TEXMEDCONNECT

LONG-TERM CARE (LTC) USER GUIDE

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

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Terms and Abbreviations

Abbreviations	Terms
API	Atypical Provider Identifier
ARD	Assessment Reference Date
CBA	Community Based Alternatives
CMS	Centers for Medicare & Medicaid Services
CS	Community Services
CSI	Claim Status Inquiry
DLN	Document Locator Number
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOPS	Explanation of Pending Status
ETN	EDI Transaction Number
FFS	Fee For Service
FSI	Form Status Inquiry
HHSC	Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization (Note: HMO has been changed to MCO)
ICF/IID	Intermediate Care Facility/Facilities for Individuals with an Intellectual Disability or Related Conditions
ICN	Internal Control Number
ID	Intellectual Disabilities
IDD	Intellectual and Developmental Disabilities
LTC	Long-Term Care
MCO	Managed Care Organization (Formerly HMO)
MCO ICN	Managed Care Organization Internal Control Number
MESAV	Medicaid Eligibility and Service Authorization Verification
MN	Medical Necessity
NF	Nursing Facility
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OES	Office of Eligibility Services
OIG	Office of the Inspector General
PDF	Portable Document Format
R&S	Remittance and Status
RUG	Resource Utilization Group
SAS	Service Authorization System
SC	Service Code
SCSA	Significant Change in Status Assessment
SG	Service Group
SSN	Social Security Number
STAR+PLUS	State of Texas Access Reform (STAR) + PLUS
TAC	Texas Administrative Code
THCA	Texas Health Care Association
TMB	Texas Medical Board

Abbreviations	Terms
TMHP	Texas Medicaid & Healthcare Partnership

Training and Support

TexMedConnect Training

The TexMedConnect for Long-Term Care (LTC) Providers computer-based training (CBT) module is an online course that can be reviewed at your own pace. It is available in the Provider Education section of the Texas Medicaid & Healthcare Partnership (TMHP) Learning Management System (LMS) at learn.tmhp.com.

Technical Support

For LTC technical issues, call the TMHP Electronic Data Interchange (EDI) Help Desk at 888-863-3638, option 4, Monday through Friday from 7:00 a.m. to 7:00 p.m. Central time. The TMHP EDI Help Desk provides technical assistance for TexMedConnect and the TMHP EDI Gateway. Contact your system administrator for assistance with modem, hardware, or Internet connectivity issues.

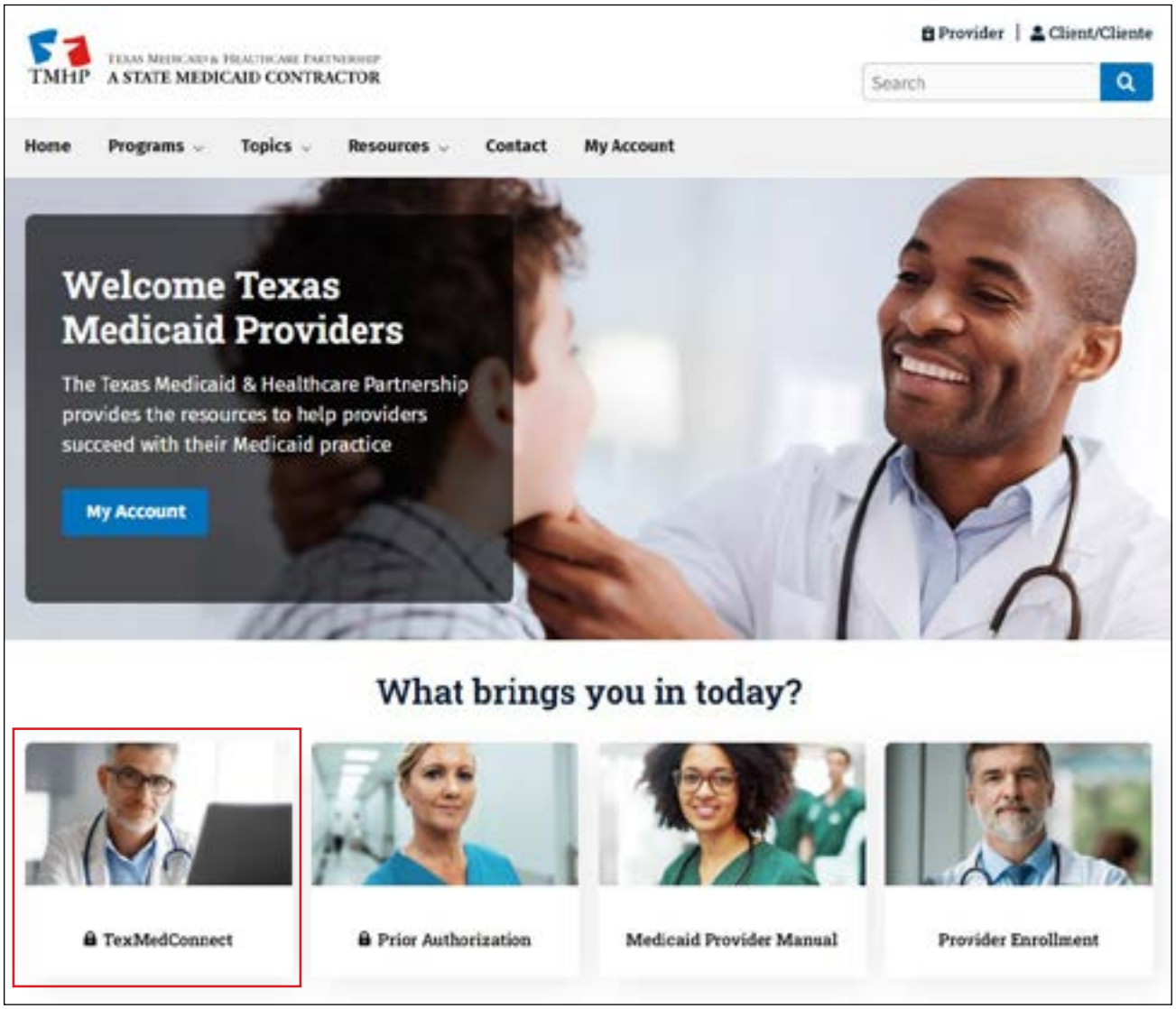
Claims Support

For questions about claims, call the TMHP LTC Help Desk at 800-626-4117, option 1 then option 2, Monday through Friday from 7:00 a.m. to 7:00 p.m Central time.

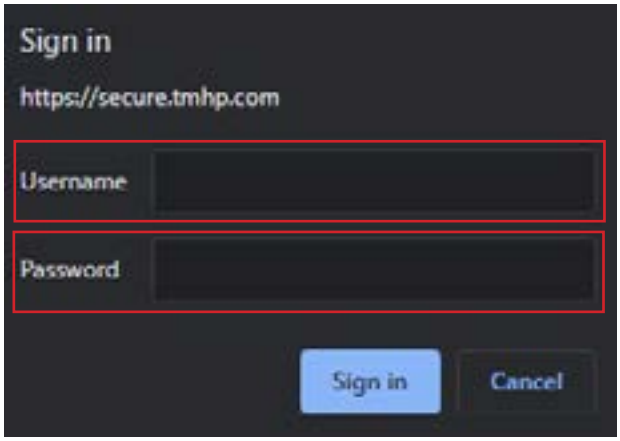
Getting Started

You can access TexMedConnect from the LTC 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 Website Security Provider Training Manual*.

1) On the tmhp.com home page, click **TexMedConnect**.



2) Enter your user name and password and click **Sign in**.

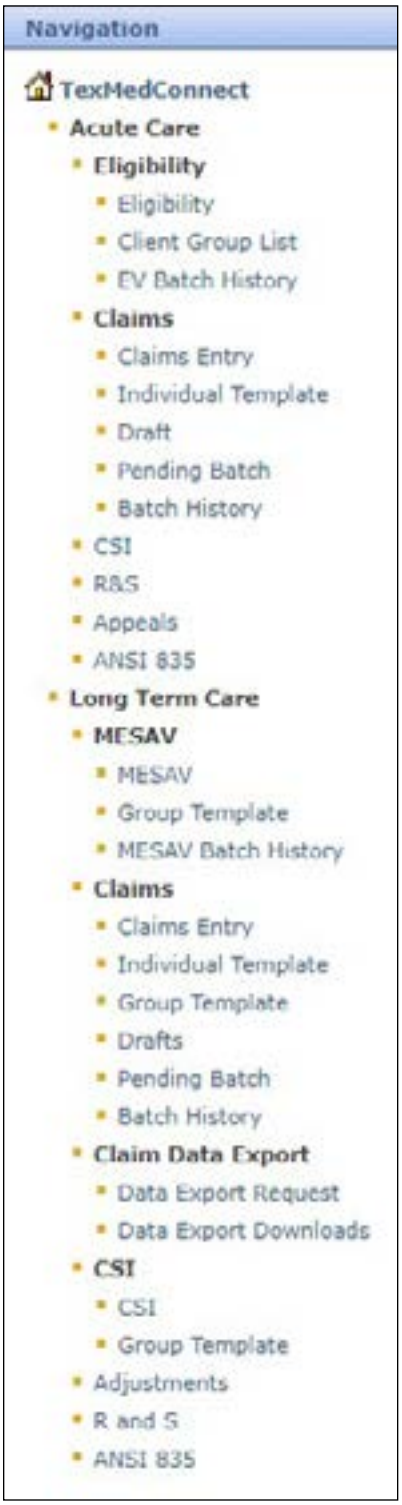


3) The TexMedConnect page will open to display the Navigation panel.

TexMedConnect Navigation Panel

All the available TexMedConnect LTC functions are located under the Long Term Care portion of the left navigation panel. You can select any feature you are allowed to access. A user's access permissions determine which options are available in the navigation panel. The provider administrator will grant access rights to the account. The

complete details about how to set up access rights can be found in the *TMHP Portal Security Training Manual*.



MESAVs

Providers can view Medicaid Eligibility and Service Authorization Verifications (MESAVs) electronically by using TexMedConnect. To prevent claim denials, providers must verify a person's eligibility for Medicaid services.

Providers can interactively verify eligibility for specific dates of service for a single person. The date range is restricted to three calendar months. The service authorization section of a MESAV indicates the billable or allowable services for the person.

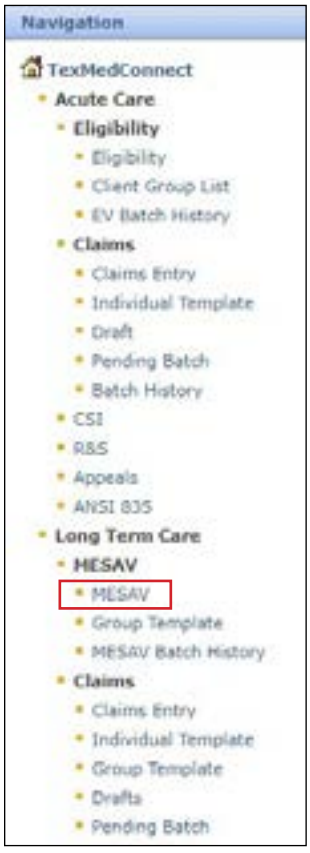
To verify eligibility for a group of people at one time, create a MESAV Group Template. Each MESAV Group Template can contain up to 250 people. You can create up to 100 Group Templates for each National Provider Identifier (NPI) number.

Note: People in a nursing facility (NF) with managed care eligibility segments must have service authorizations verified by the appropriate managed care organization (MCO). NFs should contact MCOs directly to determine service authorizations. NFs can use the Managed Care eligibility section at the bottom of the MESAV to verify enrollment with an MCO.

Submitting a MESAV Interactively

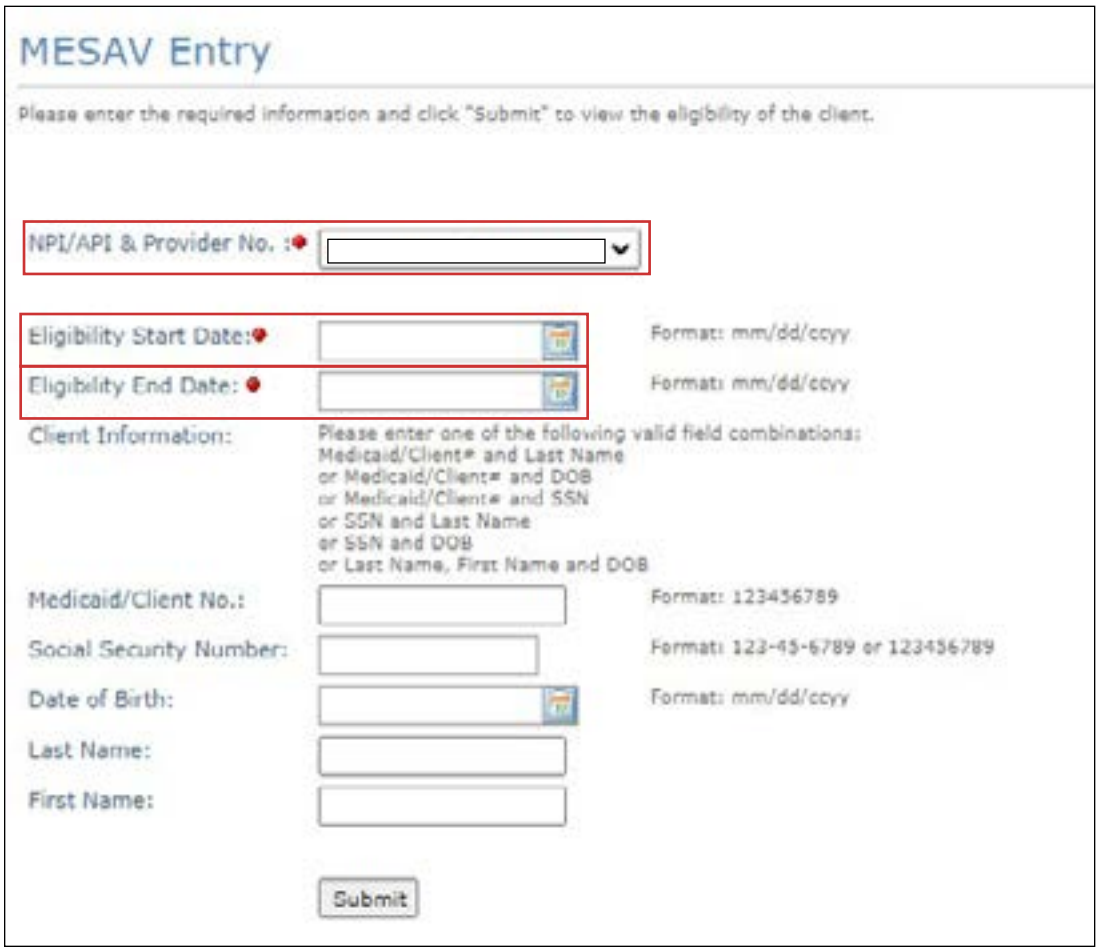
To verify a person's eligibility:

1) Click the **MESAV** link under the MESAV section on the navigation panel.



2) Complete the following required fields:

- Provider NPI/API & Provider No. (API stands for Atypical Provider Identifier)
  Note: If you perform more than one interactive MESAV, the NPI or API and provider number on the MESAV Entry page will default to the last one that you used.
- Eligibility Start Date
- Eligibility End Date
  Note: The date range may not exceed three calendar months. Selecting a date range greater than three months will result in an error.
  - The Eligibility Start Date cannot be more than 36 months before the current date or be more than three consecutive months from the Eligibility End Date.
  - The Eligibility End Date can include future dates of service but cannot be more than three consecutive months from the Eligibility Start Date. For example, if the Eligibility Start Date of the MESAV is today, the Eligibility End Date can be up to three months in the future.

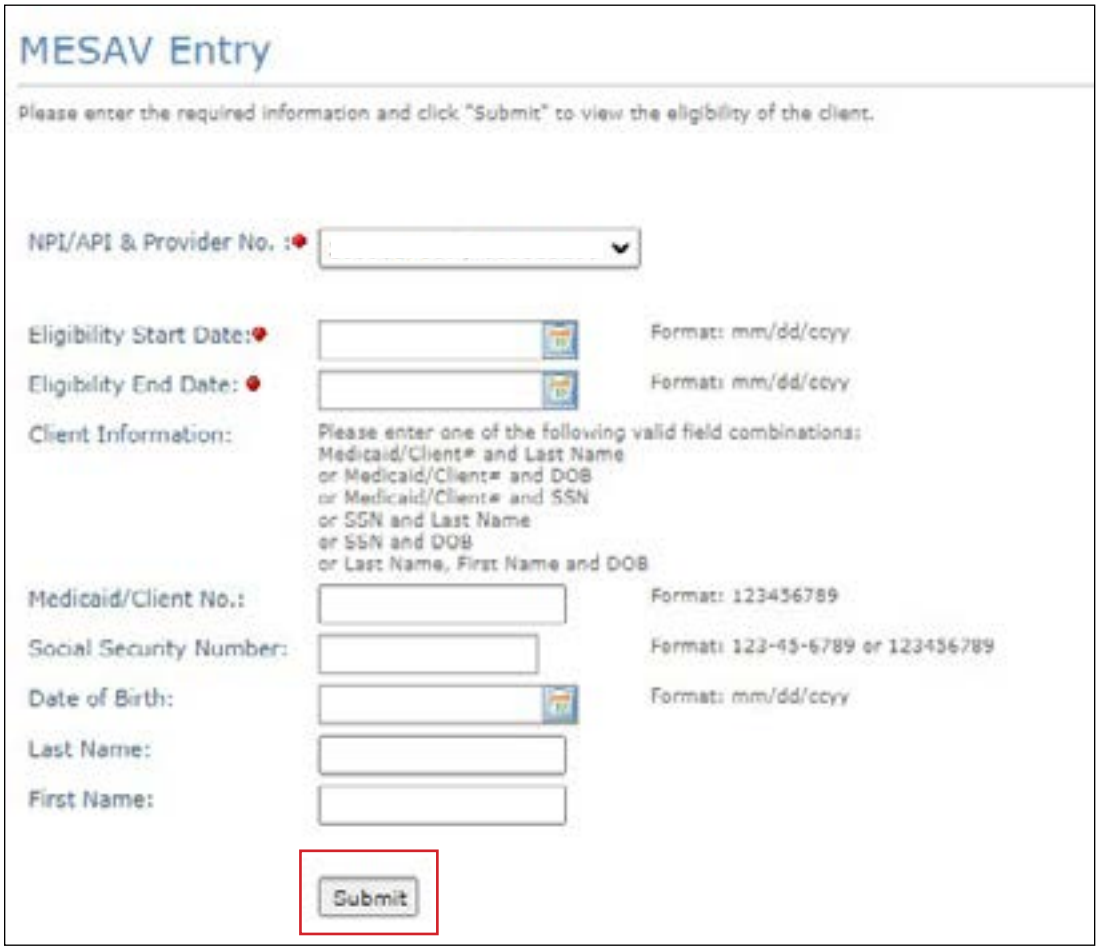


3) You must also enter additional information in any of the following field combinations:

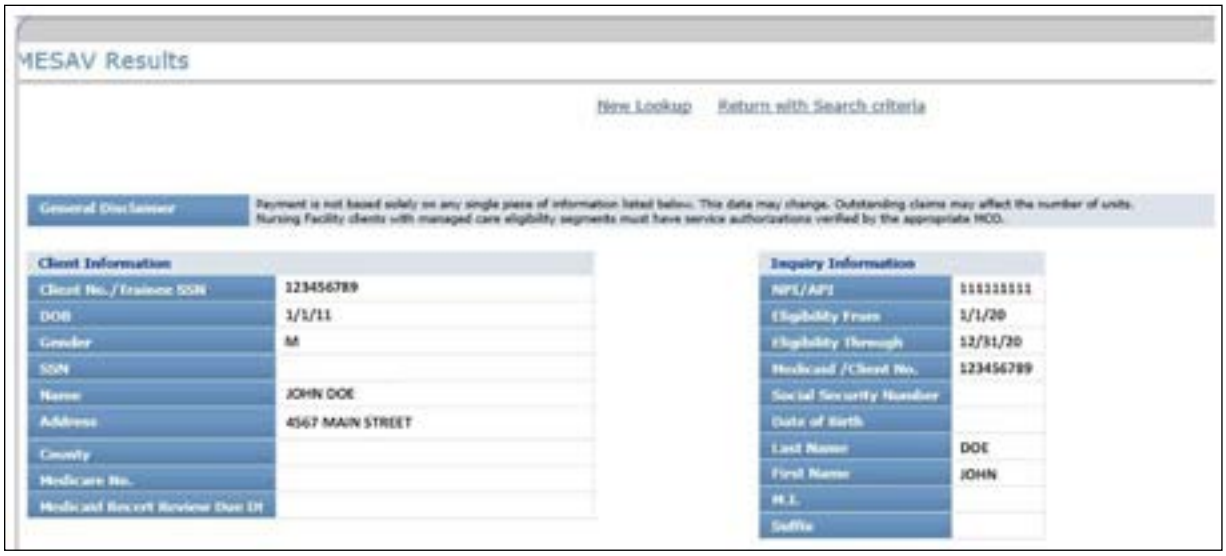
- Medicaid/Client No. and Last Name
- Medicaid/Client No. and Date of Birth

- Medicaid/Client No. and Social Security Number
- Social Security Number and Last Name
- Social Security Number and Date of Birth (DOB)
- Last Name, First Name, and DOB

4) Click the **Submit** button.



5) The MESAV results screen will then be displayed. This screen shows the person's demographic information as well as their Medicaid Recert Review Due Date.
Note: Knowing the Medicaid recertification review due date allows providers and MCOs to perform tasks that help Medicaid recipients meet their recertification dates.



Note: The Medicaid recertification review due date is not available for some LTC clients, including children who are enrolled in foster care and Medicaid clients who are enrolled through Social Security (Coverage Code R, Program Type 13).

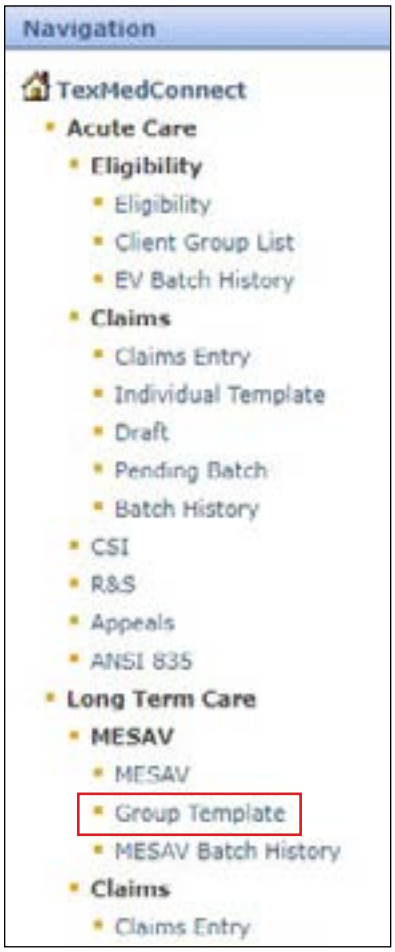
6) The MESAV results screen will allow you to print the MESAV results in a Portable Document Format (PDF) file. To print the PDF, click the **PDF** icon at the top right of the screen. If you want to print a paper copy of the results, click **Print** on your browser's toolbar.
Note: PDF copies of MESAVs are current only at the time of printing and are not necessarily accurate afterwards. MESAV information can change daily. For the most up-to-date information, you should perform another MESAV electronically.

Creating a MESAV Group Template

The Group Template feature allows you to create a list of people for whom you would like to verify eligibility.

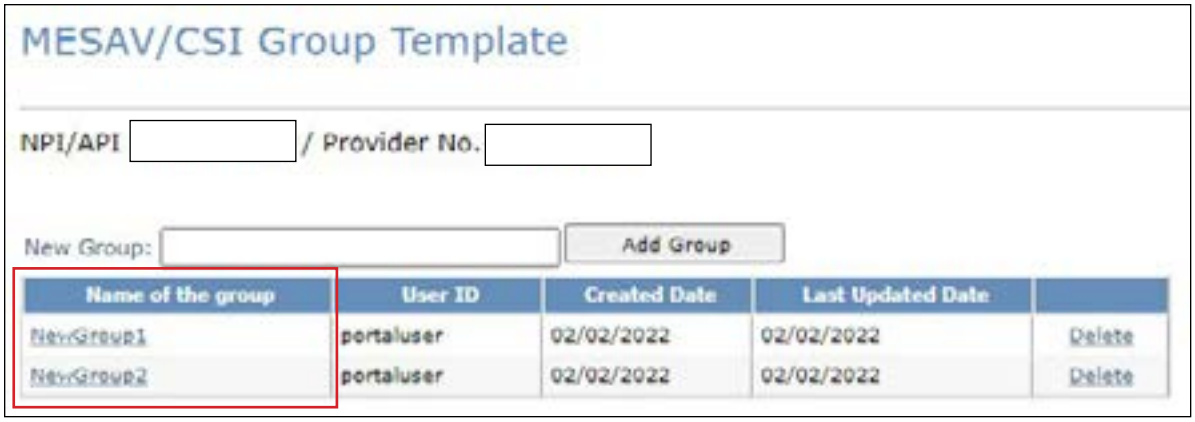
To create a MESAV Group Template and add a person:

1) Click **Group Template** under the MESAV section in the navigation panel.

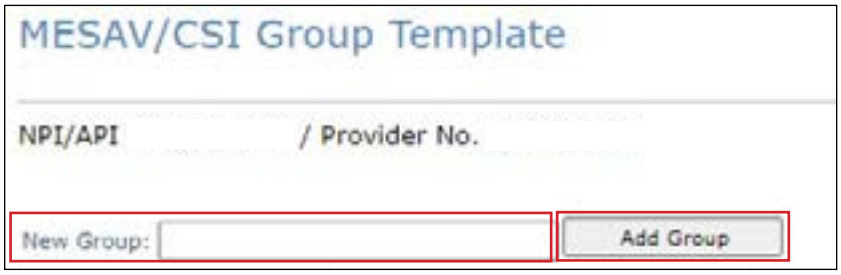


2) The MESAV/CSI Group Template screen will open. Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

3) If you have already created a group and want to add a person to an existing Group Template, click the link from the list that is displayed under the "Name of the group" column and skip to Step 5.



4) If you have not created a group or want to add a person to a new Group Template, enter the New Group name of your choice and click **Add Group**.

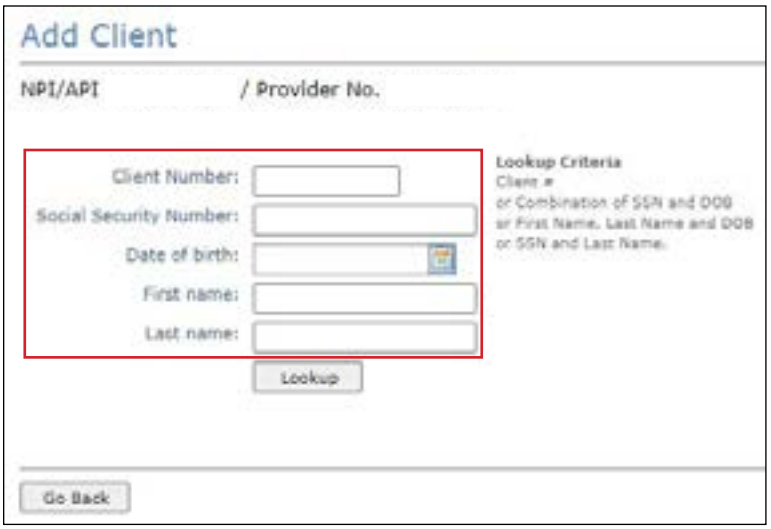


5) To add a person to the Group Template, click **Add Client**.

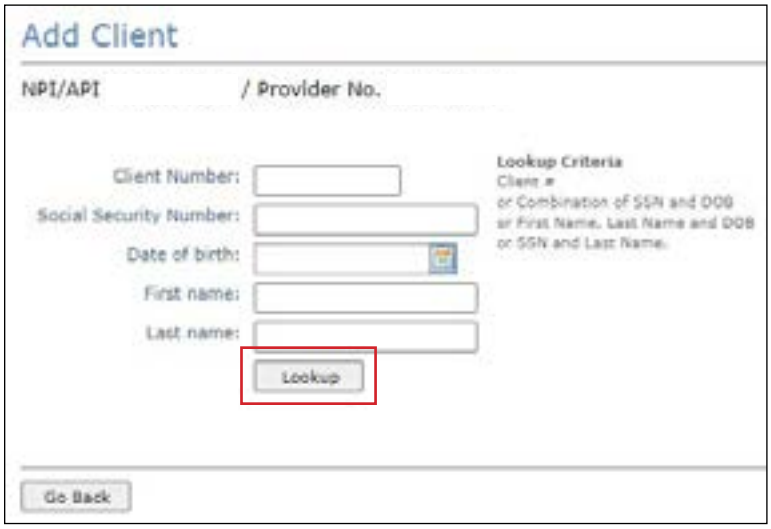
6) The Add Client page will open. Enter the person's information. If you do not have the person's Client Number, you must use one of the following combinations to find the person:

- Social Security number and last name
- Social Security number and date of birth

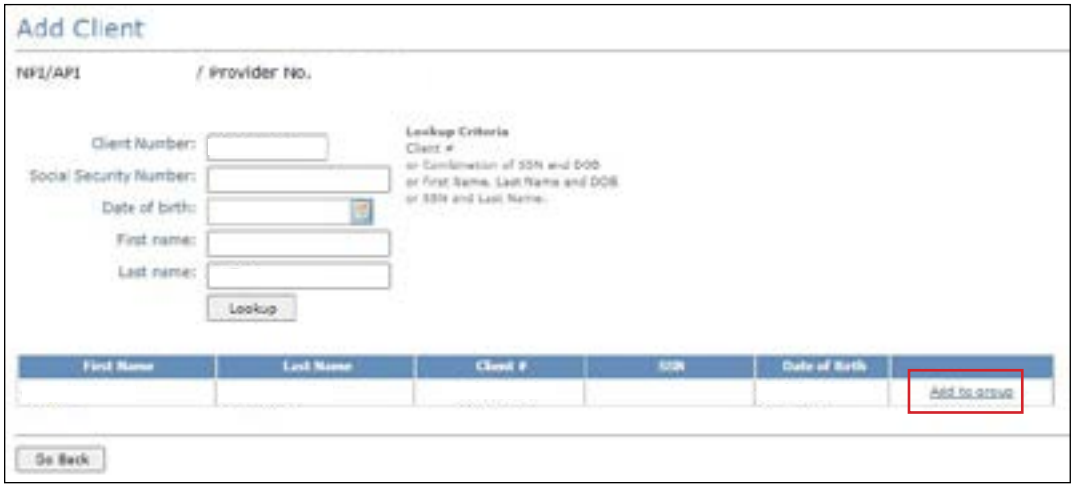
- Last name, first name, and date of birth



7) Click **Lookup**.



8) To add the person, click **Add to group**.



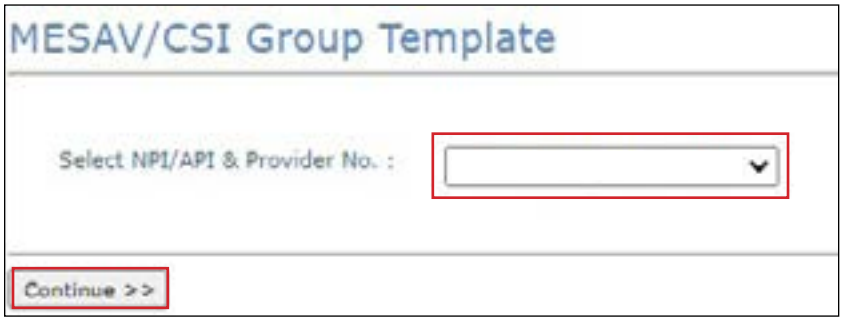
The person will be added to the MESAV Group Template that you are working on. The MESAV group template feature allows you to create up to 100 groups for each NPI or API and provider number. Each group can contain up to 250 people, and you have the option to view, add, and delete people from the groups

Submitting a MESAV Group Template

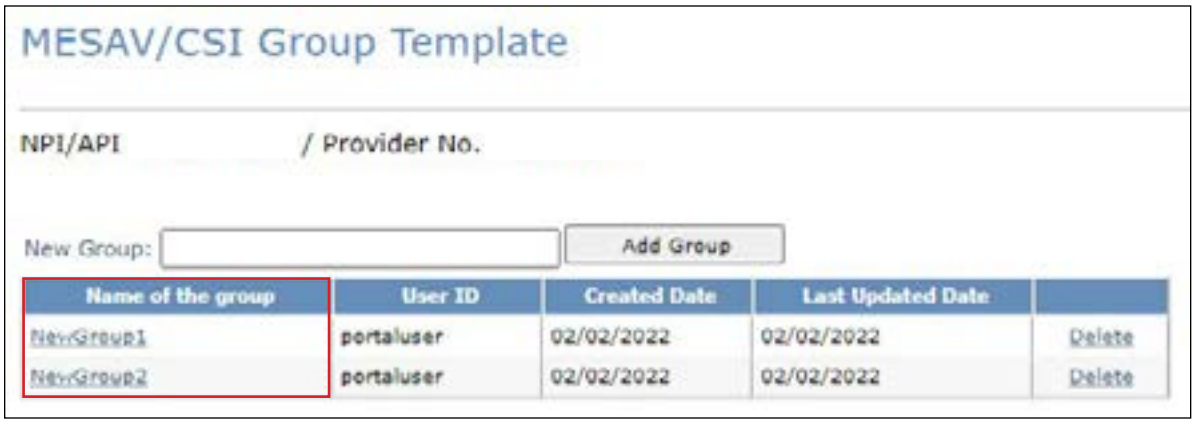
To verify eligibility using a Group Template, perform the following steps:

1) Click **Group Template** under the MESAV section in the left navigation panel.

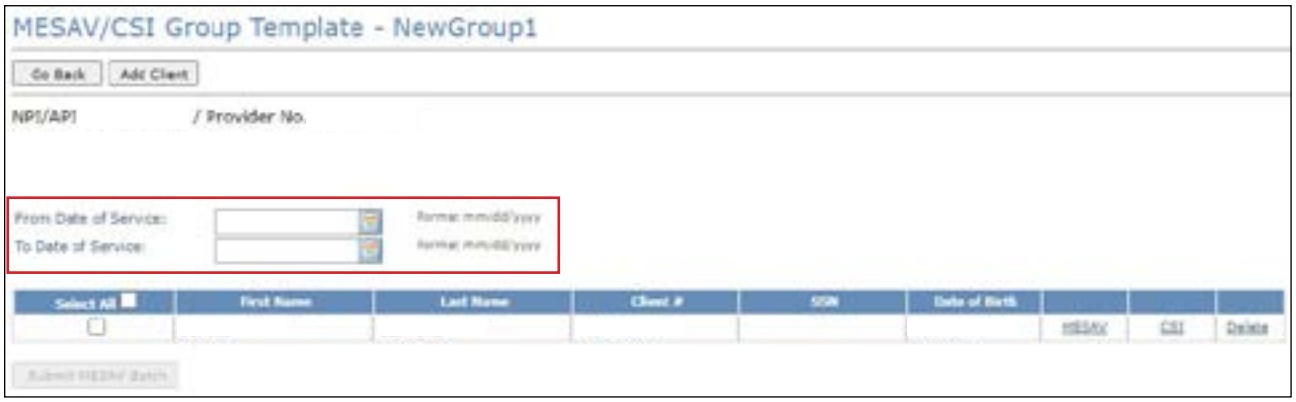
2) Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.



3) Select one of the templates listed under “Name of the group” to open the group list.



4) Enter a date range in the From Date of Service and To Date of Service fields. The date range can be up to three months long.



5) Check the individual boxes of the templates that you want to submit, or to submit all the templates check the **Select All** box.

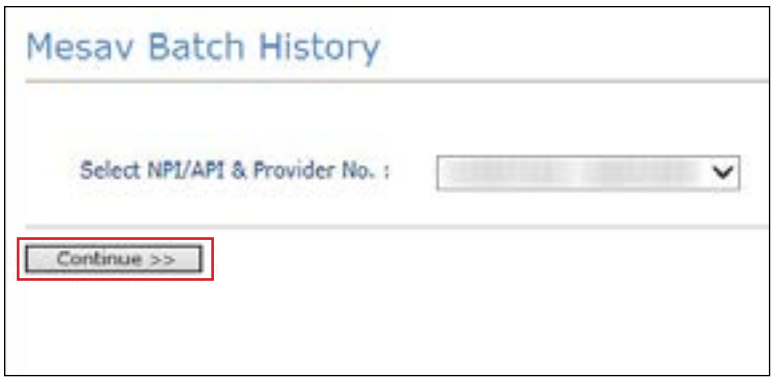
6) Click **Submit MESAV Batch** at the bottom left of the screen. The batch will be processed and be ready for viewing within 24 hours.

