LONG-TERM CARE (LTC) USER GUIDE

ONLINE PORTAL BASICS, GENERAL INFORMATION, AND PROGRAM RESOURCES

Contents

Learning Objectives

This user guide is intended to assist long-term care providers enrolled in Texas Medicaid, including nursing facilities, hospice providers, and Home and Community-Based Services/Texas Home Living (HCS/TxHmL) providers. After reading this user guide, you will be able to:

- Understand the Medicaid team roles.

- Identify National Provider Identifier (NPI) requirements.

- Obtain an LTC Online Portal administrator account.

- Understand basic LTC Online Portal features.

- Understand how to properly request prior authorization for nonemergency ambulance transport.

- Recognize how to prevent Medicaid waste, abuse, and fraud.

- Understand compliance with the Health Insurance Portability and Accountability Act (HIPAA).

- Identify additional resources to assist you.

Medicaid Team

The following groups and people make up the Medicaid Team. Together, they make it possible to deliver Medicaid services to Texans.

- **Centers for Medicare & Medicaid Services (CMS)** – The agency in the U.S. Department of Health and Human Services that is responsible for federal administration of Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP).

- **Person** – Refers to individual who is enrolled into a program and served by Texas Medicaid. Formerly referred to as "client" or "individual."

- **Managed care organization (MCO)** – A state-contracted entity that has been given delegated authority to provide acute and long-term services to support enrolled managed care members.

- **Program provider** – An entity that provides services under a contract with the Texas Health and Human Services Commission (HHSC). "Program provider" is the preferred term for "provider agency." Program providers are the crucial players in a quality health care program. The focus of a program provider is to provide the best care possible while being reimbursed for services rendered that are covered by Texas Medicaid.

- **HHSC** – Provides administrative oversight of Texas Health and Human Services programs, including the Medicaid acute care program; CHIP; State of Texas Access Reform (STAR); State of Texas Access Reform PLUS (STAR+PLUS); and long-term services and supports (LTSS) to elderly and people with physical, intellectual, and developmental disabilities. It also regulates providers of LTSS, administers the state's guardianship program, and provides direct administration of some programs. HHSC's Office of Eligibility Services (OES) determines eligibility for Medicaid.

- **Texas Medicaid & Healthcare Partnership (TMHP)** – Contracted by the state as the claims administrator to process claims for providers under traditional Medicaid. TMHP processes and approves claims for traditional LTC. TMHP does not pay LTC claims; the comptroller pays the claims. TMHP's responsibilities also include the following:

  - Determining medical necessity (MN)

  - Educating providers

  - Providing timely processing of claims (except for services covered by the STAR+PLUS premium) and representing HHSC at fair hearings

  - Producing provider procedure manuals (updated monthly), quarterly LTC Provider Bulletins, and Remittance and Status (R&S) Reports

  - Maintaining the TMHP Call Center/Help Desk Monday through Friday, 7:00 a.m.–7:00 p.m., Central Time, excluding holidays

  - Conducting training sessions for providers, which includes technical assistance on the TexMedConnect online application

- **Texas State Legislature** – Allocates money for the Texas Medicaid budget.

National Provider Identifier (NPI)/Atypical Provider Identifier (API) Requirements

HIPAA established the NPI as the standard identifier for health care providers and requires covered health care providers, clearinghouses, and health plans to use this identifier in HIPAA-covered transactions.

A 10-digit, unique NPI is required on all claims submitted electronically through third-party software or through TexMedConnect. On the LTC Online Portal, an NPI is used for security purposes and links providers to their assessments so that only those persons associated with that NPI are viewable. Without an NPI, providers would not be able to locate their assessments on the LTC Online Portal.

Note: HHSC Medically Dependent Children Program (MDCP) nurses are not required to apply for an NPI. They enter an API, which is assigned by the appropriate region. To view the HHSC Community Services regional contacts, go to hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts.

To obtain an NPI, go to nppes.cms.hhs.gov/NPPES.

An NPI or an API is required for claims and assessment submissions using the following methods:

- LTC Online Portal

- TexMedConnect

- Third-party software vendor

The LTC Online Portal

Providers must use the LTC Online Portal to submit forms, screenings, evaluations, and the Long-Term Care Medicaid Information (LTCMI) section of the Minimum Data Set (MDS) Assessment. The benefits of using the LTC Online Portal include the following:

- It is a web-based application.

- The system is available 24/7.

- TMHP provides LTC Online Portal technical support by telephone at 800-626-4117, option 3, from 7:00 a.m.–7:00 p.m. Central Time, Monday through Friday, excluding holidays.

- Edits are in place to verify the validity of data at the time it is entered.

- The system provides error messages that must be resolved before submission.

- Providers have the ability to monitor the status of forms, assessments, screenings, and evaluations by using Form Status Inquiry (FSI) or Current Activity.

- The system allows providers to submit additional information.

LTC Online Portal Security

To use the LTC Online Portal, providers must request access to it. Your facility may already have an account. You may need to contact your facility's administrator for user access. An administrator account is required for LTC Online Portal access. Providers should have multiple administrator accounts in case one administrator is unavailable.

The administrator account is the primary user account for a provider number. The administrator account provides the ability to add and remove permissions (access to LTC Online Portal features) for other user accounts on the same provider number.

A user account can be created by an administrator. User account permissions and limitations are set by the holder of an administrator account. This allows administrators to set the level of access according to employees' responsibilities.

Third-party vendors may submit the LTCMI section of an MDS assessment directly on the LTC Online Portal on behalf of a provider. Providers using a third-party software vendor are still required to obtain LTC Online Portal access for rights to submit the LTCMI section of the assessment. For questions related to this functionality, providers should contact their third-party software vendors.

If you already have an administrator or user account, go to www.tmhp.com/programs/ltc and click the **LTC Online Portal** button to access the LTC Online Portal.

If you do not have an account, you can create one by following the steps below. To do so, you will need the following information:

- **Provider number**—nine-digit number assigned by HHSC when the provider signs the contract to provide Medicaid services

- **Vendor number**—four-digit number assigned by HHSC when the provider signs the contract to submit forms on the LTC Online Portal

- **Vendor password**—providers must call the Electronic Data Interchange (EDI) Help Desk at **888-863-3638** to obtain their vendor password
  Note: It may take three to five business days to receive the password, which is randomly generated by TMHP.

How to Create an LTC Online Portal Administrator Account

1) Go to www.tmhp.com.

2) Click the **My Account** button.
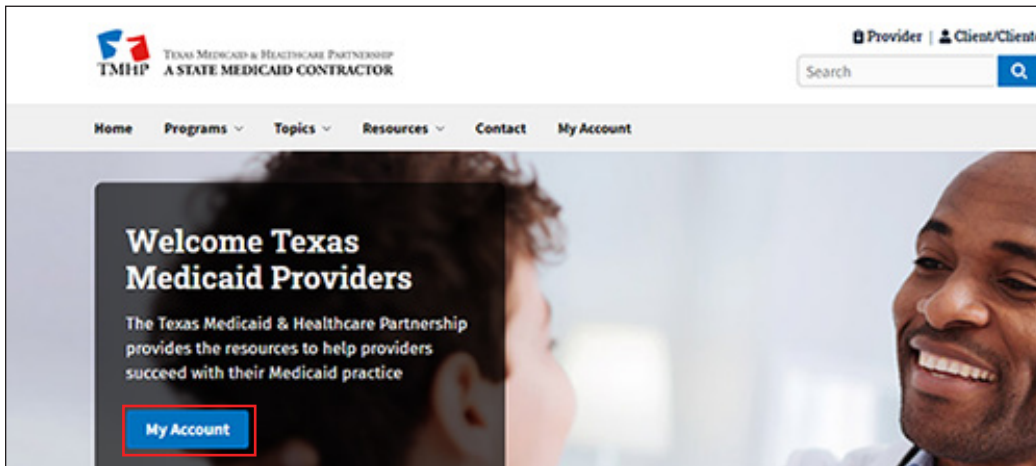
3) Sign in or click the **Cancel** button if you do not have a user name and password.

4) Click the **Activate My Account** button, then click the **Go** button.
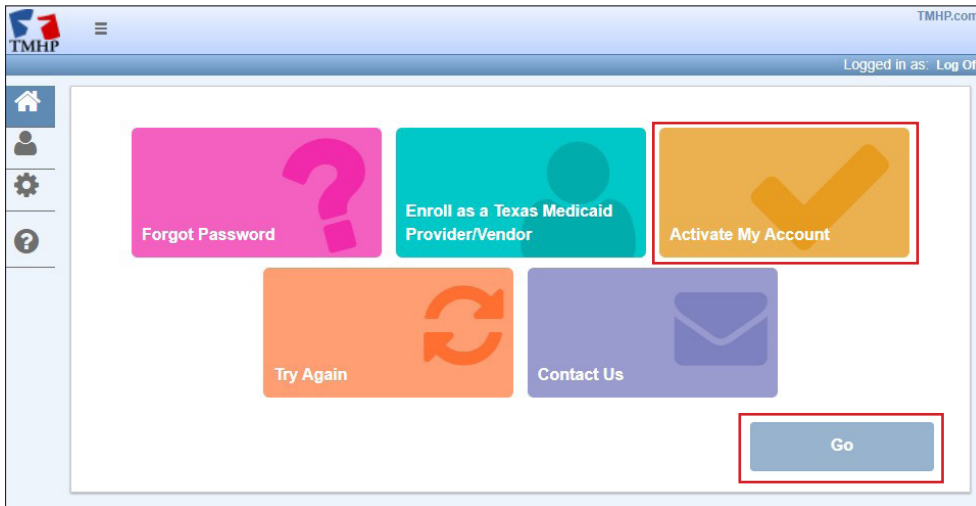
5) From here, you have a few options:

a) If you are not currently a Texas Medicaid provider, you will be prompted to enroll in Texas Medicaid. To enroll as a Texas Medicaid provider, click the **Enroll as a Texas Medicaid Provider/Vendor** button. Then click the **Go** button. For more information about enrollment, visit https://www.hhs.texas.gov/providers/medicaid-provider-enrollment.
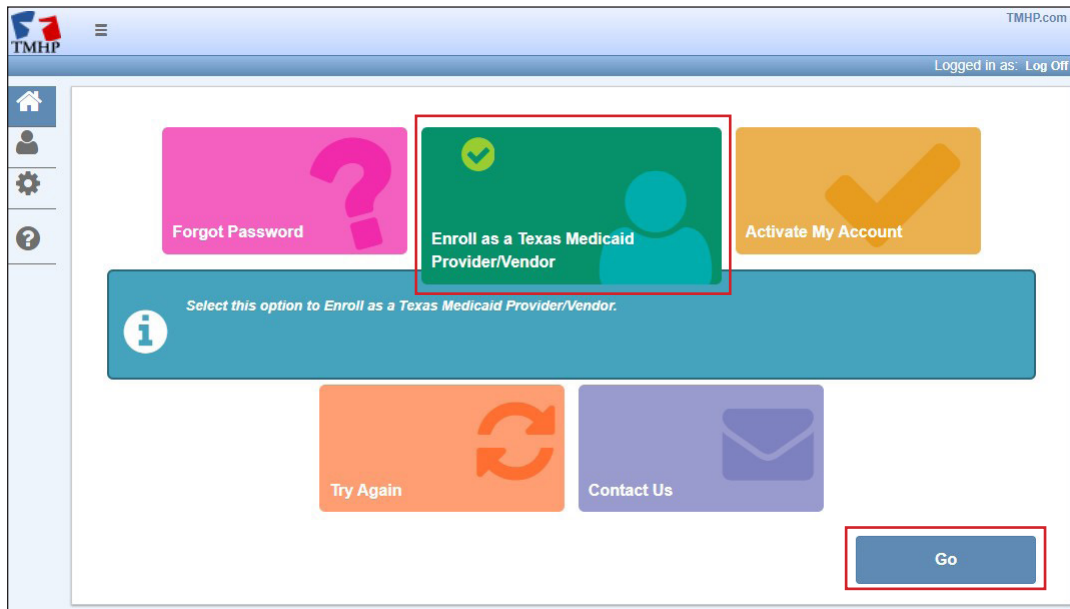
b) To create a new TMHP user account with an existing provider/vendor account, click the **Create Account and link to a Nursing Facility/Waiver Program provider** link, then click **Next**. This option will allow you to submit forms 3618 and 3619, MDS Initial Assessments and MDS Quarterly Assessments, Medical Necessity/Level of Care (MN/LOC) Assessments, 8578 Assessments, Individual Movement forms, PASRR Level 1 (PL1) Screenings, PASRR Evaluations (PEs), Star Kids Screening and Assessment Instrument (SK-SAI) forms, H1700 Individual Service Plan (ISP) forms, and Star Kids Individual Service Plan (SK-ISP) forms.

c) To create a new TMHP user account with an existing provider/vendor account, click the **Create Account and link to a Long-Term Care provider** link, then click **Next**. This option will allow you to view R&S Reports and submit 3071s and 3074s on behalf of the LTC provider.
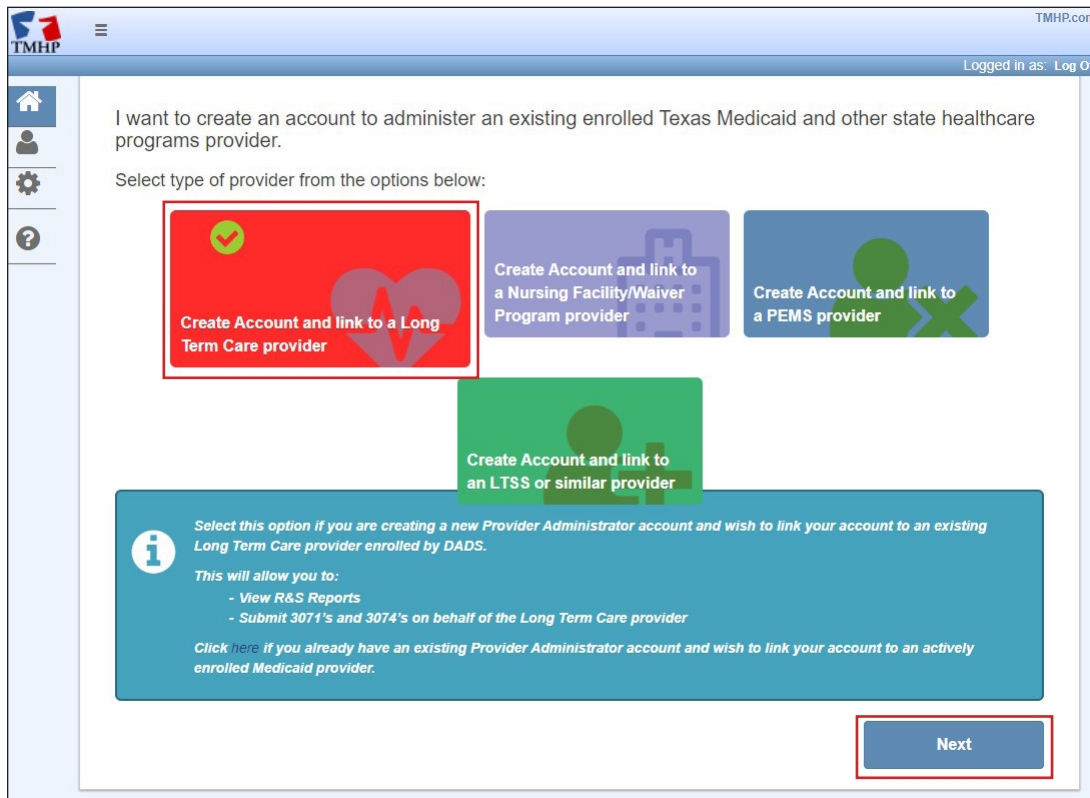
6) Enter your provider number, and then click the **Look-up** button.
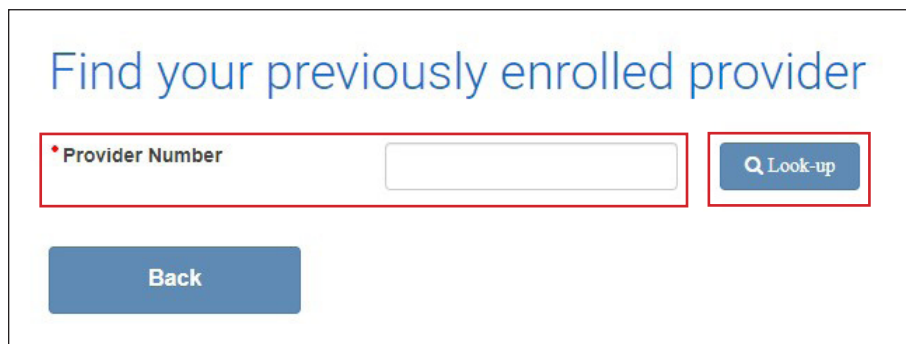
7) Fill in all the required fields as indicated by the red dots.

