corrections are needed during the Authorization Process or the LA Review Process, the assessment or form may be returned to the original submitter to make corrections, add notes, or inactivate the assessment or form. This is known as the "Remand Process" and applies to multiple forms.

4.96 After submitting a form, is it necessary to send it to the workflow each time?

After a form is successfully submitted on the LTCOP, a unique DLN is generated. The system automatically moves each form to the workflow.

4.97 What should we do if we need to revise an IPC Renewal Form, but the renewal is due before we begin using the LTCOP on May 2, 2022?

The IPC Renewal Form should be completed in the CARE system before entering the IPC Revision Form. If the IPC Renewal Form has an effective date prior to May 1, 2022, it will need to be entered into both the CARE system and the LTCOP.

You may contact UR at 512-438-5055 to discuss specific situations.

4.98 Do program providers need to enter their current suspensions and terminations on May 2, 2022?

If the suspension or termination was entered in CARE by COB on April 6, 2022, the data will be migrated to the LTCOP.

If the suspension or termination was not entered in CARE by COB on April 6, 2022, and the effective date is prior to May 1, 2022, the form must be entered into both the CARE and LTCOP systems.

If the suspension or termination was not entered in CARE by COB on April 6, 2022, and the effective date is on or after May 1, 2022, the form only has to be entered into the LTCOP beginning May 2, 2022.

4.99 I understand that 8578 ID/RC Assessments are going to be entered into the LTCOP, but currently SCs are reviewing the assessments in the CARE system. Will SCs continue to review assessments in the CARE system or start reviewing in the LTCOP?

SCs will be expected to review 8578 ID/RC Assessments in the LTCOP unless the effective date is prior to May 1, 2022. Assessments with an effective date prior to May 1, 2022, must be reviewed in CARE. You must enter all 8578 ID/RC Assessments with effective dates that either overlap, are on, or are after May 1, 2022, in the LTCOP beginning May 2, 2022.

4.100 Is the 8578 ID/RC Assessment and IPC Form changing on the HHSC website?

An updated hard-copy template of the IPC Form will be published to the HHSC website on May 2, 2022. There will be no changes to the 8578 ID/RC Assessment.

4.101 On the LTCOP, the IPC Form is a 16-page document under the "Printable Forms" section. Do we use that version of the IPC Form, or do we use the standard IPC Form found on the HHSC website?

The 3608 and 8582 IPC Forms on the HHSC website should be used. The updated hard-copy templates for these forms will be published on May 2, 2022.

4.102 Will temporary discharges still be entered, and will MESAV show hospitalizations?

HCS and TxHmL providers will enter "temporary discharges" on the TMHP LTCOP by submitting the IMT—Suspension Form with the proper suspension reason. The list of suspension reasons on the IMT—Suspension Form includes hospitalization. After the IMT—Suspension Form moves to status ***Processed/Complete***, a client hold record will be shown on the MESAV.

4.103 Is there training on how to submit assessments and forms in the LTCOP?

Yes. Refer to the Long Term Care page of the TMHP LMS website for HCS and TxHmL trainings, including user guides, item-by-item guides, and webinars. You must create an account the first time that you access the LMS and log in with those credentials thereafter. Refer to the *Learning Management System (LMS) Registration and Navigation Job Aid for Providers* or email TMHPTrainingSupport@tmhp.com for assistance.

4.104 When a form's status is updated, is the status updated for all other forms listed for that individual in the LTCOP? For example, when the 8578 ID/RC Assessment status is updated, is the Pre-enrollment Form automatically updated to the same status?

Generally, the form status only reflects changes of that specific form. However, the status of a form can be affected when the form is pending the completion of another form or forms.