Viewing a MESAV Batch History

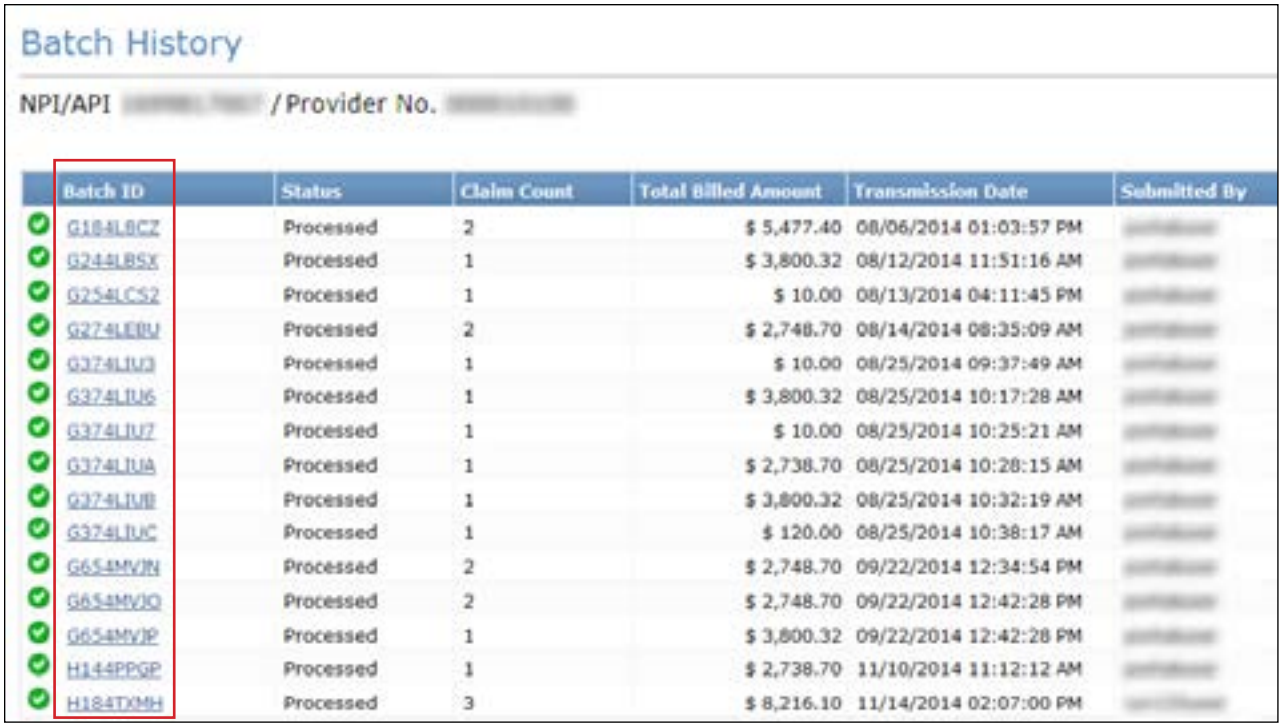
To view a MESAV Batch History, perform the following steps:

1) Click **MESAV Batch History** under the MESAV section on the navigation panel.

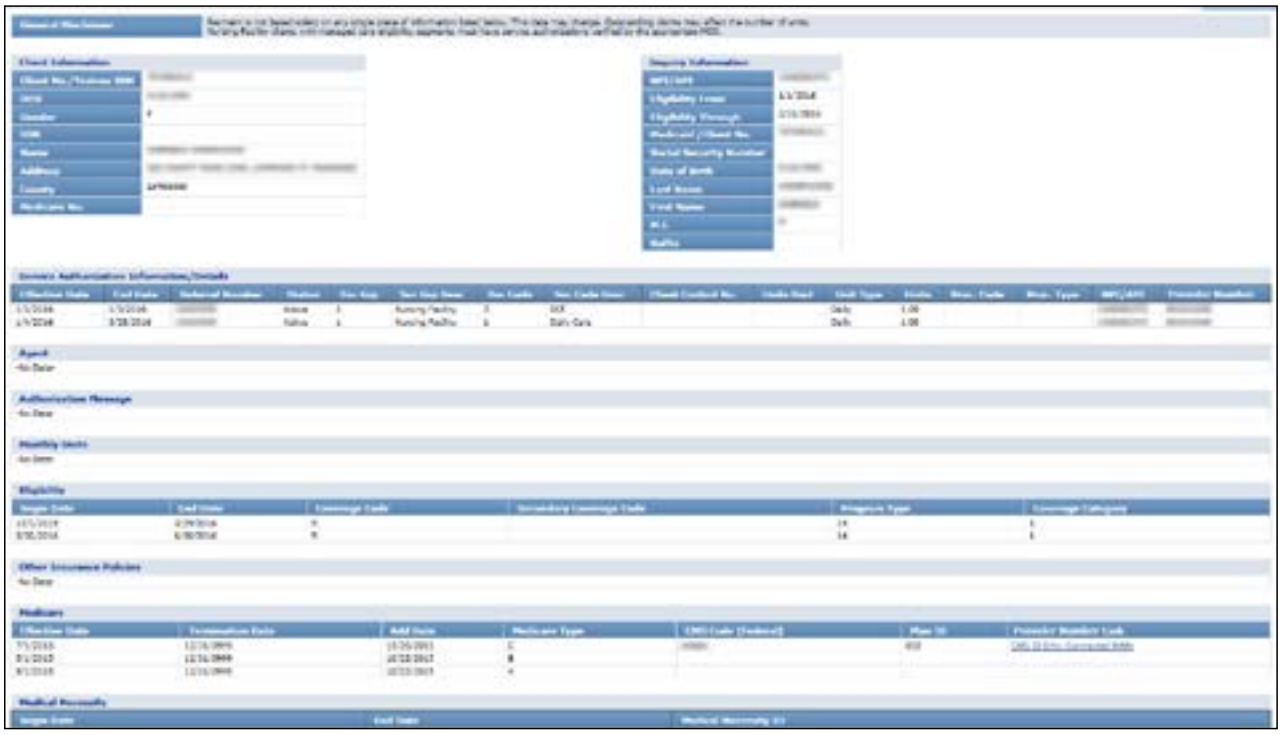
2) Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.



3) Click the **Batch ID** of the MESAV batch that you would like to view.



4) The MESAV will open in a new window. Review the status for each client number that you selected.



MESAV – Other Insurance (OI) Applicable to Service Groups (SGs) 1, 6, 8

For NF (SG 1), non-state Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) (SG 6), and Hospice (SG 8) providers, there is an LTC TexMedConnect MESAV screen titled "Other Insurance Policies." Providers in SGs 1, 6, and 8 can view the policies that a person in their care has for the service dates that are entered on the MESAV. The OI section contains all the active lines of coverage that have been reported to TMHP.

Note: Each listing contains detailed information about the insurance company, subscriber information, and lines of coverage (including types of coverage, effective date, termination date fields, and whether or not the coverage is LTC relevant).

The OI information should be used to assist providers in filing claims with insurance companies and obtaining the disposition of those claims as paid or denied. For claims to be submitted for people with Medicaid, the insurance company claim disposition information must be provided, or the claim may be denied.

If, as a result of filing the insurance claim, it is discovered that the insurance information on the MESAV is incorrect for a person, the TMHP Third-Party Liability (TPL) Resource Line is available to handle updates to the insurance information. Call the LTC Help Desk at 800-626-4117 and choose option 6 for answers to inquiries about OI insurance referrals.

MESAV Medicare Eligibility

The Medicare section includes the policy's Effective Date, Termination Date, Add Date, Medicare Type, CMS Code (federal), Plan ID, and Provider Number Link. The MESAV Medicare section will be displayed underneath the

Other Insurance Policies section of the MESAV.

Medicare

Effective Date	Termination Date	Add Date	Medicare Type	CMS Code (Federal)	Plan ID	Provider Number Link
7/1/2015	12/31/3999	11/26/2015	C	[illegible]	010	CMS ID Info: Contracted MAPs
5/1/2015	12/31/3999	10/22/2015	B			
5/1/2015	12/31/3999	10/22/2015	A			

Filing a Claim

Claims filed on TexMedConnect by NFs for people who have transitioned to managed care will be forwarded to an MCO. If any issues or questions arise regarding a claim that has been forwarded to an MCO, providers must contact the MCO directly. TMHP cannot answer questions regarding claims that are rejected by an MCO. Claims that are submitted by NF providers regarding people who are not transitioning to managed care will not be forwarded.

Users may submit the following claim types:

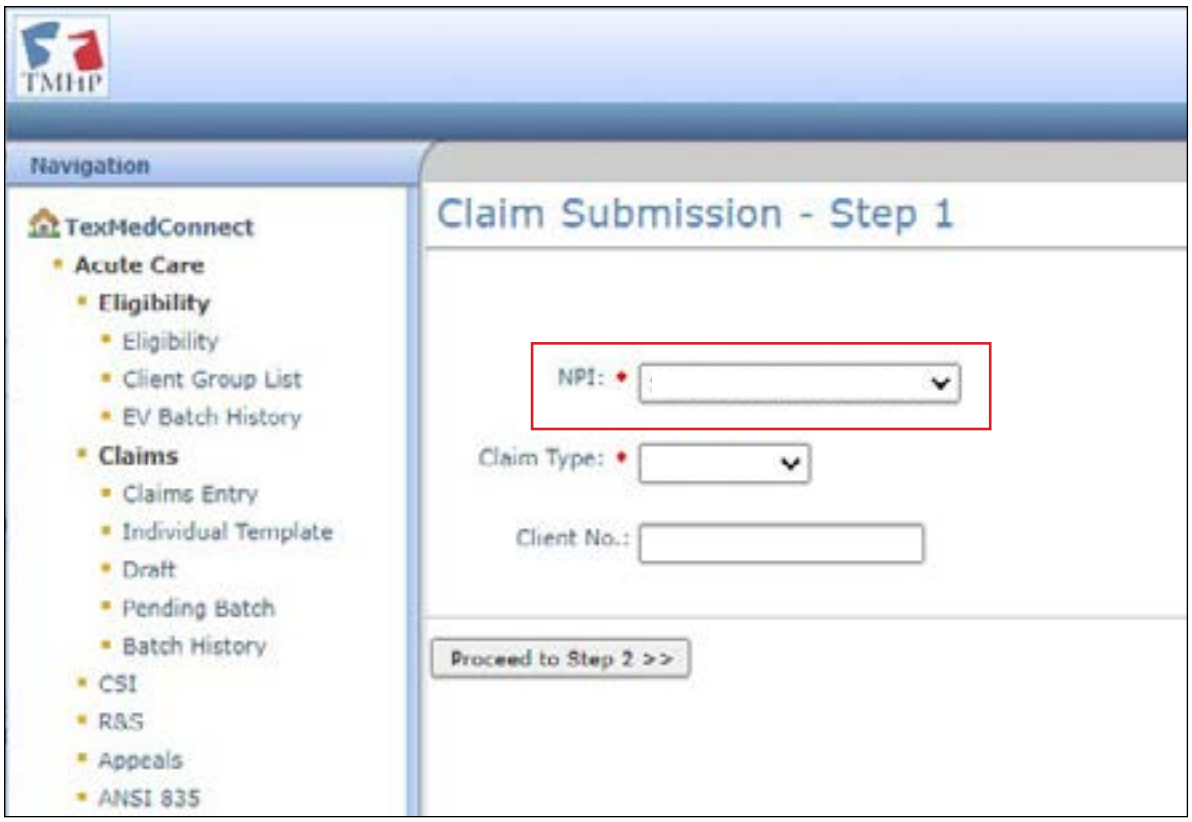
- Professional: Services rendered by an individual provider
- Dental: Services rendered by a dental provider and billed by the LTC provider
- Institutional: Services rendered in a facility
- Nurse Aide Training (NAT): Classes, testing, and materials for nurse aides

Entering a Claim on TexMedConnect

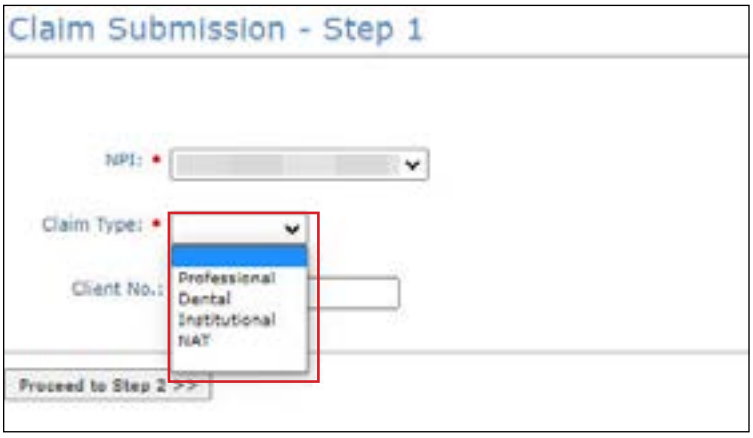
The following steps are used to begin the process of submitting all claim types (Professional, Dental, Institutional, and NAT):

1) Click **Claims Entry** under the Claims section in the navigation panel.

2) A list of NPIs/APIs, provider numbers, and related data will be displayed according to the user's login information. Select the appropriate NPI/API and provider number from the NPI drop-down menu.

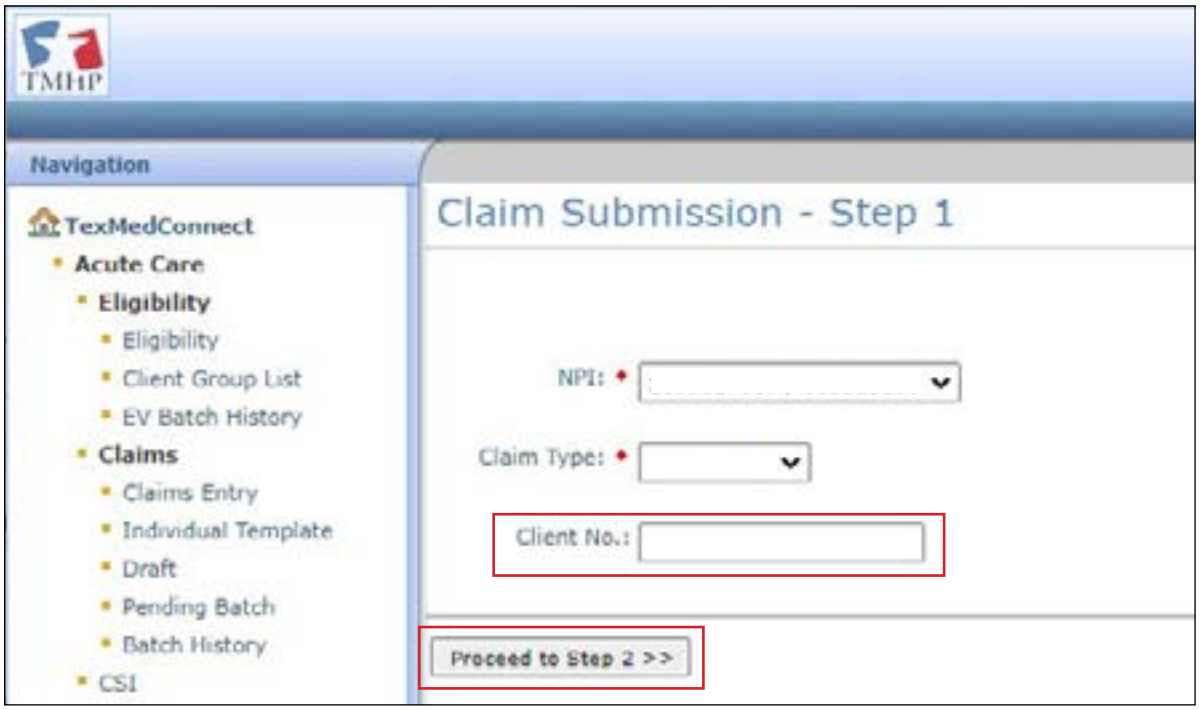


Choose the appropriate claim type from the drop-down menu. You also have the option to enter a client number at this time.

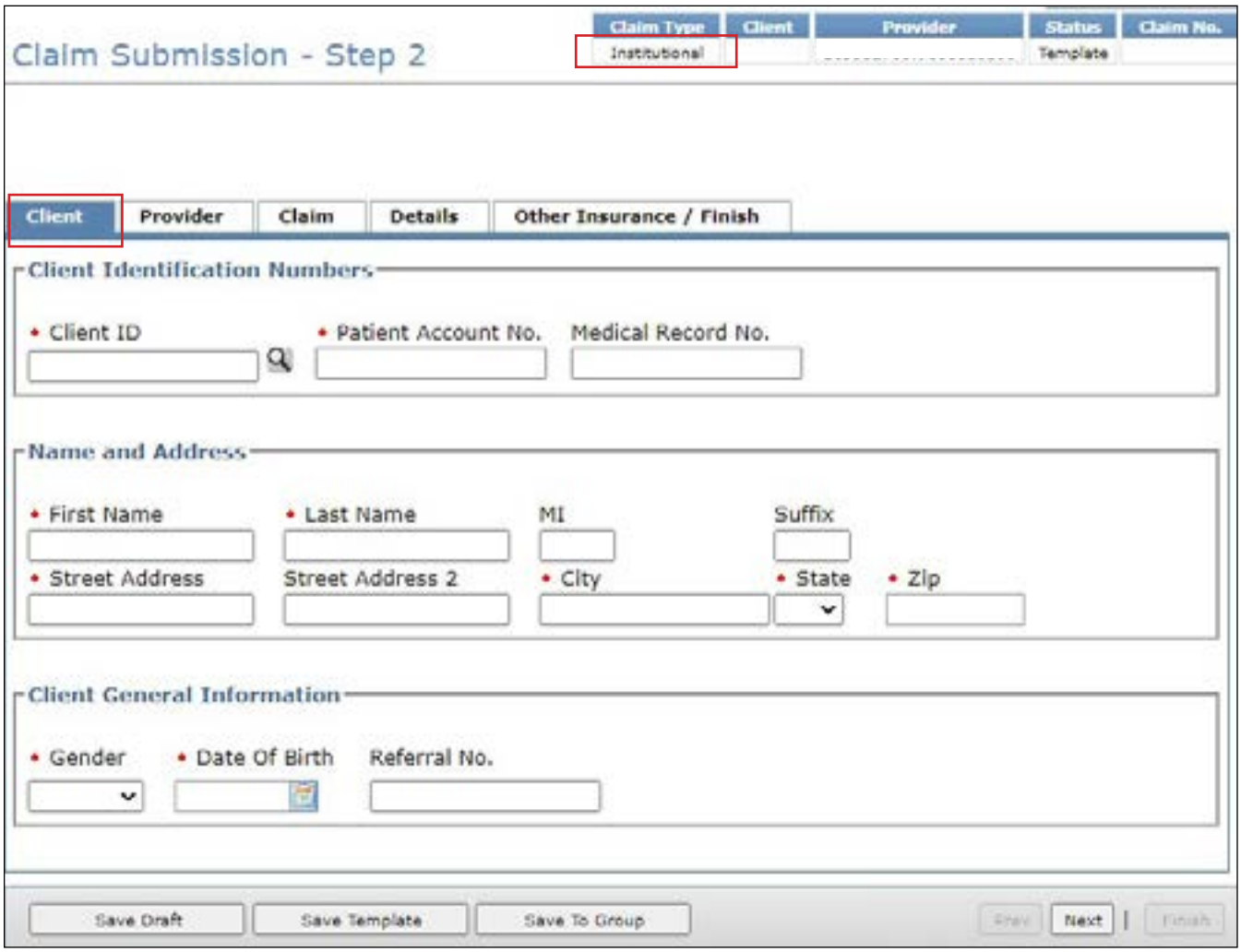


Note: Although a client number is not required, providing one will save time. The system will use the client number to autofill many of the required fields. If a client number is not entered, you must manually enter information into the required fields under the Client tab (this includes the referral number even though there is no red dot in this field).

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



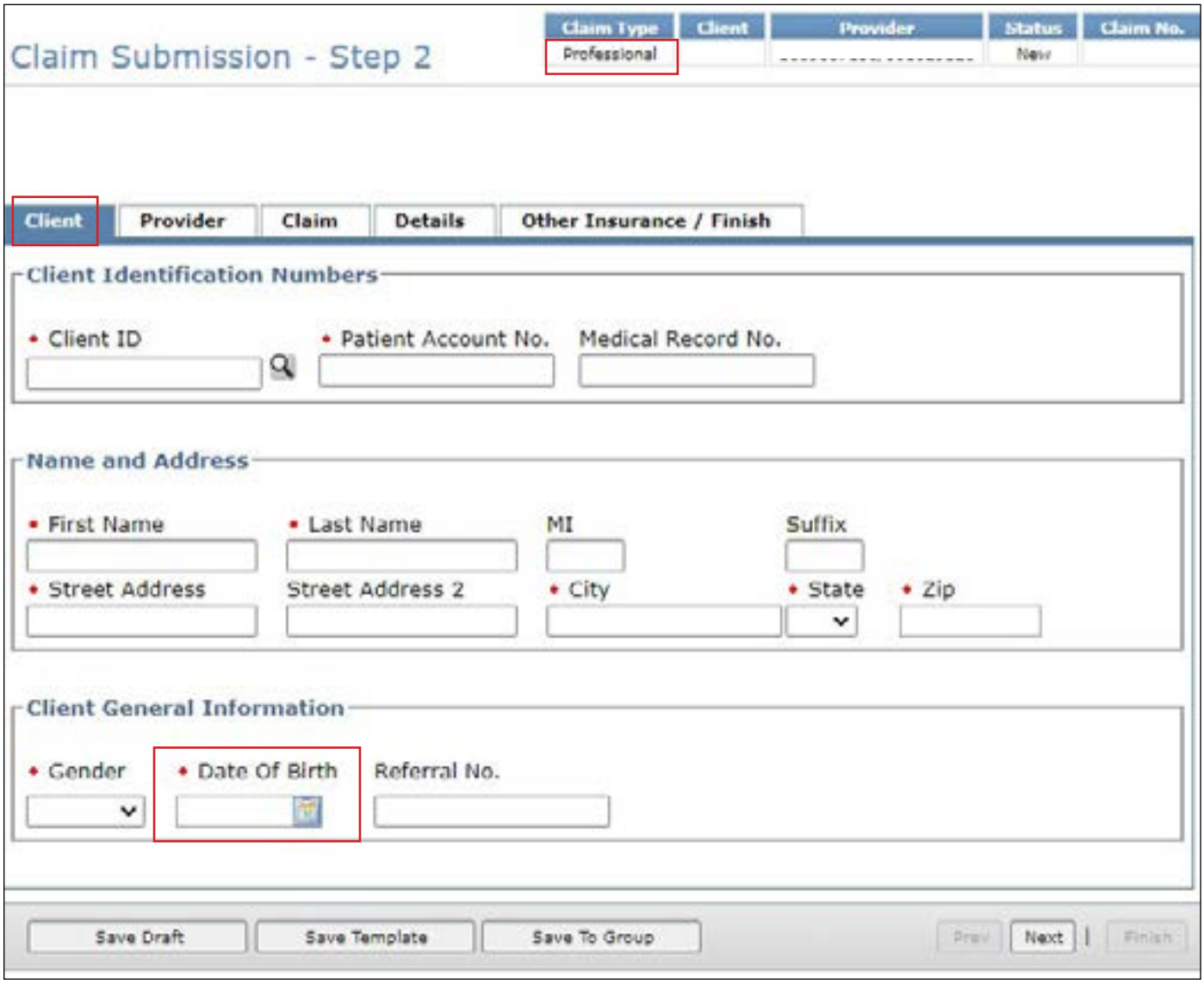
4) The Claim Submission screen will be displayed for the claim type that you selected. It will default to the Client tab. The type of claim you are working on appears in the Claim Type box in the upper right of the screen. You must complete all the required fields (indicated by a red dot) on each tab. If you entered the client number on the Claims Entry - Step 1 screen, many of these fields will be autofilled. Most fields can be edited if needed. After the claim has been submitted successfully, an Internal Control Number (ICN) will be displayed in the Claim No. field. The ICN is also known as a claim number.



Entering a Professional Claim

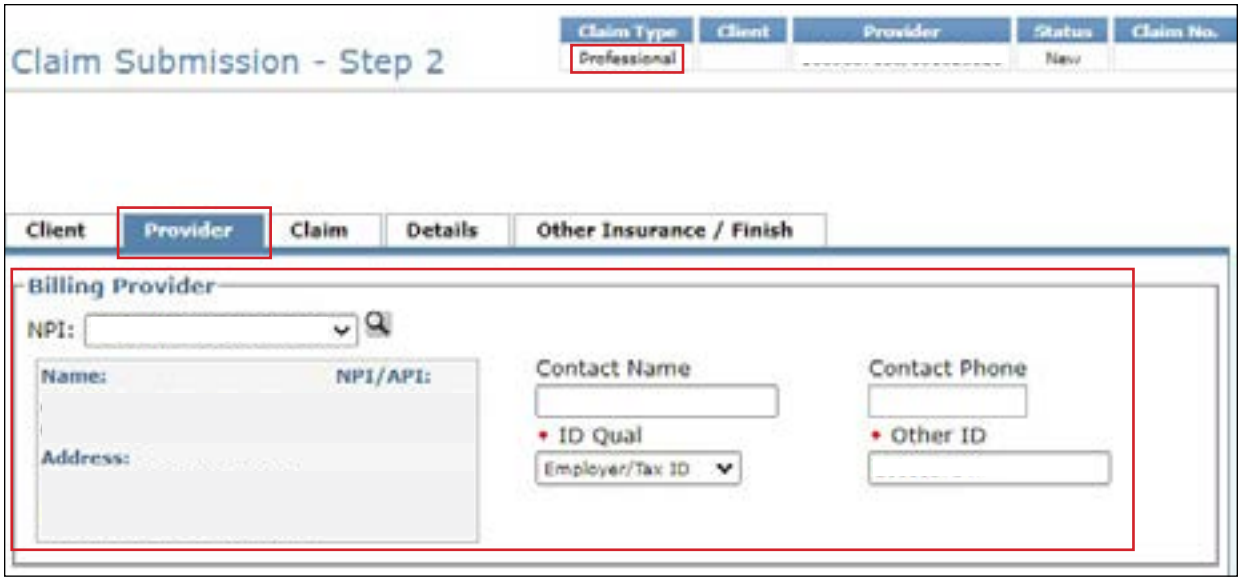
To enter a professional claim:

1) Begin on the Client tab. You must complete all required fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field.



Note: If more than one contract is associated with an NPI number, you must include a referral number on the claim or the claim will be denied. As noted earlier, you can use the MESAV function to search a person's eligibility and access the referral number.

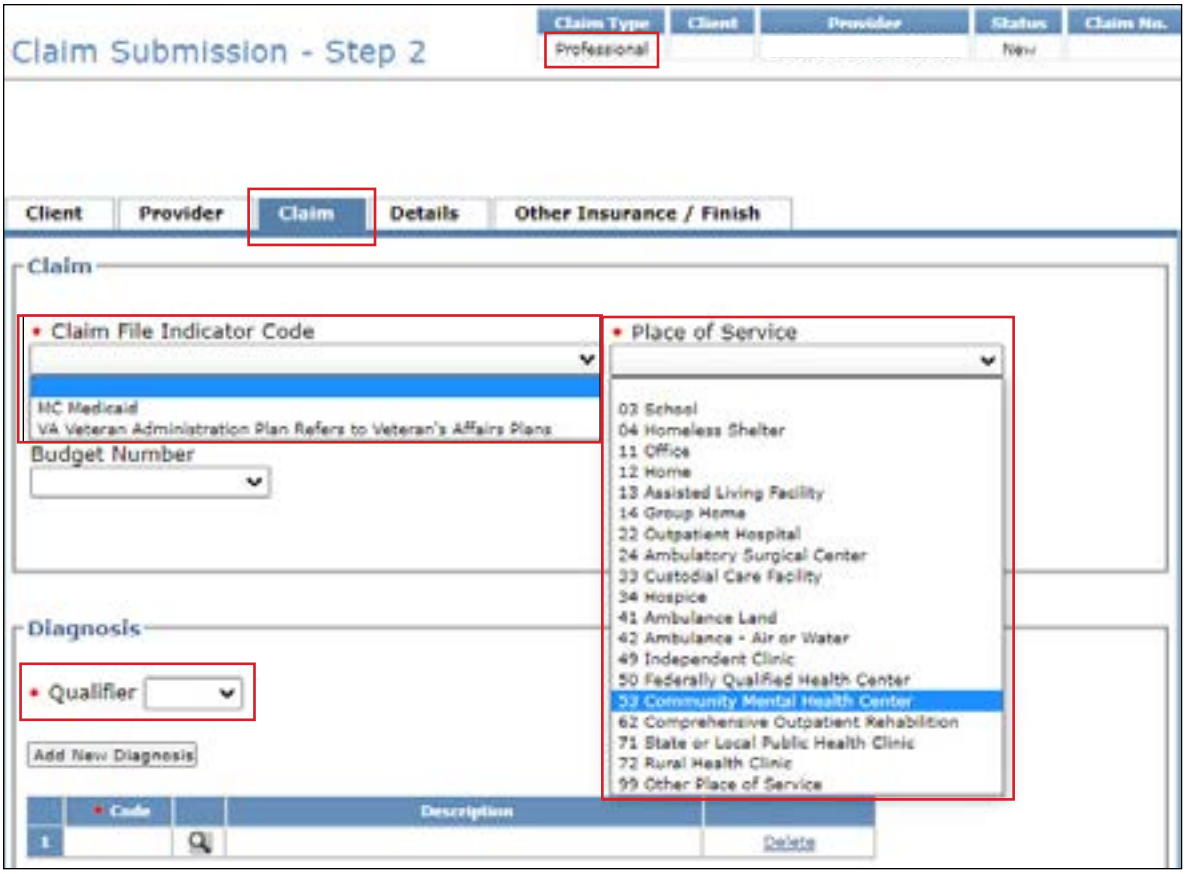
2) Select the Provider tab. You must complete all required fields that are indicated by a red dot. TexMedConnect autofills the billing provider information using the NPI/API that was selected on the Claims Entry screen.



3) Select the Claim tab. You must complete all required fields that are indicated by a red dot.

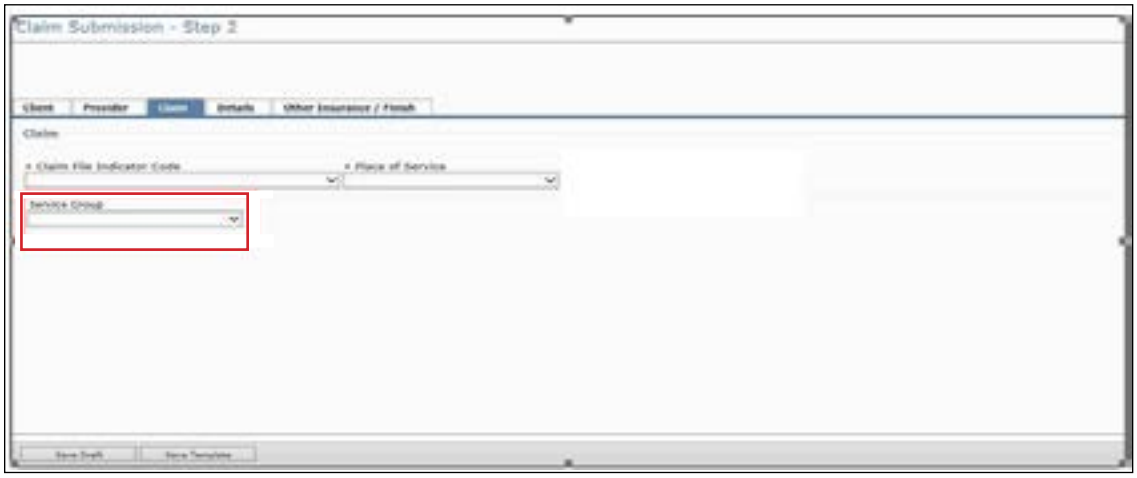
- A valid principal diagnosis code is required for professional claims. Inputting an invalid diagnosis code may result in an error message (and not allow a claim to submit) in TexMedConnect.
- To add more diagnosis codes, click **Add New Diagnosis**.
- To view the diagnosis description, click the magnifying glass icon.

Note: The Qualifier field is used to indicate an *International Classification of Diseases*, Tenth Revision (ICD-10) diagnosis code. Select from the drop-down menu based on the diagnosis code entered.



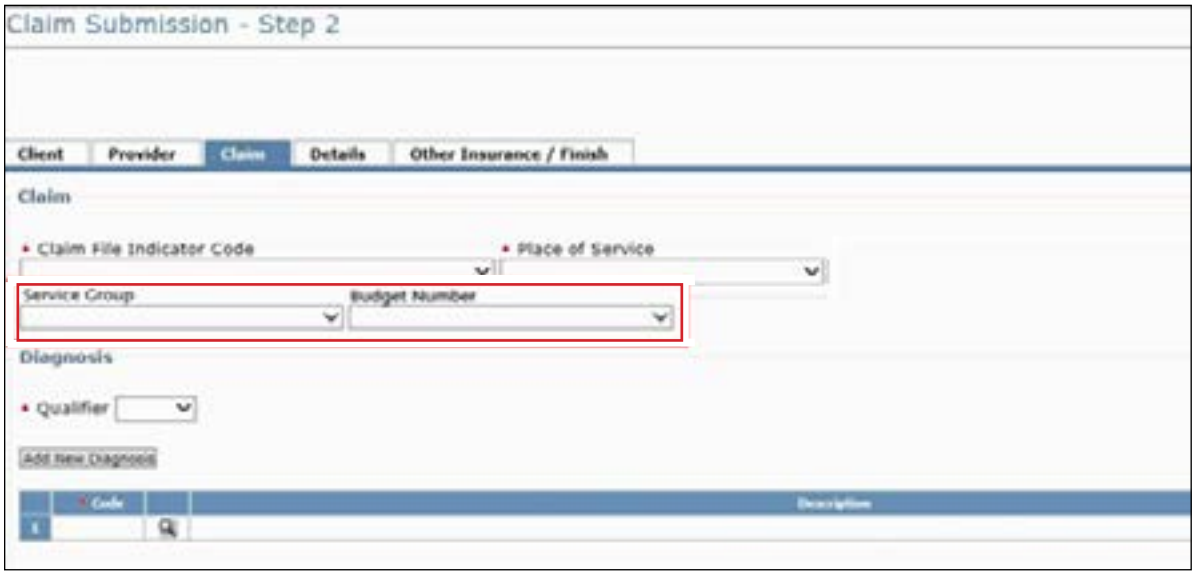
Note: The HHSC-LTC Bill code crosswalk requires that modifiers start in position 1 and for any subsequent modifier to be in sequential order and not be duplicated. Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate the SG, residence SG, and budget number. Instead, billing providers will indicate the SG, residence SG, and budget number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.

- The Service Group drop-down menu is to be used on LTC Professional, Institutional, and Dental claims by billing providers with multiple SGs linked to the same LTC Provider Contract number. It will not appear for other providers.



- The Budget Number drop-down menu will appear only for providers billing LTC Professional claims for Title XX services. Providers will need to select the correct budget number from the drop-down menu.

Note: The provider can be linked to multiple service groups. SG 7 or SG 20 needs to be selected in the Service Group field for the Budget Number field to display. If the provider is linked only to SG 7 or SG 20, the Service Group field is not displayed.



Note: Billing providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC-LTC Bill Code Crosswalk. It is important to remember that modifier placements changed as of February 1, 2019, so providers should consult the Crosswalk to update their previously saved claims and templates to reflect the new modifier positions.

4) Select the Details tab. You must complete all fields that are indicated by a red dot.

- To add a blank row, click **Add New Detail row(s)**. To duplicate an existing row, highlight the row and click **Copy Row**. To delete a row, scroll over and click **Delete** at the end of the row.

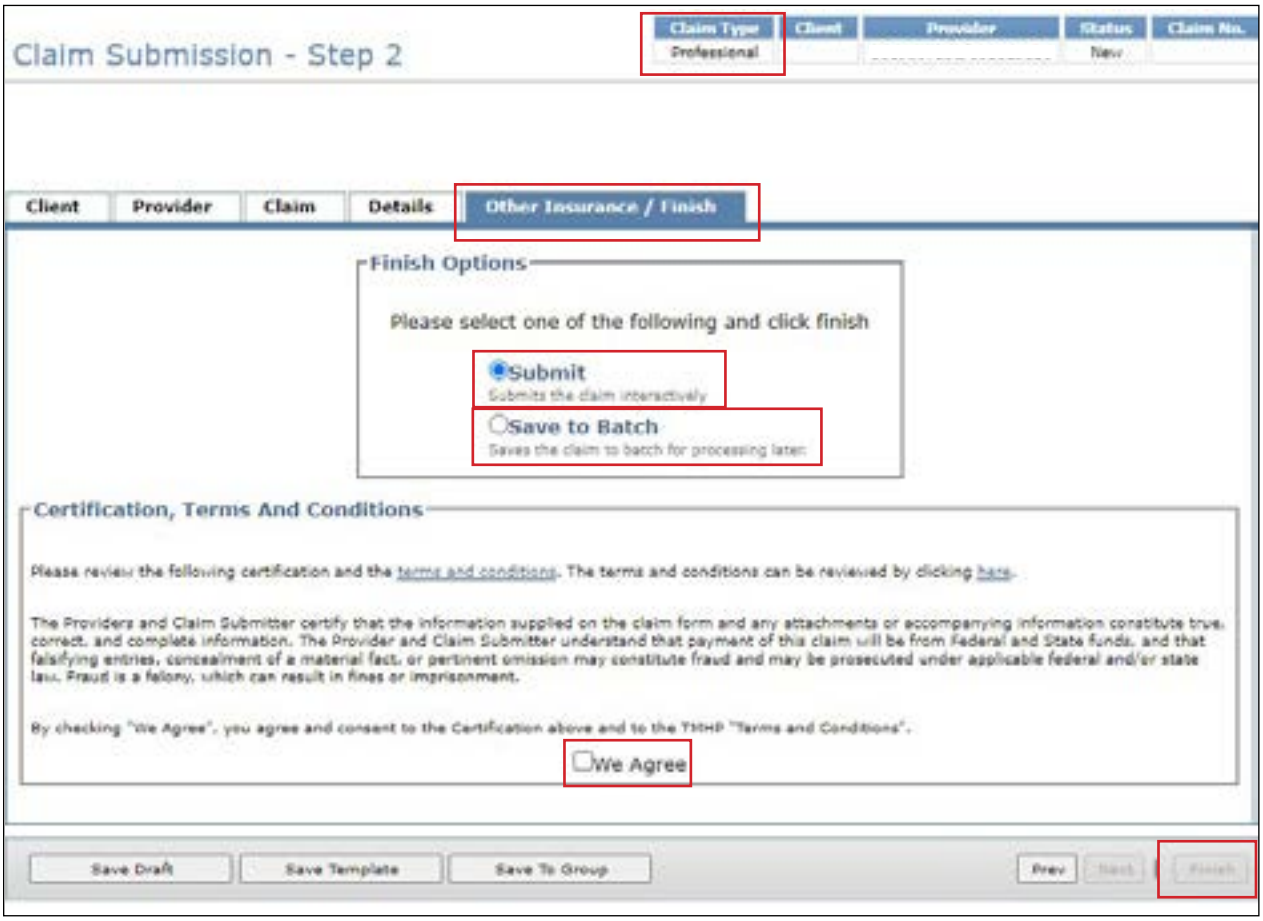
5) Select the Other Insurance/Finish tab.
Note: OI information is not required on a Professional claim, only an Institutional claim.

a) Select either the **Submit** radio button or the **Save to Batch** radio button.

b) Check the **We Agree** box.