8) Check the **I agree to these terms** box at the bottom of the screen, under the "General Terms and Conditions" section, to indicate agreement. You cannot agree to these terms until you have scrolled through all the General Terms and Conditions.

9) Click the **I'm not a robot** box on the left side of the screen. You will be required to authenticate your status before moving forward in the process.

10) Click the **Submit** button to create your account.

11) Click the **My Account** button to be directed to your account.
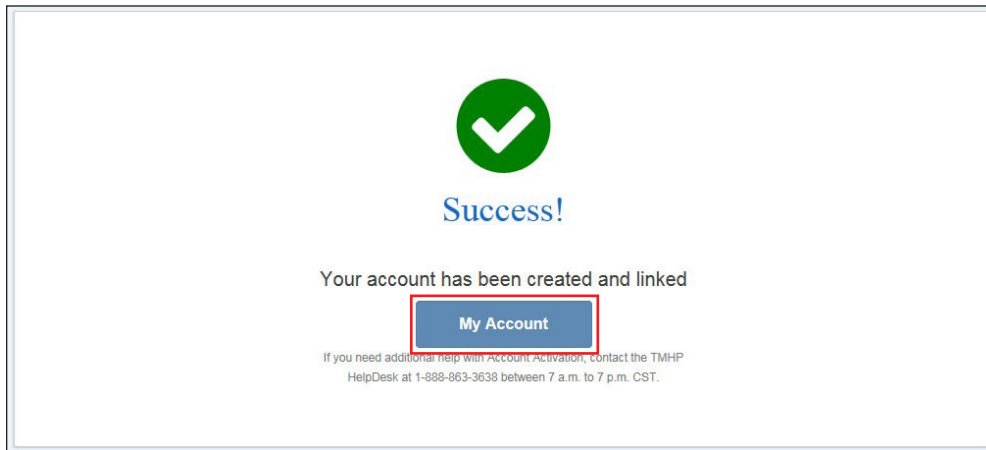
Note: The user name and password are used for future log ins to your account. Make a copy for your records.

My Account

My Account is used to perform various maintenance activities for your account, such as setting up user accounts, changing passwords, and other administrative tasks.

To access My Account:

1) Go to www.tmhp.com.

2) Click the **My Account** button.
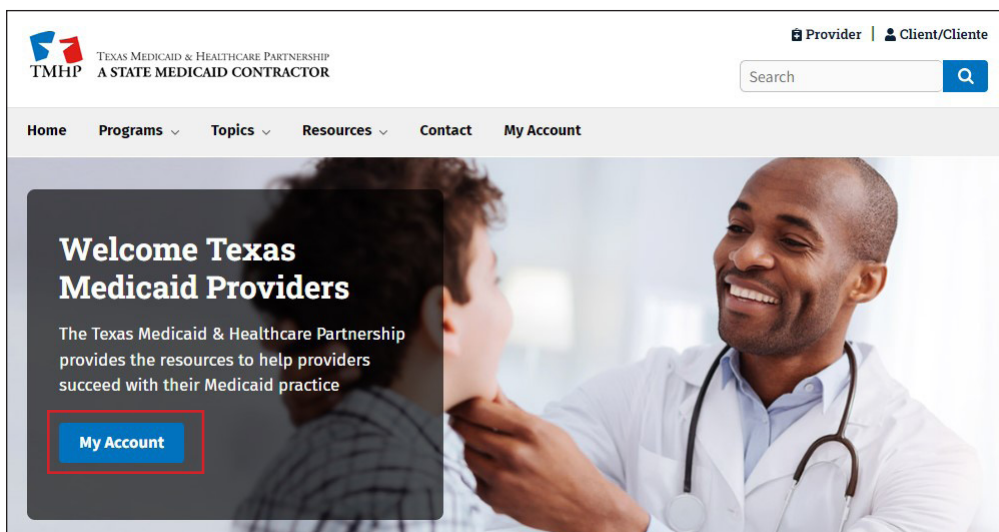
Note: You may be prompted to enter your LTC Online Portal User ID and password.

3) The My Account page appears.
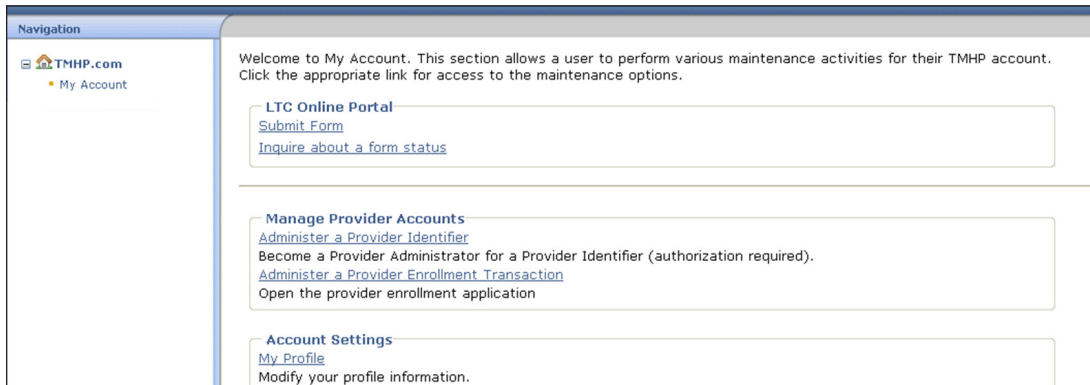
Logging into the LTC Online Portal

1) Go to www.tmhp.com.

2) Click **Programs** located at the top of the screen and.
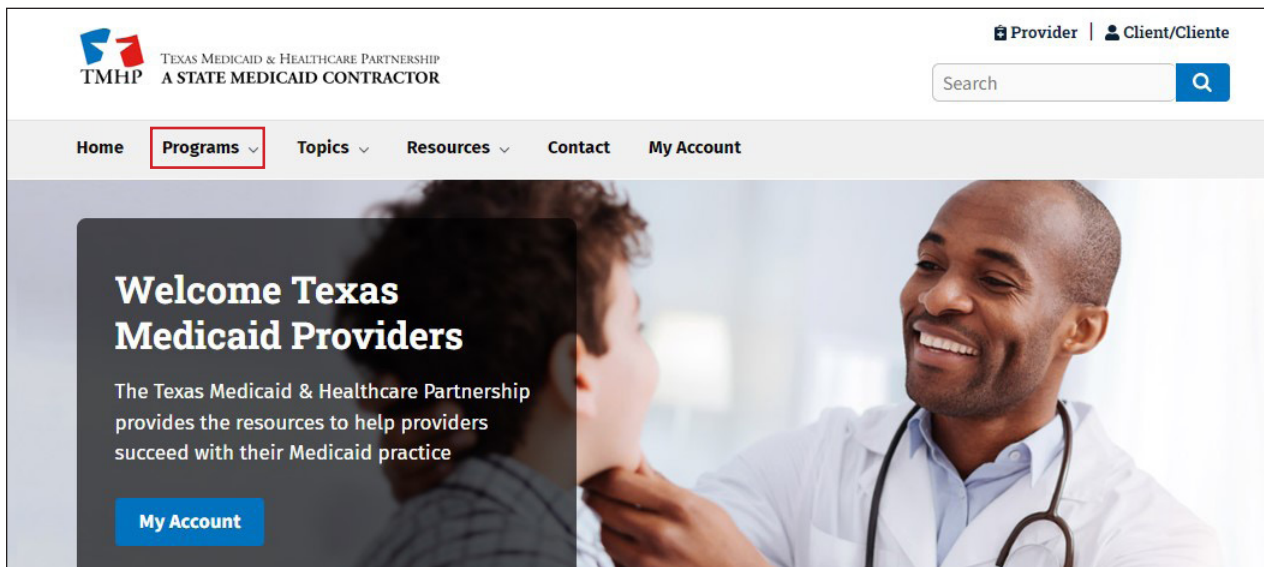
3) Click **Long-Term Care (LTC)** from the drop-down menu.
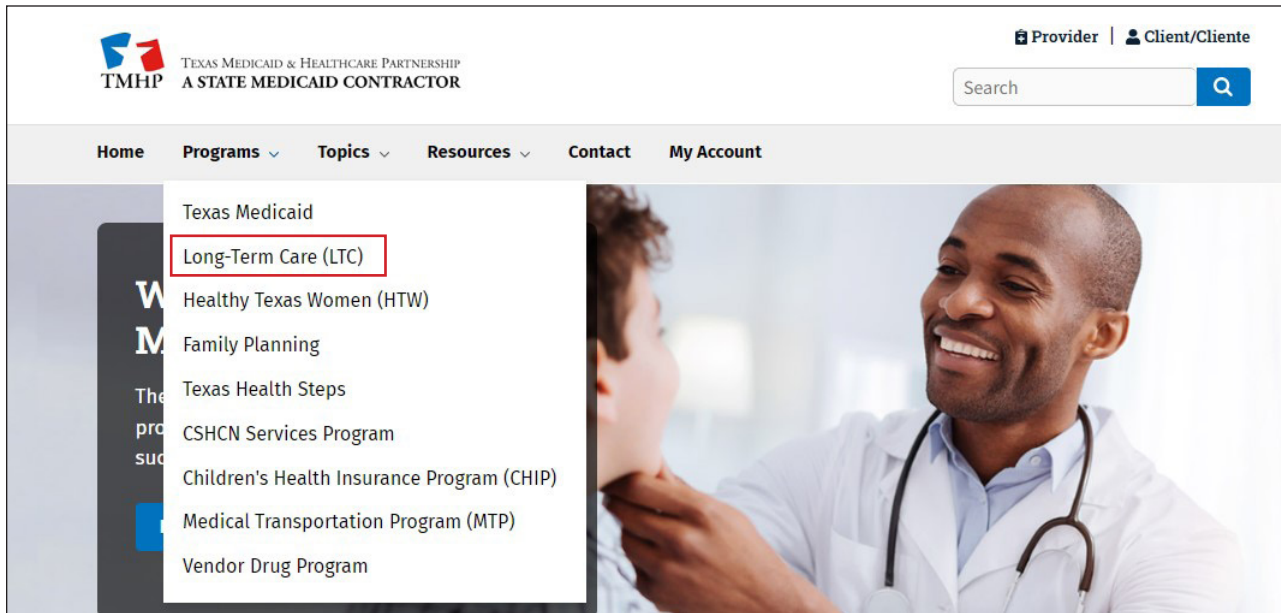
4) Click the **LTC Online Portal** button.
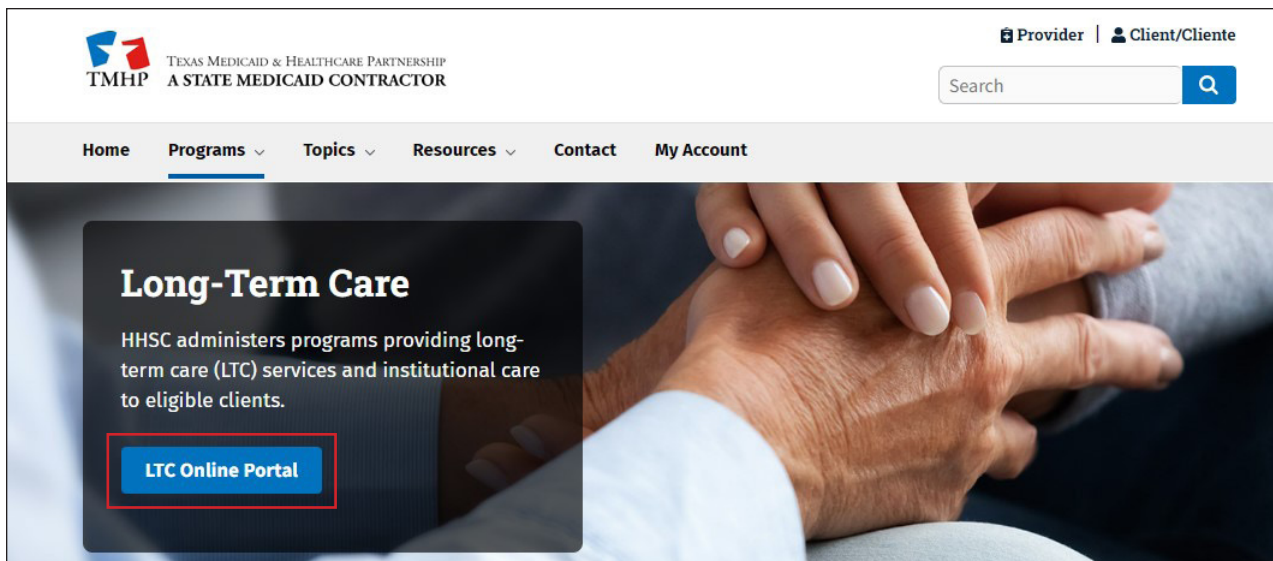
5) Enter your user name and password. Then, click **Sign in**.

6) The Form Status Inquiry page displays by default.

LTC Online Portal Basics

Blue Navigational Bar Links

The blue navigational bar contains features that are available in your LTC Online Portal. Available features may vary based on your security permissions.