The following are a few examples:

- The Pre-enrollment Form will remain in status ***Pre-enrolled*** until the 8578 ID/RC PC 2 Assessment and IPC Initial Enrollment Form are submitted.
- The Pre-enrollment Form automatically updates to status ***Pending Enrollment*** when the 8578 ID/RC PC 2 Assessment and IPC Initial Enrollment Form are submitted and are waiting to get to a finalized status of ***Processed/Complete***.
- The Pre-enrollment Form automatically updates to status ***Enrolled*** when the 8578 ID/RC PC 2 Assessment and IPC Initial Enrollment Form are approved and in the finalized status of ***Processed/Complete***.
- The Pre-enrollment Form automatically updates to status ***Denied*** when the 8578 ID/RC PC 2 Assessment or IPC Initial Enrollment Form is denied.
- The status of the IMT Form and 3615 Request to Continue Suspension of Services Form automatically updates when a suspension is ended and the individual is either returned to service or terminated.

Refer to the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for further details and additional scenarios.

Section 5: General Questions

5.1 Is the provider number the same as the NPI number?

In TMHP systems, the 9-digit number on your provider agreement is referred to as your provider number. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Enumeration System (NPPES). An NPI must be obtained before a provider can enroll as a Texas Medicaid provider.

5.2 Is the CARE System phasing out? How will we know what is moving to TMHP and what is staying in CARE?

CARE is not phasing out with this migration. However, the HCS and TxHmL form and claim submission on CARE is phasing out. Additional functions remaining in CARE include:

- 1185 Permanency Plan Status Report
- 249 PPR Approval Status (Inquiry)
- 309 Permanency Plan Review
- 686 Critical Incident Update
- 286 Critical Incidents Data Inquiry
- C97 WS/C Authority Review Notations
- 410 Add Case to ID/Demographics
- 325 Register individual: CARE-ID
- 360 Death/Separation of individual: Add/Change/Delete

5.3 Is the client ID the same as the CARE ID or Medicaid ID? Will the same CARE ID be used?

The client ID is known as the Medicaid ID in TMHP systems. Providers utilizing CARE for DOS prior to May 1, 2022, will continue to use the same CARE ID. TMHP does also utilize the CARE ID as secondary identification. For DOS on or after May 1, 2022, the provider will use the client/individual number, also known as the Medicaid ID number, for all form submissions and claims entered into the TMHP system.

5.4 What contingency plan does TMHP and HHSC have if the data conversion from CARE is corrupt during the migration process or if there is a major problem with the start date?

HHSC and TMHP have been and continue to run numerous cycles of the data conversion throughout the project timeline and will ensure the copied data is validated prior to May 2, 2022.

5.5 Are the provider numbers already assigned for HCS and TxHmL the ones that are currently filed through CARE or will new provider numbers be needed?

HHSC will continue to use the 9-digit provider/contract number that identifies the contract under which an individual is receiving services.

5.6 What is the difference between the provider number, the vendor number for HCS, the contract number, the component code, the NPI, the Taxpayer Identification Number (TIN), and the Employer Identification Number (EIN)?

The provider/contract number is the 9-digit number given by the HHSC Contracts Administration which identifies the contract under which the individual is receiving services.

The vendor number is generally a 4-digit number that is comprised of the existing Component Code preceded by a zero.

The component code is a 3-digit unique code that identifies a state hospital, state school, state center, community center, or a private provider.

The NPI is a 10-digit number which is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number that covered health-care providers, all health plans, and health-care clearinghouses must use in the administrative and financial transactions adopted under HIPAA.

The TIN is a 9-digit identification number used by the Internal Revenue Service (IRS) in the administration of tax laws.

The EIN is also known as the Federal Tax Identification Number and is used to identify a business entity.

5.7 Will providers receive a list of contacts so that we can have support as we transition?

Providers will have access to several job aids to assist with the transition, which will include a contact list, bill code crosswalk, and data crosswalk. You are encouraged to continue to visit the TMHP website frequently for updates, which will include quarterly bulletins, articles, and FAQs; as well as quick reference tools which will assist in determining what data will remain in CARE and what data will be found in TMHP.

5.8 Are the service codes changing for HCS services? Is Level of Need (LON) changing?

Service codes will change for some services within HCS and TxHmL. Providers will use the updated LTC Bill Code Crosswalks to include the changes for DOS on or after May 1, 2022. HHSC will continue to use the LON.