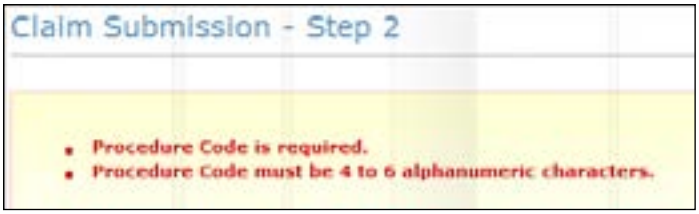
c) Click **Finish**.

d) If the claim is submitted successfully, an ICN will be displayed at the top of the page.

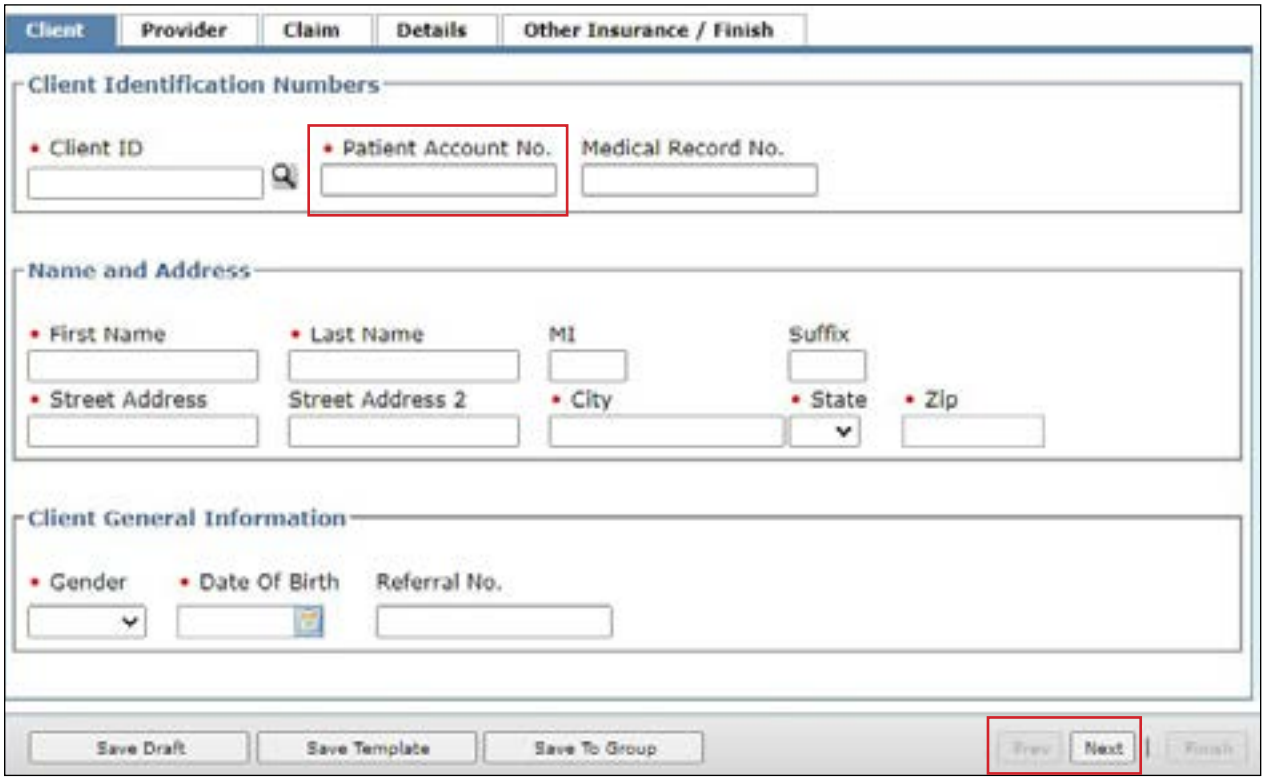


To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**.

To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide. If there is any missing or invalid information, an error message will be displayed. Click the tab that is indicated in the error message. Error fields are indicated with red exclamation marks. After you have made the necessary corrections, click **Finish** in the lower right corner of the screen.



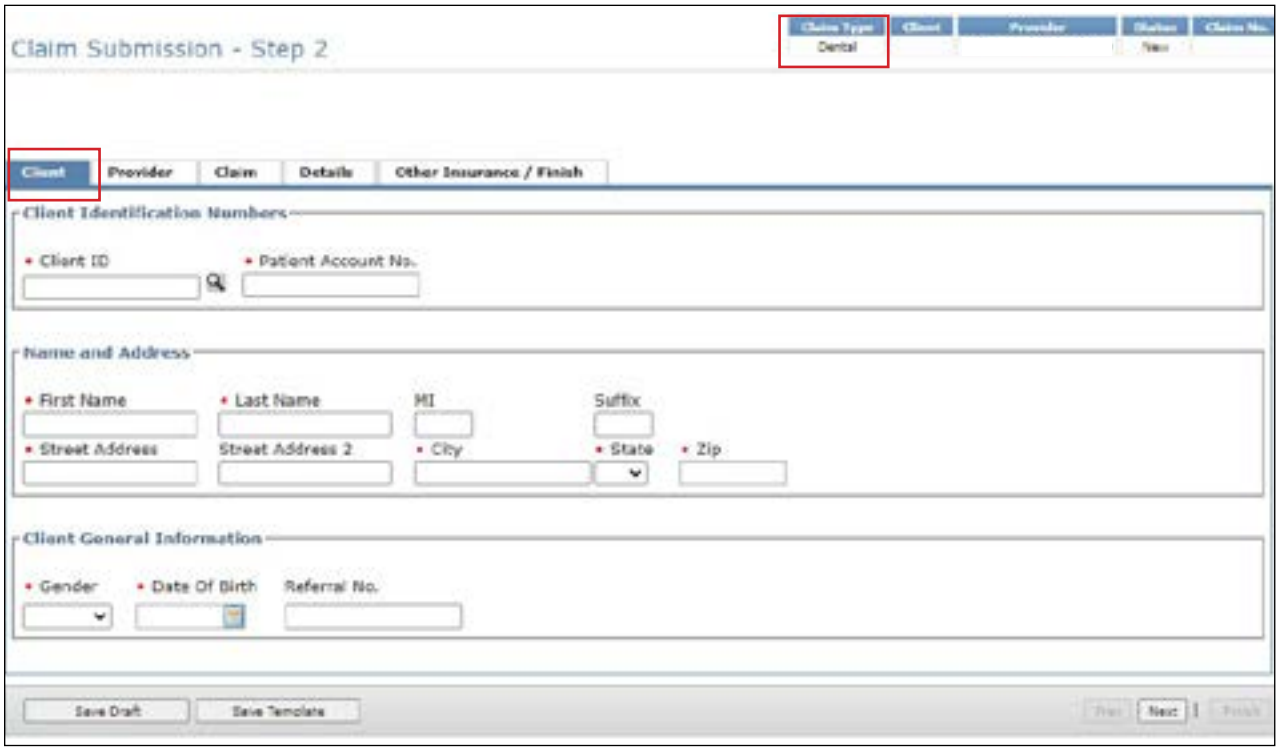
6) In each tab, any field with an error is marked with a yield sign. You must correct these errors before you can resubmit the claim. You can navigate through the claim by clicking each tab or by clicking **Prev** or **Next** at the bottom of the Claim Submission – Step 2 screen.



Entering a Dental Claim

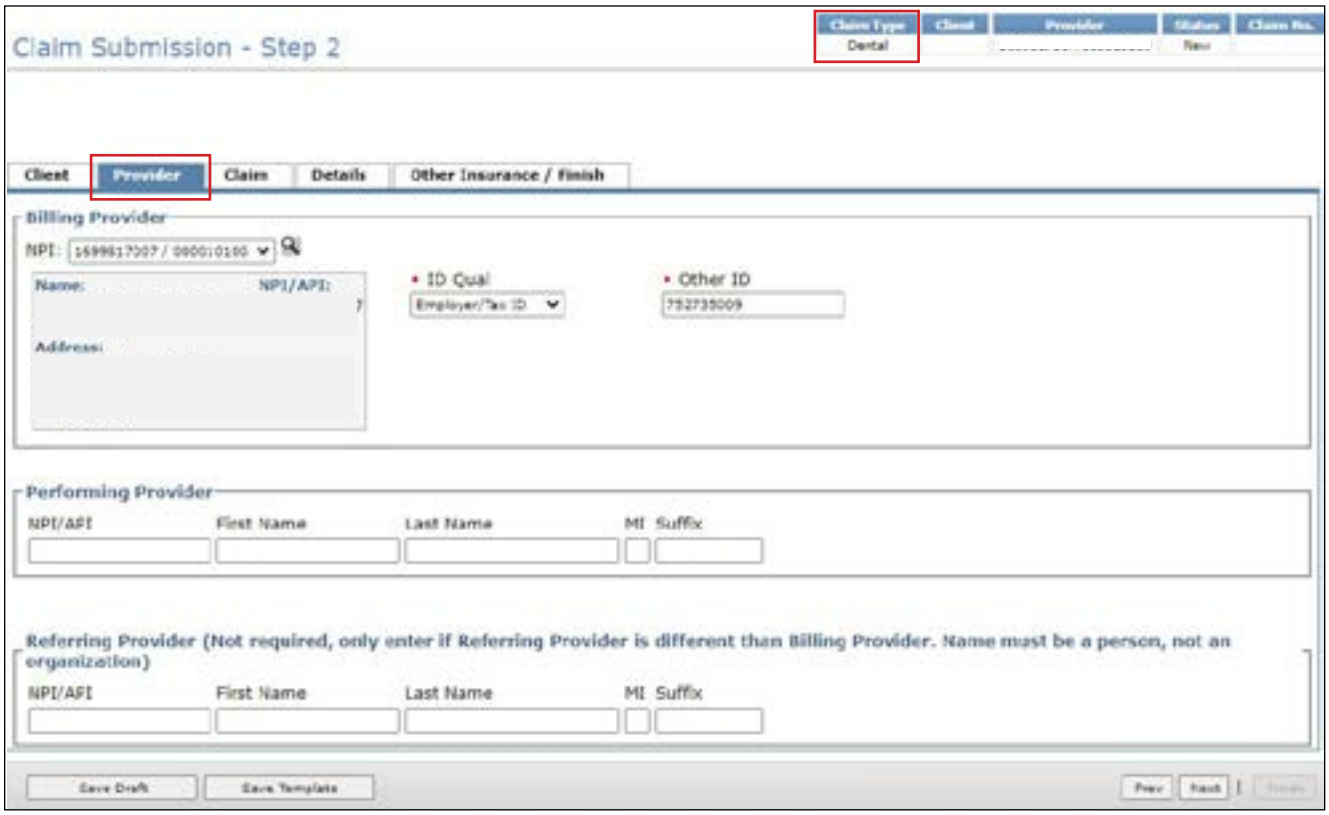
To enter a Dental claim:

1) Select the Client tab. You must complete all required fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field.



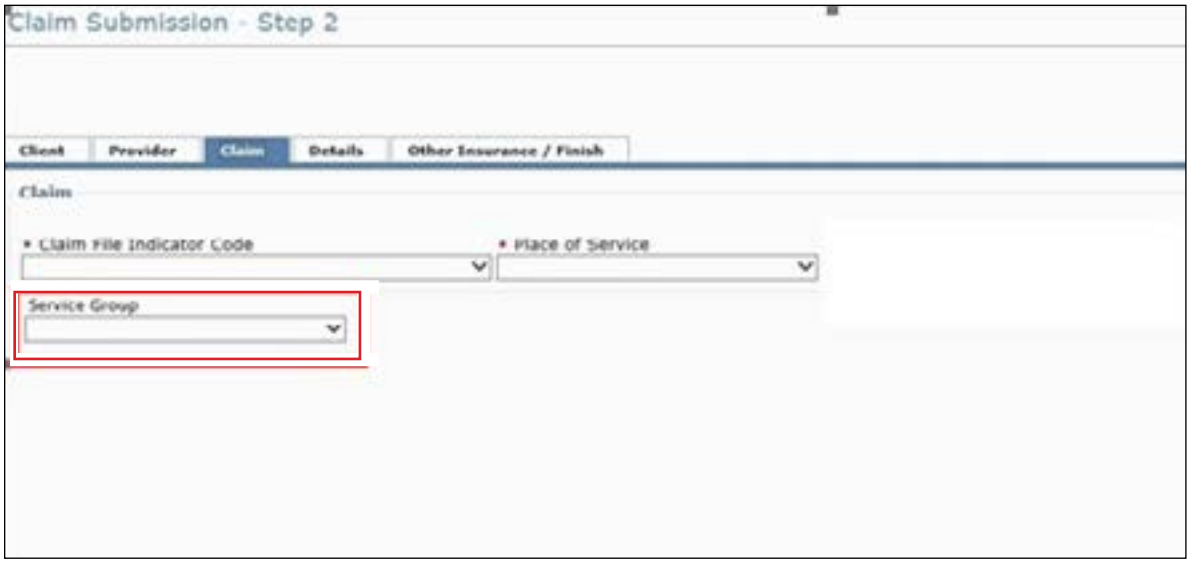
2) Select the Provider tab. TexMedConnect autofills the billing provider information using the NPI that was selected on the Claims Entry screen. You can enter the NPI/API and contact name in the Performing Provider

section, but it is not required.



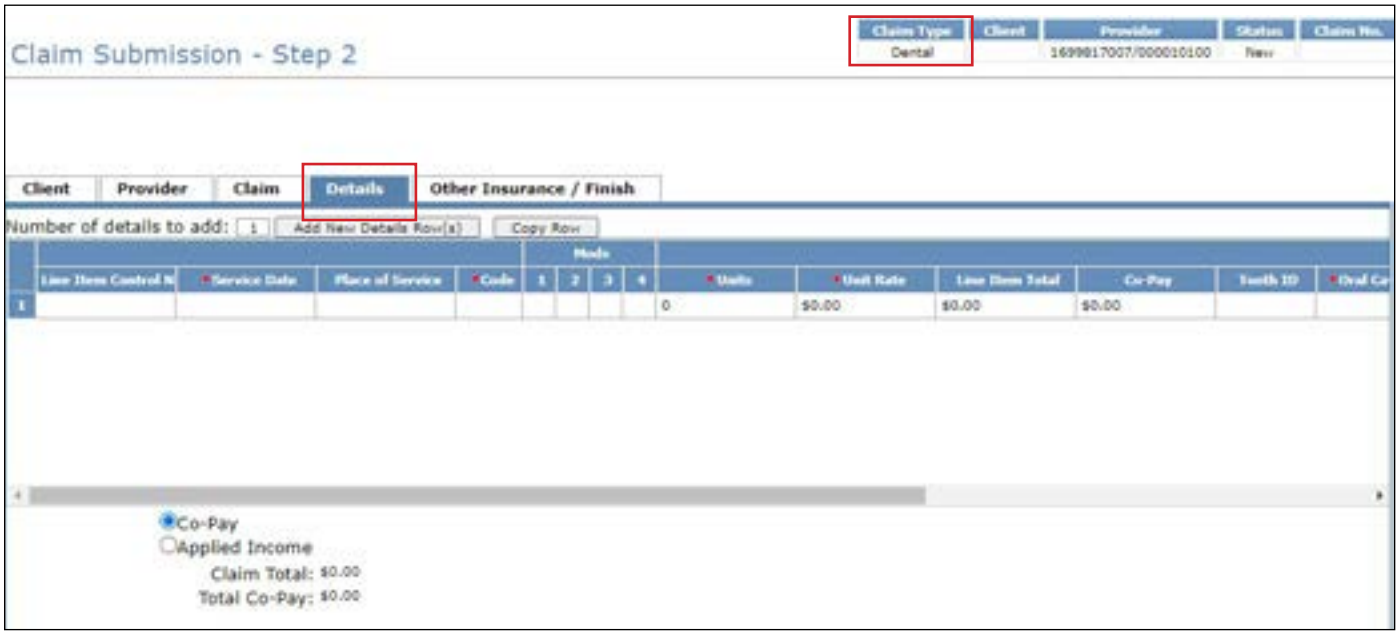
3) Select the Claim tab. Enter the general claim information. You must choose a claim File Indicator Code and Place of Service.

Note: The HHSC-LTC Bill Code Crosswalk requires that modifiers start in position 1, and for any subsequent modifier to be in sequential order and not be duplicated. Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate the SG, residence SG, and budget number. Instead, billing providers will indicate the SG, residence SG, and budget number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect. The Service Group drop-down menu is to be used by billing providers with multiple SGs that are linked to the same LTC provider contract number.



Note: Billing providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC LTC Bill Code Crosswalk. It is important to remember that modifier placement has changed as of February 1, 2019, so providers should consult the Crosswalk after that date and update their previously saved claims and templates to reflect the new modifier positions.

4) Select the Details tab. You must complete all required fields that are indicated by a red dot. Entering a future date is not allowed in the Service Date field.



- To add more rows, click **Add New Detail Row(s)**.
- To copy the information from the previous detail, click **Copy Row**.
- To delete a row, scroll over and click **Delete** at the end of the row.
  Note: When completing the Code field, if there is no HCPCS or CPT code, enter the Bill Code. For the Oral Cavity, select the best option from the drop-down menu.

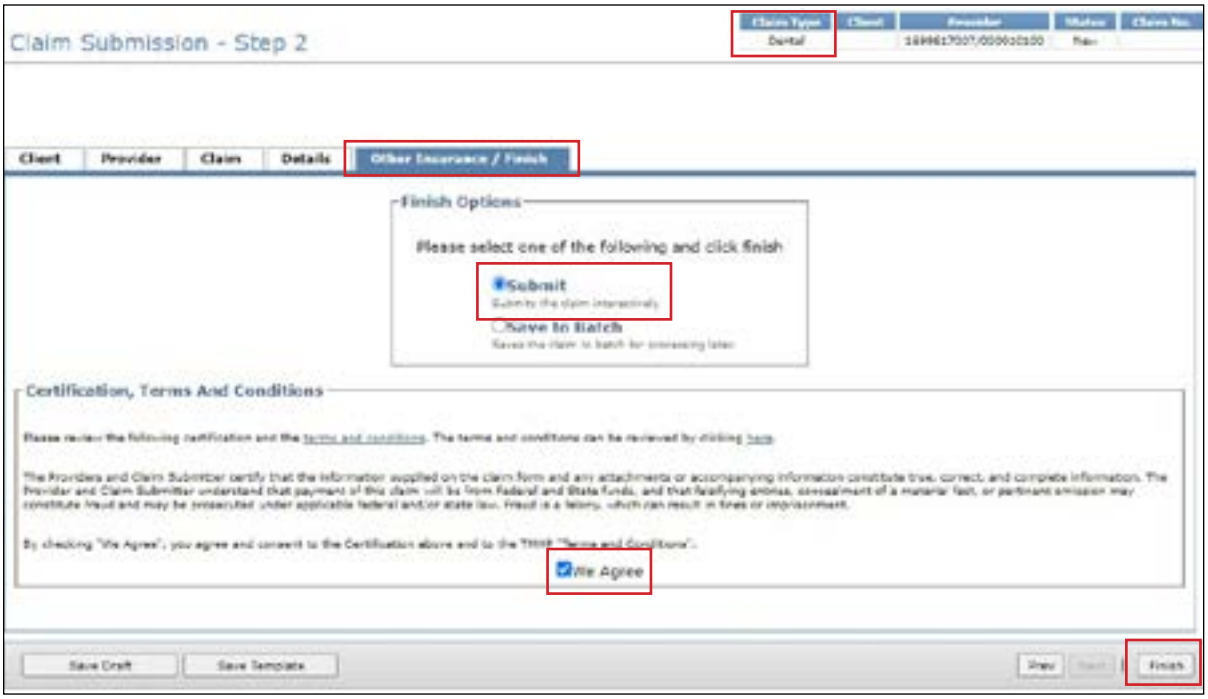
5) Click **Other Insurance/Finish**.
Note: OI information is not required on a Dental claim, only an Institutional claim.

a) Select either the **Submit** or **Save to Batch** radio button.

b) Check the **We Agree** box in the Certification, Terms, and Conditions section.

c) Click **Finish** in the lower right corner of the screen.

d) If the claim is submitted successfully, an ICN will be displayed at the top of the page.



To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**.

To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

Entering an Institutional Claim

TMHP will forward certain Institutional claims to MCOs. These claims can be set to the following statuses:

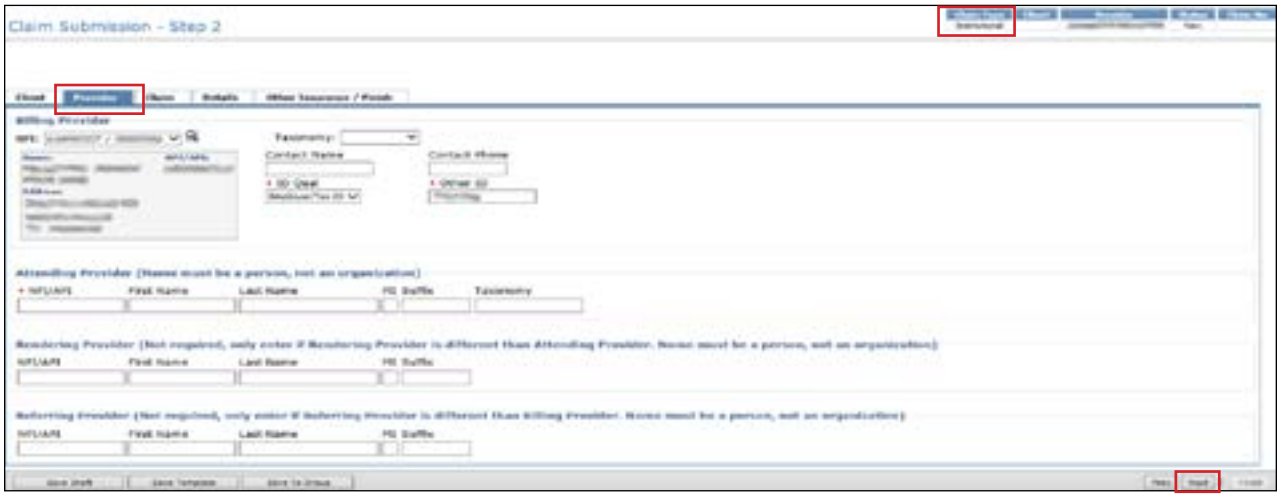
- Forwarded: The claim has been forwarded to (but not yet accepted or rejected by) an MCO.
- Rejected: The claim has been rejected by TMHP or the MCO to which it was forwarded.
- Accepted: The claim has been accepted by TMHP or an MCO. When a claim is accepted by an MCO, it is assigned a 28-character alphanumeric EDI transaction number (ETN).

Claims that are handled by TMHP, not by an MCO, can also be set to the following statuses:

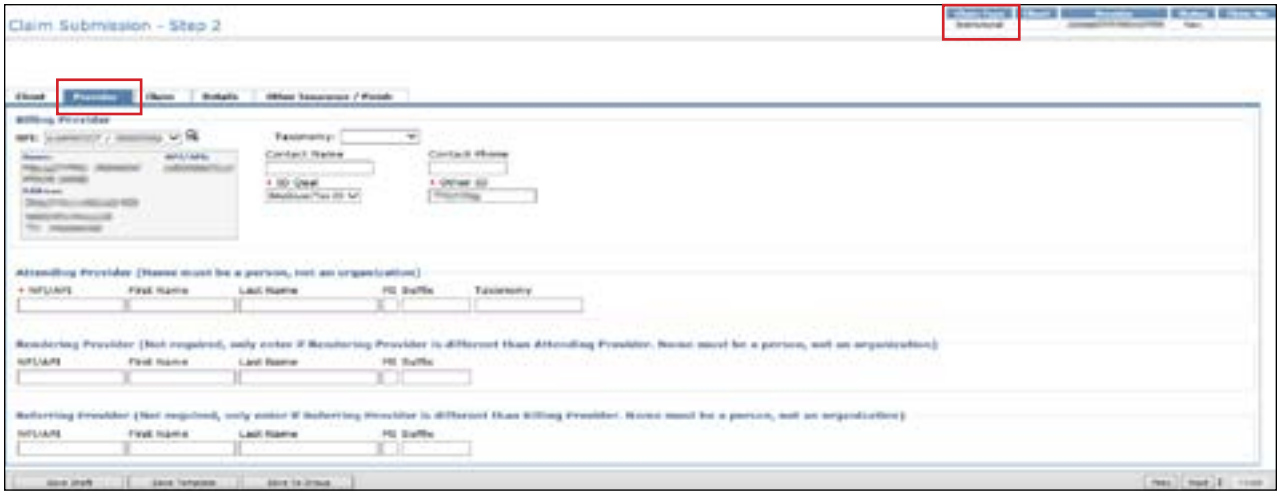
- I: In Process
- D: Denied
- A: Approved for Payment
- FT: Forced Transfer
- S: Suspended
- T: Transferred
- P: Paid
- PF: Paid Forced Transfer
- PT: Paid Transfer
- PZ: Zero Net Balance to the Provider

To enter an Institutional claim:

1) Select the Client tab. You must complete all the required fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field. After you have completed all the required fields, click **Next** or select the Provider tab.



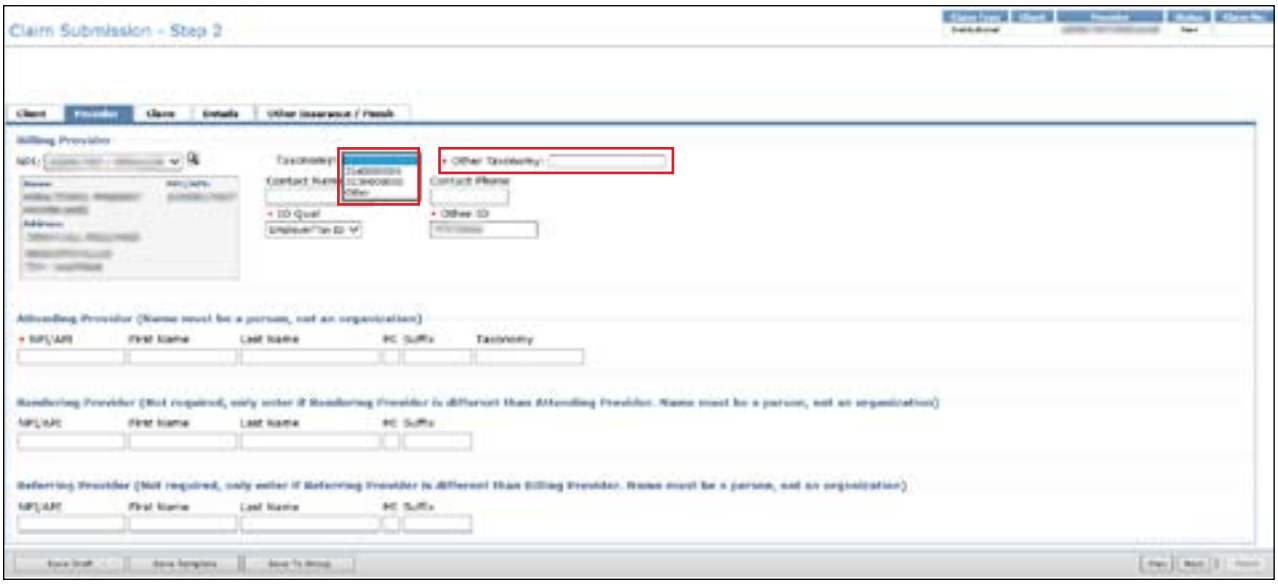
2) Select the Provider tab. You must complete all required fields that are indicated by a red dot.



3) The Taxonomy drop-down menu is autofilled with three values. Taxonomy codes further define the type, classification, or specialization of the healthcare provider. If a provider attempts to submit a claim to TMHP without a valid taxonomy code, regardless of the date of service, the claim will be rejected, and the provider will receive an error message.

   According to the Centers for Medicare & Medicaid Services, all healthcare providers must select a taxonomy code(s) when applying for an NPI. The values in the Taxonomy drop-down menu are:

   - 314000000X (for skilled NFs)
   - 313M00000X (for other NFs)
   - Other
     Choose the provider taxonomy code that was used by your facility when it initially applied for an NPI. If neither of the two autofilled codes applies, choose **Other**. If you choose **Other**, a text box called Other Taxonomy will be displayed and must be filled in.

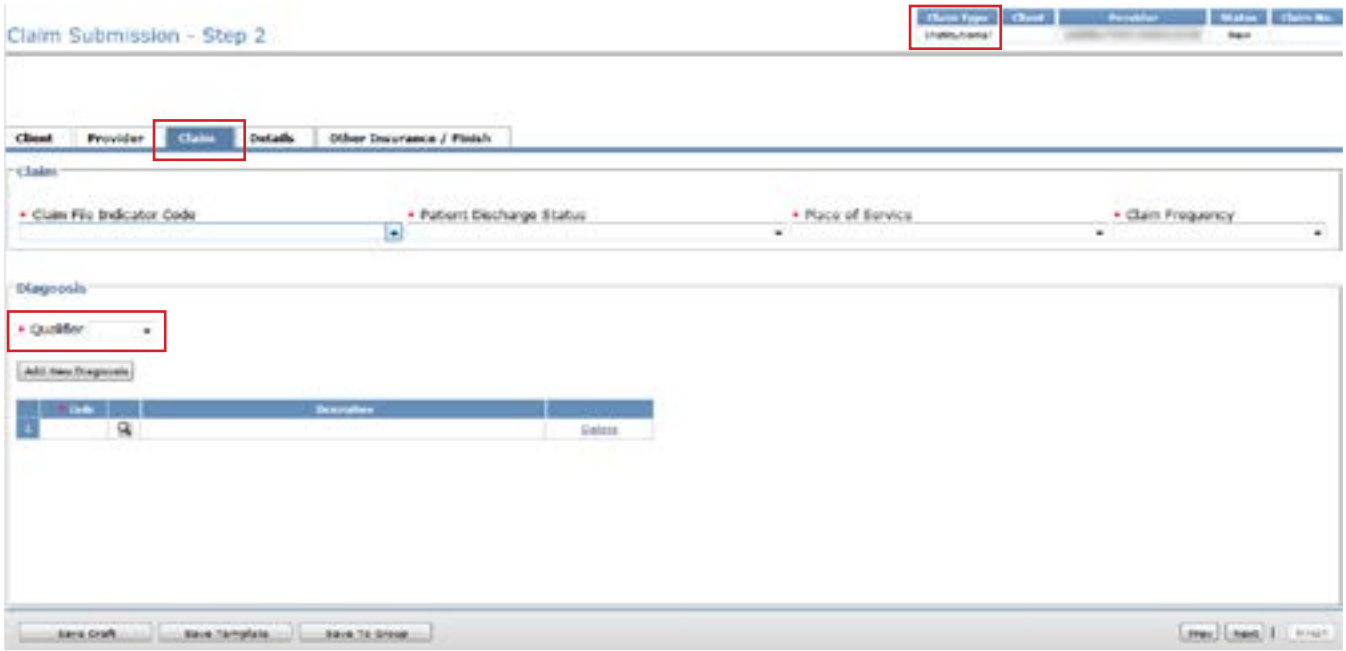


   Note: If an API was chosen, the Taxonomy field will not be displayed.

4) The Attending Provider is required to enter their NPI/API and name. If the Rendering Provider is different from the Attending Provider, that provider information should be added.

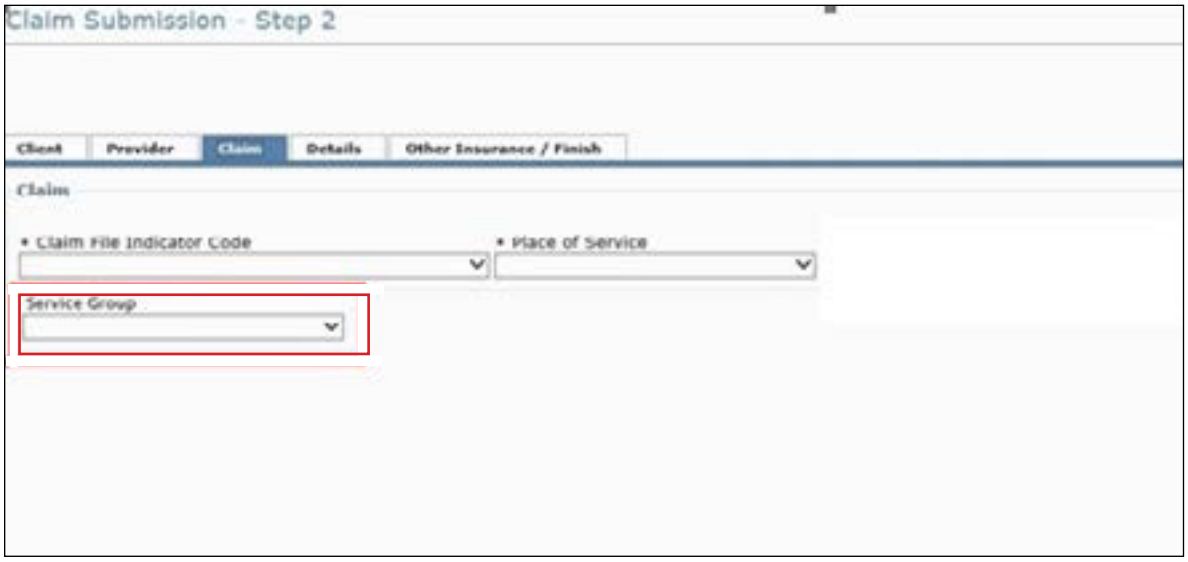
Note: For the claim to be successfully processed, the NPI/API for the Attending Provider, Billing Provider, and Rendering Provider (if entered) must be different. Additionally, the NPI/API for both the Attending Provider and Rendering Provider must be for a person, not a facility.

5) Select the Claim tab. You must complete all the required fields that are indicated by a red dot. Choose the appropriate indicator from the Claim File Indicator Code drop-down menu.



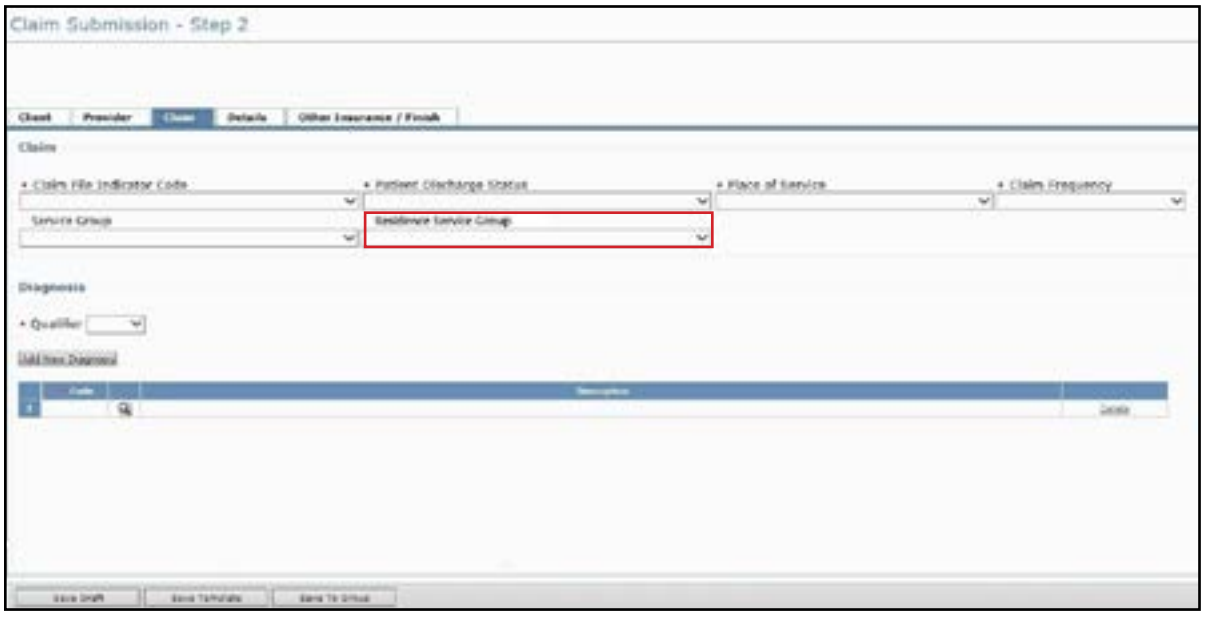
Note: The HHSC-LTC Bill Code Crosswalk requires that modifiers start in position 1, and for any subsequent modifier to be in sequential order and not be duplicated. Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate the SG, residence SG, and budget number. Instead, billing providers will indicate the SG, residence SG, and budget number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.