Depending on your security permissions, the options that are available on the blue navigational bar may include Submit Form, Search (with drop-down options for Form Status Inquiry, Letters, and Vendors), Worklist (with drop-down options for Current Activity and Drafts), Printable Forms, Alerts, and Help.
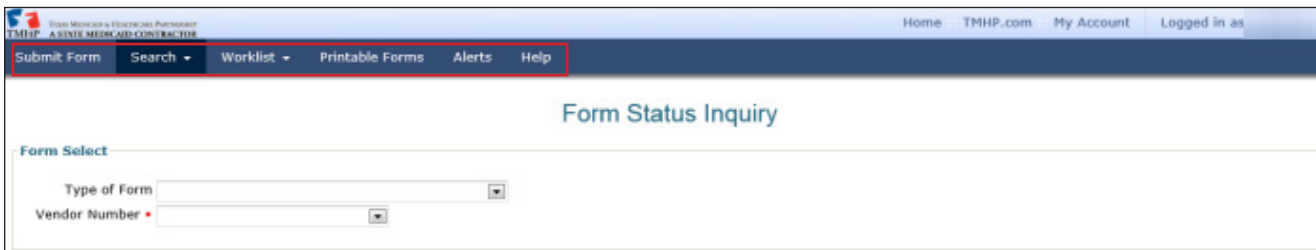
Home

The **Home** link in the light-blue navigational bar will take you to the Long-term Care web page on tmhp.com.
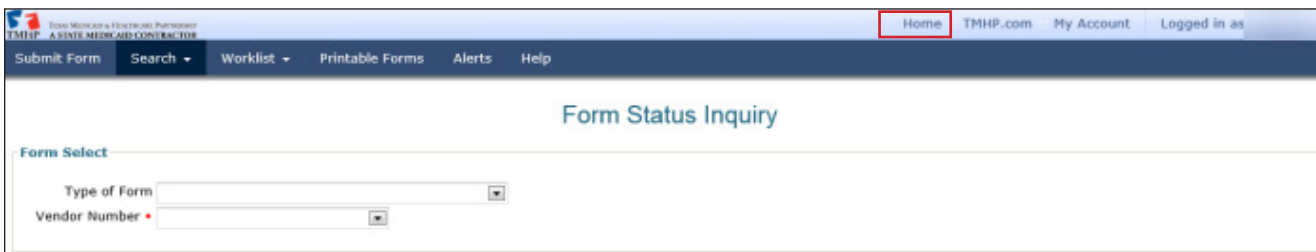
From the TMHP home page, providers may:

• Access the LTC Online Portal.

• Access TexMedConnect.

• Submit a prior authorization.

• Access provider manuals and guides.

• Access bulletins and banner messages.

Submit Form

The Submit Form feature allows providers to submit forms.

To submit a form:

1) Click the **Submit Form** link located on the blue navigational bar.

2) Choose an option from the Type of Form drop-down box. The forms that are available will vary depending on your security permissions.

3) If desired, enter additional information about the person in the Recipient section. This will autofill the form or screening with the person's demographical information (except gender).

4) Click the **Enter Form** button to display the form for data entry.

5) Enter all required information as indicated by the red dots.

6) From here, you have two choices:

   a) Click the **Save as Draft** button in the yellow Form Actions bar to save the form or screening until you are ready to submit. The form or screening does not have to be complete to save the draft.

b) Click the **Submit Form** button located at the bottom of the screen to submit the form or screening.

Form Status Inquiry (FSI)

The FSI feature provides a query tool for monitoring the status of documents that have been successfully submitted.

FSI allows you to retrieve submissions in order to:

- Research and review statuses.

- Review specific documents.

- Provide additional information on certain documents.

- Make updates to a document when it is allowed.

- Export search results to Microsoft Excel®.

Note: FSI can retrieve information from the previous seven years. The search is based on the TMHP received date.

To search for a document using FSI:

1) Click the **Search** link on the blue navigational bar.

2) Choose **Form Status Inquiry** from the drop-down menu.

3) Choose the appropriate document from the Type of Form drop-down box.

- This choice will determine the type of document that will be displayed in the FSI results page. For example, if a provider chooses the MDS 3.0: Minimum Data Set (Comprehensive) form, the results will only display MDS 3.0: Minimum Data Set (Comprehensive) assessments. No MDS 3.0 Quarterly assessments will be displayed in the search results.

- If you are the original submitter, you may skip the Type of Form field and enter the Document Locator Number (DLN) of the document you need to retrieve. If you are not the original submitter, you must choose the type of form even if you enter a DLN.

4) Complete the required From Date and To Date fields. Dates are searched against the TMHP received date (date of successful submission).

5) Searches can be performed by DLN only, by form type, or across form types. For form type and across form types searches, you can narrow results by entering specific criteria in the additional fields: DLN, Last Name, First Name, SSN, Medicaid Number, Form Status, Purpose Code, and Reason for Assessment.

- The narrowing search criteria fields that will be displayed when performing an FSI will vary based on the type of form that is selected.

- Example: When performing an FSI on forms 3618, 3619, 3071, or 3074 or on the PL1 Screening Form or PE, the Purpose Code and Reason for Assessment fields will not be displayed because they are applicable only when performing an FSI on MDS assessments.

6) Click the **Search** button, and the LTC Online Portal will return any matching submissions (records). Only 50 records will be displayed at a time. To view the next set of records, you must choose another page from the Select a page drop-down box. You may also export the search results to Microsoft Excel®.

7) Click the **View Detail** link to the left of the DLN to display the details of the form.

Current Activity

The Current Activity feature allows persons with the proper security permissions to view submitted documents with status changes that have occurred within the last 14 calendar days. After 14 days, the information is removed from the search results, and you must use FSI to locate documents.

Note: The initial Current Activity page will display a list of all vendor/provider numbers to which the user is linked.

To locate a document using Current Activity:

1) Click the **Worklist** link on the blue navigational bar.

2) Choose **Current Activity** from the drop-down menu.
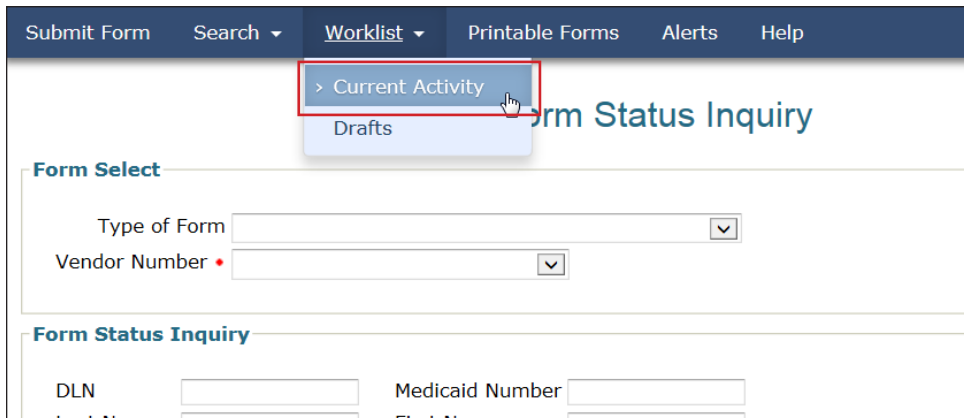
3) Click the desired Vendor/Provider Number combination. The Current Activity for that Vendor/Provider Number will display.
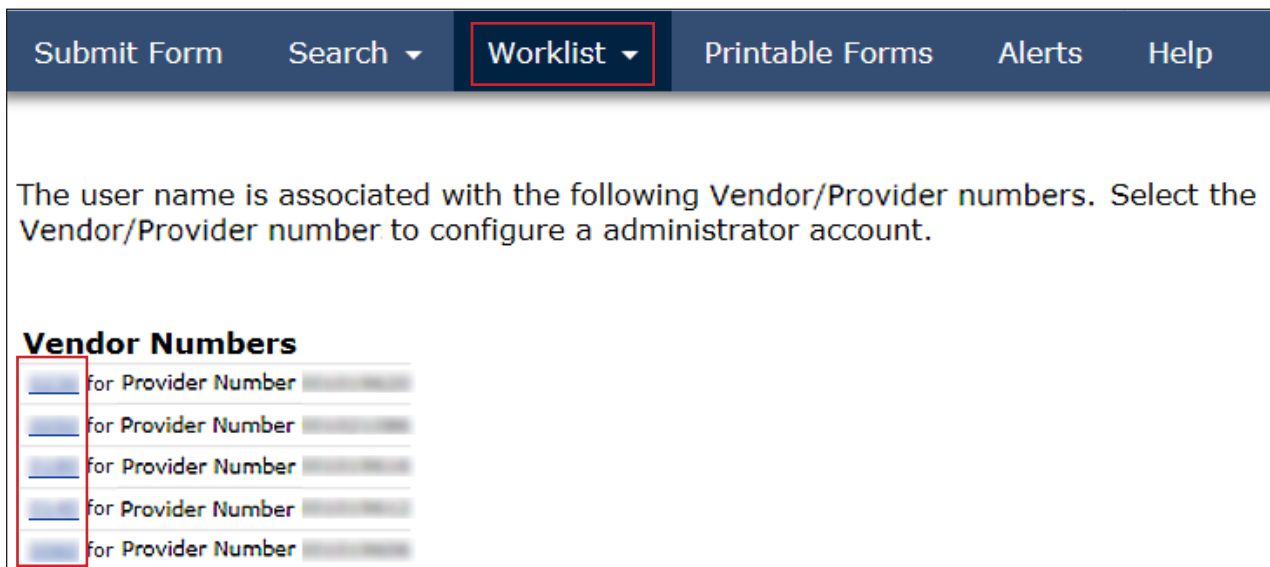
4) The results page will display document submissions and status changes that have occurred within the last 14 calendar days. The search results include the following columns:

- DLN (sorted by type of form)

- Received—TMHP received date

- Medicaid—Medicaid number

- SSN—Social Security number

- Medicare—Medicare number

- Name —Name of the person submitted for services

- Status —Status of the form

5) The numbers in the first column are the DLNs associated with the particular vendor/provider number that you selected in step 3. Click the **DLN** link to display the details of the document that you wish to view.

To sort the Current Activity results, you may click the following column headers to sort by ascending or descending: DLN, Received, Medicaid, Medicare, Name, or Status.

Drafts

Drafts are documents that have not been submitted on the LTC Online Portal but have been started and saved. Documents that are saved as drafts do not have an assigned DLN, however a DLN will be assigned once the draft is submitted. Access to drafts is allowed for users within the same facility with the security permissions of a local authority (LA) or a nursing facility.

When a document is saved as a draft, the document is saved under the vendor number that was previously selected. Drafts are deleted after 60 calendar days.

To access a saved draft:

1) Click the **Worklist** link on the blue navigational bar.

2) Choose **Drafts** from the drop-down menu.
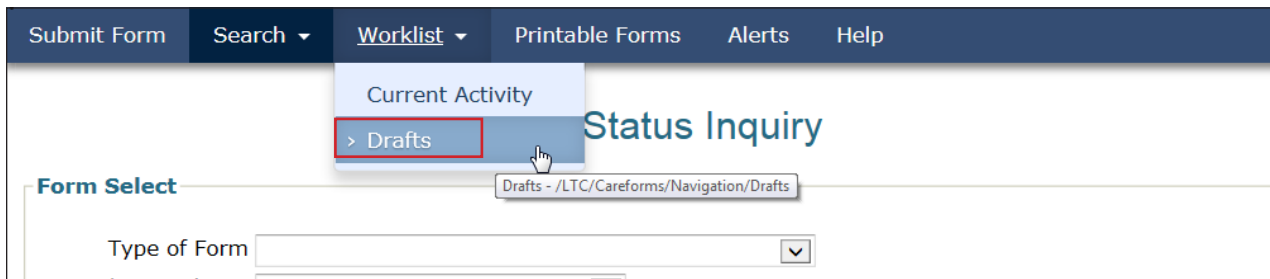
Note: The initial Drafts page will display a list of all vendor/provider numbers to which the user is linked.

3) Click the appropriate vendor number hyperlink under Vendor Numbers. The vendor/provider number combinations show any documents associated with the vendor/provider number combination used to sign into the LTC Online Portal.
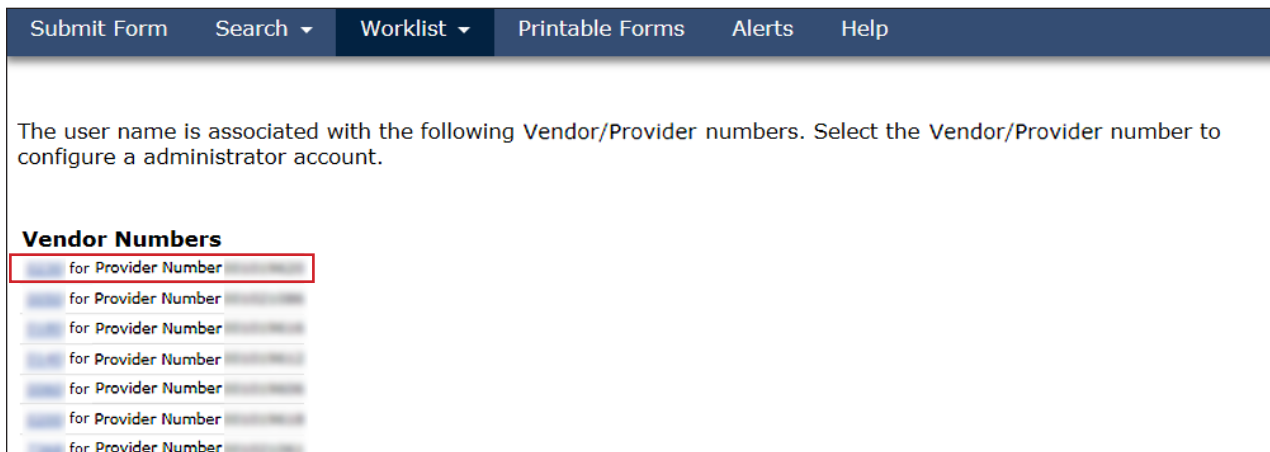
4) A list of drafts saved for the selected vendor/provider number will display.
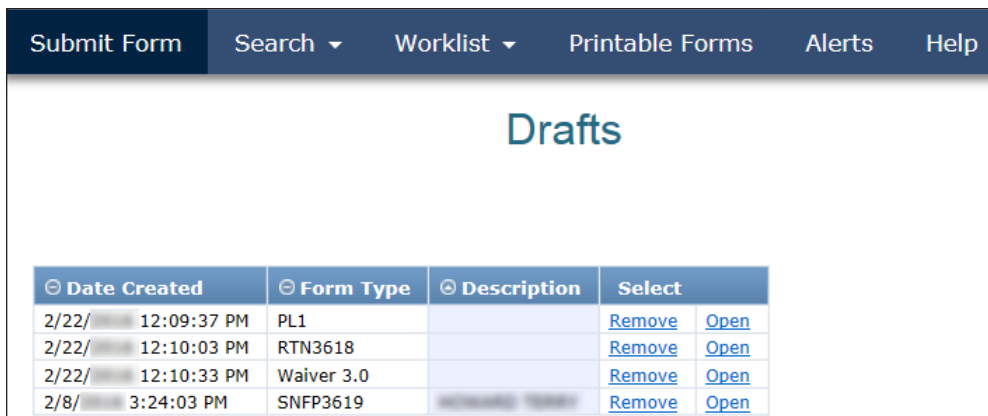
5) From here, you have two choices:

a) Click the **Open** link to edit and submit the draft.

b) Click the **Remove** link to permanently delete the draft. If you choose the **Remove** link, the following confirmation message will appear with two choices:
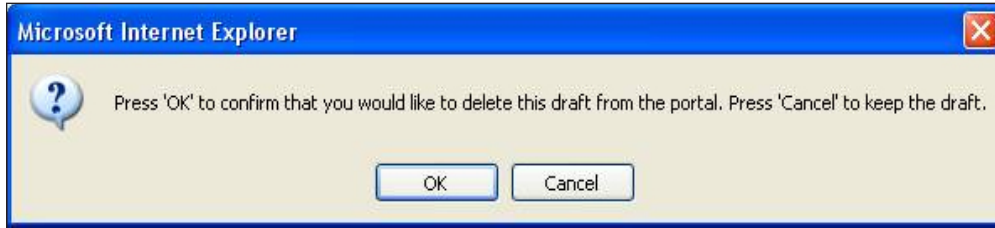
- Click the **OK** button to delete the draft.