5.9 Is the referral number assigned to the individual at admission to the HCS or TxHmL programs during the enrollment process?

The referral number is assigned by HHSC when the initial IPC is approved.

5.10 Will the Travis Questionnaire W21 be moved to TMHP, or will it remain in the CARE system?

The Travis Questionnaire is now in the CSIL application and is now called the Questionnaire for Waiver Program Interest Lists.

CSIL is accessed through the HHS Enterprise Portal.

5.11 Will we have to upload our clients' demographics, or will they be uploaded from the CARE system automatically?

Client demographic information from the CARE system will be loaded on the LTCOP.

5.12 What if a client doesn't appear on our account?

Only individuals associated with your contract will appear on your roster. There could be several reasons as to why the client does not appear, such as eligibility, incorrect information, delay in transfer, etc.

5.13 Are we using the same computer we use for the CARE system?

The LTCOP is a web-based application and can be accessed with any computer with an Internet connection and the appropriate credentials.

5.14 If we need to add more dental funds on the same day we receive the dental bill, will it be denied and terminated?

A revision can be submitted at any time.

5.15 Why is the DADS acronym still being used?

The DADS acronym is a legacy term, and any references to "DADS" will be replaced with "HHSC" in the LTCOP in future enhancements.

5.16 During the 180-day wait time for approval of MI and ME, is the program provider expected to admit the individual?

Program provider expectations are not changing related to enrollment activities, and they are still expected to follow TAC rules regarding the enrollment process.

5.17 Will the HHSC Portal still be required?

The IDD Operations Portal will still be used to submit supporting documentation.

5.18 Is the HCS Program a lifetime program?

Individuals enrolled in the HCS program must maintain eligibility criteria as outlined in TAC 9.155.

5.19 Why would a consumer be placed on suspension?

The suspension reasons for HCS and TxHmL are listed in the TAC and are not changing. You can also reference the *Individual Movement Form Item-by-Item Guide* for a list of suspension reasons listed on the IMT Form's "Suspension Reason" drop-down field on the LTCOP.

5.20 Where can I locate user guides and other resources focused on TMHP systems?

Educational resources, including user guides, for TMHP systems can be accessed on the TMHP LMS and the LTC Reference Material page located on the TMHP website.

5.21 What does "individual association" mean?

Provider to Individual association is referencing a documented relationship that is established by the submission of certain forms. This is to ensure that program providers only see information for clients that are assigned to them and have that relationship officially documented on those forms.

5.22 How do I setup direct deposit and EFT?

Providers with questions about how to sign up for or obtain direct deposit or how to sign up for EFT, contact HHSC Accounting at 737-867-7580 or vendor@hhs.texas.gov.

5.23 Is the vendor number the component code?

The vendor number is based on the component code.

5.24 Is a program provider the LIDDA?

No, program providers are the agencies providing services to their clients. LIDDAs serve as the point of entry for publicly funded Intellectual or Development Disabilities (IDD programs), whether the program is provided by a public or private entity.

5.25 What is a coach review?

Coach review is a term used to indicate a form is being reviewed by HHSC-LTC staff or a Coach.

5.26 What is Location Availability?

Location Availability is part of the Capacity Verification Process. Before an individual can be added to a program provider's list, the LTCOP verifies that the program provider has both the availability in their contract with HHSC-LTC to serve the individual, and that the program provider location has an open spot for the individual.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

5.27 What list of things do we need to complete to enroll with TMHP?

Reference the Provider Enrollment page on the TMHP website to begin the enrollment process.

5.28 Is there a quick reference document related to the forms on the LTCOP?

A QRG is not available on these topics, but you can access educational resources, including user guides and item-by-item guides, on the TMHP LMS.

5.29 When will users begin to submit forms and claims to TMHP?

Users will start submitting forms and claims beginning May 2, 2022, to TMHP. Providers must submit claims to TMHP for DOS on or after May 1, 2022. Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for a list of TMHP accounts that must be setup before then.