The Service Group drop-down menu is to be used by billing providers with multiple SGs linked to the same LTC provider contract number.



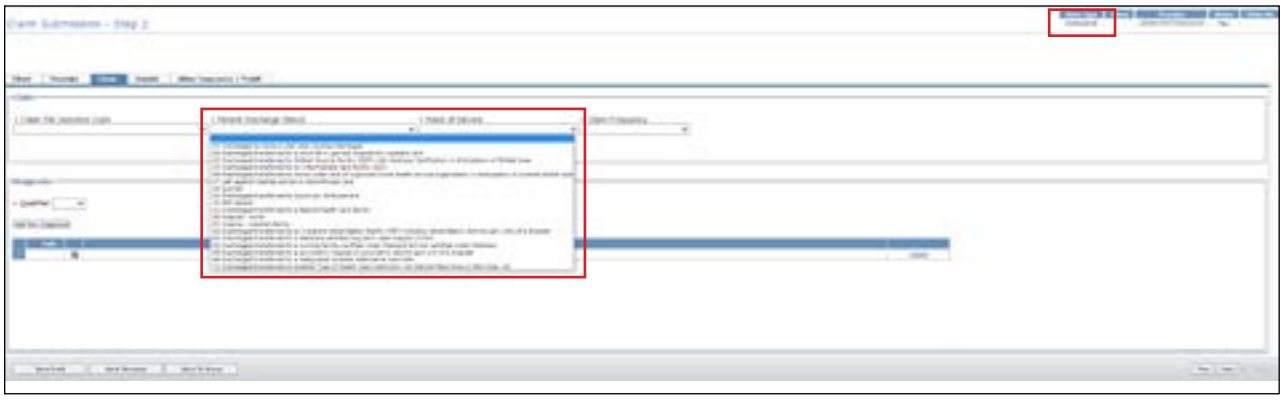
The Residence Service Group drop-down menu will be used by SG 8 (hospice) billing providers to indicate the person's residence at the time of service for LTC institutional claims. It will be a conditional field, but claims will be rejected if the field is not filled out when required (that is, when people are in an ICF/IID or nursing facility and the correct SG is either left blank or not selected).

Note: The provider can be linked to multiple SGs. SG 8 needs to be selected in the Service Group field for the Residence Service Group field to be displayed. If the provider is linked only to SG 8, the Service Group field is not displayed.

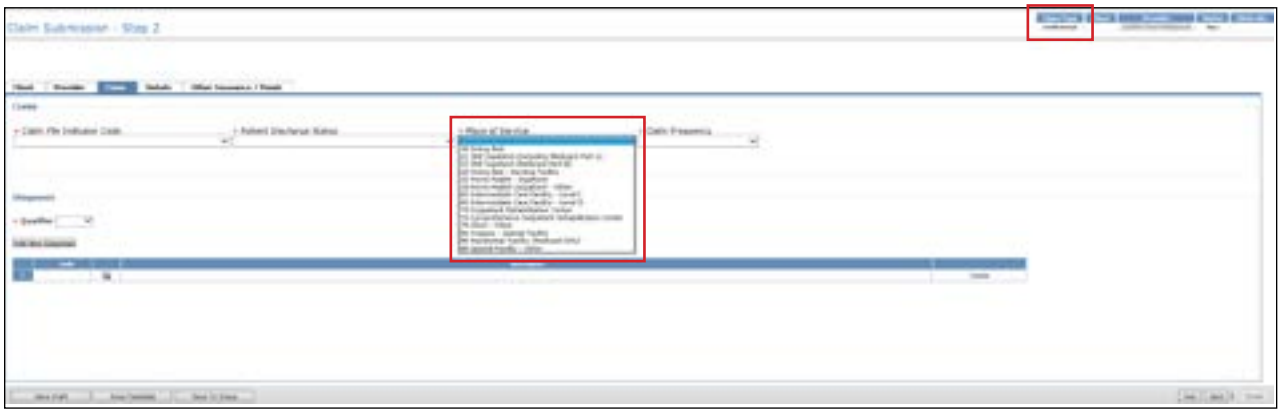


Note: Billing providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC-LTC Bill Code Crosswalk. It is important to remember that modifier placements changed as of February 1, 2019, so providers should consult the Crosswalk to update their previously saved claims and templates to reflect the new modifier positions.

6) Choose the appropriate status from the Patient Discharge Status drop-down menu.

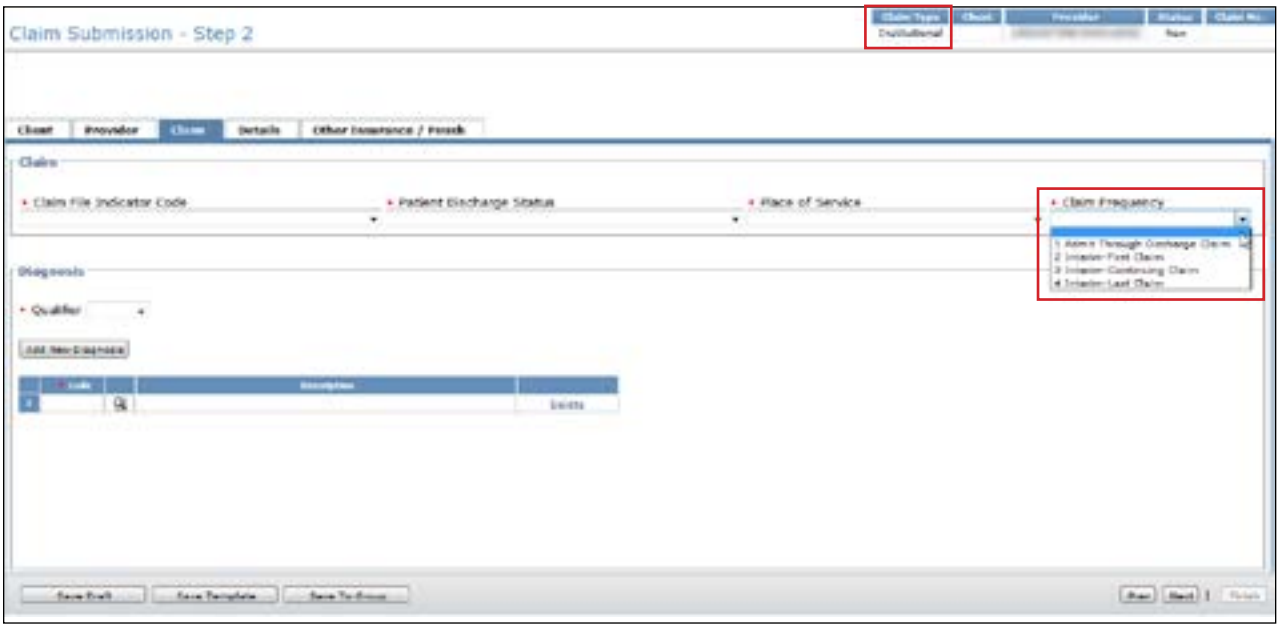


7) Choose the appropriate facility type from the Place of Service drop-down menu.



8) Choose the appropriate claim frequency from the Claim Frequency drop-down menu:

- Choose **1 Admit Through Discharge Claim** when the claim will cover the duration of the stay.
- Choose **2 Interim-First Claim** if this is the first claim billed for the person.
- Choose **3 Interim-Continuing Claim** for all dates of service between the first and last claims.
- Choose **4 Interim-Last Claim** if this is the last claim billed for the person.



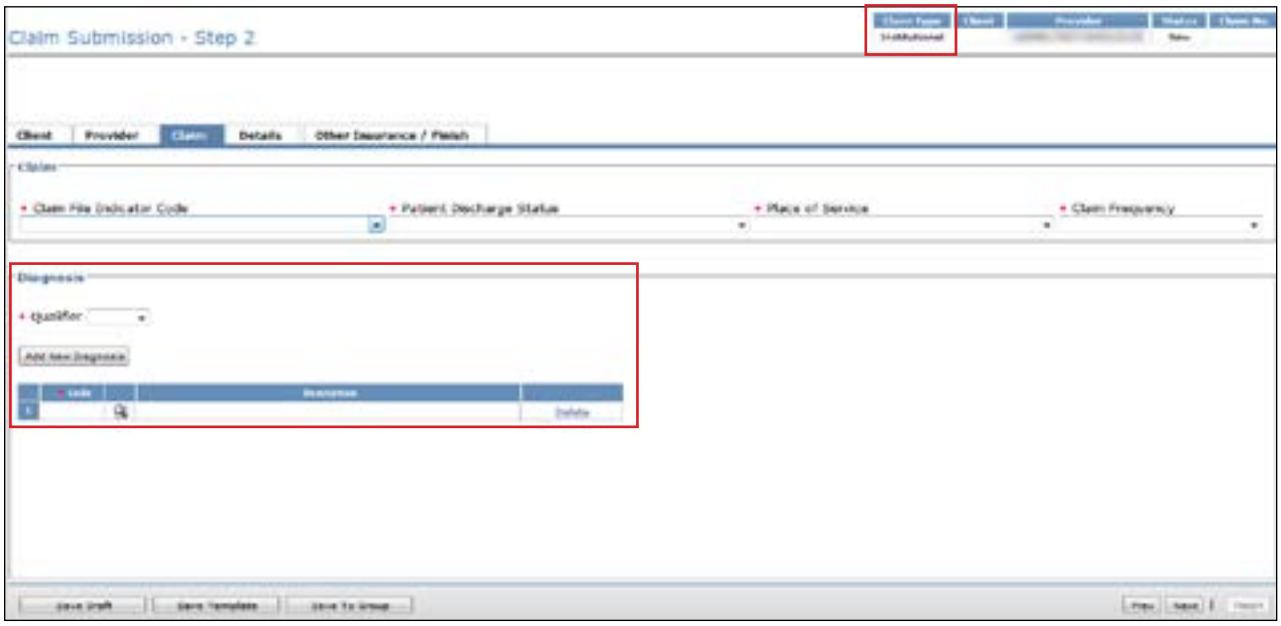
9) Depending on the value selected in the Claim Frequency field, the Admit Date field may be required. The admit date is the date that the person was admitted to the facility.

10) The Principal Diagnosis code is required for institutional claims. Entering an improper diagnosis code may result in a claim rejection by an MCO. The Admitting Diagnosis is conditional for certain values in the Claim Frequency field.

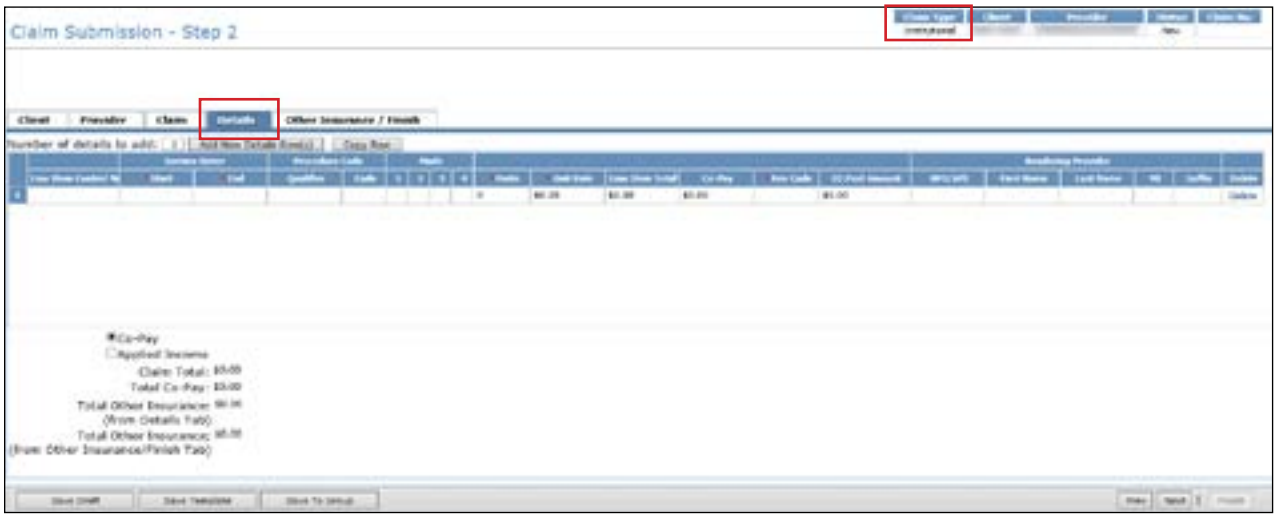
To add more diagnosis codes, click **Add New Diagnosis**. You may list up to three diagnosis codes. The third Diagnosis field is intended to be used with External Cause of Morbidity codes for ICD-10.

To view the diagnosis description, click the magnifying glass icon.

The Qualifier field is used to indicate an ICD-10 diagnosis code. Select from the drop-down menu based on the diagnosis code(s) entered.



11) Select the Details tab. You must complete all the required fields that are indicated by a red dot. If the person is in SG 1, 6, or 8, enter the total amount paid by the person's OI in the OI Paid Amount field.



To add more rows, click **Add New Detail Row(s)**. To copy the information from the previous detail, click **Copy Row**. To delete a row, scroll over and click **Delete** at the end of the row.

When billing for managed care claims with consecutive service dates without a change in the level of service Resource Utilization Group (RUG) or gap in service dates, providers must enter these claim transactions as one line item on the Details tab. Entering multiple rows for consecutive service dates can result in an initial claim denial by the MCO during processing.

Note: The Rendering Provider information in the Details tab should be added only if it is different from

the Rendering Provider listed in the Provider tab. The Rendering Provider in the Details tab should also be different from the Attending Provider and Billing Provider listed in the Provider tab.

12) Click the **Other Insurance/Finish** tab.

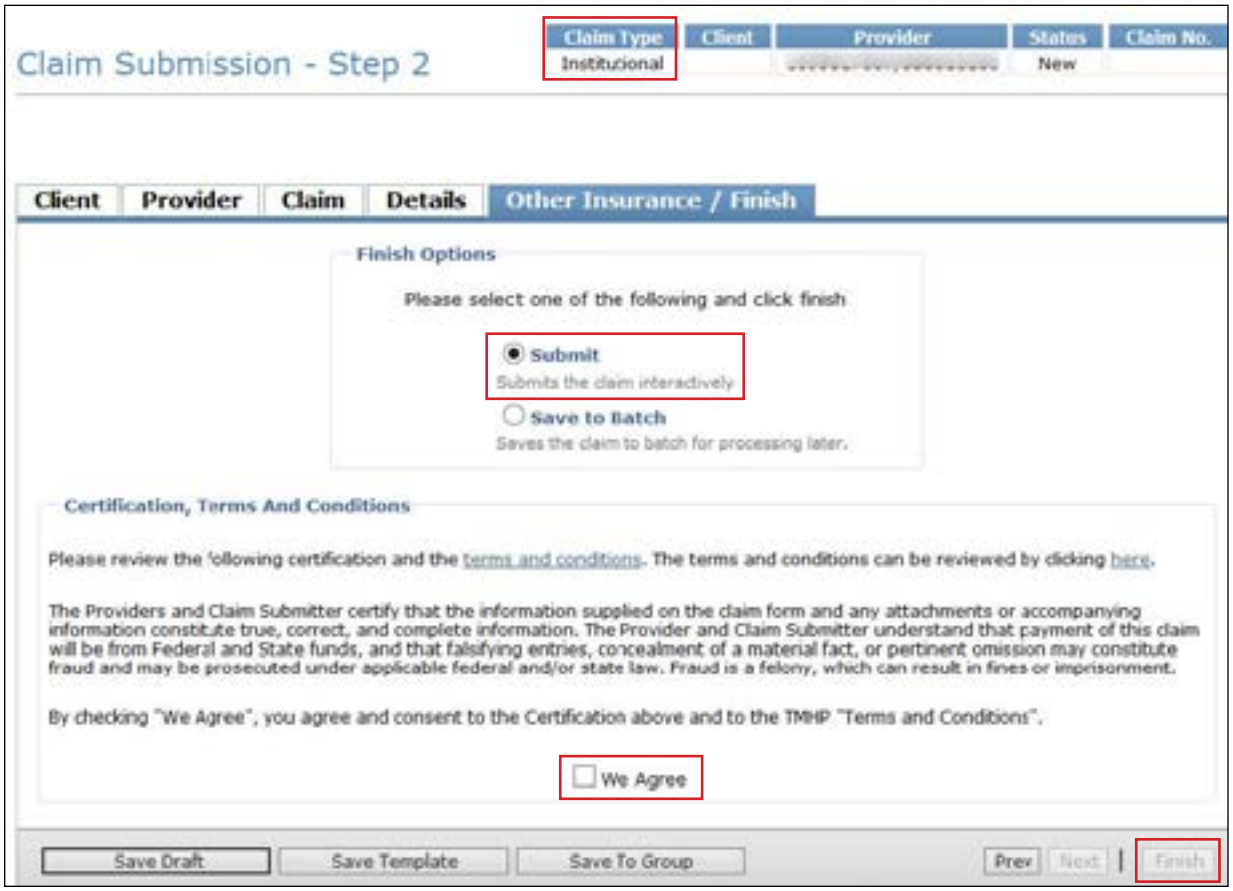
When submitting an Institutional claim, there are four scenarios for the Other Insurance/Finish section. They are:

- **Scenario 1. Other Insurance/Finish tab** – The options that are available on the Other Insurance/Finish tab are the same as those for a Professional claim unless the person is in SG 1, 6, or 8.
  Note: *If your claim will be forwarded to an MCO, it is recommended to submit the OI information directly to the MCO. Otherwise, the claim may be held for manual review by the MCO.*
  Note: *For people with Medicare in SG 1, Service Code 3 (Extended Care Facility), enter either the Medicare Part A or Part C amount in the Medicare Information section. The Medicare attestation box must also be checked when billing for SG 1, Service Code 3.*

  a) Select the **Submit** radio button.

  b) Check the **We Agree** box in the Certification, Terms And Conditions section.

  c) Click **Finish** in the lower right corner of the screen.



To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**.

To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

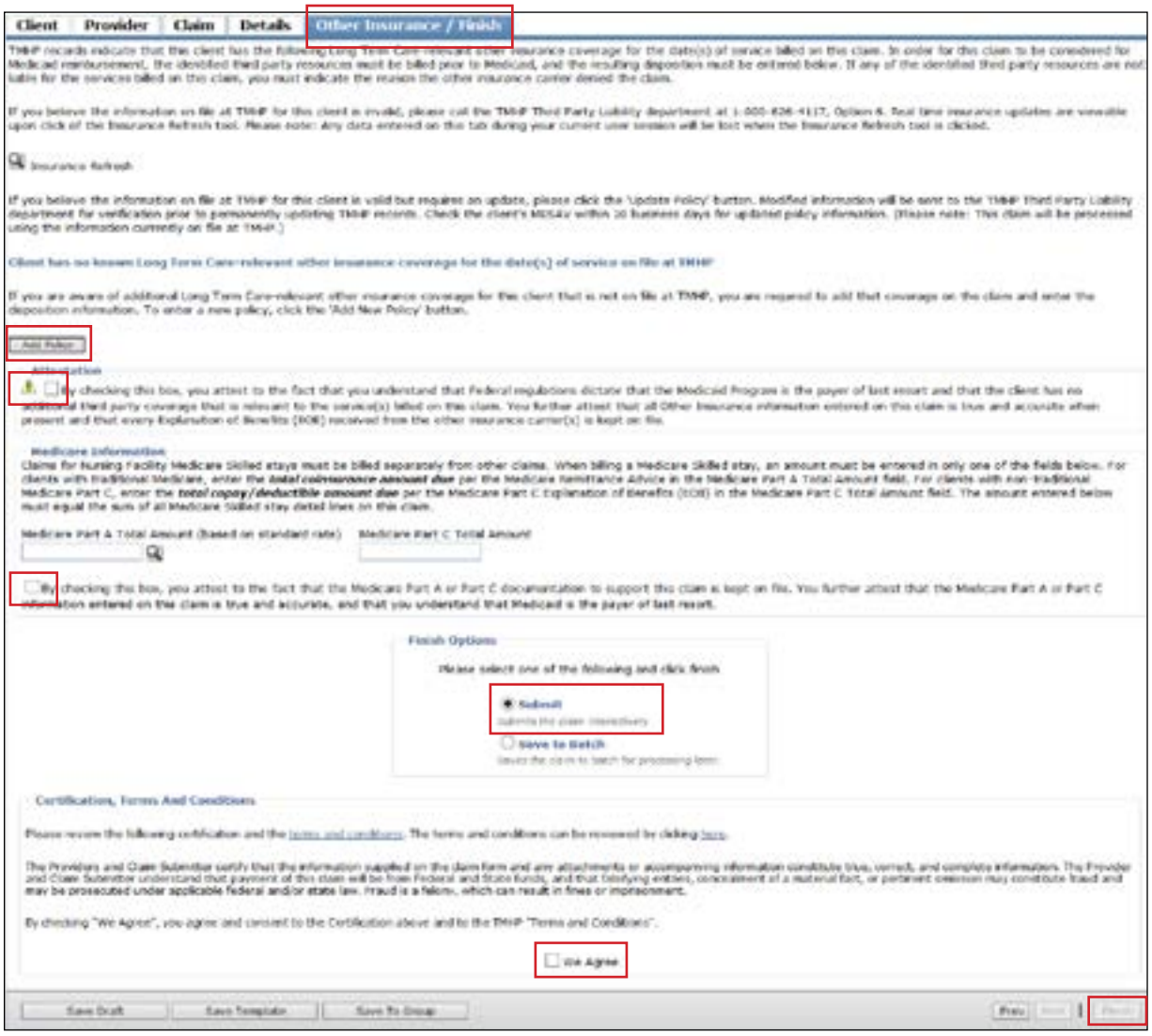
- **Scenario 2. Other Insurance/Finish tab (no known OI coverage) –** For providers in SG 1, 6, or 8.
  - If you are aware of additional OI coverage for the person that is relevant to LTC, you are required to add that coverage to the claim using the **Add Policy** function.

a) Check the box under Attestation.

b) Click the **Submit** radio button.

c) Check the **We Agree** box in the Certification, Terms And Conditions section.

d) Click **Finish** in the lower right corner of the screen.



To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**. To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

- **Scenario 3. Other Insurance/Finish Tab add OI policy**. The OI policy will be validated by TMHP's Third-Party Liability department before it is added to the OI database. However, any amount paid by OI will be taken into consideration on the submission of the claim.

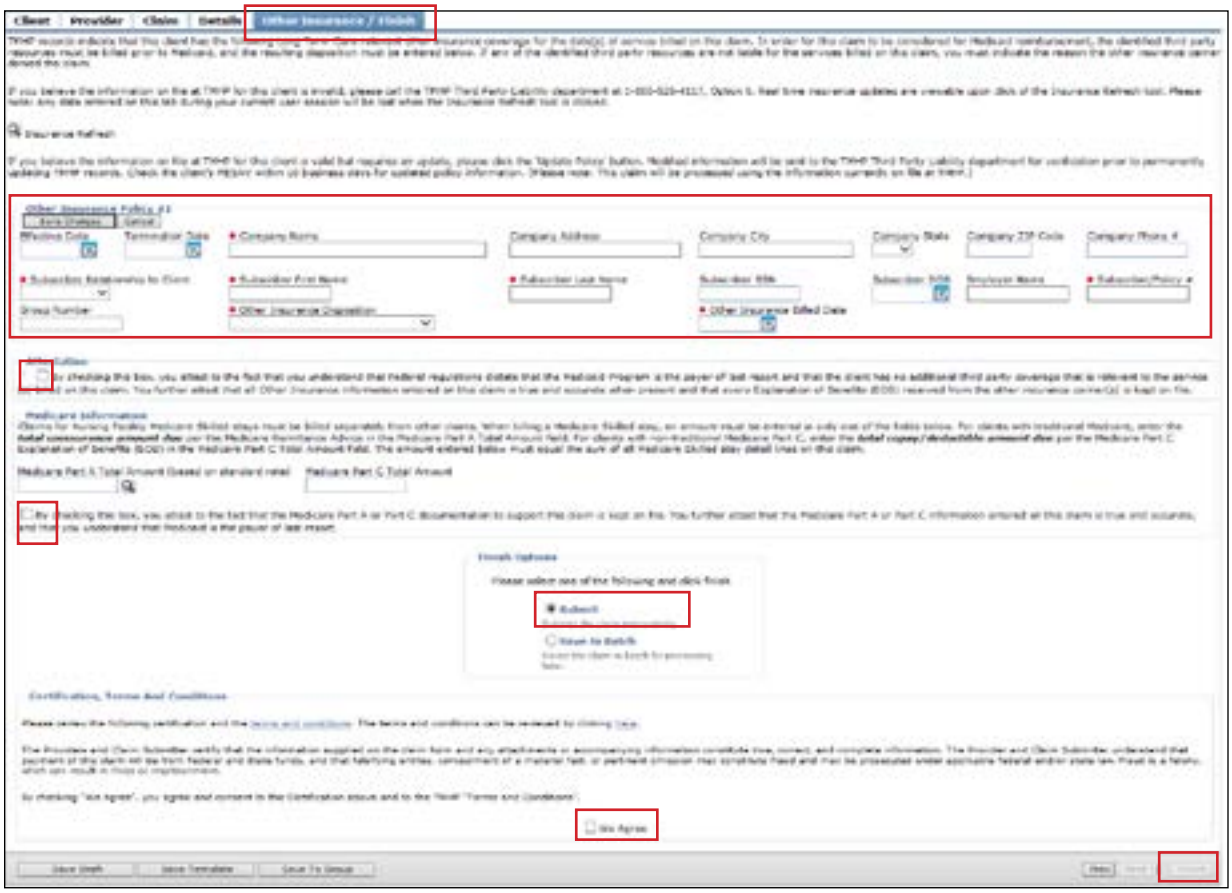
  a) Complete the required fields as indicated by the red dots.
  Note: To avoid processing errors, enter either the employer name or group number, but not both, when applicable.

  b) Check the box under Attestation.

  c) Select the **Submit** radio button.

  d) Check the **We Agree** box in the Certification, Terms And Conditions section.

e) Click **Finish** in the lower right corner of the screen.



To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**. To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

- **Scenario 4. Other Insurance/Finish Tab (with known OI coverage)**. For people in SGs 1, 6, or 8, TexMedConnect will display any known OI coverage that is relevant to LTC that is currently on file with TMHP.

  a) Verify that the OI information is valid and correct.

  b) Fill in all required OI policy information as indicated by a red dot.

  c) Choose the appropriate option in the Other Insurance Disposition drop-down menu. If no response has been received and it has been more than 110 calendar days since the billing date, choose **No response (initial bill for services)** or **No response (subsequent bill for services)**.

  d) If you chose **Paid** in the Other Insurance Disposition drop-down menu, choose an option in the Other Insurance Disposition Reason drop-down menu as shown below, and if applicable, enter the Other Insurance Paid Amount.
  Note: The amount entered in this field must match the total amount entered on the Details tab in the OI Paid Amount field.

  e) If you chose **Denied** in the Other Insurance Disposition drop-down menu, choose an option in the

Other Insurance Disposition Reason drop-down menu.

f) Enter the appropriate date in the Other Insurance Billed Date field. If you choose either of the No response options in the Other Insurance Disposition drop-down menu, the Other Insurance Billed Date must be at least 110 calendar days prior to the submission date.

g) If you need to update the OI policy, click **Update Policy** to display the Other Insurance Policy fields. After the information is updated, click **Save Changes**.

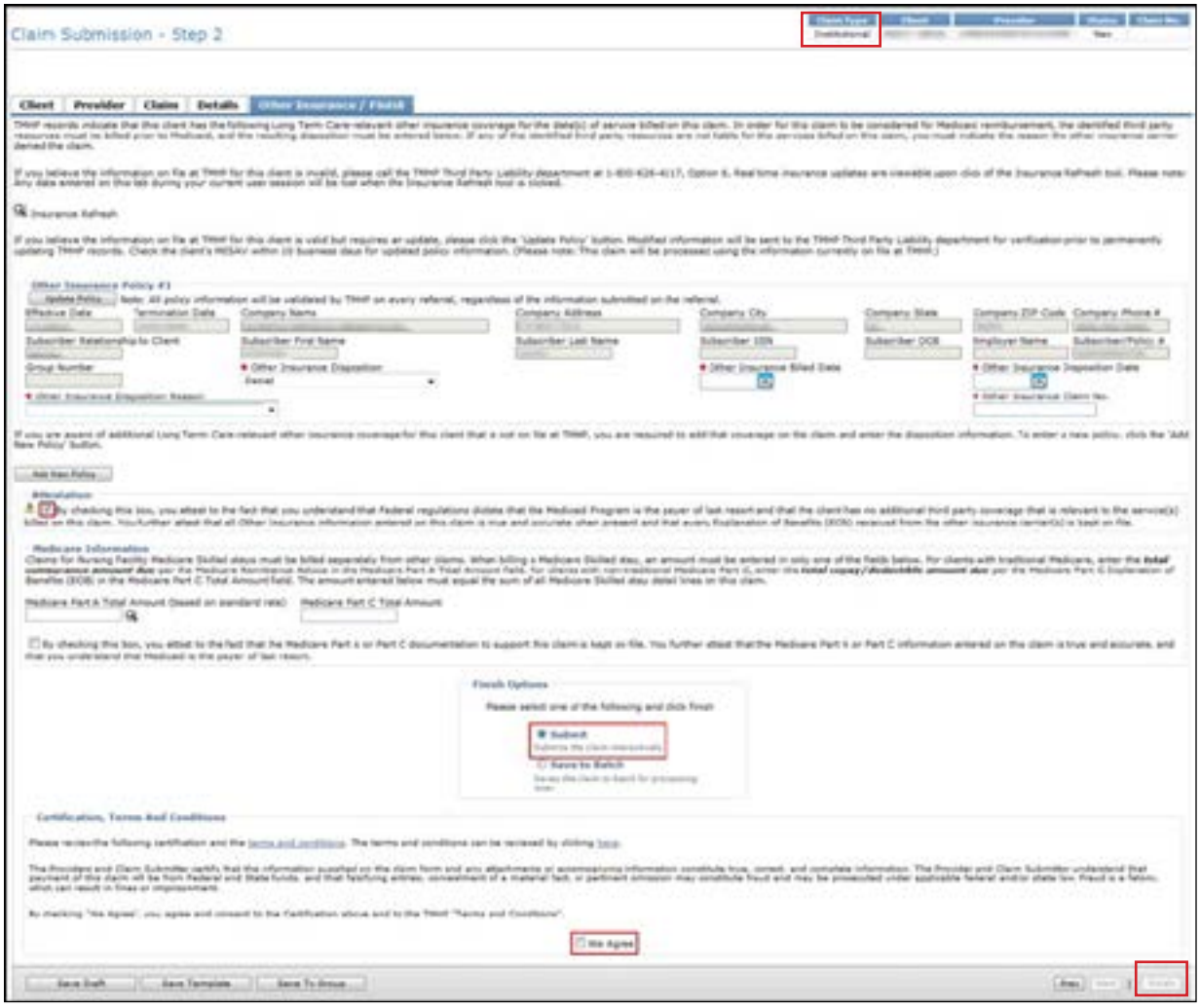
h) If you need to add another insurance policy, click **Add Policy** to display the Other Insurance Policy field.

i) Check the box under Attestation.

j) Select either the **Submit** radio button or the **Save to Batch** radio button.

k) Check the **We Agree** box in the Certification, Terms And Conditions section.

l) Click **Finish**.
Note: The OI policy will be validated by the TMHP Third-Party Liability department before it is added to the OI database.



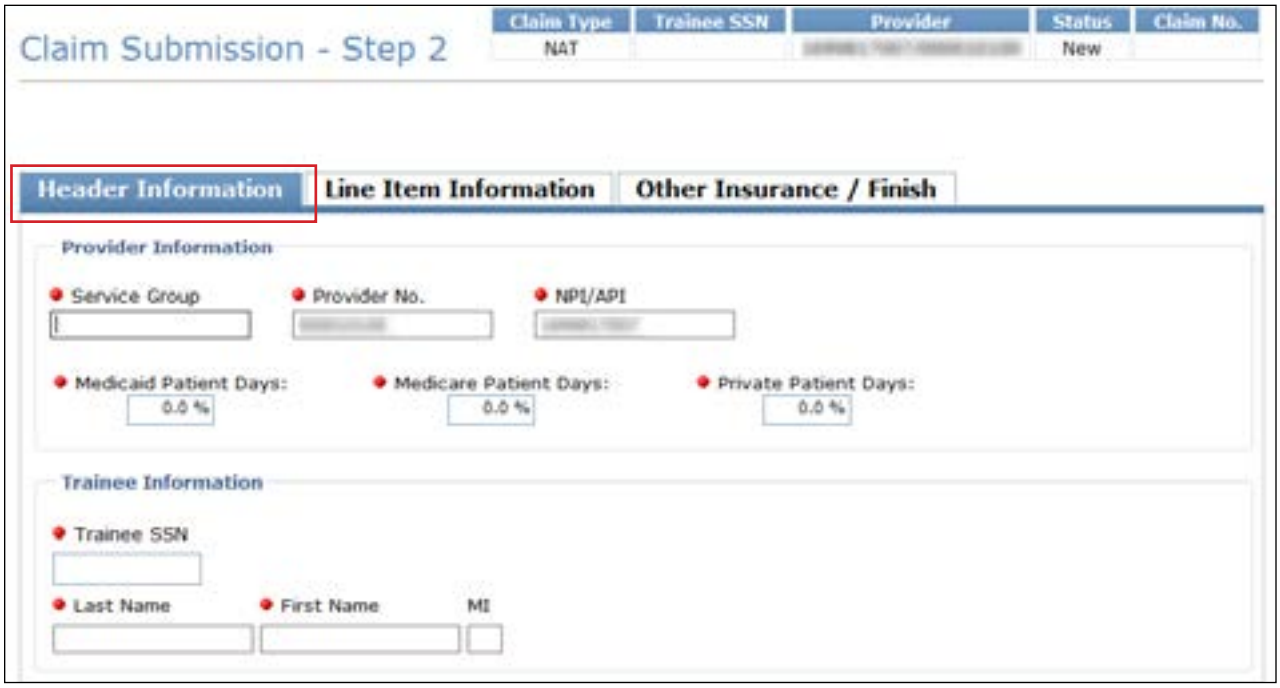
To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save**

Template. To save the claim as part of a group, click **Save To Group**. To submit the claim as part of a batch, refer to the Submitting a Batch section of this user guide.

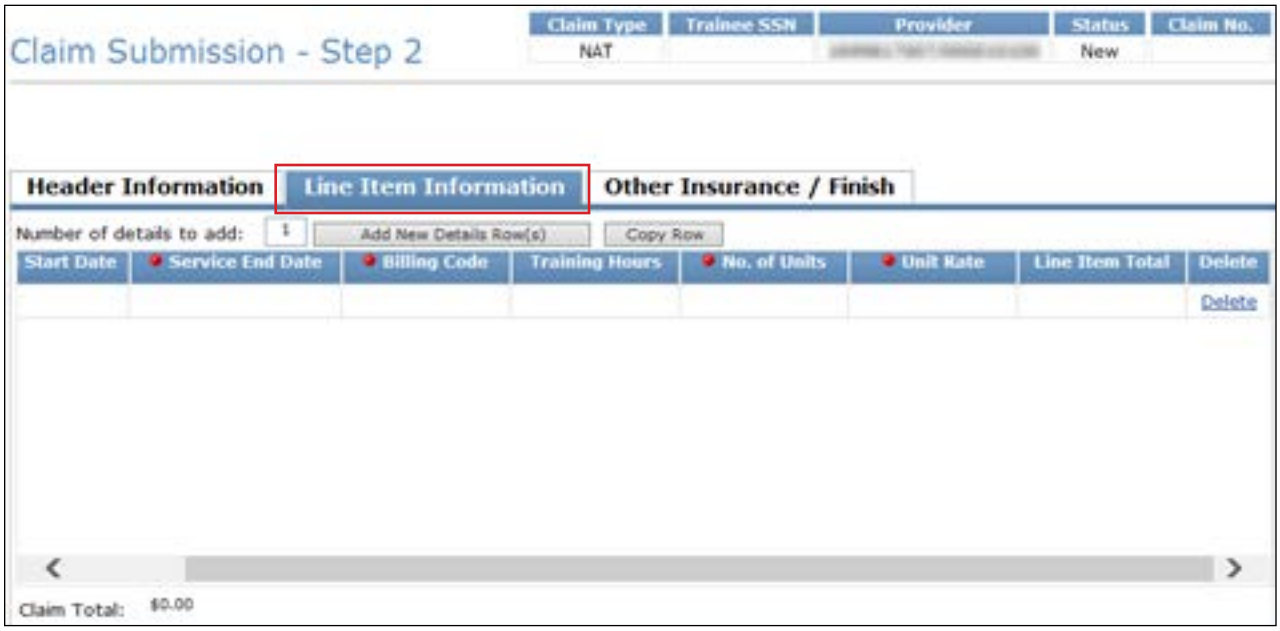
Entering an NAT Claim

To enter an NAT claim:

1) Select the Header Information tab. Complete all the required fields as indicated by a red dot. The Provider No. field and the NPI/API field will be autofilled based on the information entered in Step 1.
Note: The percentages entered for Medicaid Patient Days, Medicare Patient Days, and Private Patient Days must total 100%.