- Click the **Cancel** button to keep the draft.
  Note: After a draft is deleted, it cannot be retrieved.

Printable Forms

The Printable Forms feature allows you to view, download, print, or interactively fill out documents for your records. Documents that are accessed from the Printable Forms page open in Adobe Acrobat portal document format (PDF). Documents saved to your desktop cannot be submitted to the LTC Online Portal, but they can be printed. Below are general instructions for printing the PDF. Each version of Adobe Acrobat® is different. Refer to your printer's documentation and the help file for your version of Adobe Acrobat® for exact instructions.

1) Click the **Printable Forms** link on the blue navigational bar.

2) On the list that appears, click the name of the form that you want to display. In a new window, the Adobe Reader® application will open the selected document in PDF format.
   Note: In some versions of the Adobe product, you may be able to enter information into the document and save it to your desktop.

Example: Click **PASRR Level 1 Screening (PL1)** to display that form.

3) Click the **Print** icon located at the top left of the PDF.

4) To print the entire document:

   a) Choose the appropriate printer name from the Name: drop-down box.

   b) Click the **All** radio button in the Print Range section.

   c) Click the **OK** button.

5) To print only certain pages instead of the entire document:

   a) Choose the appropriate printer name from the Name: drop-down box.

   b) Click the **Pages** radio button in the Print Range section.

   c) Enter the page numbers you want to print in the Pages field. (Example: Entering "1–5" will print all pages 1

through 5; entering "1, 3, 7" will print only pages 1, 3, and 7.)

d) Click the **OK** button.
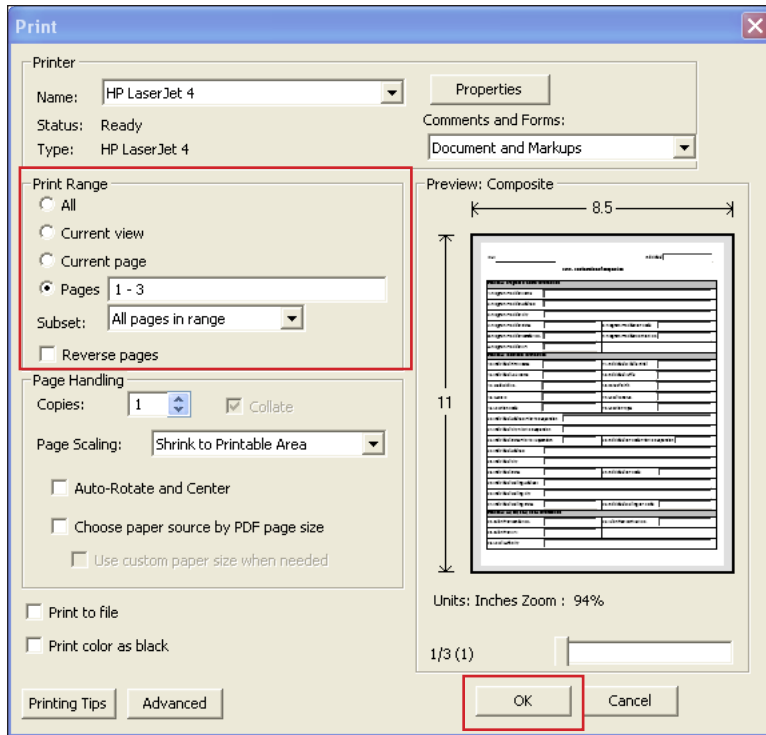
Note: Your Print screen will vary based on the version of Adobe you are using and the printer you have installed. Refer to your printer's manual and the Adobe Help Files for specific instructions.

Help

The Help feature on the blue navigational bar will display a Help page with links to online guides that assist with questions about the LTC Online Portal.

Yellow Form Actions Bar

Options found in the yellow Form Actions bar may include the following:

- Print

- Use as template

- Correct this form

- Update Form

- Add Note

- Check MN on PE

- Able to Serve the Individual

- Inactivate Form

Options will vary depending on your security level, the type of document (e.g., PL1 Screening Form, PE, MDS assessment, or Forms 3618, 3619, 3071, or 3074), and the document status.

Print

The Print feature is applicable to all submitted document types. Click the **Print** button to print completed documents.
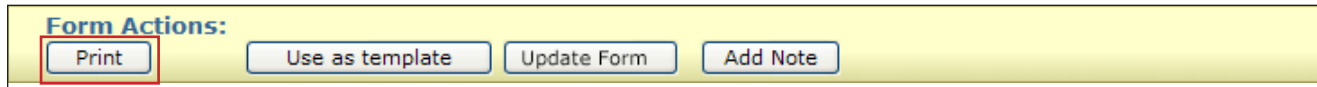
Use as template

The Use as template feature is available for most (but not all) forms, including the PL1 Screening Form and Forms 3071, 3074, 3618, and 3619. It allows you to complete a new form or screening by using the information on a completed form or screening as a template. Some fields will autofill, so be sure to check for accuracy.

Note: Do not confuse this feature with a similarly named feature in TexMedConnect.

After you find and display the form or screening using FSI or Current Activity:

1) Click the **Use as template** button. The data in the document will be used to create a new document.
   Note: Not all fields will be copied over to the new document.

2) Enter data in the fields that were not autofilled. Required fields are detonated with a red dot.

3) From here, you have two choices:

   a) Click the **Submit Form** button located at the bottom right of the screen if you are ready to submit for processing.
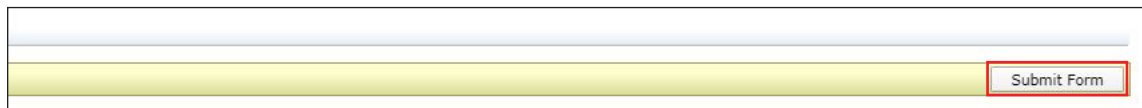
   b) Click the **Save as Draft** button located in the yellow Form Actions bar to save the document until you are ready to submit.
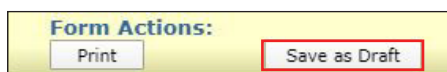
The **Save as Draft** button will be displayed in the yellow Form Actions bar only in the following circumstances:

- The provider enters any form *except* for the MDS.

- The provider creates a completely new form or screening.

- The provider creates a new form or screening from a template of a previously submitted form or screening using the **Use as template** button.

- The provider opens a draft form or assessment from the Drafts link.

Correct this form

The Correct this form feature is available for the LTCMI section of the MDS, as well as for Forms 3071, 3074, 3618, and 3619. Corrections are not allowed if a document is set to Form Inactivated, Invalid/Complete, SAS Request Pending, or Corrected status. Click the **Correct this form** button to correct a previously submitted LTCMI or form.
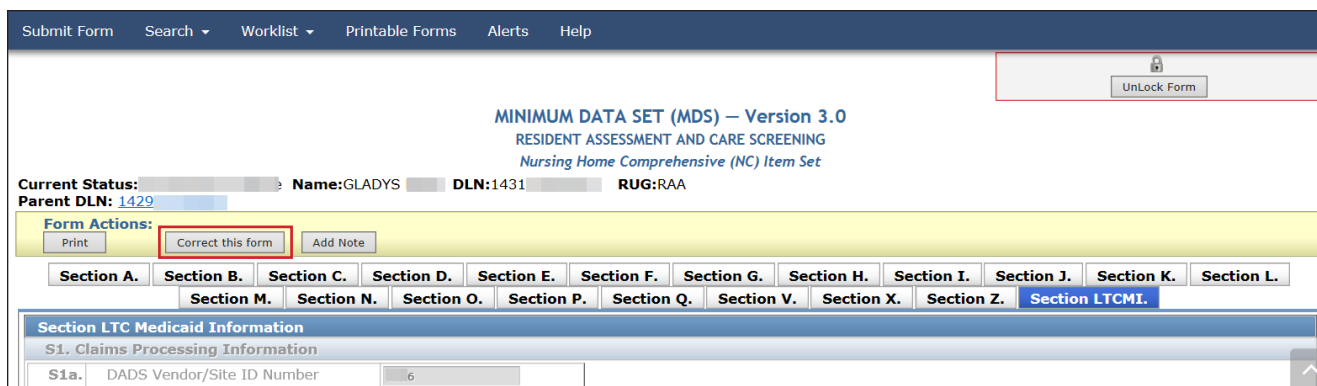
Note: For more information on how to correct a form or an LTCMI, refer to the "Corrections and Updates" section of the Long-Term Care (LTC) User Guide for Nursing Facility Forms 3618/3619 and Minimum Data Set/Long-Term Care Medicaid Information.

Add Note

The Add Note feature is available for every form *except* Form 3071 and Form 3074.
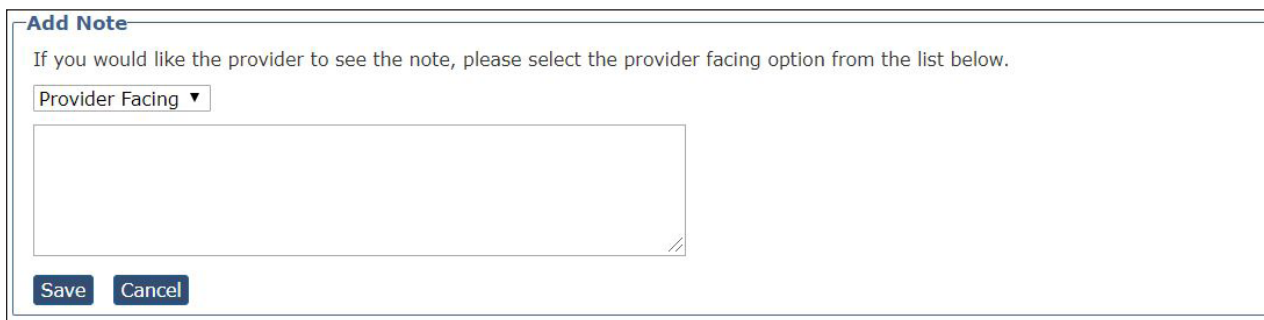
Add Note, located in the yellow Form Actions bar, may be used to add information that was not captured during the original submission, and it is not used in system processing. Information is added to the history trail of the document and not to the document itself (e.g., not added to Comments in the LTCMI section of the assessment).

To add a note to a submitted document (this example is from the PASRR Comprehensive Service Plan [PCSP] form):

1) Locate the document using FSI or Current Activity.

2) After opening the document, click the **Add Note** button. A text box will open.
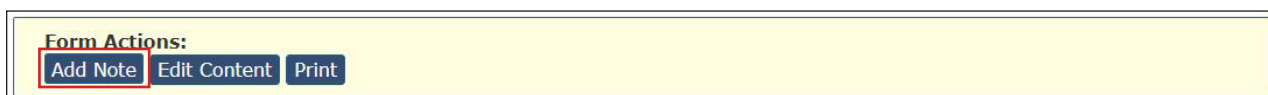
3) Enter additional information (up to 500 characters).

Note: Only certain valid characters can be added to text boxes on a form. The valid characters are 0-9, A-Z, a-z, and the following: @, ', /, +, _, and -.

4) Under the text box, click the **Save** button to save your note, or click the **Cancel** button to delete your note.

Form Actions Available When Assessment Is Set to Awaiting LTC Medicaid Information Status

When you see a status of Awaiting LTC Medicaid Information, the following form actions are available:

- Print

- Add Note

- Save LTCMI

- Populate LTCMI
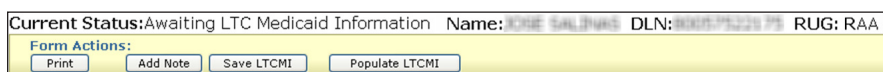
Save LTCMI

The Save LTCMI feature allows providers to save the LTCMI section of the MDS so that any entered LTCMI data is not lost until ready to submit. To save information entered onto an LTCMI, click the **Save LTCMI** button located in the yellow Form Actions bar. When an LTCMI is saved, a message will be displayed at the top of the screen with a date and time indicating that the LTCMI has been saved, and it will automatically unlock the assessment, allowing other users to access it. The assessment is saved and will remain in Awaiting LTC Medicaid Information status until it is successfully submitted. The assessment can then be accessed by using FSI by all users who have the same vendor/provider number access as the person who originally saved the information. The LTCMI will not be saved to Drafts.

The LTCMI has been successfully saved but has not been submitted. 10/5/2010 5:02:31 PM
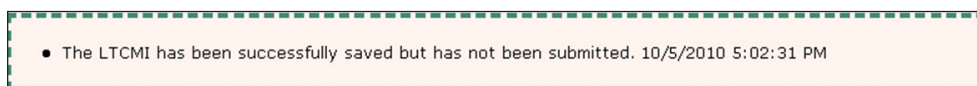
Populate LTCMI

The Populate LTCMI feature allows providers to use a person's previously submitted assessment to populate information on a new LTCMI. However, it will only fill in information from an assessment with the same vendor/provider number, and it will populate information only if the previous LTCMI was submitted within the last six months. If a previous assessment is not available, the following error message will display:

> • No previous LTCMI for this resident and provider number received within the last 6 months can be found to populate the LTCMI.

Two important reminders:

1) If information has been entered onto the LTCMI and saved before you click the **Populate LTCMI** button, the Populate LTCMI button will not be available.

2) All fields in the current LTCMI will be filled in except the S1e (Purpose Code), S1f (Missed Assessment or Prior Start Date), S1g (Missed Assessment or Prior End Date), and S10 (Comments) fields.

To fill in information on a new LTCMI, click the **Populate LTCMI** button located in the yellow Form Actions bar. Be sure to review the autofilled information for accuracy, and add any new information if needed. When the LTCMI is complete and accurate, click the **Save LTCMI** button, or click the **Submit Form** button to submit the assessment to TMHP.

Other Basic Information

Required Fields

On the LTC Online Portal, red dots indicate required fields. Fields without red dots are optional.

Field Description

If you are uncertain as to what a certain field is for, you can hover over the field with your mouse pointer, and a description of the field will display.

History Trail

Every document will have a History trail of statuses. After opening a form or assessment, scroll to the bottom. The History trail will display a list of every processing status that has been held by the document along with any appropriate details. Any notes added by the provider or any comments from TMHP or HHSC will also be located in the History trail.

UnLock Form

Upon opening, the document becomes automatically locked by the viewer and will remain locked for 20 minutes if there is either no activity or until the viewer clicks the **UnLock Form** button. The **UnLock Form** button will unlock the document so that a different user can make changes. If a document is locked, others will not be able to make changes or add information. You may be asked to unlock a document if you are seeking assistance from TMHP or HHSC.

To unlock a document, click the **UnLock Form** button located on the upper-right corner of the screen.

Error Messages

Upon submission, if required information is missing or information is invalid, error messages will display. You will not be able to continue to the next step until the errors are resolved. Error messages that include validation errors and submission errors are displayed at the top of the page.

If the document was not submitted successfully, a submission error message will appear, and the document will not move forward in the workflow. However, some error messages are simply warning messages and allow the document to proceed in the workflow.