5.30 I contract with several program providers. Do I need TMHP portal login credentials for each program provider?

You can use the same login credentials for multiple program provider numbers. Using the same credentials will enable you to see all your contract numbers from one account. Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* for more information.

5.31 Do the login credentials for the TMHP portal also work for the TMHP LMS?

No, the TMHP portal and TMHP LMS are different systems. Reference the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* to learn more about setting up your TMHP accounts, including your LMS account.

5.32 If I have an HCS enrollment that is currently in the CARE system and has not processed, will it move to the LTCOP once it is processed?

TMHP is working closely with HHSC to migrate in-process assessments and forms during the migration. These assessments and forms will appear in the LTCOP and will continue processing, if needed.

5.33 What is location capacity?

Each location has a capacity count that is stored in the HHSC system. When an individual is assigned to a location, the capacity of the location will be minus one, and when an individual is moved out of the location, the capacity of the location will be added one. The LTCOP will check the HHSC system to confirm the capacity of a location before an individual is assigned to the location.

5.34 Where can we locate "Appendix A: Scenarios for Selecting an IMT Purpose and IPC Type?"

You can find Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, and *8582 TxHmL Individual Plan of Care Item-by-Item Guide*.

5.35 How will HCS program providers place a cap on its program? Can we complete this in the LTCOP, or must we contact the HCS Contracts department?

This process is not changing. Program providers must continue to submit their request directly to the Waiver Provider Enrollment (WPE) team at IDDWaiverContractEnrollment@hhsc.state.tx.us.

5.36 If a location has been "closed," how can we "reopen" it to allow an individual to move to that location?

If a location has been "closed," you can add a new location with a new location code for that location by submitting the PLU Form. Once the PLU Form is in status ***Processed/Complete***, the individual can be assigned to that location by submitting the IMT—Individual Update Form.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the PLU Form.

5.37 I am an account administrator and have created all my TMHP accounts. Does this mean I am ready to submit claims and forms beginning May 2, 2022?

If you have followed all the steps listed on the *TMHP Account Setup for HCS and TxHmL Waiver Programs Quick Reference Guide (QRG)* to set up your TMHP accounts you should be ready to start submitting claims and forms beginning May 2, 2022.

The main function of the account administrator is to create or remove user accounts and also assign or remove user permissions. You may still need to create user accounts and give the appropriate permissions to users that need access to bill claims and submit and manage forms.

5.38 Where can we access TMHP's LMS?

You can access TMHP's LMS at learn.tmhp.com.

5.39 What does DLN mean?

A Document Locator Number is the unique number assigned to a document or form after it has been successfully submitted on the LTCOP.

5.40 Will the TMHP portal be secure like the CARE system?

Yes, the TMHP portal is a secure portal.

5.41 What is FMSA?

FMSA is the acronym used for Financial Management Services Agency and was previously known as Consumer Directed Services Agency (CDSA). FMSAs provide financial management services to individuals or LARs who serve as the employer of their service providers. Any individual or LAR electing the CDS option is required to use an FMSA.

5.42 Will providers continue to create staff IDs in the CARE system, or will this migrate to the LTCOP?

You must continue creating staff IDs in CARE. The creation of staff IDs will migrate to the LTCOP in future enhancements. The service provider delivering the service will be identified on the billing claim.

5.43 How do I make updates to a provider office and mailing address after May 2, 2022?

Providers do not have the ability to make changes to their contract or contact information in the LTCOP. Changes to a contract office and mailing address should be sent to WPE at IDDWaiverContractEnrollment@hhsc.state.tx.us.

5.44 Are Medicaid numbers, instead of the CARE ID, required on all billing documents kept in the client's chart, or do we keep the CARE ID on documents for auditing purposes?

HHS service delivery logs will be updated to remove the "CARE ID" field. The individual's Medicaid number should not be listed on service delivery logs. CARE IDs and Medicaid IDs are not required elements on written documentation.

5.45 What is the difference between an HHSC LTC staff and an HHSC LTC Coach?

The difference is based on permission and access levels.