2) Click the Line Item Information tab. Complete all the required fields as indicated by a red dot. No future date is allowed in the Service Start Date or Service End Date field.



If you want to add more rows, click **Add New Detail Row(s)**. If you want to copy the information from the previous detail, click **Copy Row**.

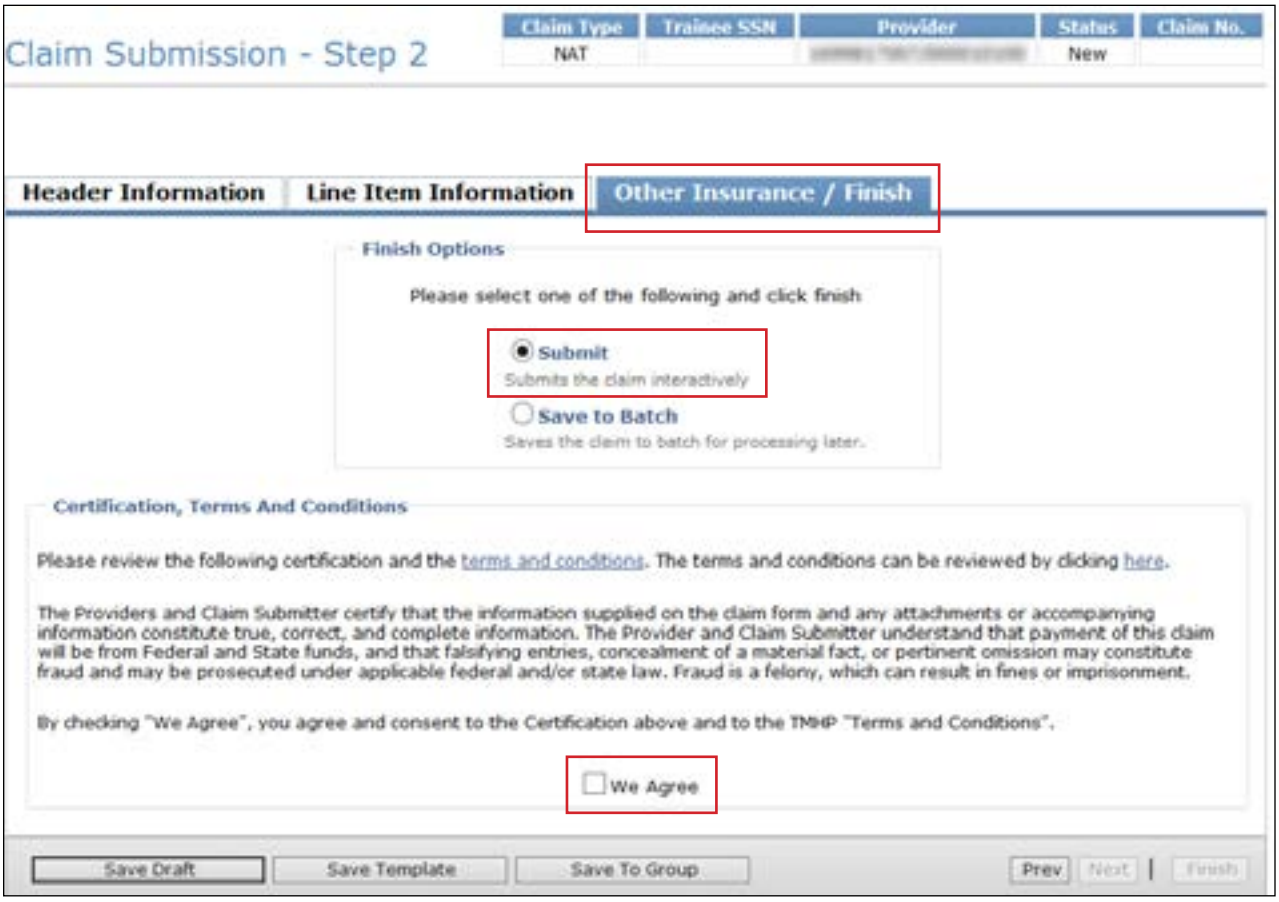
3) Click **Other Insurance/Finish**.
Note: OI information is not required on an NAT claim, only an Institutional claim.

a) Select either the **Submit** or the **Save to Batch** radio button.

b) Check the **We Agree** box in the Certification, Terms And Conditions section.

c) Click **Finish** in the lower right corner of the screen.

d) If the claim is submitted successfully, the ICN will be displayed in the Claim No. field at the top of the page.



To save the claim as a draft, click **Save Draft**. To save the claim as an individual template, click **Save Template**. To save the claim as part of a group, click **Save To Group**.

To submit the claim as part of a batch, refer to the "Submitting a Batch" section of this user guide.

Saving a Claim

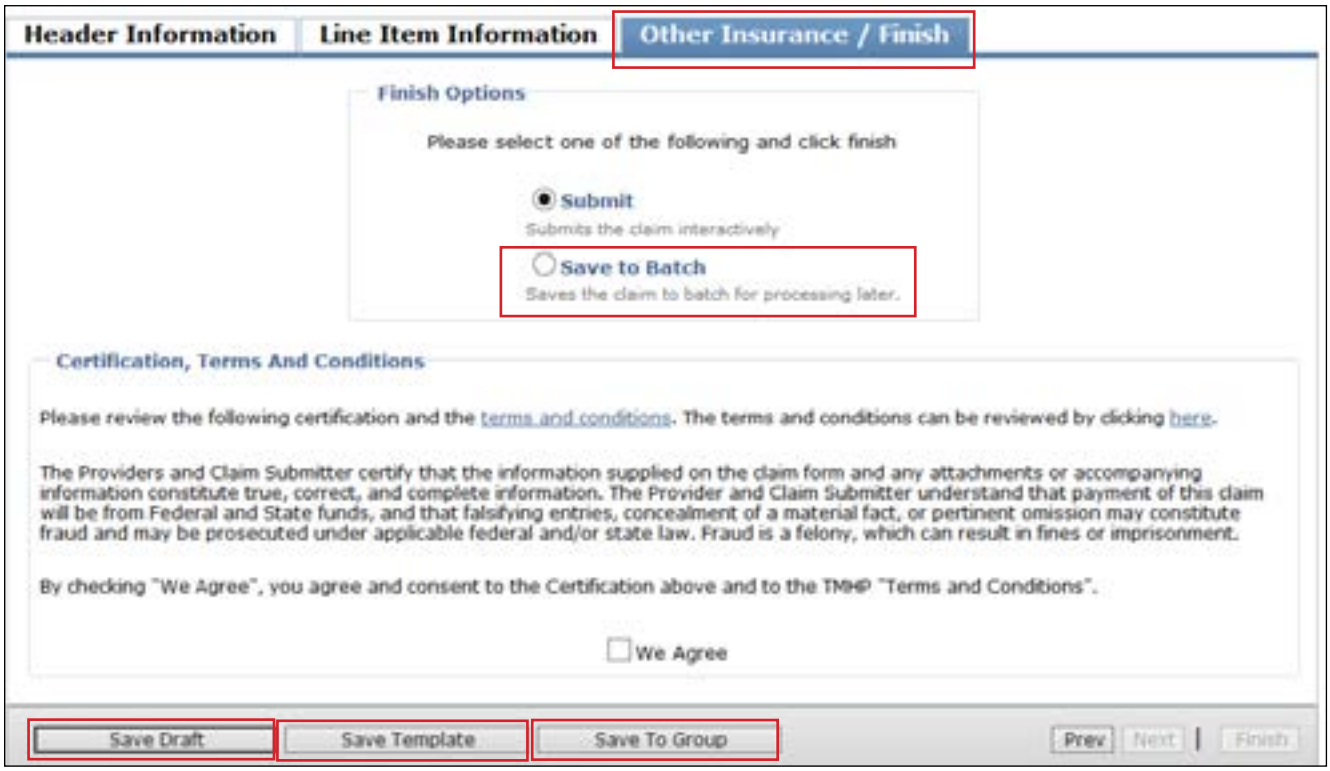
There are four options available for saving a claim:

1) Save Draft – The claim will be added to the draft list, to be completed later.

2) Save Template – The claim will be added to the template list for faster claims creation in the future.

3) Save To Group – The claim will be added to a group template, which includes templates for many people.

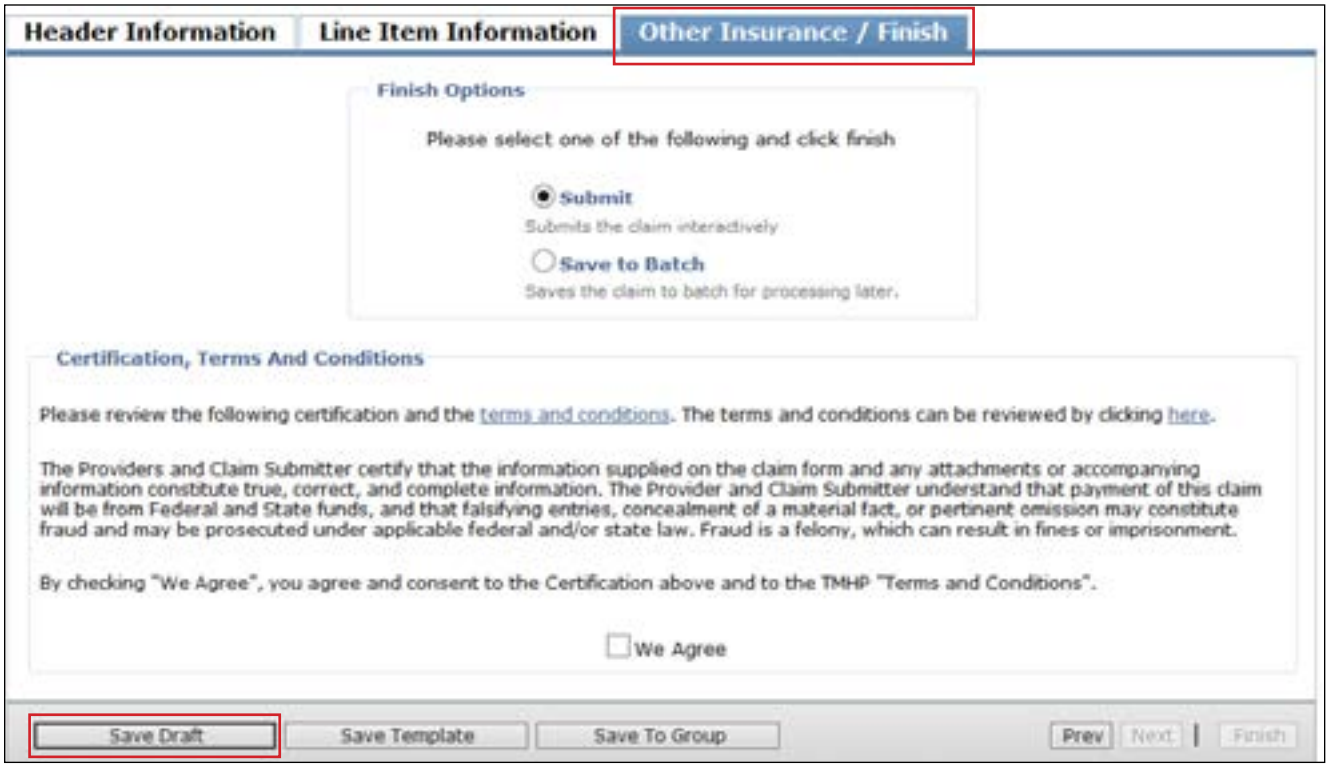
4) Save To Batch – The claim will be added to a batch of claims that can be submitted as a group.



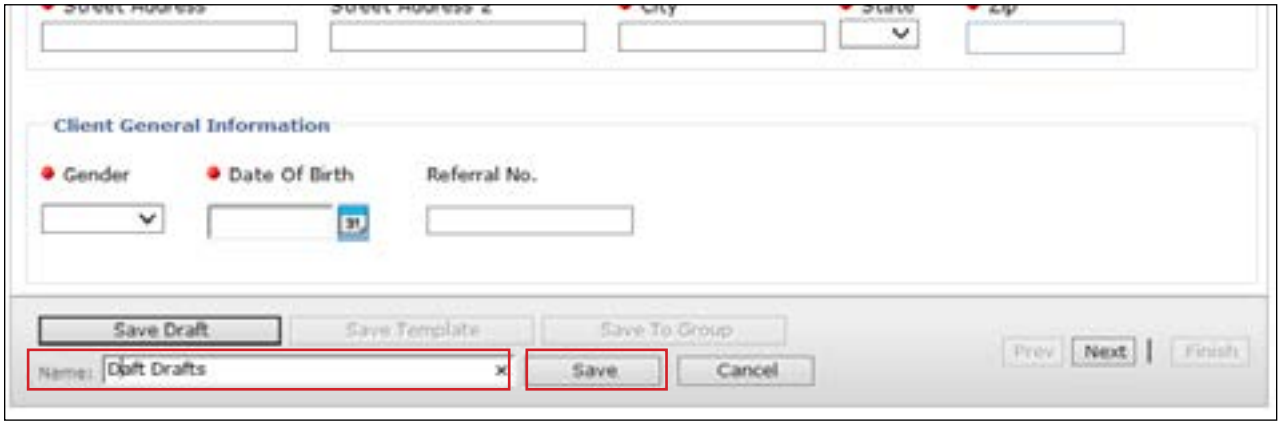
Draft Claims

Saving the claim as a draft allows the user to come back to the claim at a later time and complete it. To save a claim as a draft:

1) Click **Save Draft** at the bottom of the screen.



2) Enter a name for the draft and click **Save**. The claim will be added to the draft list. A maximum of 500 claims can be saved as drafts. Saved drafts are available for 45 days after the last time they were accessed. After 45 days have elapsed, any saved drafts are automatically deleted.



Viewing Draft Claims

To view a list of all your draft claims:

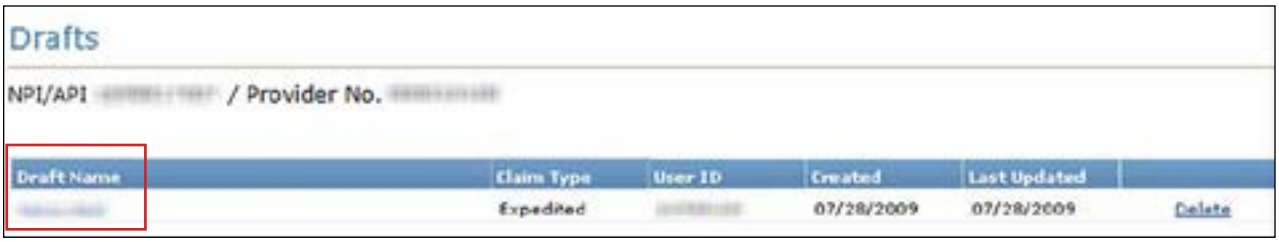
1) Click **Drafts** under the Claims section on the navigation panel.

2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

3) If there are multiple drafts, you can click a column heading to sort the list by that column category. Click a draft name to view the saved claim.

- After a claim from the draft list has been submitted, that draft claim is removed from the draft list.
- After 45 days, all drafts will automatically be deleted from the draft list.

- A maximum of 500 drafts can be created for each NPI or API and provider number.



Individual Templates

Saving as an Individual Template

To save an individual claim as a template, complete a claim and then:

1) Click **Save Template**.

2) Enter a template name, and click **Save**. The claim will be added to the Individual Template list.

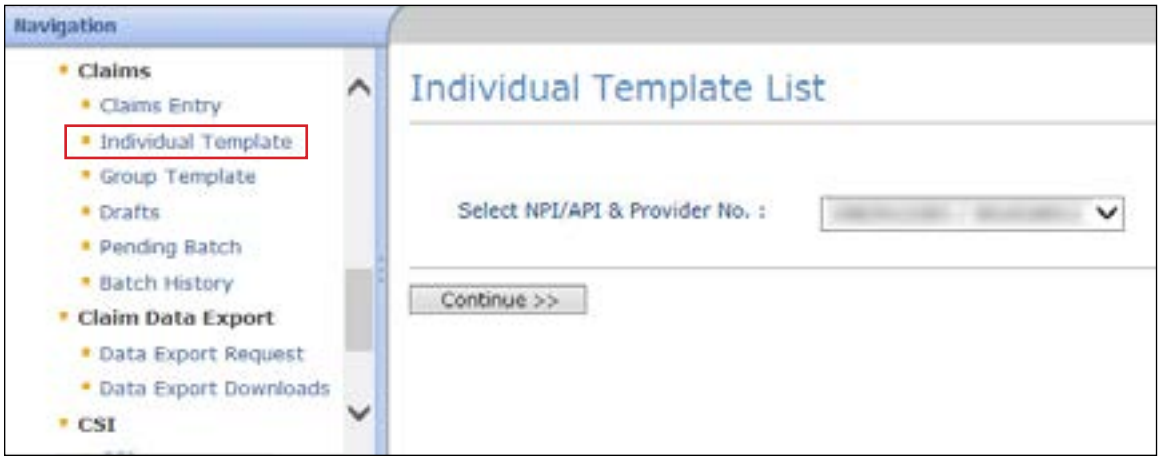
3) Templates do not disappear when they are used and can be used an unlimited number of times. However, they will be removed automatically if they have not been used for 365 days.

4) A maximum of 1,000 individual claim templates can be created for each NPI or API and provider number.

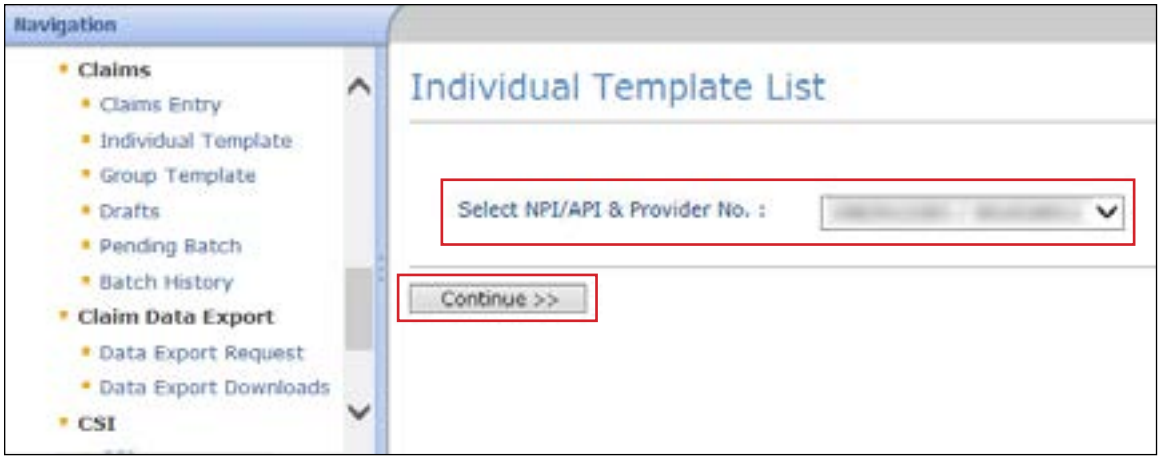
Viewing Individual Templates

To view individual templates:

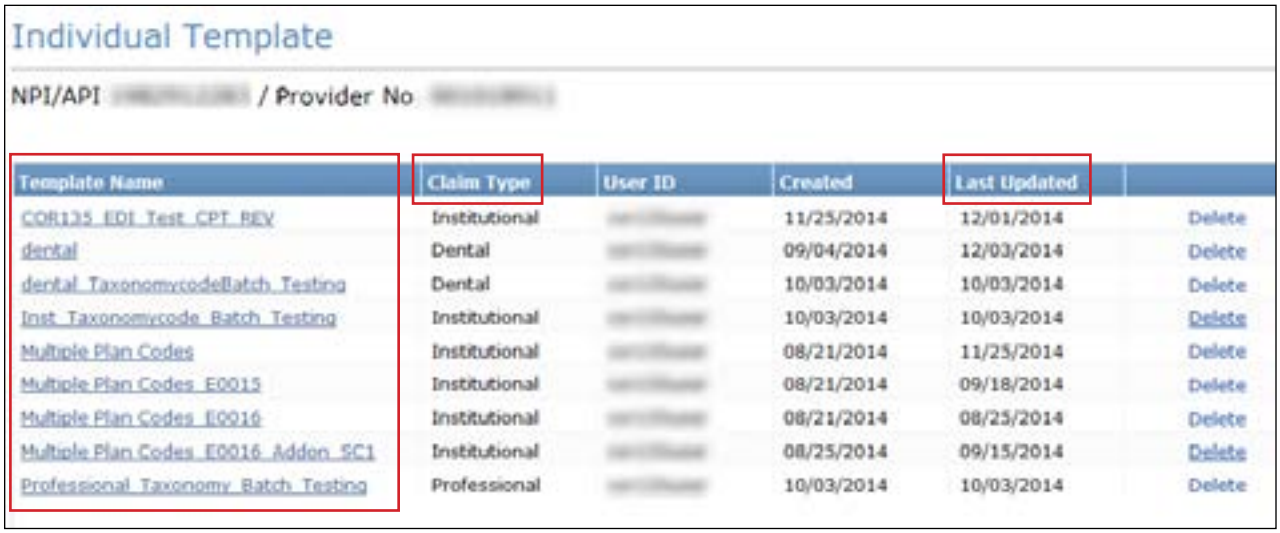
1) Click **Individual Template** under the Claims section in the navigation panel. Templates are displayed by NPI.



2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.



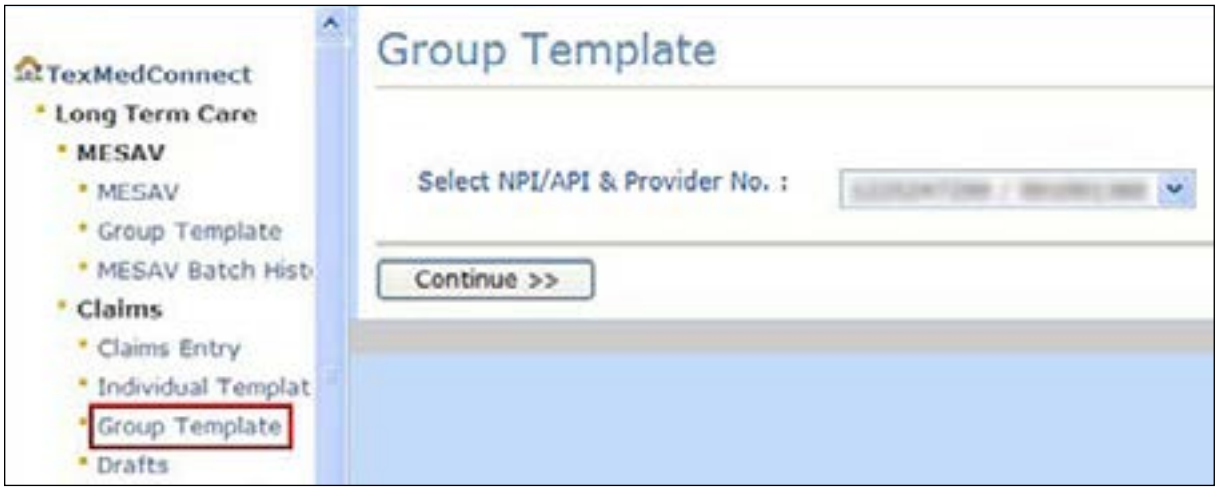
3) If there are multiple drafts, you can click a column heading to sort the list by that column category. Click on the template name to open it.



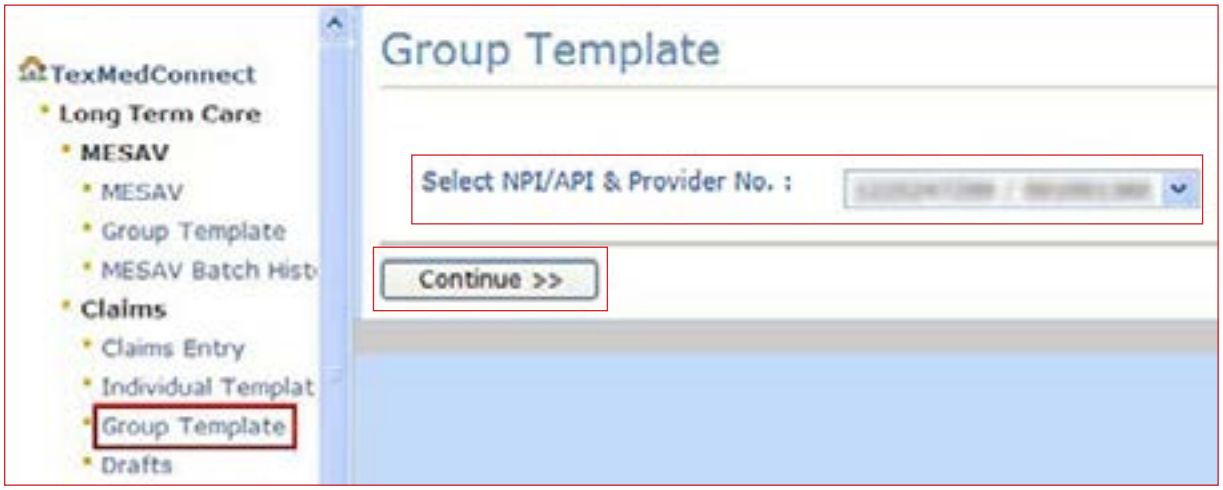
Group Templates

Viewing Existing Group Templates

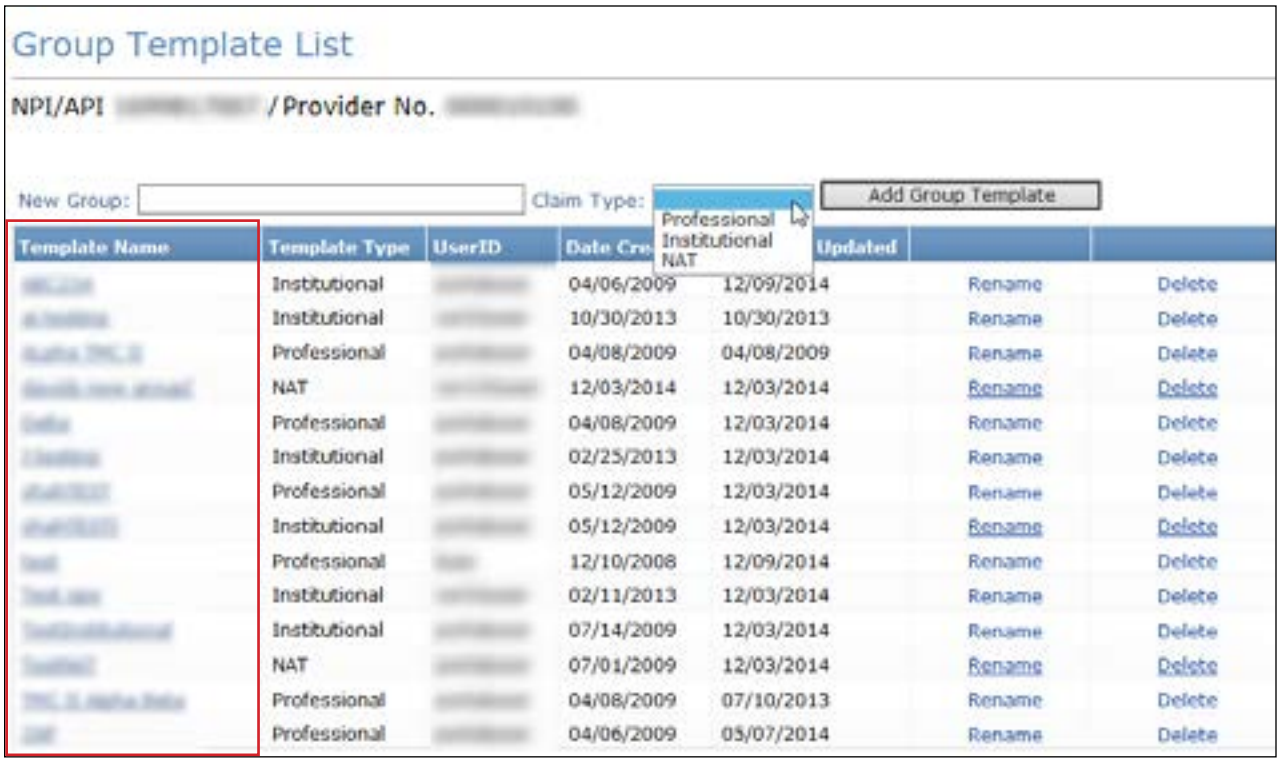
1) Click **Group Template** under the Claims section in the navigation panel.



2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.



3) Under the **Template Name** column, click the name of the template that you want to work on.

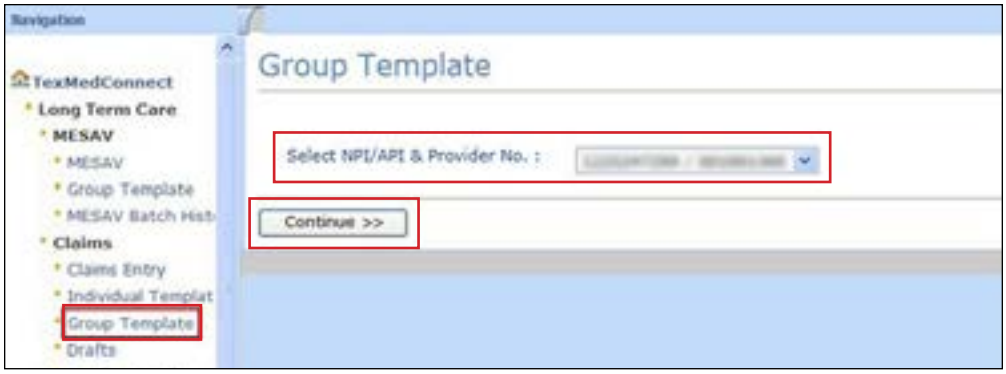


Creating New Group Templates

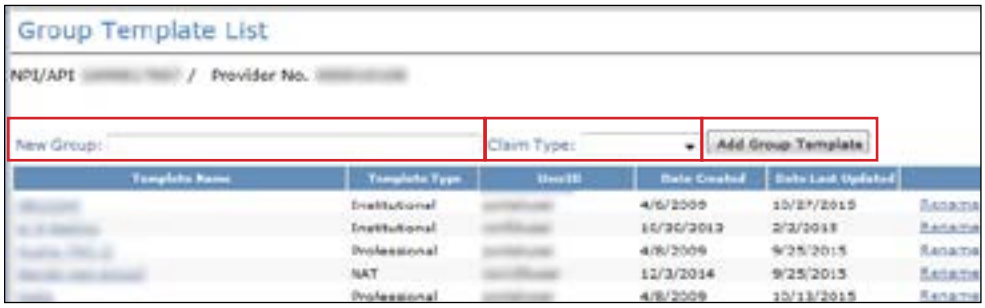
To create a new Group Template:

1) Click **Group Template** under CSI in the navigation panel.

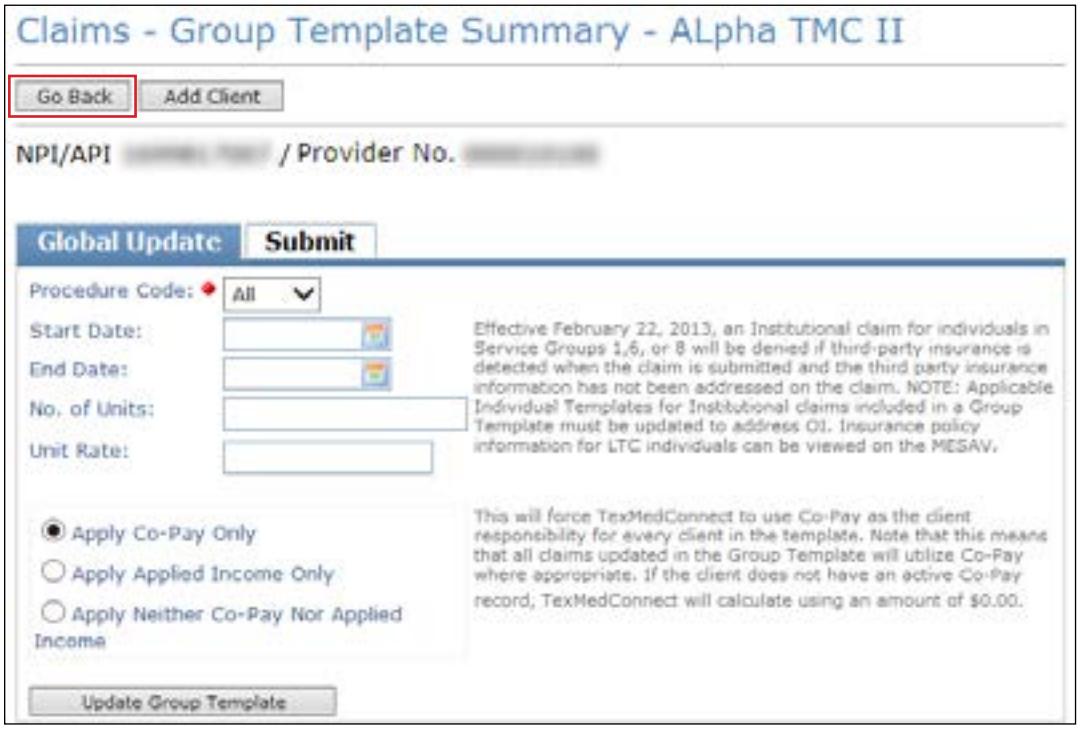
2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.



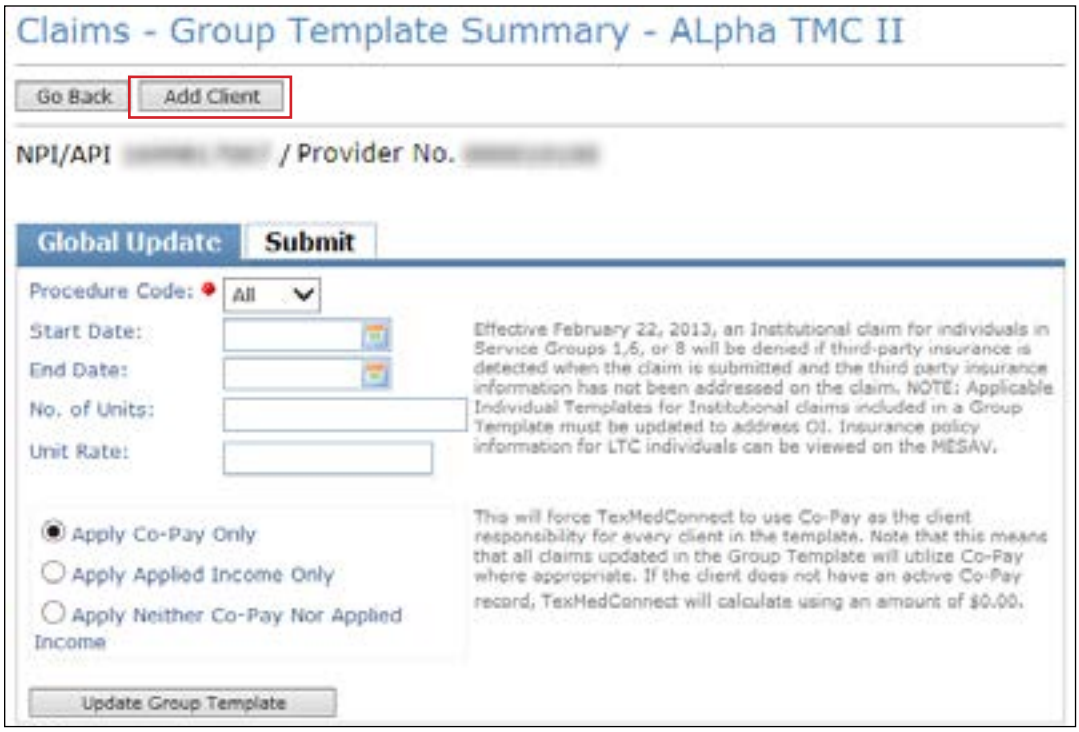
3) Enter the name of a group in the **New Group** field, choose the claim type from the drop-down menu, and click **Add Group Template**.



4) After you have created the Group Template, the Group Template Summary page will be displayed. To add a person, go to step 5. To return to the Group Template List page, click **Go Back**.



5) To add a person to the group, click the **Add Client** button.