The error message you may receive upon submission will be specific to the error that caused it, and it will explain how to correct the error. Unlike field validation error messages, submission errors are not hyperlinked.
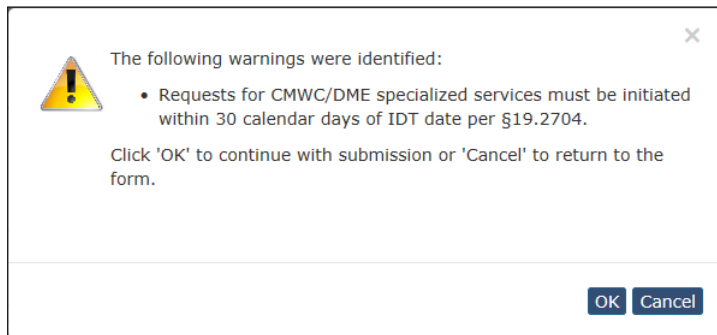
The following errors must be fixed before the form will submit:

- Other Type of Entity is a required field.
- Current Location Name is a required field.
- Current Location Street Address is a required field.

Warning Messages
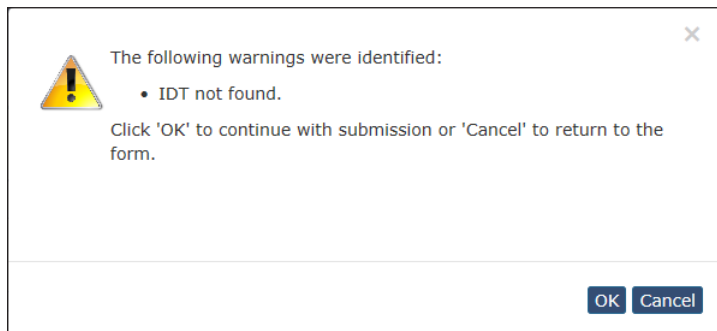
Certain error messages are simply warning messages and allow the document to proceed in the workflow by selecting **OK**. Examples include the following:

"Requests for CMWC/DME specialized services must be initiated within 30 calendar days of IDT date per §19.2704."

The following warnings were identified:

- Requests for CMWC/DME specialized services must be initiated within 30 calendar days of IDT date per §19.2704.

Click 'OK' to continue with submission or 'Cancel' to return to the form.

OK Cancel

"IDT not found."

The following warnings were identified:

- IDT not found.

Click 'OK' to continue with submission or 'Cancel' to return to the form.

OK Cancel

Entering Dates

To enter dates, you may use the Calendar icon to select the date, or enter using the mm/dd/yyyy format in the appropriate date field.

Timeout (Form or Assessment)

The LTC Online Portal will timeout an open document after 20 minutes of no activity. Any information that has been entered will be lost. To prevent this timeout from occurring when completing the **Section LTCMI** tab of an MDS assessment, complete and submit it within 20 minutes, or click on a different tab (e.g., Section A) to reset the timer, and then click the **Section LTCMI** tab to return to and complete the LTCMI.

Timeout (LTC Online Portal)

After 25 minutes of inactivity, a warning prompt will display to warn the user that a timeout may occur. To prevent a timeout from occurring, the user must click the **OK** button within five minutes of when the warning prompt appears. Otherwise, the session will timeout, and the user will be logged out of the LTC Online Portal. If the session does timeout, any information that had been entered (but not saved or submitted) will be lost. The user will need to log back into the LTC Online Portal and begin a new session.

Provider Workflow Process

Provider workflow allows providers to independently manage their documents when errors in the system's processing occur. The system sends the form and assessment information to HHSC, which then updates the Medicaid Eligibility and Service Authorization Verification (MESAV). The functionality of the provider workflow allows providers to manage their rejections that occurred during the nightly processing. The benefit to this process is shorter time for resolution.

In summary, documents are sent to the provider workflow if they are set to Provider Action Required status.

Documents reach this status if:

- The form or assessment has not been successfully processed.

- An error occurred during the nightly batch processing.

Note: Rejection error messages can be found within the form and assessment History trail on some forms and in the PASRR Transaction ID (PTID) History trail on other forms. The provider is responsible for resolving any rejection error messages.

The provider workflow is the responsibility of the provider to monitor and manage. On the Nursing Facility Specialized Services (NFSS) form, the nursing facility will need to monitor the Provider Action Required status of an individual PTID within a DLN (form). System processing errors, including rejection messages, are found within the Form or PTID History trail when the form or PTID is set to Provider Action Required status. After a form or PTID is set to Provider Action Required status, provider action is required before processing on that particular form or PTID continues.

The form types that are being sent to the provider workflow include 3618, 3619, NFSS (PTID), MDS 3.0, and Minimum Data Set Quarterly (MDSQTR) 3.0.

Finding Documents Set to Provider Action Required Status

Using FSI

To find the items in your workflow set to Provider Action Required status (i.e., items with system processing errors to be resolved by the provider):

1) Click the **Search** link on the blue navigational bar.

2) Choose the **Form Status Inquiry** link from the drop-down menu.

3) Choose the form type (e.g., 3618) from the Type of Form drop-down box.

Note: Choosing Form 3618 or 3619, MDS 3.0: Minimum Data Set (Comprehensive), MDSQTR 3.0: Minimum Data Set (Quarterly), or NFSS: Authorization Request for PASRR NF Specialized Services from the Type of Form drop-down could result in Provider Action Required status. Therefore, each of these Type of Form options must be reviewed individually. The examples will include Form 3618 and the NFSS form. Providers will need to review all the other applicable types of forms as well.

4) Enter the From Date and To Date range in the designated fields.

5) Choose **Provider Action Required** from the Form Status drop-down box.

6) Click the **Search** button in the lower-right of the screen to submit the inquiry.

7) Those 3618 forms with status Provider Action Required will appear.

8) Click the **View Detail** link to open the form.

9) Scroll to the bottom of the page to view the History trail.

10) Locate the Provider Action Required status in the lower left of the History trail, and make note of the rejection message below that corresponds to the Provider Action Required status.

11) Perform the necessary research to resolve the error. For more information on provider workflow rejection messages, refer to the [Provider Workflow Rejection Messages](#) section in this user guide.

12) Depending on the results of the research, providers can choose one of three options to move the form or assessment out of the provider workflow. Based on the rejection reason, there are situations in which the appropriate provider action is to contact HHSC Provider Claims Services.

- **Correct this form**: Correct this form allows providers to submit a correction. The original form or assessment with Provider Action Required status will be set to Corrected status and will have a parent DLN to the new or child form. The new form or assessment replaces the original form or assessment. Review the correctable fields covered in the "Correct This Form" section of this user guide to know when to choose Correct this form or Inactivate Form. Remember, correcting an LTCMI to include purpose code E or M will void any prior service dates and cause the MDS to be valid only for the E or M date range requested. If payment has been made, recoupment will occur.

- **Inactivate Form:** The Inactivate Form option will inactivate the form. Forms set to Form Inactivated status cannot be corrected or resubmitted. An example of when the Inactivate Form button should be used is when the research indicates that the form being submitted is a duplicate.

- **Resubmit Form:** The Resubmit Form option will set the form or assessment status to SAS Request Pending. The form or assessment will be processed during the nightly batch processing. Check the status of the form or assessment within two to four days to determine whether the form or assessment was processed successfully. The status will be set to Processed/Complete if the form is successfully processed.

13) If the provider clicks the **Correct this form** button, a parent/child DLN relationship will be created.

14) If the provider clicks the **Inactivate Form** button, the confirmation window as shown in Step 15b will appear.

15) From here, there are two choices:

a) Click the **OK** button to inactivate the form, and the form or assessment status will be set to Form Inactivated status.

b) Click the **Cancel** button to cancel the inactivation request and keep the form or assessment set to Provider Action Required status.

16) If the **Resubmit Form** button is selected, the following screen will appear that allows the provider to add any comments. Entering comments is optional.

From the drop-down menu, select **2-System** or **1-ProviderFacing.**

- **2-System**: Allows the entered comment to be viewable only by internal state staff. The comments will not be seen by the provider.

- **1-ProviderFacing**: Allows the entered comment to be viewable by both state staff and the provider.

  In either case, the comments will be seen in the History trail of the form or assessment and are for informational purposes only. These comments will *not* be used in the system processing of the forms.

a) Click the **Cancel** button to cancel the request and keep the form or assessment set to Provider Action Required status.

b) Click the **Change Status** button to set the form or assessment to SAS Request Pending status.

17) After one of the actions has been completed (Correct this form, Inactivate Form, or Resubmit Form), the status of the form or assessment will no longer be set to Provider Action Required status. Processing will continue based upon the action chosen.

18) The provider should repeat all the steps for each particular type of form until no more results are found. This example used Form 3618.

Using Current Activity

An alternate method for working documents recently set to Provider Action Required status is to use Current Activity.

Current Activity will show all documents that have been set to a different status in the last 14 calendar days. After the form or assessment has been set to Provider Action Required status for over 14 calendar days, it must be located using FSI.

When a form or assessment is being considered for Provider Action Required status, you may want to perform a resident search to see if the resident has any other forms or assessments that are set to Provider Action Required status.

Current Activity can be found on the blue navigational bar in the drop-down menu under the Worklist heading.

MDSQTR 3.0	Received		SSN	Medicaid	Medicare	Name	Status
	4/1/20:	3:21:50 PM		+			Awaiting LTC Medicaid Information
	4/1/20:	3:21:50 PM		+			Awaiting LTC Medicaid Information
	4/1/20:	3:21:50 PM					Awaiting LTC Medicaid Information
	3/24/20	4:09:36 PM					Provider Action Required

Provider Workflow Rejection Messages

Below are the rejection messages that providers will receive as a result of an error occurring during the nightly batch processing. The messages are in order by message number.

The table contains three columns:

1) **Provider Message**. This is the system message that will be displayed in the form's History trail on some forms and the PTID History on other forms.

2) **Form/Assessment**. These are the types of forms or assessments that can receive the rejection message. Some messages apply only to certain types of assessments. When only specific types are affected, they are shown. Otherwise, MDS would indicate all types.

- Admission assessment: A0310A=01

- Annual assessment: A0310A=03

- Significant change in status assessment: A0310A=04

- Significant correction to prior comprehensive assessment: A0310A=05

- Quarterly review assessment: A0310A=02

- Significant correction to prior quarterly assessment: A0310A=06

3) **Suggested Action**. This is the suggested action based on the type of form or assessment in which the message is displayed.

General Instructions for Resolving Error Messages

1) Review the effective date on the form or assessment to ensure that it is correct. For Forms 3618 and 3619, the effective date is the Date of Above Transaction. For MDS Admission assessments, the effective date is A1600. Entry Date. For all other MDS assessments, the effective date is Z0500B. Date RN Assessment Coordinator signed assessment as complete. Effective dates can vary depending on the type of form or assessment.

   - If the effective date is incorrect, take the appropriate action to correct the form or assessment.

   - Form 3618 or 3619: Correct the form on the LTC Online Portal and submit changes.

   - MDS: Correct the assessment by following the guidelines in the [RAI User's Manual](), and submit the modified MDS to the CMS database. Then complete the LTCMI section on the LTC Online Portal.

   - If the effective date is correct, continue to Step 2.

2) If a Form 3619 (admission or discharge) is rejected, and the Date of Above Transaction is prior to the most recent Service Authorization begin date on the recipient's MESAV, contact HHSC LTC Provider Claims Services at 800-438-2200 to request manual processing.

3) If the steps above do not resolve the error message, continue to the [Specific Instructions]() section in this user guide for the specific provider message displayed in the History trail of the form or assessment and its suggested action to correct the error.

Specific Instructions for Resolving Error Messages

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

GN-9101 – GN-9105: This form cannot be processed because the individual's Applied Income is not available to the authorization system. Contact the HHSC Eligibility Worker to update the individual's Applied Income. Once the Applied Income has been updated, this form can be resubmitted.	3618, 3619, MDS, NFSS	The person's applied income is not available to the authorization system.
		• Pull a MESAV for the recipient covering the date requested on the form or assessment.
		  Note: If the recipient does not already have Service Authorizations for your contract, this information will not be available on the MESAV.
		• If the MESAV does not show an Applied Income for the dates of the form or assessment, contact the HHSC Eligibility worker to update the Applied Income records.
		  • When the Applied Income has been updated, resubmit the rejected form or assessment. If the recipient is already established in your facility, you may monitor the MESAV for updated Applied Income.
		• If the MESAV does show an Applied Income for the dates of the form or assessment, resubmit the rejected form or assessment.

GN-9106: This form cannot be processed because HHSC does not have Long Term Care Financial Eligibility for this individual and timeframe. Contact the HHSC Eligibility Worker or SSI office.	3618, 3619, MDS, NFSS	The person's Medicaid eligibility is not available to the authorization system.
		• Pull a MESAV for the person covering the date requested on the form or assessment.
		  Note: If the person does not already have Service Authorizations for your contract, this information will not be available on the MESAV.
		• If the MESAV does not show LTC Financial Eligibility for the dates of the form or assessment, contact the HHSC Eligibility worker or Supplemental Security Income (SSI) office to update the Financial Eligibility records.
		  • When the Financial Eligibility has been updated, resubmit the rejected form or assessment. If the recipient is already established in your facility, you may monitor the MESAV for updated Financial Eligibility.
		• If the MESAV does show Financial Eligibility for the dates of the form or assessment, resubmit the rejected form or assessment.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
GN-9248: This form cannot be processed due to one or more invalid Diagnosis Codes. Correct the Diagnosis Codes and resubmit.	MDS, NFSS	The submitted Primary International Classification of Diseases (ICD) Diagnosis Code is not valid. • Modify the Primary Diagnosis Code in the LTCMI section as needed, and resubmit the rejected assessment. • If the Primary Diagnosis Code on the LTCMI section is valid, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.
GN-9254: This form cannot be processed because the provider is not authorized to provide services on the effective date of the form. Correct the effective date as needed. For 3619 admissions, resubmit once the Medicare contract is effective in the system.	All	The provider's contract is either not in effect as of the effective date of the form or assessment or the provider is not authorized to bill for the type of services covered by the form or assessment. • Review the facility contract to determine whether the contract is in effect and authorizes the type of services covered by the form or assessment. • If the effective date of the form or assessment is wrong, modify the form or assessment, and resubmit the rejected form or assessment. • If the contract is not yet in effect, resubmit the rejected form or assessment after the service code is effective in the system. For 3619 admissions, resubmit the rejected form after the Medicare contract is effective in the system.