5.46 Do we have to suspend all consumers and then re-establish them in the new TMHP system using the 3615 Request to Continue Suspension of Services Form?

You will not suspend any individuals unless they are truly on suspension based on the suspension reasons listed in the TAC.

5.47 When assigning permissions to staff, is there a way to assign them to multiple staff members at one time?

No, there is not a current method to assign permissions to multiple individuals at the same time.

5.48 Is a temporary discharge (such as hospitalization) the same as a temporary suspension?

The IMT—Suspension Form on the LTCOP is for temporary suspension cases, and the allowed suspension reasons include hospitalization. Reference the *Individual Movement Form Item-by-Item Guide* to view a complete list of suspension reasons.

5.49 If a consumer moves, but there is not a change in LIDDA or services provided, is a new location code needed or is the one in place updated?

If an individual moves (as in, his/her own home address changed), the program provider or LIDDA can submit an IMT—Individual Update Form to update the individual's address. If an individual moves from one location to another location associated to the same program provider, the program provider can submit an IMT—Individual Update Form to update the individual's new location code. The new location code for the individual can be an existing location of the program provider.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and *Individual Movement Form Item-by-Item Guide* for more information.

5.50 Beginning May 2, 2022, will program providers be able to change the LON or LOC status for an individual, or will SCs be the only ones who can change this?

The 8578 ID/RC PC 4 Request Change of LON Assessment can be submitted by the program provider on the LTCOP starting May 2, 2022. LIDDAs will be the only ones to submit the 8578 ID/RC PC 2 Enrollment Assessment to enter and change the LON/LOC during the enrollment process.

5.51 I have several forms that have been held up for months in the CARE system. Who can I speak with for assistance in getting this resolved prior to the migration?

You may send your issues to the HCS/TxHmL PES message line at 512-438-2484.

5.52 Once the system goes live for the HCS and TxHmL programs, will we be given a "trial and error" phase at the beginning where we will not be penalized for mistakes?

The TMHP LTCOP will prompt the individual performing the data entry when a field has been completed incorrectly. A grace period cannot be offered as the claims administration system requires complete and correct data to process a claim. TexMedConnect will reject a claim if there are missing required elements.

5.53 Where and how can I find the diagnosis code of a client? I do not see it in MESAV.

The diagnosis code is the ICD10 code and can be found on the 8578 ID/RC Assessment's "Diagnosis" tab. For additional assistance obtaining client diagnosis codes, email the HCS or TxHmL Policy departments at hcspolicy@hhs.texas.gov or txhmlpolicy@hhs.texas.gov.

5.54 Where can we see if an LON increase was approved?

Providers can use the FSI function of the LTCOP to search for 8578 ID/RC PC 4 Change Level of Need on Existing Assessments and its status. When the assessment moves to HHSC review, HHSC staff will either approve or modify the LON change. This will move the assessment status to either ***LON Approved*** or ***LON Modified***. If there are no errors with the assessment, it continues in the workflow to the MI check process, ME check process, and SAS process until its completion. Once completed, the assessment will be in status ***Processed/Complete***.

5.55 Is the funding in CARE separate from the funding in MESAV?

The funding process has not changed, so it will be the same under both CARE and TMHP.

5.56 Are program providers able to access the CARE system to enter 8578 ID/RC Assessments, 3608 IPC Forms, 8582 IPC Forms, and billing before May 2, 2022?

Yes, however some CARE screens will be inactive starting end of day Wednesday, April 6, through Saturday, April 30, 2022, due to the migration of data from CARE to TMHP's LTCOP. HHSC will notify you if the migration tasks are done before May 1, 2022. CARE billing will continue to be available for processing. Refer to the "Inactive HCS and TxHmL Provider CARE Screens" article on tmhp.com for more information on which CARE screens will be inactive or permanently disabled.

Forms that were entered in CARE by COB on April 6, 2022, will be migrated to the LTCOP. Forms that were not entered in CARE by COB on April 6, 2022, and that have an effective date prior to May 1, 2022, must be entered in both the CARE and LTCOP systems. Forms that were not entered in CARE by COB on April 6, 2022, and that have an effective date on or after May 1, 2022, only need to be entered in the LTCOP beginning May 2, 2022.