6) You can define the start date and end date, the number of units, and the unit rate for all claims in the template. You must select one of the following three radio buttons:

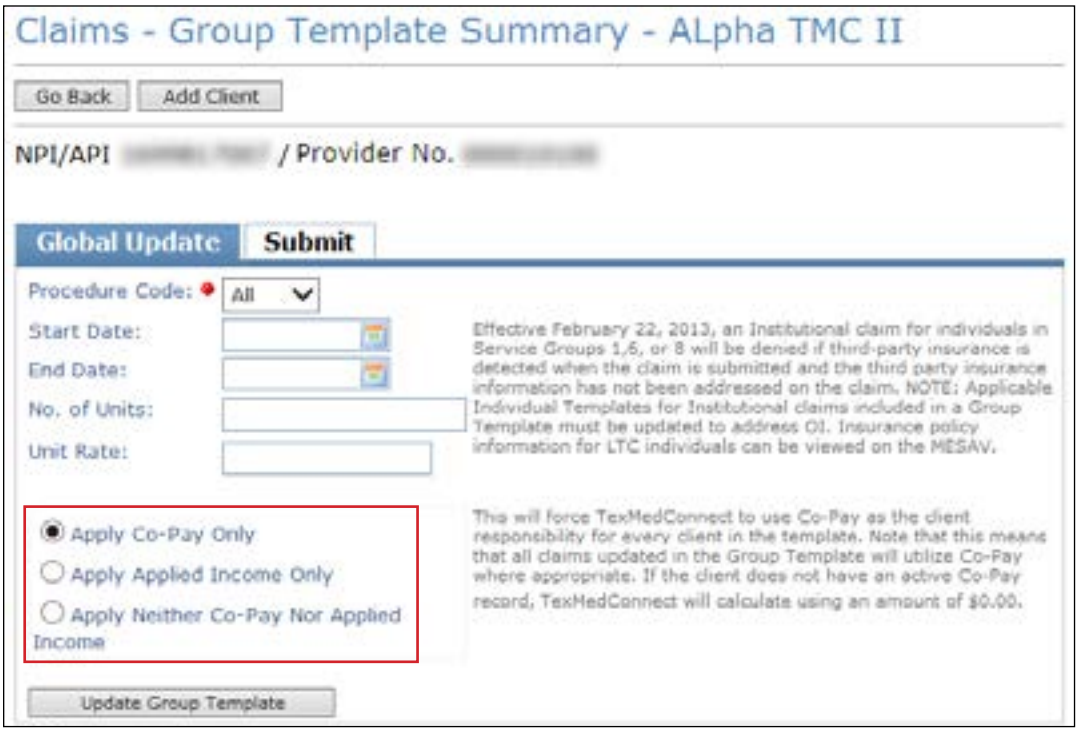
- **Apply Co-Pay Only**
- **Apply Applied Income Only**
- **Apply Neither Co-Pay Nor Applied Income**

  If you choose **Apply Co-Pay Only,** TexMedConnect will use Co-Pay as the individual responsibility for every person in the template. This means that all claims that are updated in the template will use Co-Pay where it is appropriate to do so. If the person does not have an active Co-Pay record, TexMedConnect will make calculations using an amount of $0.00.

  If you choose **Apply Applied Income Only,** TexMedConnect will use Applied Income as the individual responsibility for every person in the template. This means that all claims updated in the Group Template will use Applied Income where appropriate. If the person does not have an active Applied Income record, TexMedConnect will make calculations using an amount of $0.00.

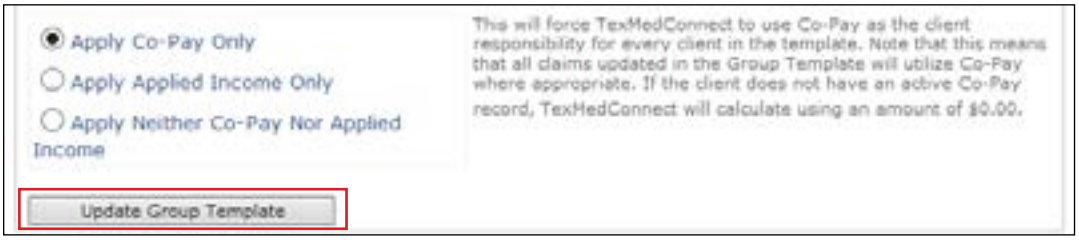
  If you choose **Apply Neither Co-Pay Nor Applied Income,** TexMedConnect will use no individual responsibility for every person in the template. This means that the individual responsibility field will be set to zero whether or not the person has an active individual responsibility record. The total payment calculated by TexMedConnect will be higher than the actual payment if any of the claims should have had

individual responsibility deducted.



7) When you have entered all the required information, click **Update Group Template** to apply that information to all of the claims in the group.

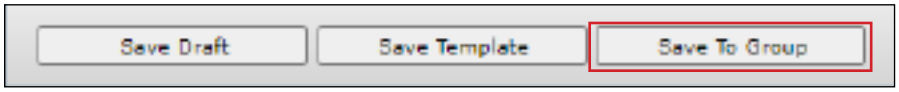
A template will remain in the system after each use. However, if a template has not been used for 365 days, it will be deleted from the system. A maximum of 100 group templates can be created for each NPI or API and provider number. Each group template can store up to 250 claims.



Saving as a Group Template

To create a group template, enter the information for a claim, but before you submit the claim:

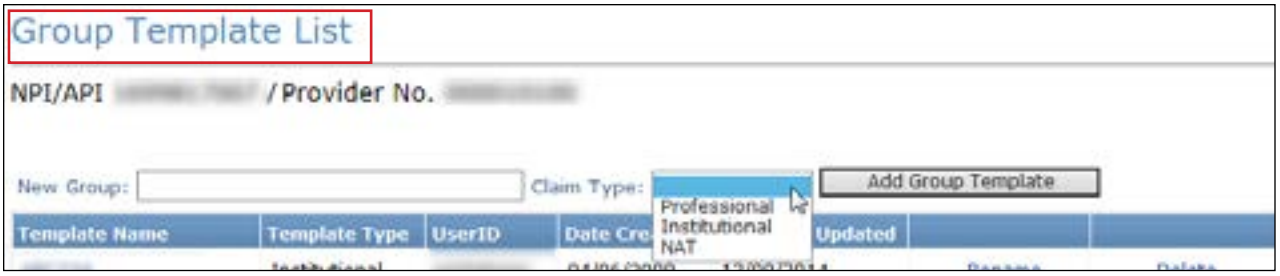
1) Click **Save To Group**.



2) Enter a group template name and click **Save**.

Note: If you enter the name of an existing template, the claim will be added to that existing group template.

Note: If you enter the name of a new group template, a new template will be added to the Group Template list. To modify the settings for the new template, see the Group Templates section of this user guide.



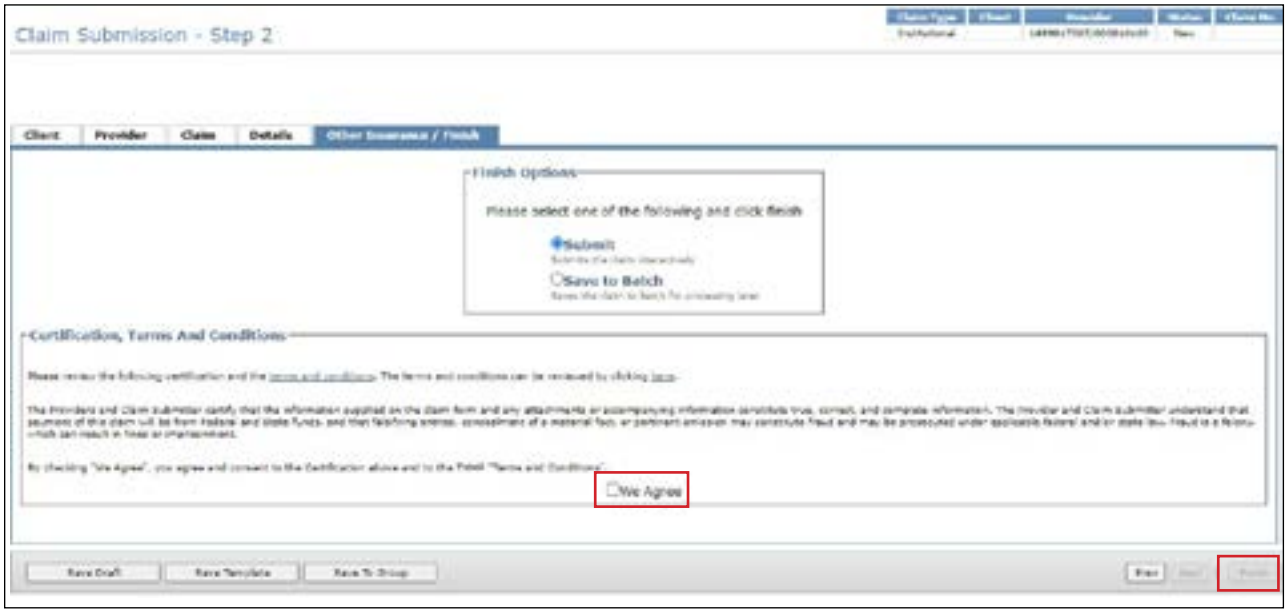
Batch Claims

Saving to a Batch

To save a claim as part of a batch:

1) After completing a claim, select the **Save to Batch** radio button.

2) Check the **We Agree** box and then click **Finish**. The claim will be saved as part of a batch, and you will be returned to the cliams entry screen so you can continue to enter more claims.



You can save up to 250 claims to a batch. Pending batches that are not submitted after 45 days are deleted from the system. You can view or edit claims in a pending batch before you submit them.

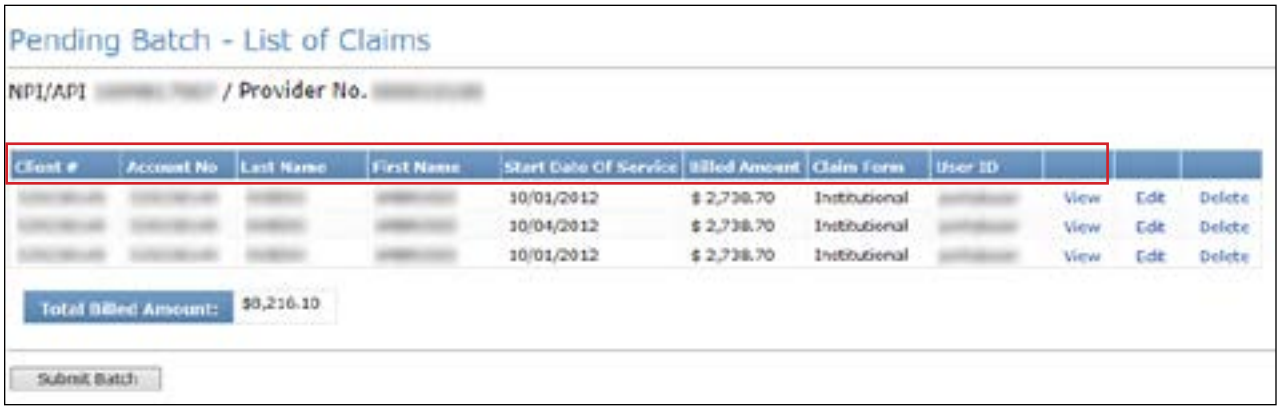
Submitting a Batch

To submit a batch:

1) Click **Pending Batch** under the Claims section in the navigation panel.

2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

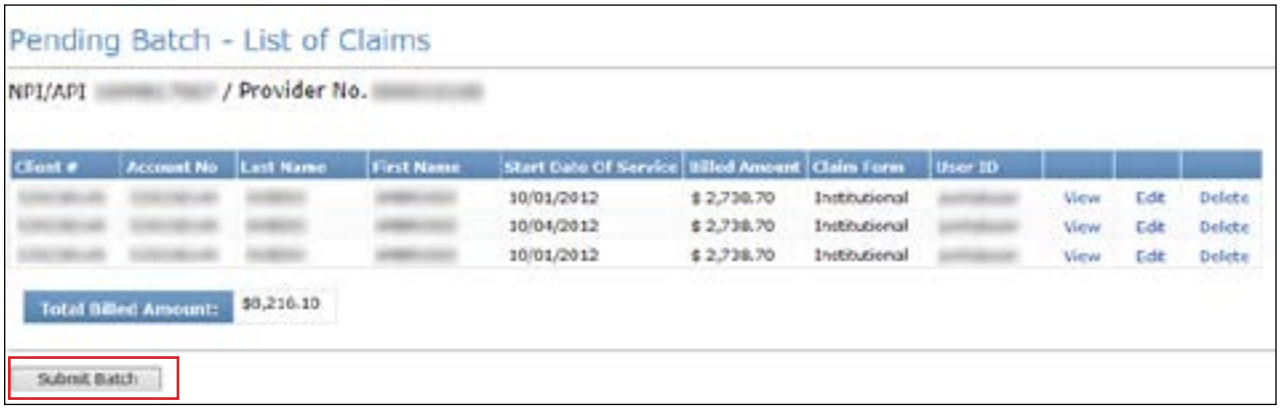
3) The Pending Batch page will display for the selected NPI or API and provider number. The pending batch list shows the claims that are ready to be submitted. Clicking a column heading will sort the list by the data in that column.



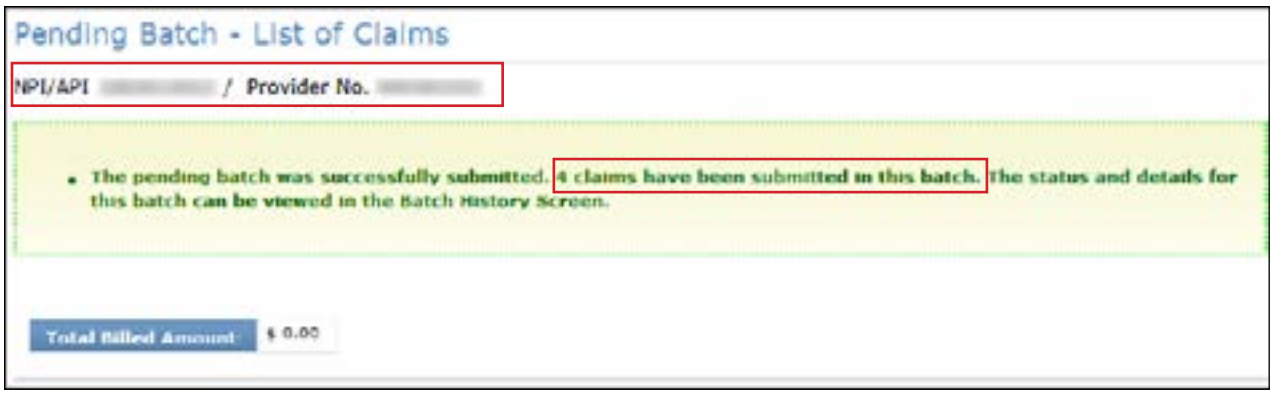
4) If there are more claims than can fit on one screen, click **Continue** to go to the next page.

5) If you want to return to a previous page, use your internet browser's **Back** button.

6) On the last screen of the pending batch list, click **Submit Batch**. All claims in that batch will be submitted, even those created by other users.



7) When the batch is submitted, a confirmation message will inform the user whether the submission was successful and will provide the number of claims that were submitted in the batch.



View Batch History

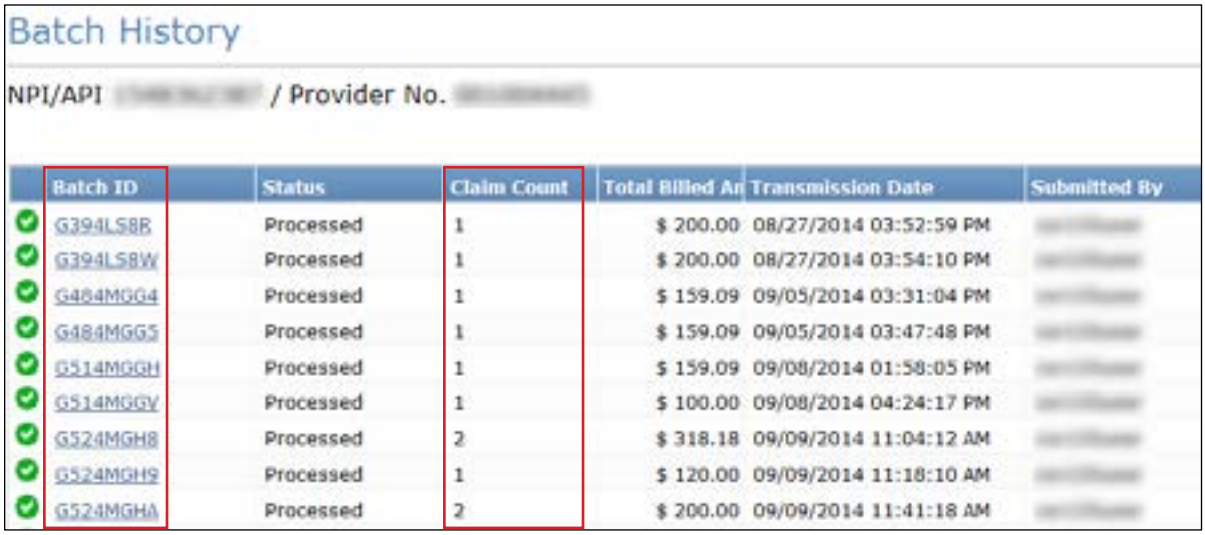
You can view the batch history of previously submitted claim batches. Batches that are more than 120 days old are automatically deleted.

To view a batch history:

1) Click **Batch History** under the Claims section in the navigation panel.

2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

3) Click on a Batch ID to view the list of claims included in that batch. The Batch History will display all available batches.
Note: The Claim Count column indicates the total number of processed claims, not necessarily the total number of paid claims.


Batch History

NPI/API [redacted] / Provider No. [redacted]

Batch ID	Status	Claim Count	Total Billed An	Transmission Date	Submitted By
G394LS8R	Processed	1	$ 200.00	08/27/2014 03:52:59 PM	[redacted]
G394LS8W	Processed	1	$ 200.00	08/27/2014 03:54:10 PM	[redacted]
G484MGG4	Processed	1	$ 159.09	09/05/2014 03:31:04 PM	[redacted]
G484MGG5	Processed	1	$ 159.09	09/05/2014 03:47:48 PM	[redacted]
G514MGGH	Processed	1	$ 159.09	09/08/2014 01:58:05 PM	[redacted]
G514MGGV	Processed	1	$ 100.00	09/08/2014 04:24:17 PM	[redacted]
G524MGH8	Processed	2	$ 318.18	09/09/2014 11:04:12 AM	[redacted]
G524MGH9	Processed	1	$ 120.00	09/09/2014 11:18:10 AM	[redacted]
G524MGHA	Processed	2	$ 200.00	09/09/2014 11:41:18 AM	[redacted]

4) You will see a list of the claims for the batch that you clicked. The claims that are listed can be a mix of claims to different MCOs and to TMHP. Claims can be set to the following three statuses:

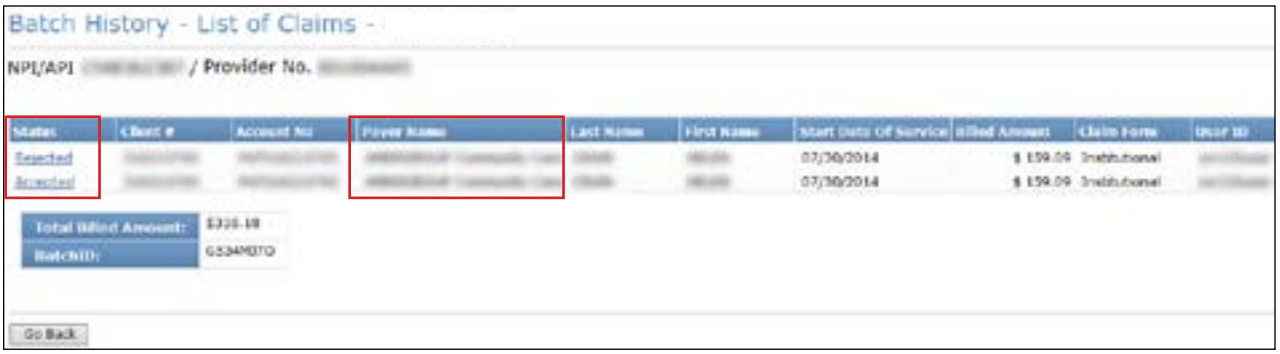
- Forwarded: The claim has been forwarded (but not yet accepted or rejected) by an MCO.
- Rejected: The claim has been rejected by TMHP or the MCO to which it was forwarded.
- Accepted: The claim has been accepted by TMHP or an MCO.

Claims that are handled by TMHP can also be set to the following statuses:

- I: In Process
- D: Denied
- A: Approved for Payment
- FT: Forced Transfer
- S: Suspended
- T: Transferred
- P: Paid
- PF: Paid Forced Transfer
- PT: Paid Transfer
- PZ: Zero Net Balance to the Provider

In addition to the status of the claims and other information, there is a Payer Name column. The Payer Name column will display the name of the MCO that the claim was forwarded to, rejected, or accepted by. TMHP will be

displayed when the claim is accepted by TMHP. A blank column indicates that TMHP has rejected the claim.



5) Click the status of a claim to view the details of that claim.

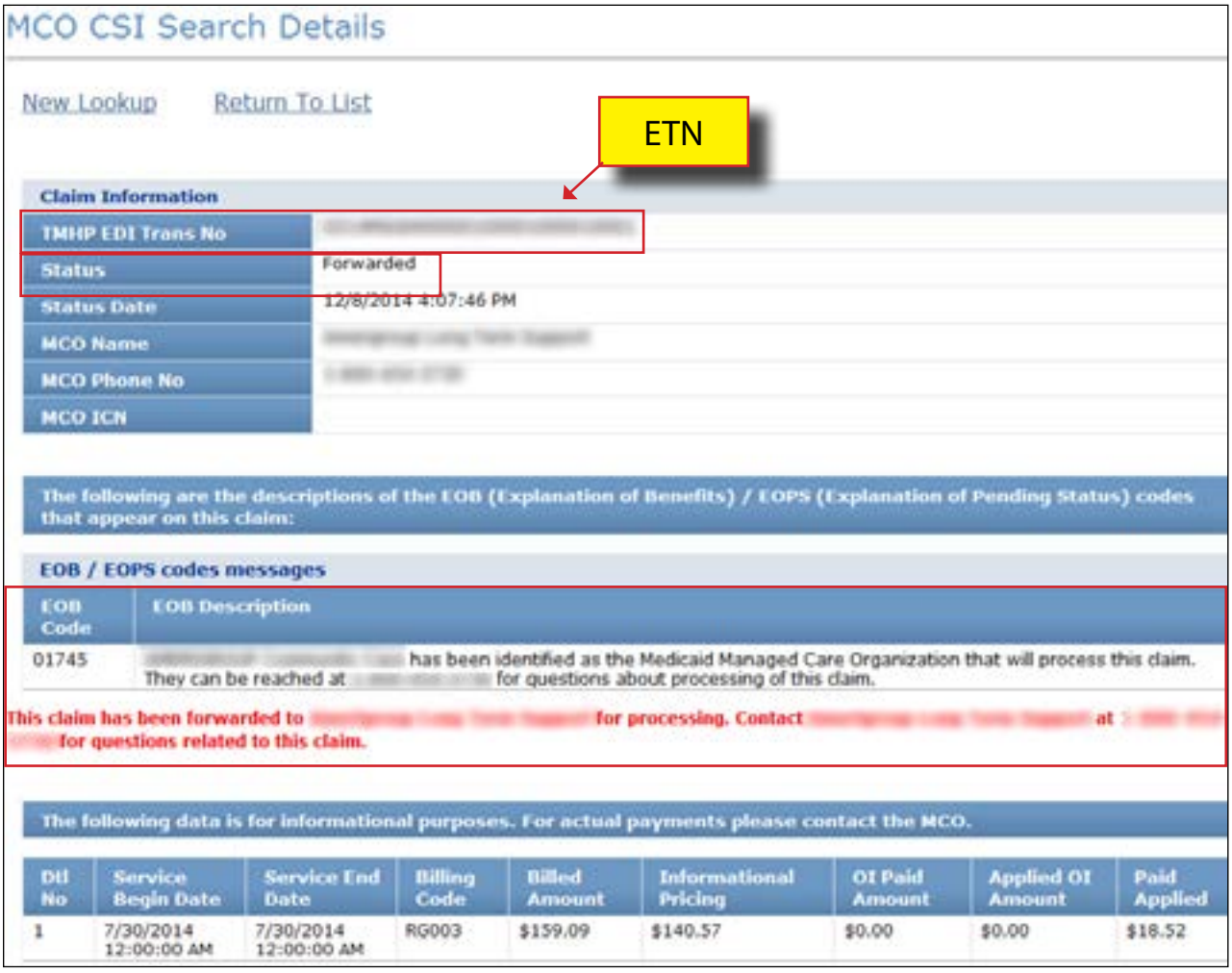
If the status of the claim that you clicked was Forwarded:

- The forwarded claim will have a 28-character alphanumeric ETN. This is not the same as the internal control number (ICN) associated with fee for service (FFS) claims.
- The first eight characters of the ETN are the same as the Batch ID.
- The claim will remain in the Forwarded status until the MCO responds with either Accept or Reject.

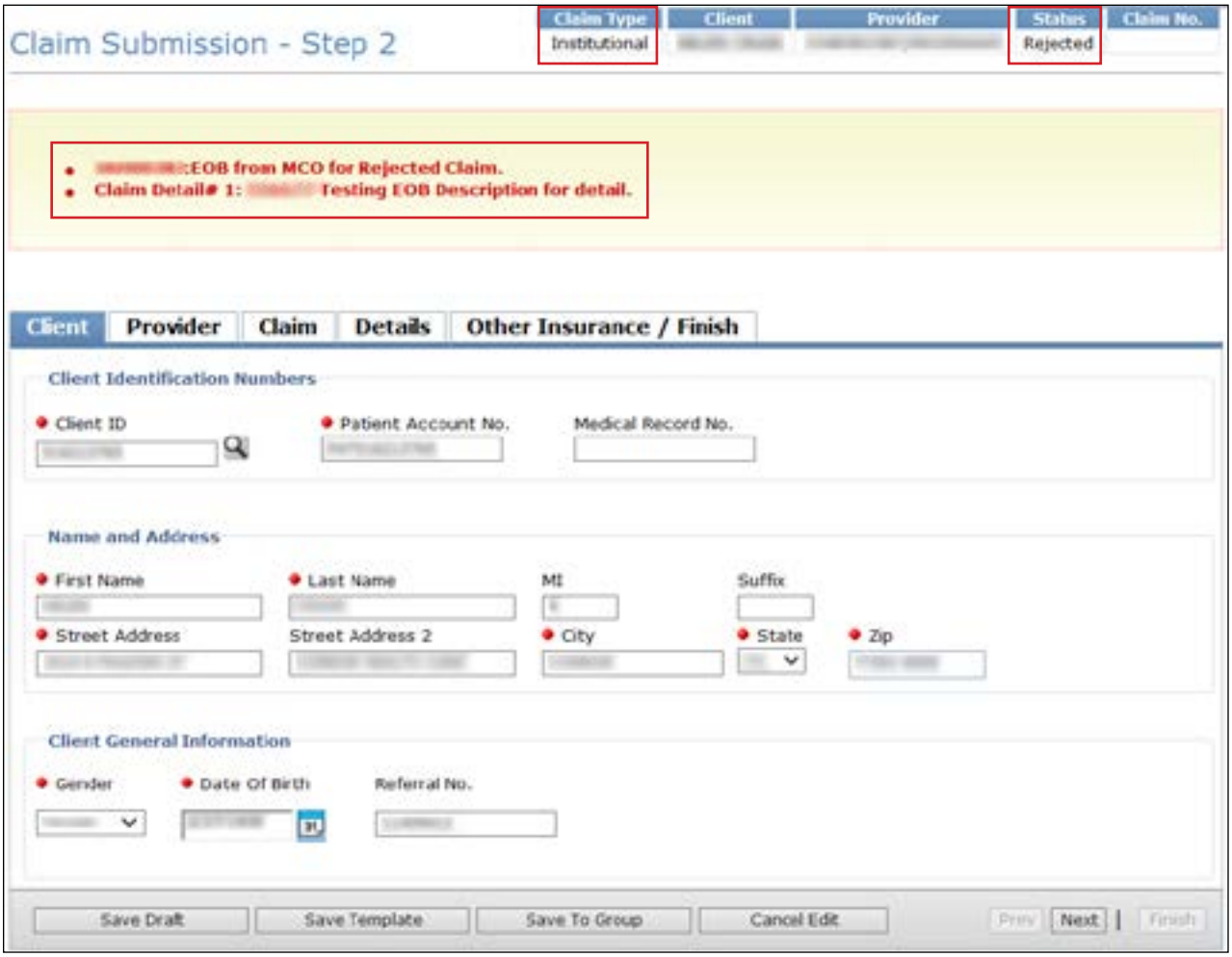
As shown in the image below, the name and contact information of the MCO are identified in multiple places on the screen. After a claim has been forwarded to the MCO, providers must work directly with the MCO regarding any issues with the claim.

When TMHP forwards a claim to an MCO, TMHP will assign an Explanation of Benefits (EOB) code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB code.

The last section on the screen, the Detail Service Line, will list information such as the billing code and the Informational Pricing column (which is how TMHP would have priced the claim if it was processed as FFS for SG 1, Service Codes 1 and 3).


MCO CSI Search Details
New Lookup
Return To List
ETN
Claim Information
TMHP EDI Trans No
Status
Forwarded
Status Date
12/8/2014 4:07:46 PM
MCO Name
MCO Phone No
MCO ICN
The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:
EOB / EOPS codes messages
EOB Code
EOB Description
01745
has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at for questions about processing of this claim.
This claim has been forwarded to for processing. Contact at for questions related to this claim.
The following data is for informational purposes. For actual payments please contact the MCO.
Dtl No
Service Begin Date
Service End Date
Billing Code
Billed Amount
Informational Pricing
OI Paid Amount
Applied OI Amount
Paid Applied
1
7/30/2014 12:00:00 AM
7/30/2014 12:00:00 AM
RG003
$159.09
$140.57
$0.00
$0.00
$18.52

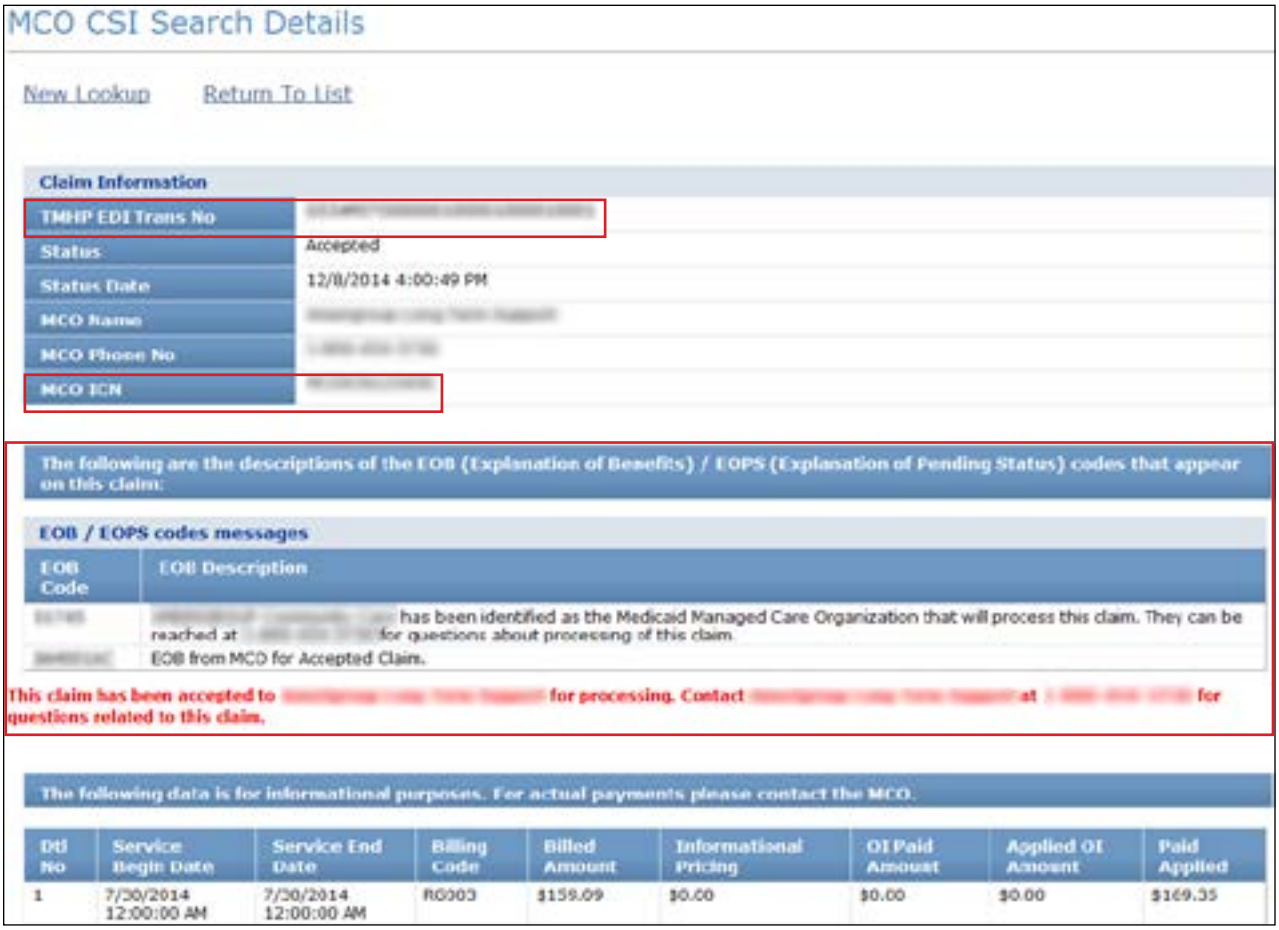
a) If the status of the claim that you clicked was Rejected, you will see a yellow message box at the top of the screen that lists the rejected EOBs. The MCO may choose to list the EOBs with a description. If a description is not present, then only the EOB number will be displayed.



b) If the status of the claim that you clicked was Accepted and the payer is an MCO, then the MCO CSI Search Details page will display.

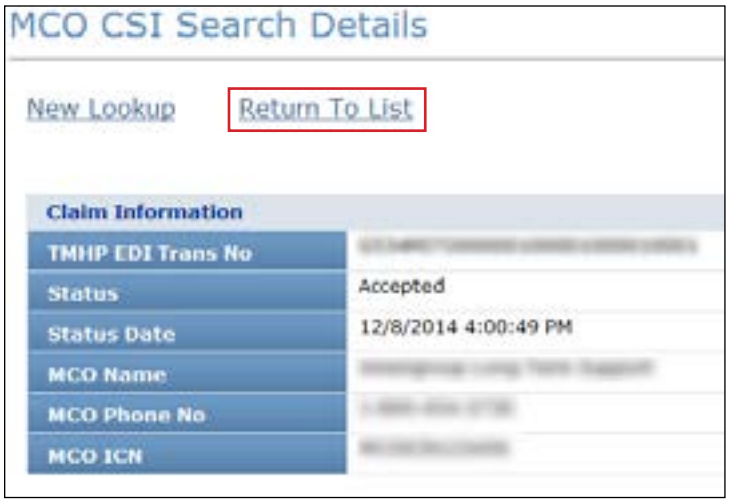
After a forwarded claim has been accepted by an MCO, the MCO ICN field will autofill. The MCO ICN is a unique identifier that the MCO assigns to a forwarded claim.

The header EOBs and descriptions returned by the MCO for the accepted claim will be displayed in the EOB/EOPS codes messages column. If the MCO does not return the description of the EOB, it will appear as blank. The provider will need to use the MCOs EOB Crosswalk to interpret the EOBs.



c) If the status of the claim that you clicked was Accepted and the payer is TMHP, the CSI Search Details page will display.

6) Click **Return To List** to return to Batch History. The results are saved for 60 days.



Claims Data Export

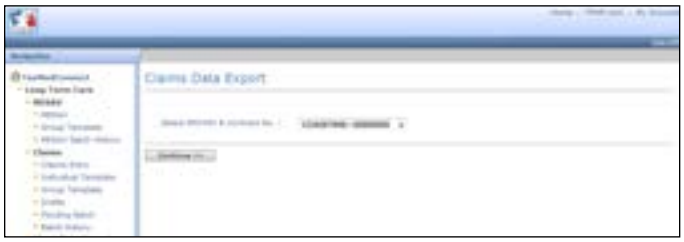
If you want to request an extract of claims data for a particular date range, you can use the Claims Data Export feature. The maximum date range between From Dates of Service and To Dates of Service for each search is six months.

Note: Claims Data Export is available only to users with administrative rights on their account.

To request the claims data to be exported:

1) Click **Data Export Request** under the Claims Data Export section in the left navigation panel.

2) Select the NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

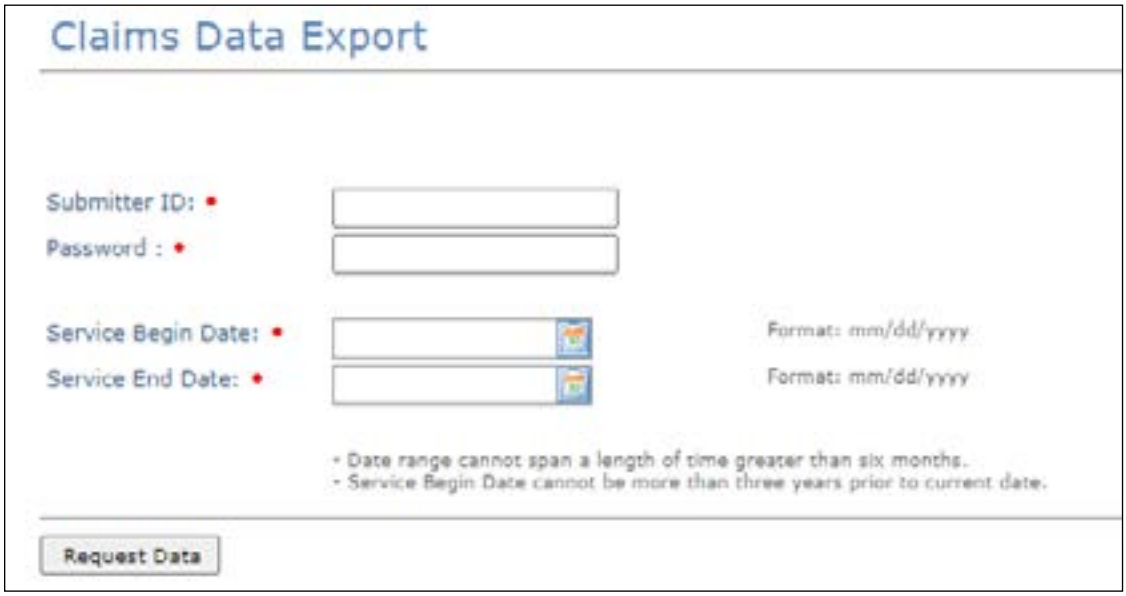


3) Enter your submitter ID, password, Service Begin Date, and Service End Date and then click **Request Data**. The date range must be no more than six months long.