NF-0001: This form cannot be processed because the individual's Applied Income is not available to the authorization system. Contact the HHSC Eligibility Worker to update the individual's Applied Income. Once the Applied Income has been updated, this form can be resubmitted.	MDS, 3619 (Admit)	The recipient's Applied Income is not available to the authorization system.
		• Pull a MESAV for the recipient covering the date requested on the form or assessment.
		  Note: If the recipient does not already have Service Authorizations for your contract, this information will not be available on the MESAV.
		• If the MESAV does not show an Applied Income for the dates of the form or assessment, contact the HHSC Eligibility worker to update the Applied Income records.
		  • When the Applied Income has been updated, resubmit the rejected form or assessment. If the recipient is already established in your facility, you may monitor the MESAV for updated Applied Income.
		• If the MESAV does show an Applied Income for the dates of the form or assessment, resubmit the rejected form or assessment.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0002: This assessment cannot be processed because there is no gap in the Level records for this individual, for the Purpose code timeframe on the assessment.	MDS (Admit, Annual, Quarterly)	There is no gap in Level records for the resident during the purpose code timeframe. • Pull a MESAV for the purpose code timeframe requested on this assessment, and determine whether the dates are reflected in the Level section of the resident's MESAV. Validate whether a gap in coverage exists. • If there is a Level record with valid continuous coverage on file, a purpose code is not needed. Inactivate the assessment on the CMS database. • If the expected gap is not reflected on the Level record, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance. • If the purpose code dates are wrong, modify the purpose code dates on the LTCMI and resubmit the rejected assessment.
NF-0003: This assessment cannot be processed because the individual does not have 3 month prior Medicaid or SSI eligibility. Contact the HHSC Eligibility Worker or SSI office.	MDS (Admit, Annual, Quarterly)	There is no "3-month prior nursing facility" or "prior month SSI" eligibility for the resident during the purpose code timeframe. One of these two specific types of eligibility is required to process an assessment with purpose code M. • Pull a MESAV for the purpose code timeframe requested on this assessment, and determine whether a Level record is needed for the dates requested on the LTCMI. If a Level record is needed, continue with the steps below. If not, inactivate the MDS. • Determine if the MESAV reflects either Prior Coverage (P) or Type Program 11 in the Medicaid section of the MESAV for the dates requested on the LTCMI. • If the Prior Coverage (P) or Type Program 11 verified through the resident's MESAV matches the dates requested on the LTCMI, resubmit the rejected assessment. • If the Prior Coverage (P) or Type Program 11 dates on the recipient's MESAV differ from the dates requested on the LTCMI, modify the dates on the LTCMI and resubmit the rejected assessment. • If the resident's MESAV does not reflect Prior Coverage (P) or Type Program 11 eligibility for the period requested, contact the HHSC Eligibility worker or SSI office. If the resident is ineligible, change the purpose code to E, if a Level record is needed.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0004: This assessment cannot be processed because the individual does not have a corresponding Nursing Facility admission (missing 3618/3619). Verify that the admission 3618/3619 has been processed.	MDS	There is no 3618/3619 admission for the resident that covers one or more days of the assessment period. (If the resident is a person in hospice, a hospice provider number should be entered on the LTCMI.) • Review the facility's records to determine whether the resident is considered Medicare or Medicaid and what the admission date to your facility is. • Review the LTC Online Portal to determine the status of the admission (3618/3619). • If the 3618/3619 is not processed, determine why the form was rejected. Correct the current 3618/3619 admission, or inactivate the rejected form and submit a new 3618/3619 admission. • If the 3618/3619 is processed, compare the processed date to the rejection date of the MDS. If the admission was processed after the MDS was rejected, resubmit the rejected MDS. • If a 3618/3619 admission has not been submitted because the resident is in hospice, review the LTCMI to verify that a hospice provider number has been entered. If not, modify the LTCMI on the LTC Online Portal to include the hospice provider number. • If the processed date on the admission is prior to the MDS rejection, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.
NF-0008: This assessment cannot be processed because an assessment with the same effective date but different Reason for Assessment has already been processed. Continue to submit assessments based on the individual's MDS assessment schedule.	MDS (Quarterly)	An assessment with the same effective date and a different assessment reason is already on file. A Quarterly assessment cannot replace it. • Verify that the MDS Assessment Complete Date on the rejected assessment is correct. If it is not, submit a modification to the CMS database to correct it. • If the MDS Assessment Complete Date is correct, determine which Reason for Assessment is appropriate and inactivate the other MDS. • If the processed assessment is inactivated, the rejected assessment can be resubmitted after the inactivation is processed. If the rejected assessment is inactivated, no further action is needed.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0010: This assessment cannot be processed because an assessment with the same effective date has already been processed and is not a Quarterly Review Assessment. Continue to submit assessments based on the individual's MDS assessment schedule.	MDS (Significant Correction to a Prior Quarterly)	An assessment other than a Quarterly with the same effective date is already on file. A significant correction to a prior Quarterly cannot replace it. • Verify whether the MDS Assessment Complete Date on the rejected assessment is correct. If not, submit a modification to the CMS database to correct it. • If the MDS Assessment Complete Date is correct, determine which reason for assessment is appropriate and inactivate the other MDS. If the processed assessment is inactivated, the rejected assessment can be resubmitted after the inactivation is processed. If the rejected assessment is inactivated, no further actions are needed.
NF-0011: This admission cannot be processed because you have reached the limit of Swing Bed days for this individual for a 12 month period. Submit an admission if the individual becomes eligible to receive additional Swing Bed services.	3618 (Admit)	The provider has reached the limit of swing bed days allowed for the recipient during a 12-month period. • Medicaid swing bed services are limited to 30 days per stay. Verify the dates, and if the submitted date is wrong, correct the rejected admission and resubmit.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0012: This form cannot be processed because the individual is currently in Hospice. If the individual is no longer enrolled in the Hospice program, contact the Hospice provider and request that they discharge the individual from the program. Once the Hospice discharge is processed, resubmit your form. If the individual is a Hospice recipient, inactivate your form.	3618, 3619	The recipient has a Service Authorization for hospice as of the effective date of the submitted form.
		• Review the facility's records to determine whether the recipient is in hospice.
		• If the recipient is in hospice, inactivate the nursing facility form.
		  Note: 3618/3619s should not be submitted on Hospice recipients.
		• If the recipient has requested to terminate the hospice program, contact the hospice provider and request that the provider submit a discharge Form 3071.
		  • If the Form 3071 has already been submitted, allow 10 days for processing before resubmitting the rejected admission.
		  Note: If the form is rejected again, the hospice provider needs to follow up with HHSC LTC Provider Claims Services.
		  • If the Form 3071 has not yet been submitted, allow the time requested by the hospice provider for processing of the hospice discharge before resubmitting the rejected admission.

NF-0013: This admission cannot be processed because it is effective during a Service Authorization for a different provider. Correct the admission date or contact the other provider to determine proper dates.	3618 (Admit)	The recipient has a Service Authorization for a different facility (a processed admission and discharge for a different provider cover the submitted admission date). • Contact the prior facility to request that a correction be submitted for their discharge. If the other facility's discharge is incorrect, allow seven days for processing time and resubmit the rejected admission. • If the recipient was in the other provider's facility before and after being in your facility, the other facility must submit a retroactive discharge and admission, creating a gap during which the recipient was in your facility. An admission and discharge pair will also need to process for your facility to fill the gap. Two pairs will need to be processed. Coordinate with the other facility.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0014: This admission cannot be processed because an earlier admission into your facility has already been processed. Verify the discharges and admissions for this individual and submit the missing discharge. Resubmit this admission once the previous discharge is submitted.	3618 (Admit)	The recipient has a Service Authorization for the same facility (a processed admission for the same provider covers the submitted admission date). • Review the recipient's records to find the discharge date between the begin date of the current Service Authorization and the date on this admission form. • Pull a MESAV to verify the begin date of the most recent Service Authorization. • Determine through the LTC Online Portal whether that discharge form has been submitted or not. Correct the discharge if it was rejected, or submit a discharge if it was missing. • Resubmit the rejected admission.

NF-0017: This admission cannot be processed because a later admission has already been processed. This admission occurs in the past and must be one of a pair, which will create a separate Service Authorization. If the discharge following this admission is missing or rejected, both forms must be submitted on the same day.	3618/3619 (Admit)	A later admission is already in the recipient's file. This admission will have to be submitted with a matching discharge to process as a retroactive pair.
		• Review the facility's records to determine which discharge follows this admission.
		• Pull a MESAV, and review the Service Authorizations to see if a gap exists for the period that will be created by the admission and discharge pair.
		• If a gap exists, resubmit the rejected admission and submit the following discharge. Both forms must be submitted on the same day. The system will process the two forms as a pair.
		• If a gap does not exist, review the facility's records to determine whether a discharge prior to the rejected admission is reflected on the recipient's MESAV.
		  • If the discharge is not reflected on the recipient's MESAV, submit the missing or rejected discharge, followed by the admission and discharge pair.
		  • If the discharge is reflected on the recipient's MESAV, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0018: This discharge cannot be processed because the individual is currently admitted to Medicare Part A Coinsurance and does not have a corresponding Nursing Facility admission (missing 3618). Verify that the admission 3618 has been processed.	3618 (Discharge)	The recipient has a Service Authorization for Medicare Part A Coinsurance as of the submitted discharge date. • Review the facility's records to determine which admission is prior to this discharge. • Pull a MESAV, and review the Service Authorizations to determine if coinsurance is authorized for your facility. If so, submit a 3619 discharge to close the coinsurance. • Review the status of the prior 3618 admission in the LTC Online Portal. If it is rejected, verify whether the issue still exists and take the necessary actions to process the admission. • After the admission has been processed, resubmit the rejected discharge. • If the rejected discharge is reflected on the recipient's MESAV, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.
NF-0019: This discharge cannot be processed because the individual is not admitted into your facility. If an admission prior to this discharge is rejected, the rejected admission must be processed first. This discharge can then be resubmitted.	3618 (Discharge)	This admission and discharge pair is either retroactive to the current authorizations, or the recipient is currently authorized at a prior facility. • Review the facility records to identify the admission prior to the date of this discharge. • If the pair is retroactive, the admission and discharge must be submitted at the same time. A gap in the Service Authorizations must exist for this time period to fill. If the recipient has been in your facility previously, you may be able to confirm this gap by pulling a MESAV and verifying dates. • If the prior admission form was rejected, correct that form and resubmit. The admission must be processed before the discharge can be processed. • If the prior admission form is missing, submit that missing form, and then resubmit the rejected discharge.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0020: This discharge cannot be processed because a later discharge has already been processed. This discharge appears to be one of a retroactive pair. If an admission after this discharge is missing or rejected, resubmit the admission and this discharge on the same day.	3618 (Discharge)	This discharge is part of a retroactive pair. • Review the facility records to identify the admission prior to the date of this discharge. • Pull a MESAV, and review the Service Authorizations. The discharge and admission should split one of the authorizations when these forms process. • The discharge and admission pair must be submitted at the same time. • If the form is not part of a pair, it should be a correcting discharge, not a new discharge. Inactivate the rejected discharge, and correct the transaction date of the later discharge.
NF-0021: This discharge cannot be processed because a later admission to another provider has already been processed. This discharge appears to be one of a retroactive pair. If an admission prior to this discharge is missing or rejected, resubmit the admission and this discharge on the same day.	3618 (Discharge)	This discharge is part of a retroactive pair. • Review the facility records to identify the admission prior to the date of this discharge. • Pull a MESAV, and review the Service Authorizations. There should be no other authorization during the admission and discharge timeframe when these forms are processed. • The admission and discharge pair must be submitted at the same time. • If the form is not part of a pair, it should be a correcting discharge, not a new discharge. Inactivate the rejected discharge, and correct the transaction date of the earlier discharge.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0022: This discharge cannot be processed because the individual does not have a corresponding Nursing Facility admission (missing 3618). Verify that the admission 3618 has been processed.	3618 (Discharge)	The corresponding nursing facility admission is not in the recipient's file.
		• Review the facility's records to determine the admission prior to the date of this discharge.
		• Pull a MESAV, and review the Service Authorizations to determine whether the prior admission has been processed and authorized services. If the MDS for the admission has not been processed, services will not be authorized.
		• If the MESAV reflects that the recipient is currently in the facility per an admission prior to the admission that corresponds with this discharge, research the recipient's records to identify the discharge between those two admissions.
		  • Submit that missing or rejected discharge, followed by the admission that corresponds with this rejected discharge.
		  • Resubmit this rejected discharge.
		• If this rejected discharge is reflected on the recipient's MESAV, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