5.57 If an NPI is not available for our office, what will we need to log into our accounts? Will each employee have their own username and password?

All health-care and HIPAA-covered organizations must obtain an NPI from the Centers for Medicare & Medicaid Services (CMS). The organization's NPI must be used in all HIPAA-standard transactions. For more information about NPIs, visit the National Provider Identifier Standard (NPI) page of the CMS website.

You must enter the NPI for your organization during account setup. Individual usernames and associated permissions are assigned and must be used to log in for day-to-day use.

5.58 What will happen to the FileZilla reports?

The approved claims, claims exception, and R&S reports for CARE-initiated claims will continue to go to the FileZilla folders.

Claims processed through TMHP will not have reports or files going to FileZilla. The approved claims and claims exception reports will be done by TaskmasterPro, which sends a TMHP claims file that is then processed and put in folders on Globalscape.

The file that is currently being tested in conjunction with TaskmasterPro is the TMHP replacement for the CARE Service Utilization file. It will go to the FileZilla folders in place of the current CARE file.

5.59 Can a new user request access to CARE?

The CARE system is currently available for new user registration.

5.60 Can LIDDAs register new people in CARE?

LIDDAs must continue to add or update HCS and TxHmL interest list records in CARE. However, on May 1, 2022, LIDDAs must begin adding and updating HCS and TxHmL interest list records in the CSIL application. If an individual does not have a CARE ID, the LIDDA must register the individual in CARE. The LIDDA will receive a system-generated CARE ID and must then assign a local case number in CARE before adding the CSIL record.

5.61 What is the provider contract capacity?

The provider contract capacity is data found in the HHSC-LTC Provider system. The CAP is the max amount of individuals a facility is set to serve, and sometimes a facility will want to either reduce or increase their "CAP."

If providers would like to increase or decrease their CAP for their contract number, submit the following on agency letterhead, if possible, to IDDWaiverContractEnrollment@hhsc.state.tx.us:

- Legal entity name
- Contract number
- Component code
- Signature of the individual listed on Form 2031
  Note: *To update the current signature authority on file, submit an updated Form 2031.*

5.62 Do all our consumers have to enroll using their Medicaid number?

If an individual's Medicaid ID is not available during the process of enrollment, a CARE ID may be used on the LTCOP to enroll the individual. If the individual has a Medicaid ID, use the Medicaid ID to enroll the individual.

5.63 Must we use a VPN to access the LTCOP or TexMedConnect?

No, you will use the production version of the LTCOP and TexMedConnect, which is a website that is open to the public. People who have set up their user accounts may log into these systems. VPNs were only used during testing of the systems.

5.64 If we created usernames and passwords several months ago, are we able to update our passwords?

TMHP recommends changing your password every 30 days as a best practice to keep your account secure. If you are unable to log into your account, you can request a password reset as outlined on page seven of

the *Basic Tasks for Managing an Account on the Secure Provider Portal Job Aid*. Upon completion of the password reset, you will be able to log into your TMHP secure portal account.

5.65 We've submitted our application packet to enroll with TMHP. How do we know if it was approved?

You can email the TMHP Provider Relations (PR) mailbox at provider.relations@tmhp.com for assistance.

5.66 On May 2, 2022, can I check a client's eligibility for the month of May?

Yes, you can verify client eligibility for past, current, and future dates not exceeding a 90-day date span.

5.67 Is the MESAV eligibility start and end date the Medicaid date or IPC date?

The dates entered by the user to determine eligibility are the dates for which claim services are to be provided and what the provider uses to determine program eligibility. The effective date and end date are the client's eligibility dates for the program that are indicated in the results.

5.68 Is the ANSI 835 format like the FileZilla Reports?

The 835 files are in X12 format. Refer to the *835 Companion Guide* to view TMHP specific details on the 835 that is produced or the Implementation Guide on the X12 website for information on the full implementation.