   The Service Begin Date cannot be more than three years prior to the current date.

If you do not know your submitter ID and password, contact the EDI Help Desk at 888-863-3638 from 7:00 a.m. to 7:00 p.m. Central time, Monday through Friday.

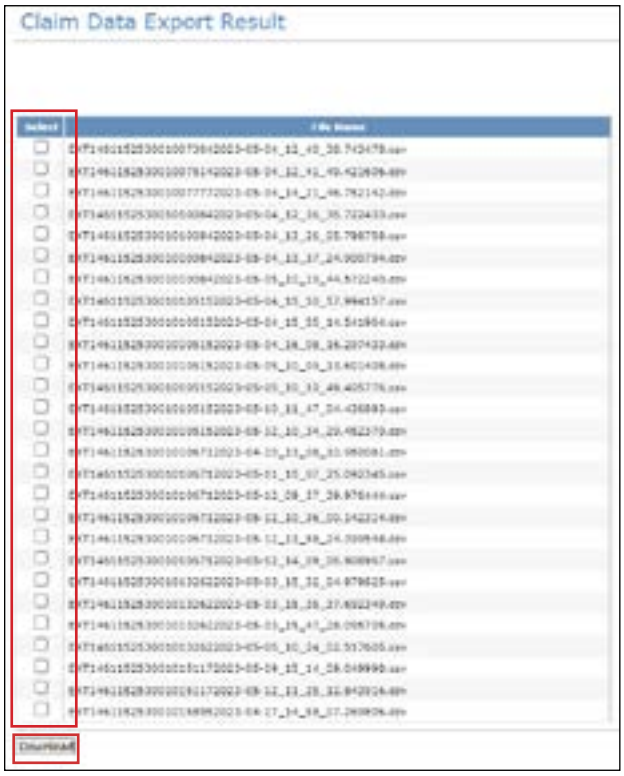
The requested data will be available on the next business day (the data will be in MS Excel® format).



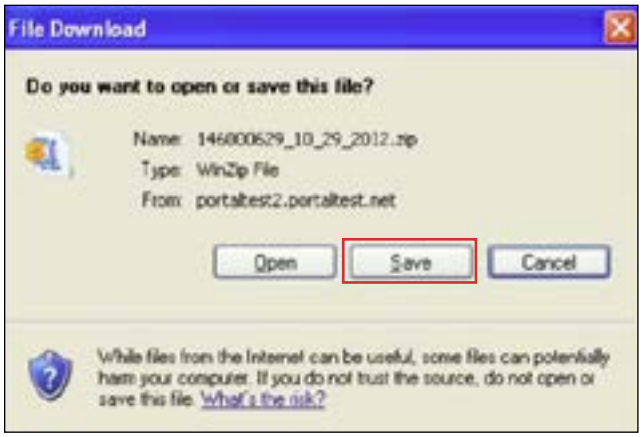
4) To download the requested data, click **Data Export Downloads** under the Claims Data Export section in the left navigation panel.

5) Enter your submitter ID and password, and click **Submit**.

6) The Claim Data Export Result page will display the requested file when it is ready to be downloaded. Check the **Select** box and then click **Download**.



7) A File Download dialog box will be displayed. Click **Save** and save the file to a location on your computer. The requested data will remain available for download for six months.
Note: Your computer must be able to open WinZip® files (zipped files) or you will not be able to open the saved file.



These are some of the data elements you will see:

- Begin and End date
- Provider number
- Claim number (ICN)
- Service Group
- Total billed amount
- Total paid amount
- Current status
- Member's first and last names
- R and S report date
- R and S report number
- Detail number (indicates the number of rows in a claim)
- Billing code
- Billing units
- Paid units
- Paid rate
- Modifiers
- Service code (example: 10c would be Day Habilitation)
- EOB codes

More Information about Claims Data Export

For those who would like more information, a video detailing the Claims Data Export feature of TexMedConnect is available on the Texas Medicaid & Healthcare Partnership's (TMHP's) YouTube channel. The Claims Data Export video is for LTC providers and financial management services agencies (FMSAs) and covers the following topics:

- Converting a Claims Data Export file to Excel
- Viewing cost reporting information in the Claims Data Export
- Working with data in the Claims Data Export

For more information, contact the LTC Help Desk at 800-626-4117, option 1.

Claims Status Inquiry (CSI)

CSI is used to determine the status of submitted claims. There are four different ways to perform a CSI:

1) Lookup Fee For Service Claim by Claim Request
2) Lookup Fee For Service Claim by Client Claim Request
3) Lookup Managed Care Claim by Transaction Number
4) Lookup Managed Care Claim by MCO ICN

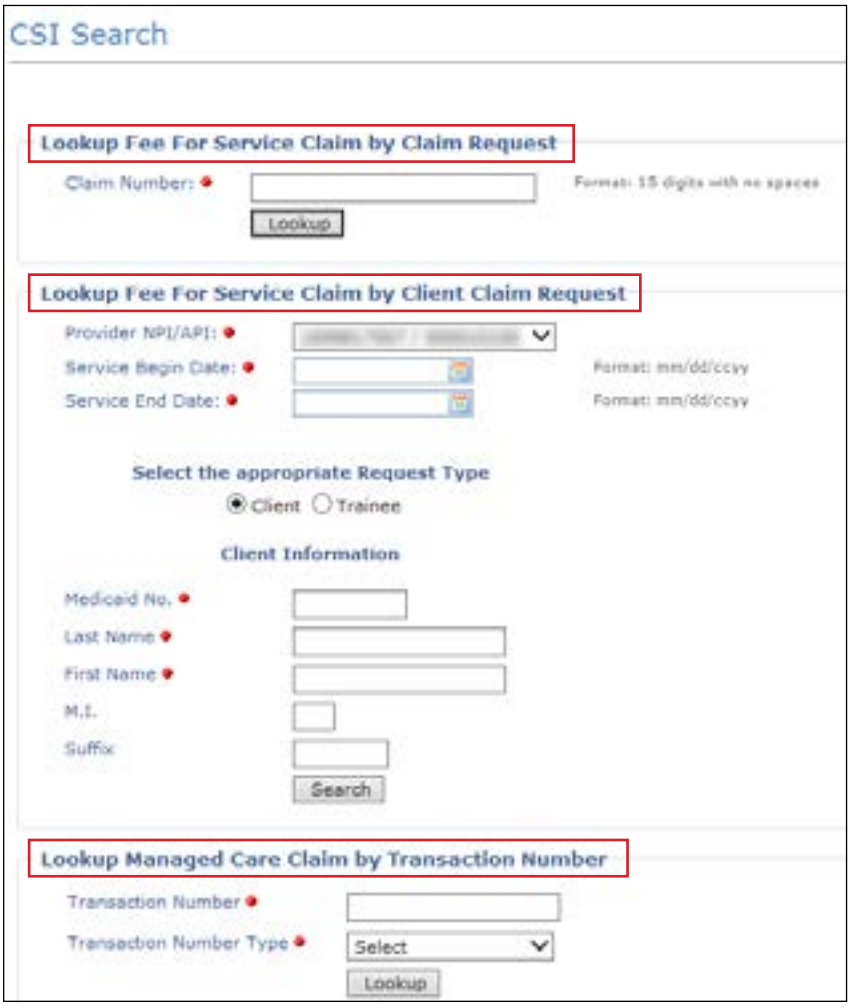
TMHP will forward certain Institutional claims to MCOs. These claims can be set to the following statuses:

- Forwarded: The claim has been forwarded to (but not yet accepted or rejected by) an MCO.
- Rejected: The claim has been rejected by TMHP or the MCO to which it was forwarded.
- Accepted: The claim has been accepted by TMHP or an MCO.

Claims that are handled by TMHP, instead of an MCO, can be set to the following statuses:

- I: In Process
- D: Denied
- A: Approved for Payment
- FT: Forced Transfer
- S: Suspended
- T: Transferred
- P: Paid
- PF: Paid Forced Transfer
- PT: Paid Transfer
- PZ: Zero Net Balance to the Provider

Three years of claims history are available. The system returns a maximum of 250 results for each search. If your search returns more than 250 results, you may want to use the Claim Data export function. The CSI Search screen is shown below:



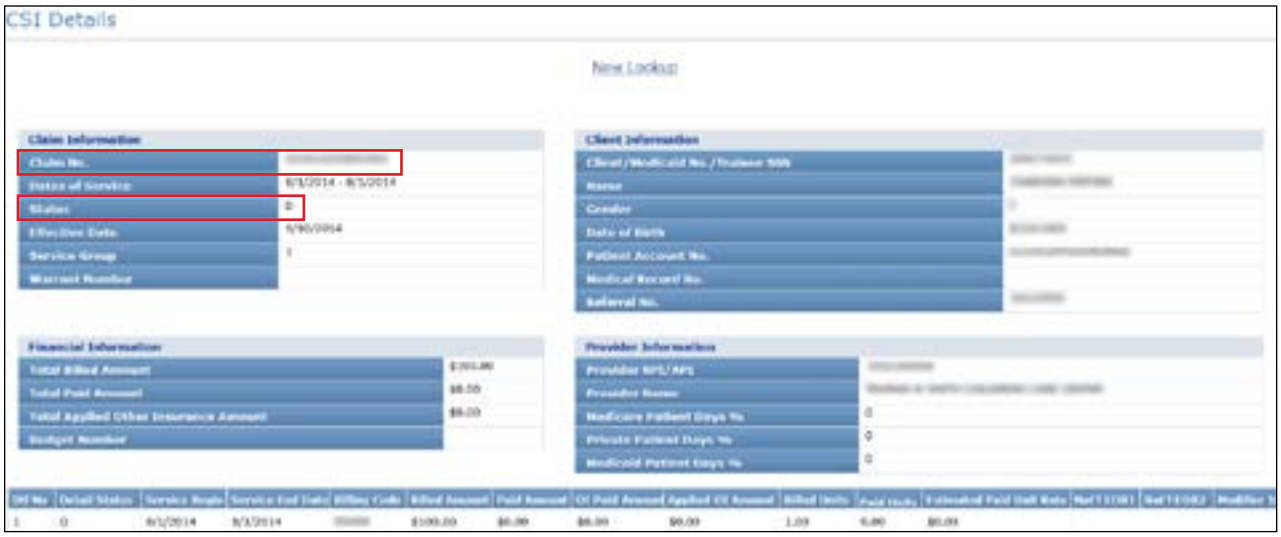
CSI Search: Lookup Fee For Service Claim by Claim Request

To search for a claim by Claim Request:

1) Enter the claim number in the Claim Number field and click **Lookup**.

2) The CSI Details page will be displayed and will autofill most of the fields, including the status of the claim. For SGs 1, 6, and 8, the detailed claim information includes the Total Applied OI Amount, as well as the OI Paid

Amount and Applied OI amount.

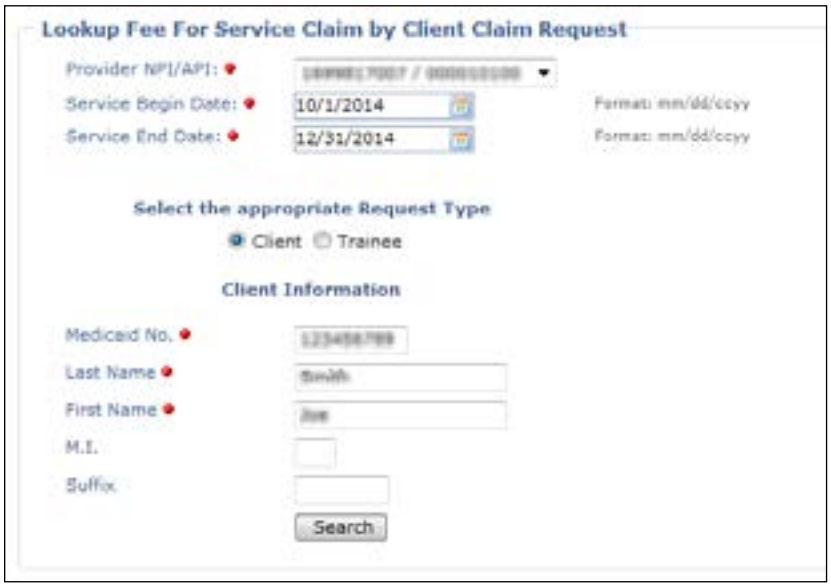


CSI Search: Lookup Fee For Service Claim by Client Claim Request

When searching by client information, the following conditions apply:

- You must enter both a Service Begin Date and a Service End Date. The end date cannot be more than three consecutive months from the begin date.
- The Service Begin Date cannot be more than 36 months before the current date.

1) Click the **CSI** link under the CSI section on the navigation panel. The search criteria page will display.



2) Complete all fields that are indicated by a red dot.

3) Click **Search**.

4) The CSI Details page will be displayed and will autofill with the client information.

CSI Search: Lookup Managed Care Claim by Transaction Number

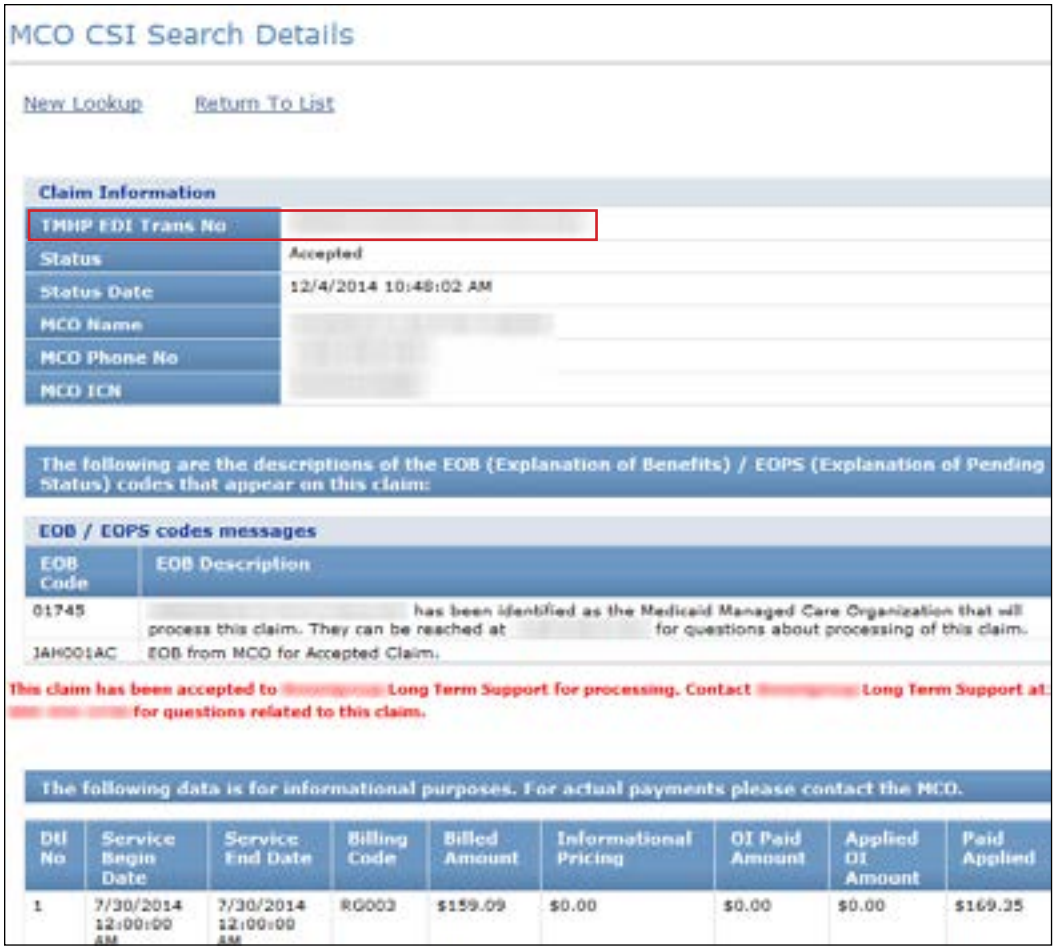
This section allows providers to use a transaction number to search for claims that have been forwarded to MCOs. An ETN is needed to search for these forwarded claims. An ETN is not the same as an MCO internal control number (MCO ICN) or as an ICN associated with FFS claims. An ETN is a 28-character alphanumeric value, the first eight characters of which are the Batch ID.

The status of the claim is shown in the Claim Information section on the Status line. The three possible statuses for a claim that has been forwarded to an MCO are:

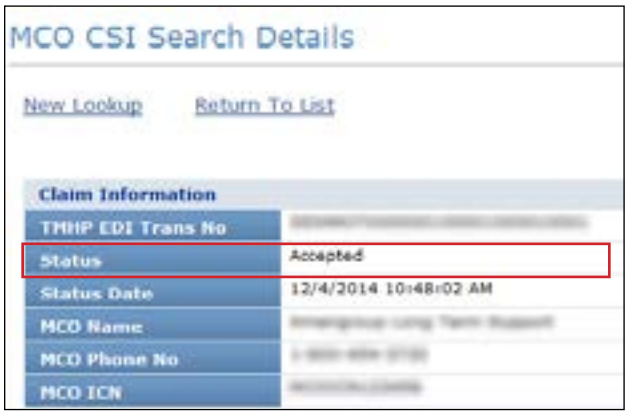
- Forwarded
- Accepted (by the MCO)
- Rejected (by the MCO)

1) In the Transaction Number field, enter the ETN of the claim that you are searching for, choose **TMHP EDI Trans No** from the Transaction Number Type drop-down menu, and click **Lookup**.

2) The MCO CSI Search Details page will be displayed and will autofill with the ETN in the Claim Information section.



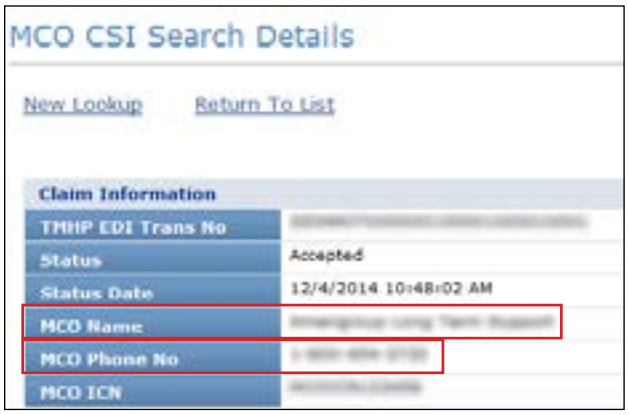
3) The status of the claim will be shown in the Claim Information section on the Status line.



4) The name and contact information of the MCO that received the forwarded claim is located in the Claim Information section.

Note: If any issues or questions arise regarding a claim that has been forwarded to an MCO, providers must

contact the MCO directly. TMHP cannot answer questions regarding claims rejected by an MCO.

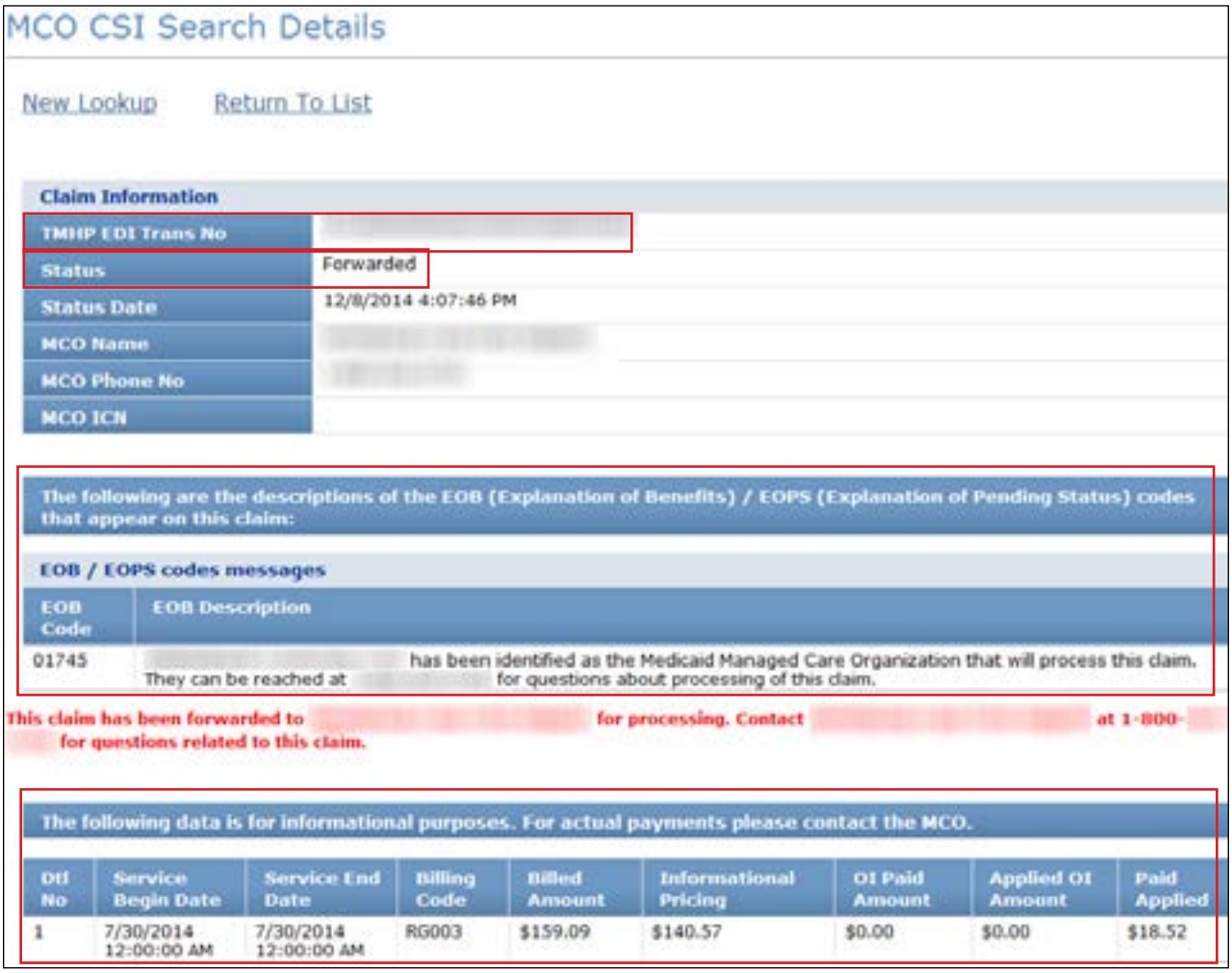


5) The name and contact information of the MCO are identified in multiple places on the screen.

When TMHP forwards a claim to an MCO, TMHP will assign an EOB code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB code.

The last section on the screen, the Detail Service Line, will list information such as the billing code and the Informational Pricing amount (which is how TMHP would have priced the claim if it was processed as FFS for NF

Daily Care [SG 1, Service Code 1] and Medicare Coinsurance [Service Code 3]).



CSI Search: Lookup Managed Care Claim by MCO ICN

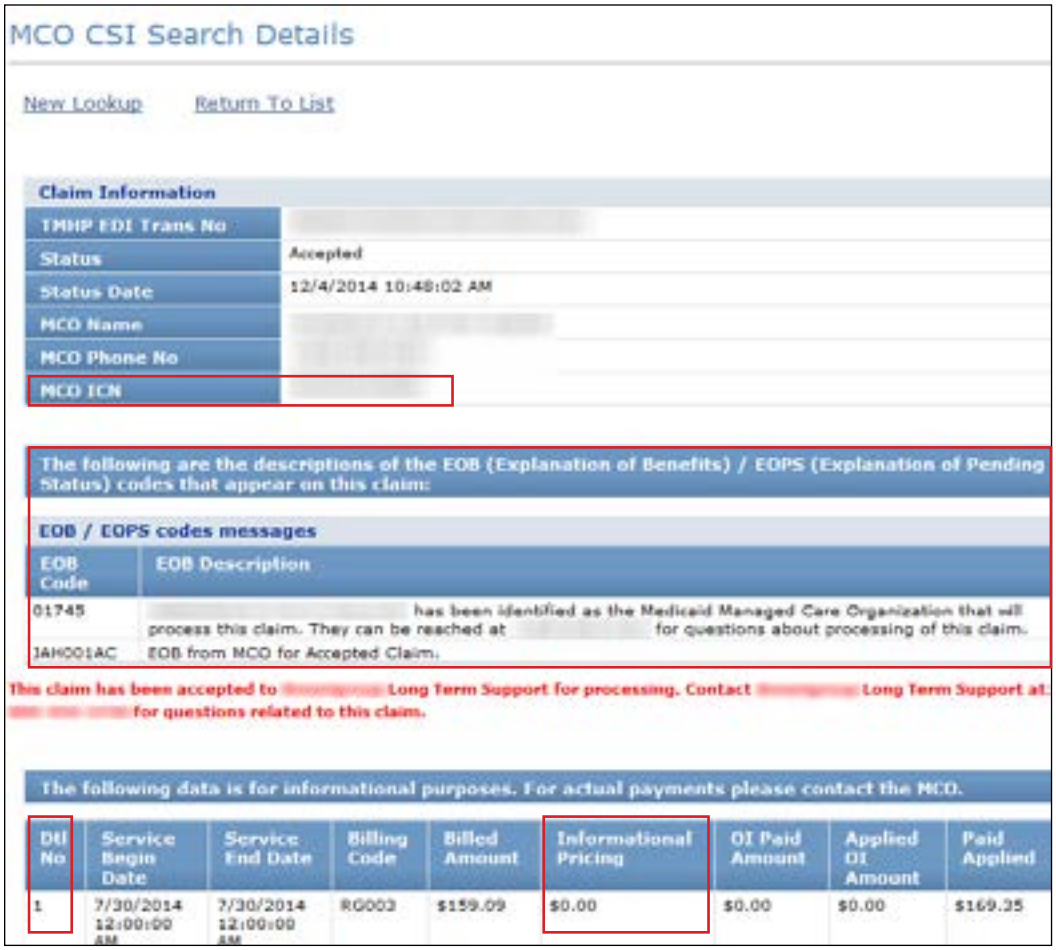
Providers can use an MCO ICN to search for claims that have been forwarded to MCOs. The ICN is assigned by the MCO that accepted the claim.

1) In the Transaction Number field, enter the **MCO ICN** of the claim for which you are searching and choose MCO ICN from the Transaction Number Type drop-down menu. Because multiple MCOs may have similar ICN numbering strategies, you must choose the appropriate payer name from the drop-down menu, and click **Lookup**.

2) The MCO CSI Search Details page will be displayed and will autofill with the MCO ICN in the Claim Information section. This MCO CSI Search Details screen will be identical to the one that is generated when searching using an ETN or clicking the hyperlink from the Batch History screen.

   TMHP will assign an EOB code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB code.

   The last section on the screen, the Detail Service Line, will list information such as the billing code and details in the Informational Pricing amount (which is how TMHP would have priced the claim if it was processed as FFS for NF Daily Care [SG 1, Service Code 1] and Medicare Coinsurance [Service Code 3]).



Creating a CSI Group Template

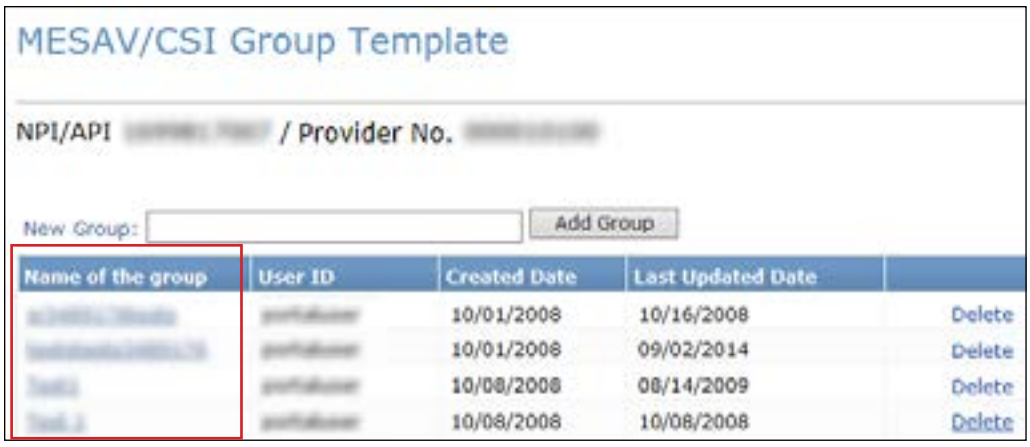
The Group Template feature allows you to create a list of people for whom you would like to verify eligibility.

To create a CSI group template and add a person:

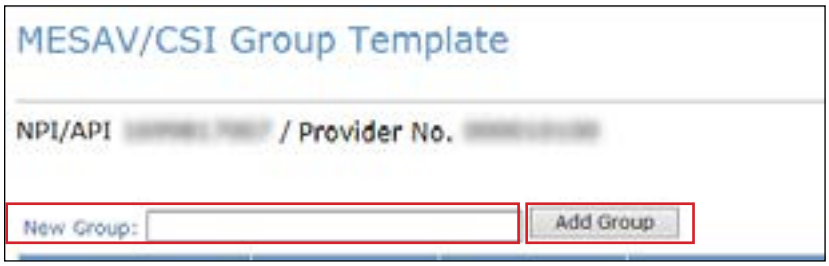
1) Click **Group Template** under the CSI section in the navigation panel.

2) The MESAV/CSI Group Template screen will open. Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and then click **Continue**.

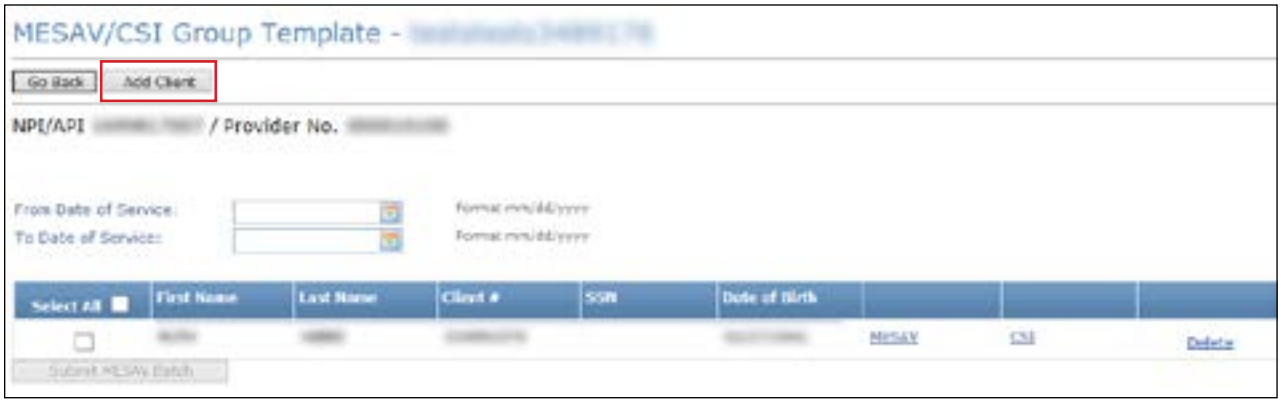
3) If you have already created a group and want to add a person to an existing group template, click the link from the list displayed in the Name of the group column and skip to Step 5.



4) If you have not created a group or want to add a person to a new group template, enter the New Group name of your choice and click **Add Group**.

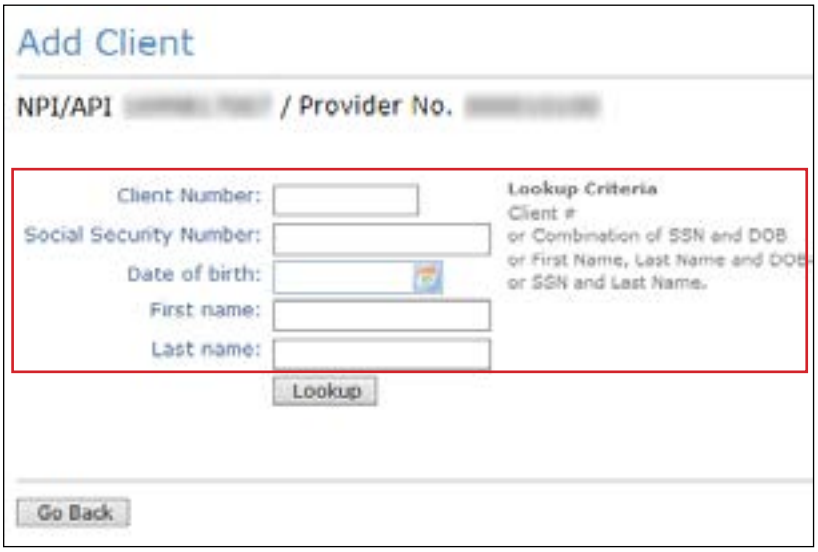


5) To add a person to the group template, click **Add Client**.

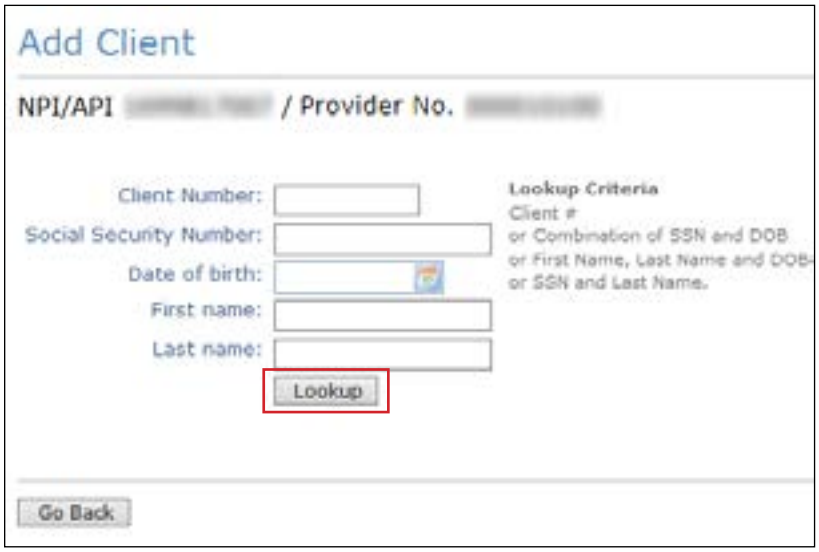


6) The Add Client page will open. Enter the person's information. If you do not have the person's client number, you must use one of the following combinations to find the person:

- Social Security number and last name
- Social Security number and date of birth
- Last name, first name, and date of birth



7) Click **Lookup**.



8) To add the person, click **Add to group**.

9) The person will be added to the CSI group template that you are working on.

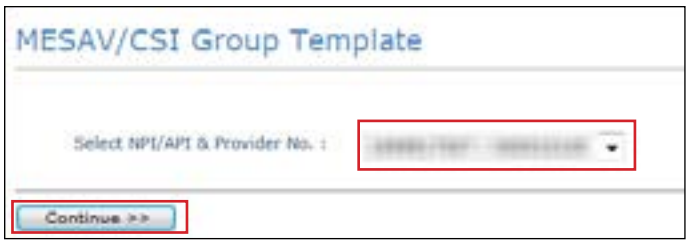
The Group Template feature allows you to create up to 100 groups for each NPI or API and provider number. Each group can contain up to 250 people, and you have the option to view, add, and delete people from the groups.

Submitting a CSI Group Template

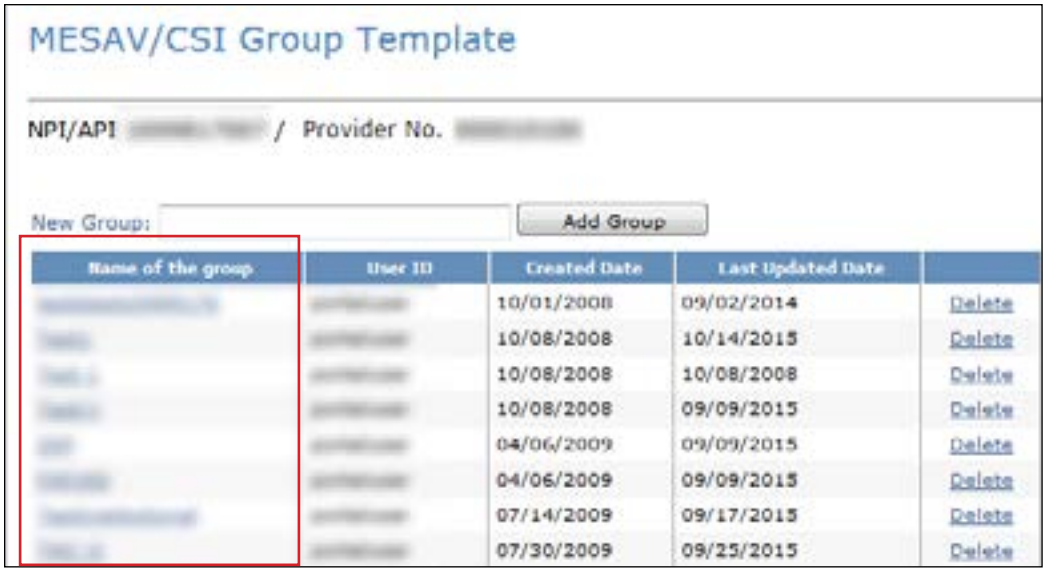
To verify eligibility using a group template:

1) Click **Group Template** under the CSI section in the left navigation panel.