NF-0023: This admission cannot be processed because it is effective during a Service Authorization for a different provider. Correct the admission date or contact the other provider to determine proper dates.	3619 (Admit)	The recipient has a Service Authorization for a different facility (a processed admission and discharge for a different provider cover the submitted admission date). • Contact the prior facility to request that a correcting discharge be submitted for their discharge. If the other facility's discharge is incorrect, allow seven days for processing time, and resubmit the rejected admission. • If the recipient was in the other provider's facility before and after being in your facility, the other facility must submit a retroactive discharge and admission to create a gap during which the recipient was in your facility. An admission and discharge pair will also need to be processed for your facility to fill the gap. Two pairs will need to be processed. Coordinate with the other facility.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0024: This admission cannot be processed alone because a later admission has already been processed. This admission is part of a retroactive pair. Identify the discharge following this admission and submit as a pair.	3619 (Admit)	The recipient has an existing Service Authorization for your facility (a processed admission and discharge for your facility cover the submitted admission date). This admission is missing one of a pair.
		• Review the facility's records to determine which discharge is prior to this admission.
		• Pull a MESAV, and review the Service Authorizations to determine the authorized services.
		• If the recipient has a closed Service Authorization for Code 3 with an end date after the rejected 3619 admission, the rejected 3619 is part of a retroactive pair. Determine the discharge prior to the date of this admission and submit that discharge and the rejected admission as a pair to create a gap in the Service Authorization on file.
		• If the recipient has a closed Service Authorization for Code 1 with an end date after the rejected 3619 admission, determine whether the end date is correct.
		  • If the end date is wrong, submit a correcting 3618 discharge to change the end date to be prior to the rejected 3619 admission. After the Service Authorization ends prior to the 3619 Admission, resubmit the rejected 3619 admission.
		  • If the end date is correct, a 3618 retroactive pair needs to be processed to create a gap for the rejected 3619 admission and corresponding discharge.
		  • Identify the 3618 discharge prior to the rejected 3619 admission and the 3618 admission prior to the current end date and submit them as a retroactive pair.
		  • After the gap has been created within the Code 1, resubmit the rejected 3619 admission with the corresponding 3619 discharge.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0026: This admission cannot be processed because the individual is admitted to Full Medicaid as of the submitted admission date. Verify the Medicaid dates and submit the needed 3618s. Resubmit the rejected Medicare Coinsurance admission once the individual is discharged from Medicaid.	3619 (Admit)	The recipient has an existing Service Authorization for full Medicaid.
		• Review the facility's records to determine which discharge is prior to this admission.
		• Pull a MESAV, and review the Service Authorizations to determine the authorized services. If the MDS for the recipient has not been processed, services will not be authorized.
		• If the recipient has an ongoing Service Authorization with a begin date prior to the rejected admission and the current Service Authorization is for full Medicaid (Code 1), a 3618 discharge must be processed prior to resubmission of the rejected 3619 admission.
		• If the recipient has a closed Service Authorization for Code 1 with an end date after the rejected 3619 admission, complete the following:
		  • Verify that the 3618 discharge was submitted for the correct date. If not, correct the discharge. If the discharge is now prior to the rejected 3619 admission, it can be resubmitted.
		  • If the 3618 discharge is correct, several 3618/3619s need to be processed between the begin and end dates of the Service Authorization. Verify all dates, and submit the needed forms.
		• If the recipient does not have Service Authorizations on the MESAV, use the statuses on the LTC Online Portal to determine the forms that have been processed. Remember, authorizations will be displayed only if the MDS has also been processed.
		  • If the most recent processed form is a 3618 admission prior to the rejected 3619 admission, a 3618 discharge must be processed prior to resubmission of the rejected 3619 admission.
		  • If the most recent processed form is a 3618 discharge after the rejected 3619 admission, verify that the 3618 discharge was submitted for the correct date. If the date is wrong, correct the 3618 discharge, and resubmit. If the 3618 discharge is now prior to the rejected 3619 admission, resubmit the rejected 3619 admission.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0028: This admission cannot be processed because the Qualifying Stay days, plus any Full Medicare days already documented, add up to more than the 20 days allowed for this Spell of Illness.	3619 (Admit, Admit Mod)	For each Medicare spell of illness, only 20 days of full Medicare coverage are allowed between one or more providers. The recipient will exceed the 20-day limit if the form is processed as submitted. • Review the recipient's Medicare remittance to determine the full Medicare qualifying stay dates for this spell of illness. • Check the Dates of Qualifying Stay on the form. The number of days on the form, plus any full Medicare days already documented for that spell of illness, cannot exceed 20 days. • If the dates of qualifying stay on the form are wrong, correct the admission, and resubmit. • To determine whether the qualifying stay dates from the Medicare remittance advice are on file, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance. • If a different 3619 admission was submitted with incorrect dates of qualifying stay, submit a correction for that form before resubmitting this rejected admission. • If this form cannot be corrected, inactivate the form. **Note:** If this is not traditional Medicare, document this in the comment section, and call 512-438-2200, option 3, or fax the Medicare Replacement's Explanation of Benefits (EOB) with a copy of the 3619 to 512-438-3400, Attention: Medicare Advantage Plan.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0029: The days of Qualifying Stay have been recorded. However, the admission for Medicare Part A Coinsurance cannot be processed because the Qualifying Stay days, plus any Full Medicare days already documented, are less than the 20 days required for this Spell of Illness.	3619 (Admit, Admit Mod)	For each Medicare spell of illness, 20 days of full Medicare coverage are required between one or more providers. The recipient has not yet met the 20-day requirement, so a Medicare Part A Coinsurance Service Authorization was not created. • Review the recipient's Medicare remittance to determine the full Medicare qualifying stay dates for this spell of illness. • Check the dates of qualifying stay on the form. The dates entered must add up to the 20-day requirement, or an additional form must document the remainder of the 20 days of qualifying stay (some full Medicare dates may have already been recorded from previous 3619 admissions). • If the Dates of Qualifying Stay on the form are wrong, correct the admission and resubmit. • If the Dates of Qualifying Stay on the form are correct, submit another form to document the remaining days of qualifying stay when that information becomes available. • To determine if the qualifying stay dates from the Medicare remittance advice are on file, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance. • If a different 3619 admission was submitted with incorrect Dates of Qualifying Stay, submit a correction for that form prior to resubmitting this rejected admission. • If this form cannot be corrected, inactivate the form. **Note:** If this is not traditional Medicare, document this in the comment section, and call 512-438-2200, option 3, or fax the Medicare Replacement's EOB with a copy of the 3619 to 512-438-3400, Attention: Medicare Advantage Plan.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0030: This admission cannot be processed because it has not been more than 60 consecutive days since the individual was discharged from Medicare (cannot begin a new Spell of Illness). Review Medicare remittance to determine when Medicare Part A Coinsurance is due. Submit a new 3619 based on the individual's Medicare remittance.	3619 (Admit)	For each Medicare spell of illness, the state will pay a maximum of 80 days of Medicare Part A coinsurance to one or more providers. The recipient will exceed the 80-day limit if the admission is processed as submitted. • Review the recipient's Medicare remittance to determine the Medicare dates for the spell of illness for this admission. • Pull a MESAV, and review the Service Authorizations to determine which authorizations are covered by the spell of illness for this admission. • Validate the dates of the spell of illness to see if this admission is part of the prior stay, or if it begins a new spell of illness (more than 60 days between Code 3 Service Authorizations). Submit corrections of any earlier 3619s as needed, and resubmit this rejected admission accordingly. • If the prior spell of illness was not ended properly, submit a 3619 discharge or 3619 correction to adjust the Code 3 to reflect the proper end date of that spell of illness. • After the 60 days between spells of illness has been resolved, resubmit the rejected admission.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0032: This discharge cannot be processed because the individual does not have a Service Authorization for Medicare Part A Coinsurance for your facility. Either the 3619 admission for your facility has not processed, or the discharge date exceeds the individual's maximum of 80 days of traditional Coinsurance (for all providers) for this Spell of Illness.	3619 (Discharge)	The recipient's corresponding Medicare Part A Coinsurance admission has not processed.
		• Review the facility records to identify the Coinsurance admission date prior to this discharge and the spell of illness for this discharge.
		• Pull a MESAV, and review the Service Authorizations to determine whether the 3619 admission has been processed and whether the spell of illness has been authorized.
		• If Coinsurance is not authorized, use the LTC Online Portal to determine the status of the 3619 admission.
		  • If the 3619 admission was rejected, correct the 3619 admission and resubmit.
		  • If the 3619 admission was never entered, submit the missing 3619 admission.
		• If Coinsurance is authorized, compare the end date of the Service Authorization to the transaction date of the rejected discharge.
		  • If the transaction date of the rejected discharge is later than the Service Authorization end date by more than one day, the discharge exceeds the 80-day limit of Coinsurance. An earlier discharge and readmission may be needed prior to the rejected discharge to allow for additional days before reaching the 80-day limit. If so, submit the missing or rejected forms.
		  • If the transaction date of the rejected discharge is earlier than the Service Authorization end date, processing may have been attempted with the forms out of order. If the admission was processed after the 3619 was rejected, resubmit the rejected discharge.
		• After the missing or rejected forms are processed, resubmit the rejected discharge.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0033: This discharge cannot be processed because a later discharge has already been processed. If an admission after this discharge is missing, resubmit with the submission of the matching admission.	3619 (Discharge)	This discharge is part of a retroactive pair. • Review the facility's records to determine which admission is after this discharge. • Pull a MESAV, and review the Service Authorizations. The discharge and admission should split one of the authorizations when these forms are processed. • When identified, the discharge and admission must be submitted on the same day as a pair. • If the form is not part of a pair, it should be a correcting discharge, not a new discharge. Inactivate this form and correct the transaction date of the later discharge.
NF-0044: This form cannot be processed because the other half of the pair of forms failed to process. Validate and submit both forms.	3618/3619 (Pair)	This form is part of a retroactive pair. The other half of the pair failed to process, so this form could not be processed alone. Determine how to resolve the problem that caused the other half of this pair to be rejected. • Review the facility's records to determine which transaction is the other half of the pair. • If the discharge date is before the admission date, the pair is creating a gap in a Service Authorization. Pull a MESAV, and review the Service Authorizations. The discharge and admission should split one of the authorizations when these forms process. • If the admission date is before the discharge date, the pair is filling a gap between or prior to Service Authorizations. Pull a MESAV, and review the Service Authorizations to see if a gap exists for the period that will be created by the admission and discharge pair. • When resolved, resubmit the pair together on the same date.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0046: This admission modification cannot be processed because the new admission date of this modification is later than the existing enrollment end date. Modify the admission date and resubmit this form, or inactivate this form and modify the corresponding discharge form to make it a counteracting form, cancelling the admission timeframe.	3618 (Admit Mod)	This admission modification is later than the end date of the Service Authorization it is trying to change. • Review the facility's records to determine the recipient's admission and discharge dates. • Pull a MESAV, and review the Service Authorizations on file. • If the correction was not done on the right admission, adjust the admission date on this correction back to the original admission date and resubmit. Then correct the admission date on the appropriate admission form and submit. • If the end date of the Service Authorization being modified is not correct, submit a discharge correction to adjust the end date and resubmit the rejected admission correction the next day. • If the Service Authorization being changed should be cancelled, inactivate this correction, and submit a correction to the corresponding discharge, making it a counteracting form to the admission form.
NF-0047: This assessment modification cannot be processed because it is an invalid change to an existing Purpose code.	MDS Mod (Admit, Annual, Quarterly)	This is a modification of a processed MDS assessment that had a Purpose code on the LTCMI. After an MDS has been processed as either a PC E or M, the form must continue to have a Purpose code on the LTCMI. A modification can change a PC M to a PC E, but a PC E cannot be changed to a PC M, and a PC E or M cannot be changed to have no Purpose code. • Review the LTCMI on the prior submission (parent form), noting the Purpose code and the dates requested. • Modify the rejected assessment, entering the appropriate Purpose code and proper dates, and then resubmit it.
NF-0048: This assessment cannot be processed because more than one assessment was submitted on the same day with the same assessment effective date.	MDS	Two assessments were submitted for processing on the same day using the same assessment effective date. • Validate the effective dates on the MDSs submitted. • If the assessment effective date is incorrect on one MDS, submit a modification to the CMS database for that assessment, and resubmit the other rejected assessment. • If one of the assessments was submitted in error, inactivate the assessment that is not needed, and resubmit the other rejected assessment.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0049: This assessment cannot be processed because an admission assessment is not appropriate, or the Date of Entry does not correspond with the correct admission. If an admission assessment is not appropriate, inactivate this assessment and submit the appropriate MDS assessment type. If the admission assessment is appropriate, modify the Date of Entry.	MDS (Admit)	An assessment that covers the Date of Entry is already on file for this resident and provider. • If the prior 3618 discharge was Return Not Anticipated, validate that Return Not Anticipated was correctly marked on the discharge form. If it was not, correct the discharge and submit. After the correction to Return Not Anticipated is processed, ending the levels per that discharge, the rejected MDS can be resubmitted. If the discharge was Return Not Anticipated and the form was marked correctly, verify that the MDS Entry Date corresponds to the admission following that discharge. If the MDS Entry Date corresponds to an earlier admission, submit a modification to the CMS database to correct the Entry Date. • If this MDS was submitted only because a current resident was admitted from the hospital as Medicare and a dual-coded MDS was being submitted, there are three options. 　• Inactivate the MDS at the CMS database and resubmit it as a dual-coded form using an appropriate Medicaid Reason for Assessment (typically a Quarterly, Annual, or Significant Change in Status Assessment [SCSA]). This will allow Medicaid to use the MDS for payment. 　• Inactivate the MDS at the CMS database and resubmit it as Medicare only (no Medicaid Reason for Assessment). The resubmitted form will not appear on the LTC Online Portal. 　• Contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, and request that the MDS be moved to Invalid/Complete status because an admission assessment was not appropriate. • If neither situation above applies, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0050: This form cannot be processed as a retroactive pair because the effective date on the discharge of pair is later then the Qualifying Stay begin date on the admission of pair. The discharge prior to the Qualifying Stay begin date and a subsequent admission are needed along with this pair to process automatically.	3619 (Pair)	This 3619 has been identified as part of a retroactive pair submitted for processing together. The Qualifying Stay dates fall between the admission and discharge dates submitted, which is not allowed. Full Medicare (Qualifying Stay) days cannot split a single admission and discharge pair. Two pairs of retroactive 3619s must be submitted instead. • Verify the Medicare Part A Coinsurance dates through the Medicare remittance advice. • Resubmit the rejected 3619 admission for the first day of Coinsurance, paired with a discharge matching the first day of full Medicare, which will end the Coinsurance Service Authorization the day before the Qualifying Stay (included on the admission of the pair). • Then resubmit the rejected 3619 discharge from Coinsurance, paired with an admission beginning after the full Medicare (Qualifying Stay) ends.
NF-0051: This form cannot be processed as a retroactive pair because the discharge of pair is marked as a death and a subsequent admission has already been processed. Verify that the individual was discharged and correct the form as needed. If the individual is deceased, contact Provider Claims Services for assistance.	3618/3619 (Pair)	This form has been identified as part of a retroactive pair submitted for processing together. However, a discharge marked Deceased cannot be processed as part of a retroactive pair, because a subsequent admission is on file. • Review the facility's records to determine the recipient's admission and discharge dates. • Pull a MESAV, and review the Service Authorizations for this recipient. Compare those dates to the dates that the recipient was in your facility. • If the discharge of the pair was submitted as a Death in error, inactivate the form, and then resubmit it as a Discharge. • If the form was correctly used to report the recipient's death, validate the transaction date and correct the form as needed. • If the transaction type (Death) and transaction date are correct, identify the admission form that was submitted with an effective date after the death and correct the transaction date on that admission. It may be necessary to contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0052: This admission modification cannot be processed because the new admission date would create an overlap with an existing Service Authorization. Verify the Service Authorizations already established and submit any additional modifications.	3618/3619 (Admit Mod)	The earlier admission date on this correction will create an overlap with an existing Service Authorization if this correction is processed. • Review the facility's records to determine the recipient's admission and discharge dates and identify the Spell of Illness. • Pull a MESAV, and compare the Service Authorizations to the earlier admission date that would be created by the rejected admission. Consider the Qualifying Stays reported on any processed 3619s. These dates create full Medicare periods, which do not appear on the MESAV. • If the end date of an existing Service Authorization needs to be changed, submit a correction to that discharge. • If the submitted admission date would overlap with a reported Qualifying Stay period, submit a correction to adjust the Qualifying Stay dates. • To determine if the Qualifying Stay dates from the Medicare remittance advice correspond with those on file, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance. • If the recipient was previously receiving hospice services, verify the dates of service with the hospice provider and make corrections as needed. • This rejected admission should be resubmitted after the file has been adjusted.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0055: This admission modification cannot be processed because the new admission date would result in more than 80 days of Medicare Part A Coinsurance for this Spell of Illness. Confirm the 80 days of Coinsurance and submit any additional modifications.	3619 (Admit Mod)	For each Medicare spell of illness, the state will pay a maximum of 80 days of Medicare Part A Coinsurance to one or more providers. The recipient will exceed the 80-day limit if this correction is processed as submitted. • Review the facility's records to determine the recipient's admission and discharge dates and identify the spell of illness. • Pull a MESAV, and review the Service Authorizations to determine the number of Coinsurance days on file, plus the number of new days that would be added by the rejected earlier admission date. Verify the begin and end dates of the Service Authorizations on file based on the actual admissions and discharges that have occurred. Remember that the discharge date results in a Service Authorization end date one day earlier than the transaction date. • Submit any corrections needed because of incorrect begin or end dates. If these corrections will reduce the total number of Coinsurance days to 80 days or less, the rejected admission may be resubmitted after the new correction forms have been processed. • If the begin and end dates on file are correct and the recipient has a Medicare replacement policy that allows more than 80 days of Coinsurance, state this in the Comments section of the 3619, and call 512-438-2200, option 3, or fax the Medicare Replacement EOBs with a copy of the 3619 to 512-438-3400, Attention: Medicare Advantage Plan. • If the spell of illness involved another facility and your facility's begin and end dates are right except for the correction, review your Medicare remittance. If the Medicare remittance advice validates that Coinsurance is due for the period that your 3619s indicate, fax them with a copy of the 3619s to 512-438-3400, Attention: ECF Form Processing, or call 512-438-2200, option 3. • If all the begin and end dates on the MESAV are correct (except for the admission the rejected form is attempting to correct), the last discharge date will need to be adjusted so the total of the new days added, plus the adjusted existing dates, equal 80 or less days. The rejected admission should then be resubmitted.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0056: This modification cannot be processed because the corresponding adjustment based on the 80-day limit would cancel a later admission that has already been processed. Verify the Service Authorizations already established and submit any additional modifications.	3619 (Mod)	For each Medicare spell of illness, the state will pay a maximum of 80 days of Medicare Part A Coinsurance to one or more providers. The recipient will exceed the 80-day limit if this correction is processed as submitted. To reduce the total to 80 days, the system would have to cancel a processed admission. • Review the facility's records to determine the recipient's admission and discharge dates and identify the Spell of Illness. • Pull a MESAV, and review the Service Authorizations to determine the number of Coinsurance days on file, plus the number of new days that would be added by the rejected form. Verify the begin and end dates of the Service Authorizations on file based on the actual admissions and discharges that have occurred. Remember that the discharge date results in a Service Authorization end date one day earlier than the transaction date. • Submit any corrections needed because of incorrect begin or end dates. If these corrections will reduce the total number of Coinsurance days to 80 days or less, the rejected form should be resubmitted after the new correction forms have processed. • If the begin and end dates on file are correct and the recipient has a Medicare replacement policy that allows more than 80 days, state this in the Comments section of the 3619, and call 512-438-2200, option 3, or fax the Medicare Replacement EOBs with a copy of the 3619 to 512-438-3400, Attention: Medicare Advantage Plan. • If the spell of illness involved another facility and your facility's begin and end dates are right except for the correction, review your Medicare remittance. If the Medicare remittance advice validates that Coinsurance is due for the period that your 3619s indicate, fax them with copies of the 3619s to 512-438-3400, Attention: ECF Form Processing, or call 512-438-3400, option 3. • If all the begin and end dates on the MESAV are correct, the rejected form will need to be corrected so the total of the new days added, plus the existing dates, equal 80 or fewer days.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0057: This discharge modification cannot be processed because the new discharge date would cancel the Medicare Part A Coinsurance record being modified. If the new discharge date is incorrect, modify and resubmit.	3619 (Discharge Mod)	The effective date of the discharge correction is prior to the Service Authorization it is attempting to close.
		• Review the facility's records to determine the recipient's admission and discharge dates and identify the Spell of Illness.
		• Pull a MESAV, and review the Service Authorizations to determine which Service Authorization ended based on the original discharge date. The system has determined that the new discharge date is prior to that begin date.
		• Verify the begin and end dates of the Service Authorizations on file based on the actual admissions and discharges that have occurred. Also, compare the time periods for Medicare Part A Coinsurance to your Medicare remittance indicating what days should be Coinsurance. Remember that the discharge date results in a Service Authorization end date one day earlier than the transaction date.
		• Verify whether the new discharge date is actually part of a retroactive pair rather than a correction. If so:
		  • Correct the discharge date back to the original date.
		  • Identify the admission that would complete the retroactive pair.
		  • Submit the rejected discharge and new admission on the same day.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0058: This discharge modification cannot be processed because the new discharge date would result in more than 80 days of Medicare Part A Coinsurance for this Spell of Illness. Confirm the 80 days of Coinsurance and submit any additional modifications.	3619 (Discharge Mod)	For each Medicare spell of illness, the state will pay a maximum of 80 days of Medicare Part A Coinsurance to one or more providers. The recipient will exceed the 80-day limit if this correction is processed as submitted. • Review the facility's records to determine the recipient's admission and discharge dates and identify the Spell of Illness. • Pull a MESAV, and review the Service Authorizations to determine the number of Coinsurance days on file plus the number of new days that would be added by the rejected later discharge date. Verify the begin and end dates of the Service Authorizations on file based on the actual admissions and discharges that have occurred. Remember that the discharge date results in a Service Authorization end date one day earlier than the transaction date. • Submit any corrections needed because of incorrect begin or end dates. If these corrections will reduce the total number of Coinsurance days to 80 days or less, the rejected discharge may be resubmitted once the new correction forms have processed. • If the begin and end dates on file are correct and the recipient has a Medicare replacement policy that allows more than 80 days, state this in the Comments section of the 3619, and call 512-438-2200, option 3, or fax the Medicare Replacement EOBs with a copy of the 3619 to 512-438-3400, Attention: Medicare Advantage Plan. • If the spell of illness involved another facility and your facility's begin and end dates are right except for the correction, review your Medicare remittance. If the Medicare remittance advice validates that Coinsurance is due for the period that your 3619s indicate, fax them with a copy of the 3619s to 512-438-3400, Attention: ECF Form Processing, or call 512-438-3400, option 3. • If all the begin and end dates on the MESAV are correct (except for the discharge the rejected form is attempting to correct), the last discharge date will need to be adjusted so the total of the new days added, plus the adjusted existing dates, equal 80 or fewer days. The rejected discharge may then be resubmitted.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0059: This discharge modification cannot be processed because the new discharge would create an overlap with an existing Service Authorization. Verify the Service Authorizations already established and submit any additional modifications.	3618/3619 (Discharge Mod)	The later discharge date on this correction will create an overlap with existing Service Authorizations if this correction is processed as submitted. • Review the facility's records to determine the person's admission and discharge dates and identify the Spell of Illness. • Pull a MESAV, and compare the Service Authorizations to the later discharge date that would be created by the rejected discharge. Consider the Qualifying Stays reported on the processed 3619s. These dates create full Medicare periods, which do not appear on the MESAV. • If the begin date of an existing Service Authorization needs to be changed, submit a correction to that admission. • If the submitted discharge date would overlap with a reported Qualifying Stay period, submit a correction to adjust the Qualifying Stay dates. • To determine whether the Qualifying Stay dates from the Medicare remittance advice correspond with those on file, contact HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance. • If the recipient is currently receiving hospice services, verify the dates of service with the hospice provider and make corrections as needed. • This rejected discharge should be resubmitted after the file has been adjusted.
NF-0061: This admission cannot be processed because a Nursing Facility admission is not appropriate for a PACE individual. Contact the individual's PACE organization.	3618/3619 (Admit)	The recipient has a Service Authorization for PACE (the Program for All Inclusive Care for the Elderly) as of the admission date. • Review the facility's records to verify that the transaction date on the rejected admission is correct. • If the submitted admission date is wrong, correct the rejected admission and resubmit. • If the admission date is correct, contact the recipient's PACE organization.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0062: This discharge cannot be processed because the individual is currently authorized for Full Medicaid. A prior 3618 discharge and a 3619 admission need to be processed prior to this discharge. If the Full Medicaid authorization is for this provider, submit the 3618 discharge prior to the Medicare stay. A 3619 admission must be processed prior to this discharge.	3619 (Discharge)	The recipient has a Service Authorization for full Medicaid (Code 1) as of the Medicare Part A Coinsurance discharge date.
		• Review the facility's records to determine the recipient's admission and discharge dates.
		• If the recipient is full Medicaid in your facility, pull a MESAV, and compare the Service Authorizations to the facility's records.
		• If the person should be classified as Medicare on this discharge date:
		  • Determine whether the 3618 discharge to the hospital prior to the Medicare stay has been submitted. If not, submit that 3618 discharge. If it was rejected, resolve the issue and resubmit the 3618 discharge.
		  • Determine whether the 3619 admission to begin Medicare Part A Coinsurance has been submitted. If not, submit that 3619 admission. If it was rejected, resolve the issue, and resubmit the 3619 admission.
		  • After the 3618 discharge and 3619 admission are processed and reflected on the MESAV, resubmit the rejected discharge.
		• If the recipient should not be classified as Medicare on this discharge date:
		  • Determine whether the discharge should be a 3618 discharge instead. If so, inactivate the rejected form and submit a 3618 discharge to close the recipient's file.
		• If the recipient is full Medicaid in a different facility, determine if the 3619 admission to begin Coinsurance has been submitted. If not, submit the 3619 admission. If it was rejected, resolve the issue, and resubmit the 3619 admission. Then resubmit the rejected 3619 discharge.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0063: This discharge cannot be processed because the individual is admitted to Medicare Part A Coinsurance for a different provider. If an admission prior to this discharge is missing or rejected, that admission must be processed prior to this discharge.	3619 (Discharge)	The recipient has a Service Authorization for Medicare Part A Coinsurance with a different provider as of the submitted discharge date. • Review the facility's records to identify the Medicare Part A Coinsurance admission date prior to this discharge. • Determine whehter the 3619 admission prior to this discharge has been submitted. If not, submit that 3619 admission. If it was rejected, resolve the issue, and resubmit that 3619 admission. • Resubmit the rejected 3619 discharge after the missing or corrected admission has been processed.
NF-0064: This discharge cannot be processed because an admission to Medicare Part A Coinsurance for a different provider has already been processed for the same day. This discharge appears to be one of a retroactive pair. If an admission prior to this discharge is missing or rejected, resubmit the admission and this discharge on the same day.	3619 (Discharge)	The recipient has a Service Authorization with a different provider that begins after the submitted discharge date. The rejected discharge and matching admission must be submitted as a retroactive pair. • Review the facility records to identify the Medicare Part A Coinsurance admission date prior to this discharge. • Determine whether the 3619 admission prior to this discharge has been submitted. If not, submit that 3619 admission. If it was rejected, resolve the issue, and resubmit that 3619 admission. • Resubmit the rejected 3619 discharge on the same day as the missing or corrected admission.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0065: This discharge cannot be processed because the individual is currently authorized for Full Medicaid for this provider. If a 3618 discharge prior to the Medicare stay and a 3619 admission are missing or rejected, resubmit those forms and this discharge on the same day.	3619 (Discharge)	The recipient has a Service Authorization for full Medicaid (Code 1) with the same provider as of the submitted discharge date.
		• Review the facility records to determine the recipient's admission and discharge dates.
		• Pull a MESAV, and verify the begin date and type of service currently authorized for the recipient.
		• If the recipient should be classified as Medicare on this discharge date:
		  • Determine whether the 3618 discharge to the hospital prior to the Medicare stay has been submitted. If not, submit that 3618 discharge. If it was rejected, resolve the issue, and resubmit that 3618 discharge.
		  • Determine whether the 3619 admission to begin Medicare Part A Coinsurance has been submitted. If not, submit that 3619 admission. If it was rejected, resolve the issue, and resubmit that 3619 admission.
		  • Resubmit the rejected 3619 discharge after the missing or corrected forms have been processed.
		• If the recipient should not be classified as Medicare on this discharge date:
		  • Determine whether the discharge should be a 3618 discharge instead. If so, inactivate the rejected form and submit a 3618 discharge to close the recipient's file.