2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down menu, and click **Continue**.

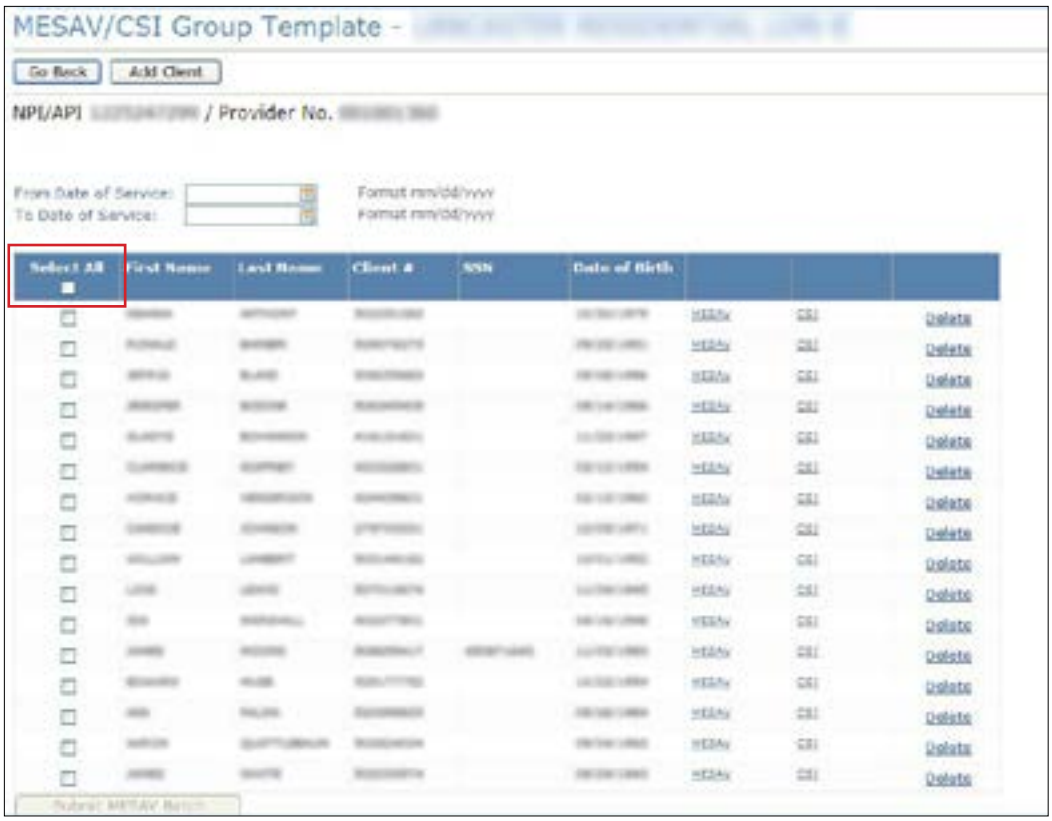


3) Select one of the templates listed in the Name of the group column to open the group list.



4) Enter a date range in the From Date of Service and To Date of Service fields. The date range can be up to three months long.

5) Check the individual boxes of the templates that you want to submit, or to submit all templates check the **Select All** box.



6) Click **Submit MESAV Batch** at the bottom left of the screen. The batch will process and be ready for viewing within 24 hours.

Adjustments

Creating an Adjustment for an FFS Claim

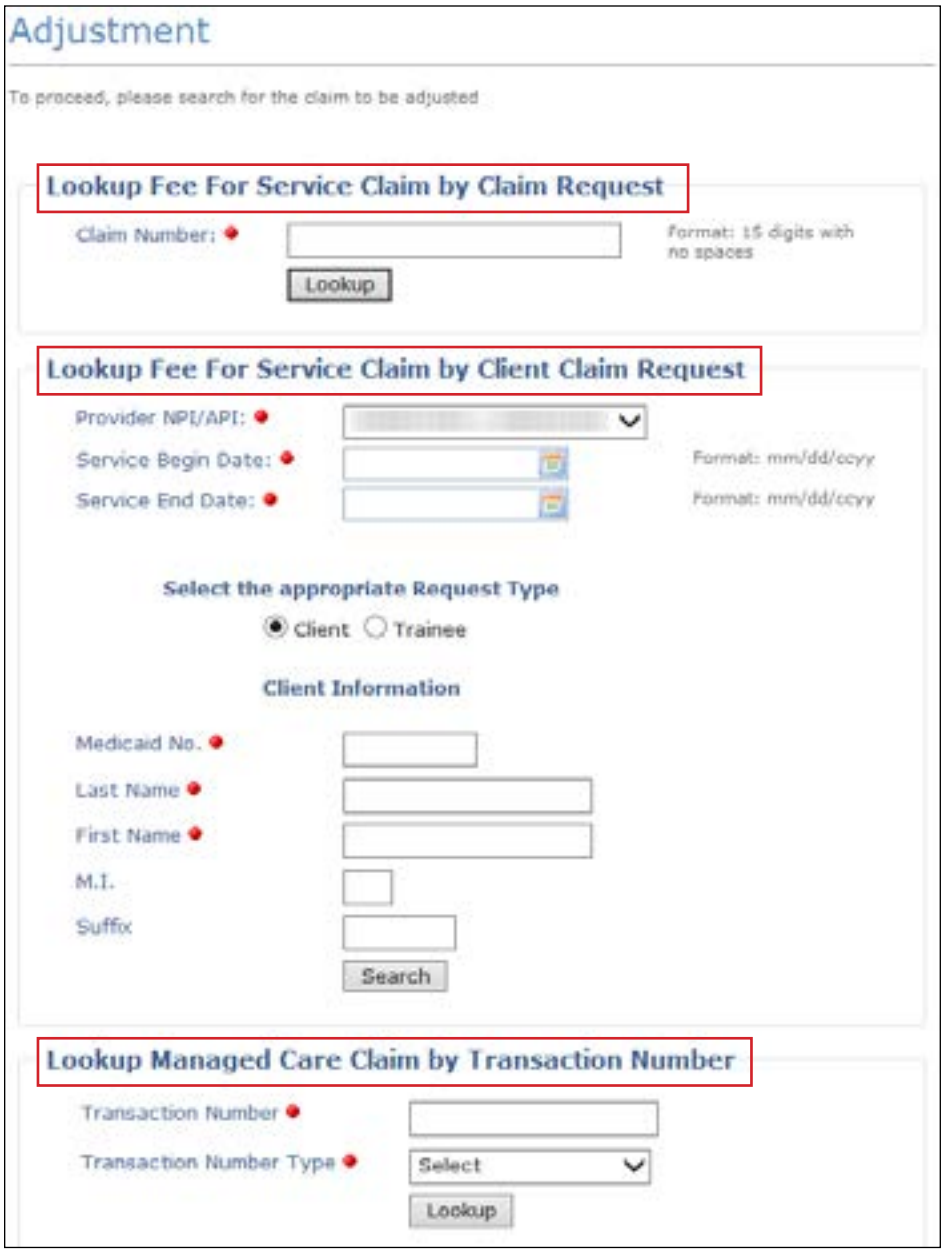
An adjustment is a change made to a previously paid claim. Adjustments are made to reimburse the Texas Health and Human Services Commission (HHSC) for overpayments and to allow providers to modify claims that were initially billed incorrectly. Only claims that are set to the Paid status can be adjusted using TexMedConnect. If you submit an adjustment then, you must return the amount that you were paid, not the amount that was billed.

Note: Providers must contact MCOs directly to make adjustments to claims forwarded by TMHP.

To make an adjustment on an FFS claim:

1) Click **Adjustments** under the CSI section in the navigation panel.

You may search for the claim by Claim Request, Client Claim Request, or Transaction Number.



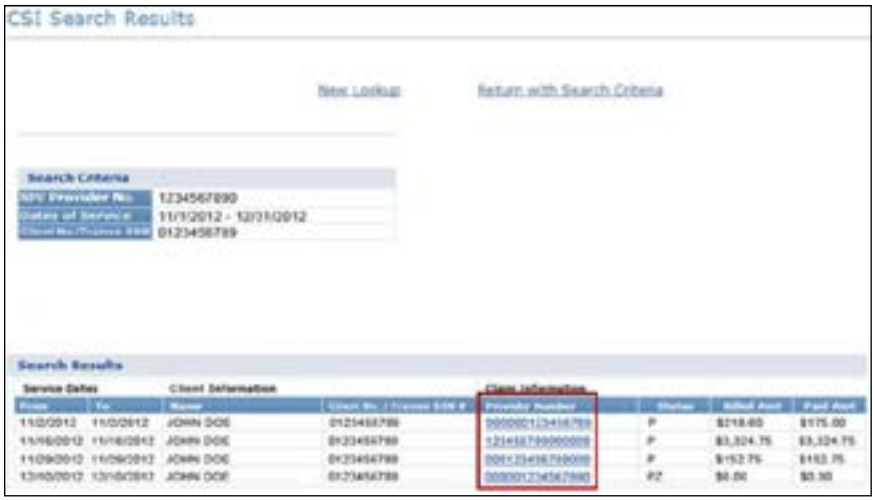
a) To search by Claim Request, enter the claim number and click **Lookup**.

b) If you do not know the claim number, you can search for the claim using the person's demographic information. Enter the required information and click **Search**.

- The date range cannot be longer than three months.
- You must enter both a Service Begin Date and a Service End Date.
- The Service Begin Date cannot be more than 36 months before the current date.
- You must complete all the fields that are indicated by a red dot.

c) You can also search for the claim by using the transaction number. Enter the transaction number and select the transaction number type from the drop-down menu. Then click **Lookup**.

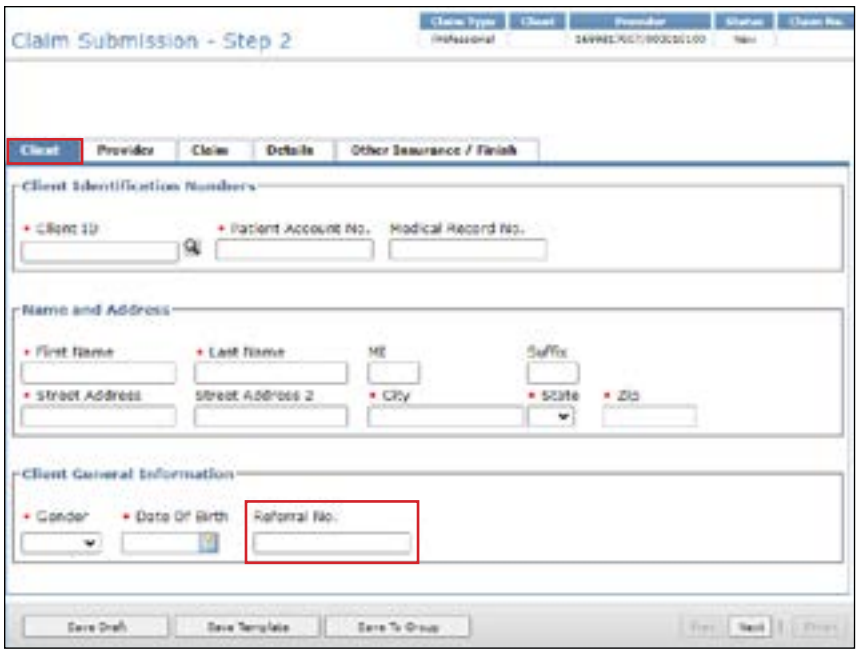
2) The search result is displayed. If more than one claim number with the same service dates and bill code is displayed as a result of your search, you can adjust the claim only with the most recent processing (or status) date. Providers can determine the most recent claim by comparing the Claim Status Dates, which are also known as the Effective Dates. To determine the most recent claim, click on the hyperlink for each claim in the list for the date range and compare the Effective Dates of each claim. Adjust the claim number with the most recent Effective Date. Click the claim number to begin adjusting the claim.



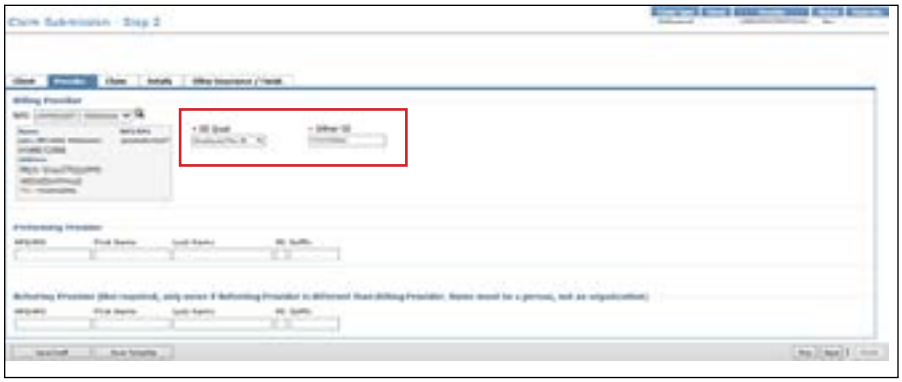
3) Select the appropriate Claim Type from the drop-down menu and click **Adjust Claim**.

4) Verify that all the required fields that are indicated by a red dot are filled out for each tab.

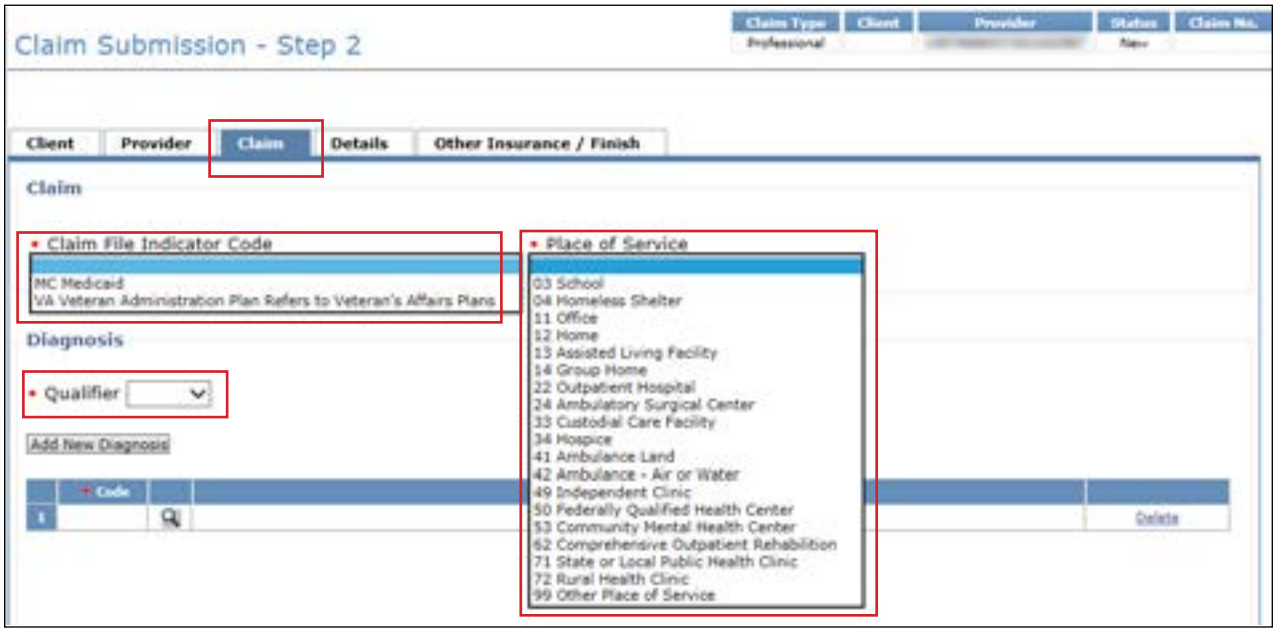
5) On the Client tab, verify that the information is correct and that there is a referral number on the Professional claim.



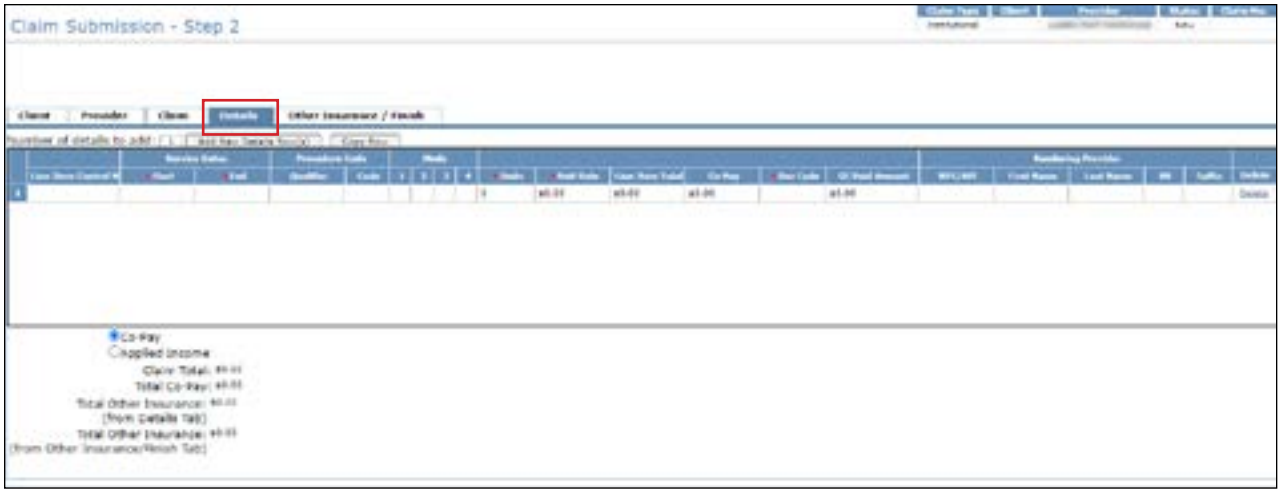
6) On the Provider tab, select the ID qualifier from the ID Qual drop-down menu and enter the other ID number in the Other ID field. If the Rendering Provider is different from the Attending Provider, that person's information should be added.



7) On the Claim tab, select a Claim File Indicator Code from the drop-down menu. Select a Place of Service from the drop-down menu. Both institutional and professional claims require a valid diagnosis code. Entering an invalid diagnosis code may result in an error message (and subsequent inability to submit a claim) in TexMedConnect. Use the Qualifier field to indicate whether the diagnosis code is an ICD-9 or ICD-10 code. The correct value is an ICD-10 code.



8) On the Details tab, the system will autofill the negative row(s) with the data that was paid on the initial claim. The Unit, Unit Rate, and Line Item Total fields will be autofilled and read-only. The fields OI and AI/Co-Pay on the negative row(s) will always be autofilled to 0. The user should not attempt to modify these fields on the negative row(s). If the initial claim to be adjusted had multiple details, all the claim detail rows will show up as negative line details. If the provider does not wish to adjust all the rows on the initial claim, then they will need to delete the rows they do not wish to adjust by using the **Delete** button on the right side of the row. The line item total will be in parentheses. If the adjustment is to return the entire amount of the claim, there is no need to click **Add New Details Row(s)**.



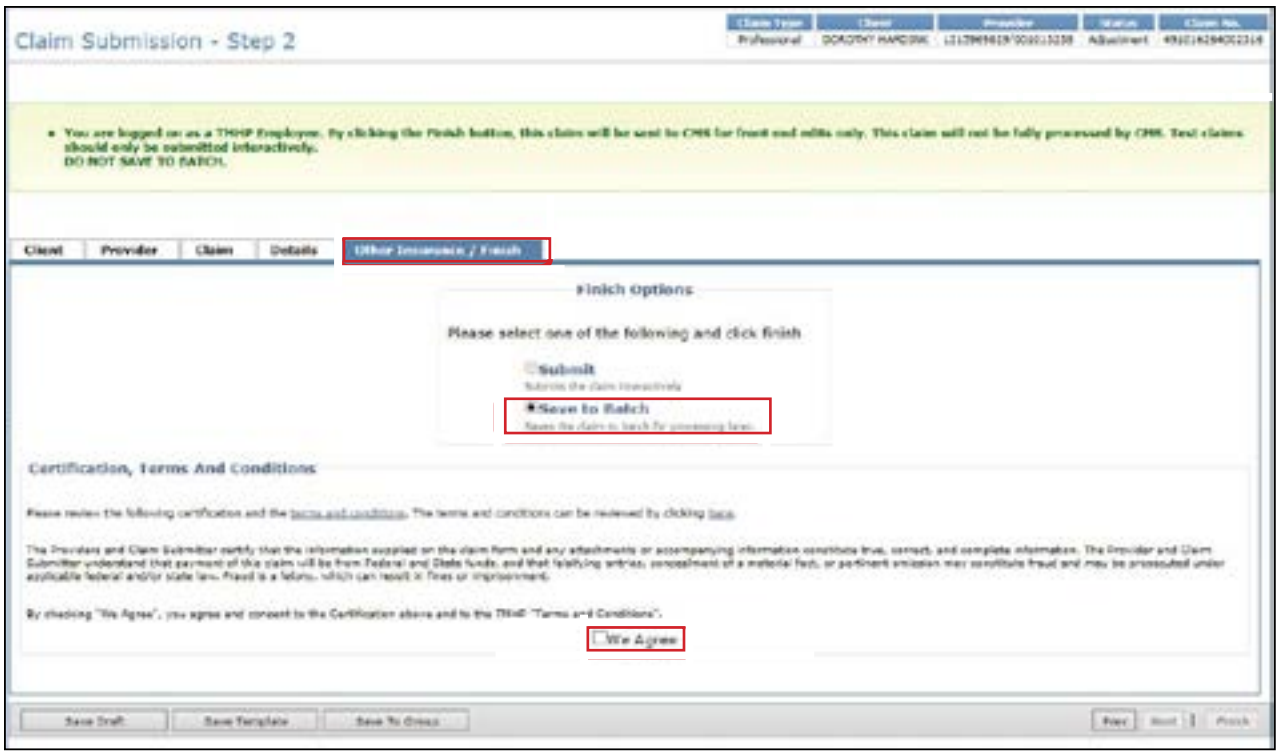
9) To bill positive units for the same adjusted claim, click **Add New Details Row(s)**. On the new row, you will add the dates of service and the accurate number of units that are to be paid. After the rate is entered, tab over to the Applied Income field. The Applied Income or Co-Pay will be calculated automatically. At the bottom left of the screen, the Claim Total and the Total Applied Income or Co-Pay that was deducted from the positive line will be displayed. The provider should also fill in the OI field on the positive line (if applicable).

Saving and Submitting an Adjustment

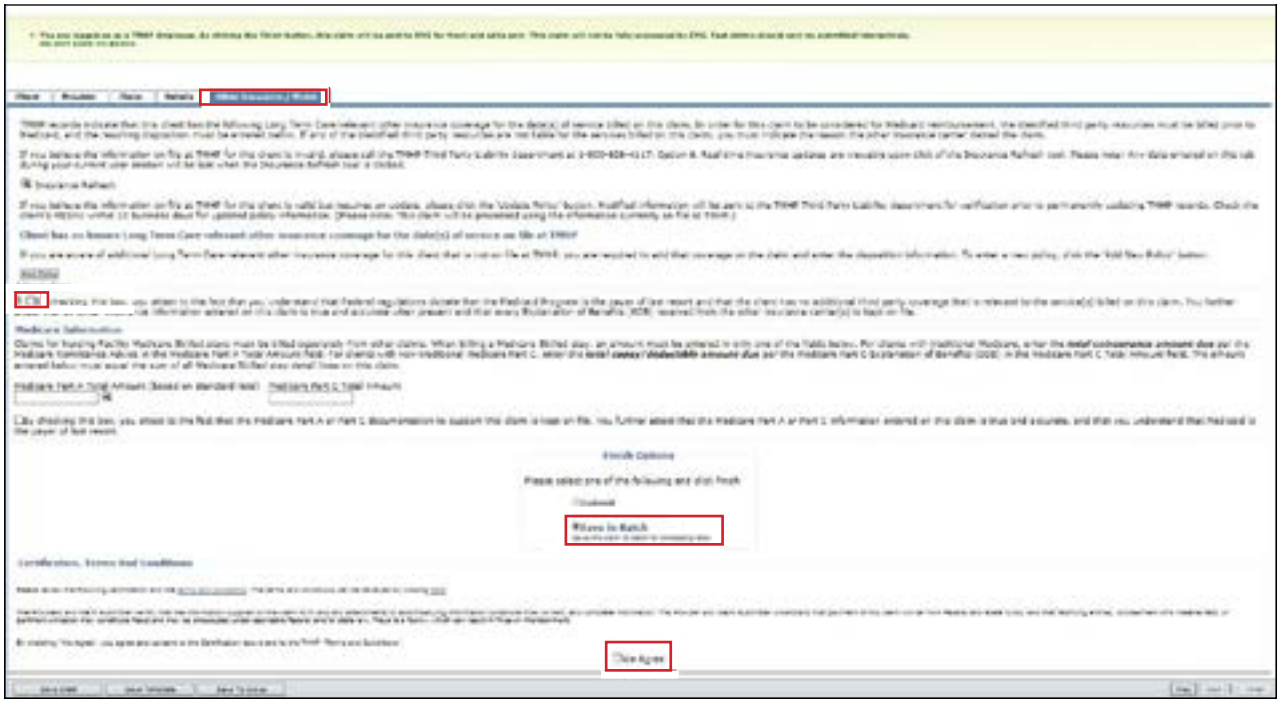
All adjustments must be submitted as batches.

To save a Professional or Dental claim adjustment as a batch:

1) Select the Other Insurance/Finish tab, select the **Save to Batch** radio button, check the **We Agree** box, and click **Finish** in the lower right corner.



2) For Institutional claims, check the box under Attestation, select the **Save to Batch** radio button, check the **We Agree** box, and click **Finish**.
Note: For claims in SG 1, 6, and 8, the OI Paid Amount entered in the Details tab must equal the OI Paid Amount in the Other Insurance/Finish Tab.



Review your batch history to ensure that the adjustment was successfully processed. The submission of the pending batch is initially Accepted but can be Rejected after the additional system edits are applied. Refer to the "Submitting a Batch" section of this user guide for information about submitting batches.

Remittance and Status (R&S) Reports

R&S Reports are generated on Mondays and Wednesdays.

- R&S Reports that are generated on Mondays cover the claims that were submitted the previous week between Tuesday after close of business until close of business on Friday.
- R&S Reports that are generated on Wednesdays cover the claims that were submitted from the previous Friday after close of business until close of business Tuesday of the current week.

The R&S function in the left navigation panel has the following two options:

- PDF: Displays the R&S in a PDF version of the paper R&S.
- ANSI 835: Allows you to download the American National Standards Institute (ANSI) 835 version of the R&S Report. This file is for providers that use third-party billing software or third-party billing agents.

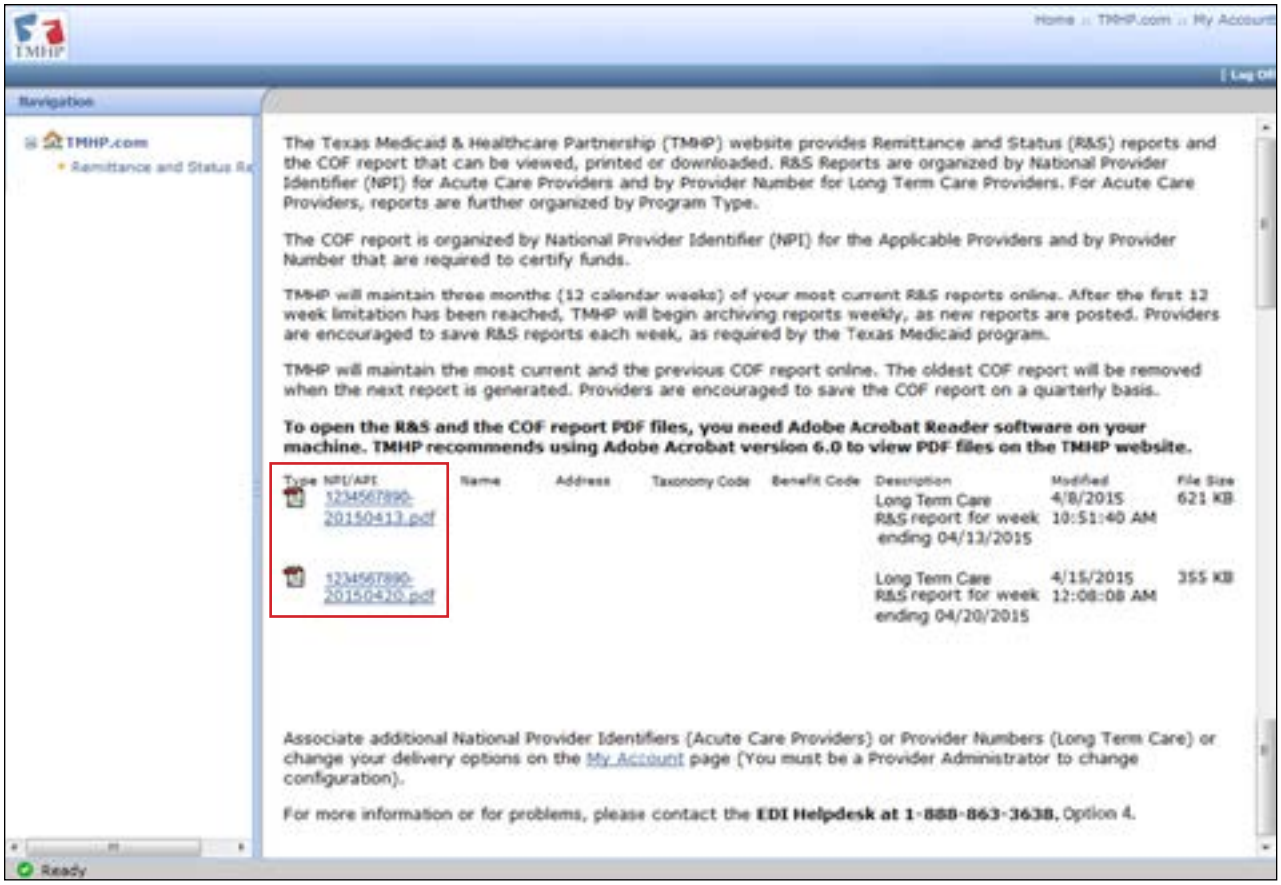
Note: An additional resource that can assist LTC providers with R&S Reports is the Remittance and Status Reports for LTC Providers Quick Reference Guide (QRG).

Viewing the PDF Version

To view the PDF version of the R&S Report:

1) Click **R and S** in the left navigation panel.

2) Select the NPI or API for which you'd like to view R&S Reports. Some providers will only have one NPI or API, whereas other providers will have more than one.



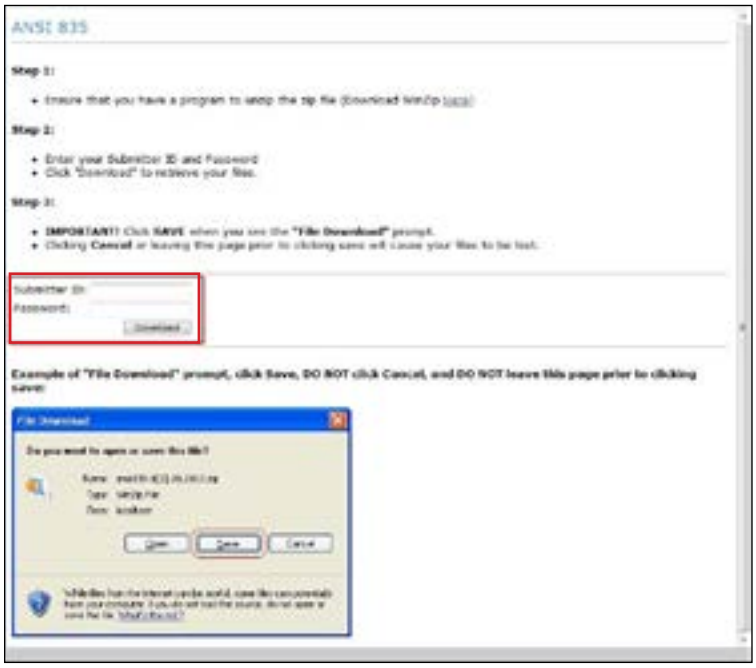
Downloading the ANSI 835 Version

You can access the 835 non-pending Electronic Remittance and Status (ER&S) Report and the pending ER&S Report through TexMedConnect.

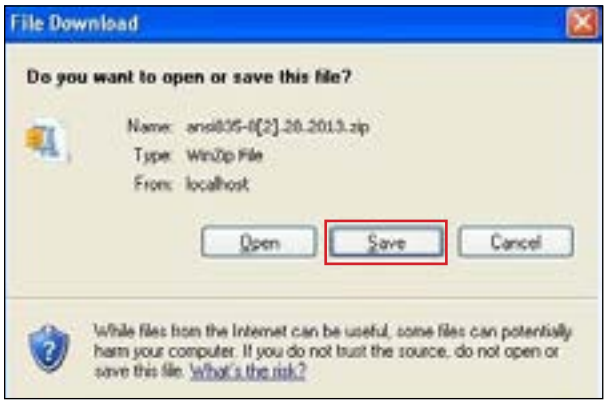
To download the ANSI 835 version of the R&S Report:

1) Click **ANSI 835** in the left navigation panel.

2) Enter your submitter ID and password and click **Download**. If you do not know your submitter ID and/or password, contact the EDI Help Desk at 888-863-3638, option 4, from 7:00 a.m. to 7:00 p.m. Central time, Monday through Friday.



3) Click **Save** and download the file to a location on your computer.



Note: Third-party software vendors, third-party billing services, and providers that program their own software can find information about the requirements for EDI ANSI X12 file types in the EDI Companion Guides, which are located on the EDI page of the TMHP website at www.tmhp.com.

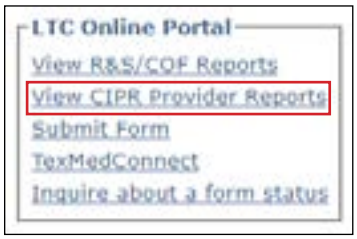
Claims Identified for Potential Recoupment (CIPR) Reports

TMHP provides CIPR Provider Reports to LTC providers that can be downloaded and viewed. When TMHP learns of a person's third-party insurance policies with retroactive dates of coverage, claims previously reimbursed by Medicaid will be identified if the claim would have been processed differently based on the third-party resource. The CIPR Provider Report contains this list of impacted claims, along with the insurance company information for the corresponding policy. Providers have 120 calendar days to adjust any claims on a CIPR report to address the updated OI information. If the claims are not adjusted, the identified claims will be recouped after the 120 calendar days.

CIPR Provider Reports are generated on a weekly basis, and TMHP maintains each CIPR Provider Report for six months. The CIPR is available in PDF format. TMHP recommends using Adobe Acrobat® version 6.0 or higher to view PDF files on the TMHP website. If a provider believes that the OI information on file is incorrect, they should contact the TMHP TPL Resource Line at 800-626-4117.

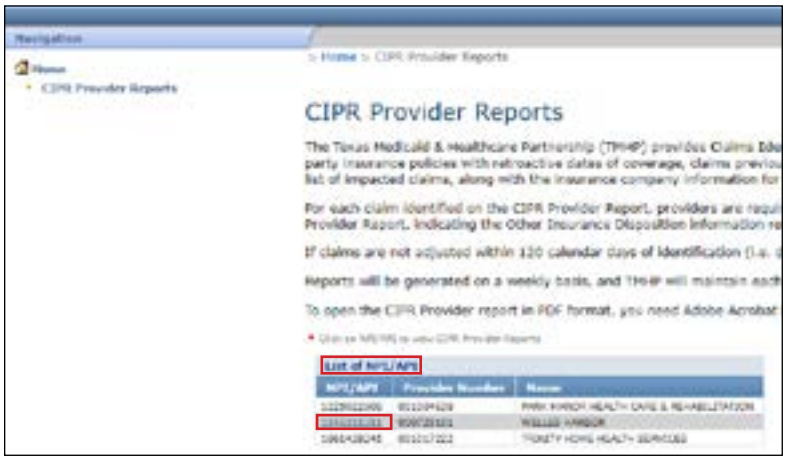
1) Click **My Account** in the top right corner of the TexMedConnect web page.

2) Click **View CIPR Provider Reports** under the LTC Online Portal section.



3) Click **CIPR Provider Reports** in the Navigation column to the left.

4) From the list of NPI/API numbers in the left column, click the number you want to see the report for.



Note: For each claim identified on the CIPR Provider Report, providers are required to submit a claim to the appropriate third-party resource for the services that were previously submitted to Medicaid.

Appendix: Using the LICN Field for HCS and TxHmL Waiver Programs

The Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs use the line item control number (LICN) field in TexMedConnect. TMHP allows claims to be submitted per HHSC billing guidelines, where the individual who provided the HCS or TxHmL 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 that indicates the accumulated units.

HCS and TxHmL Waiver Programs may 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, the Dummy ID, or the 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 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 in the “LastName,FirstName” (with no spaces) format.
- Positions 21–30 are for the internal claim ID. The internal claim ID will be used to reconcile the 837 claim to the 835 Remittance.