NF-0066: This discharge cannot be processed because the individual is admitted by a different provider. If an admission prior to this discharge is missing or rejected, the admission must be processed prior to this discharge.	3619 (Discharge)	The recipient has a Service Authorization with a different provider as of the submitted discharge date. • Review the facility's records to identify the Medicare Part A Coinsurance admission date prior to this discharge. • Determine whether the 3619 admission prior to this discharge has been submitted. If not, submit that 3619 admission. If it was rejected, resolve the issue, and resubmit that 3619 admission. • Resubmit the rejected 3619 discharge after the missing or corrected admission has been processed.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0067: This discharge cannot be processed because an admission for a different provider has already been processed for the same day. This discharge appears to be one of a retroactive pair. If an admission prior to this discharge is missing or rejected, resubmit the admission and this discharge on the same day.	3619 (Discharge)	The recipient has a Service Authorization with a different provider that begins after the submitted discharge date. The rejected discharge and matching admission must be submitted as a retroactive pair. • Review the facility records to identify the Medicare Part A Coinsurance admission date prior to this discharge. • Determine whether the 3619 admission prior to this discharge has been submitted. If not, submit that 3619 admission. If it was rejected, resolve the issue, and resubmit that 3619 admission. • Resubmit the rejected 3619 discharge on the same day as the missing or corrected admission.
NF-0068: This discharge cannot be processed because the individual already has a subsequent authorization. This discharge appears to be one of a retroactive pair. If an admission prior to this discharge is missing or rejected, resubmit the admission and this discharge on the same day.	3619 (Discharge)	The recipient has a Service Authorization that begins after the submitted discharge date. The rejected discharge and matching admission must be submitted as a retroactive pair. • Review the facility records to identify the Medicare Part A Coinsurance admission date prior to this discharge. • Determine whether the 3619 admission prior to this discharge has been submitted. If not, submit that 3619 admission. If it was rejected, resolve the issue, and resubmit that 3619 admission. • Resubmit the rejected 3619 discharge on the same day as the missing or corrected admission.
NF-0069: This discharge cannot be processed because the individual is admitted by a different provider. If an admission prior to this discharge is missing or rejected, the admission must be processed prior to this discharge.	3618 (Discharge)	The recipient has a Service Authorization with a different provider as of the submitted discharge date. • Review the facility's records to verify that the transaction date on the rejected discharge is correct. • Determine whether the 3618 admission prior to this discharge has been submitted. If not, submit that 3618 admission. If it was rejected, resolve the issue, and resubmit that 3618 admission. • Resubmit the rejected 3618 discharge after the missing or corrected admission has been processed.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0070: This admission cannot be processed because it would cancel the individual's Enrollment with a different provider. Verify the effective date as well as the Qualifying Stay date ranges and correct them as needed.	3619 (Admit)	The Qualifying Stay dates or transaction date on this admission would cancel the previous provider's Service Authorization rather than "auto discharge" the recipient from the previous provider. • Review the facility's records to determine the recipient's admission and discharge dates and identify the spell of illness. • Verify the begin and end dates of qualifying stay and submit corrections as needed. • Verify the begin date of Medicare Part A Coinsurance, and submit a correction as needed. • If the dates are correct and the Medicare remittance advice validates that Coinsurance is due for the time period that your 3619s indicate, fax the remittance advice with copies of the 3619s to 512-438-3400, Attention: ECF Form Processing, or call 512-438-3400, option 3. If the Medicare remittance advice does not correspond to the 3619s submitted, the forms will not be processed.
NF-0073: This discharge modification cannot be processed because the new discharge would create an overlap with an existing Full Medicare period. Verify the Full Medicare periods and Service Authorizations already established and submit any additional modifications.	3619 (Discharge Mod)	The additional days of Medicare Part A Coinsurance on this correction would create an overlap with full Medicare dates already on the recipient's file if this correction is processed as submitted. • Review the Medicare remittances for this spell of illness to determine the Full Medicare and Coinsurance dates. • Pull a MESAV, and compare the Service Authorizations on file and the additional Coinsurance to the remittance dates. The system has determined that the additional Coinsurance dates would create an overlap with existing Service Authorizations. Also, consider the qualifying stays reported on the processed 3619s. These dates create full Medicare periods, which do not appear on the MESAV. • Submit any additional 3619 corrections to adjust begin or end dates to allow this discharge correction to be processed.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0074: This form cannot be processed because the submitted Provider Number is not valid as of the form effective date. Adjust the effective date or resubmit with the correct Provider Number.	3618, 3619	The effective date of this form is outside the provider's contract dates. **Note:** The effective date of a discharge is the Date of Above Transaction minus one day. **Exception:** For a 3618 discharge marked Deceased, use the Date of Above Transaction instead because HHSC pays for the date of death. • Confirm the transaction date for the rejected form, and submit a correction of the date as needed. • If the date is correct, but the form is under the incorrect contract, inactivate the form, and resubmit with the proper contract. • If there is not an active contract for the transaction date, the submission will have to be held until the contract has been approved.
NF-0075: This discharge cannot be processed because a different Provider Number for the same Vendor Number is valid as of the form effective date. Adjust the effective date or inactivate this discharge and submit for the correct Provider Number.	3618 (Discharge)	This discharge has been submitted using the incorrect provider number. The facility has had a change of ownership and the discharge needs to be submitted using the provider number that was active on the effective date of the discharge. **Note:** The effective date of a discharge is the Date of Above Transaction minus one day. **Exception:** For a 3618 discharge marked Deceased, use the Date of Above Transaction instead because HHSC pays for the date of death. • Confirm the transaction date for the rejected form, and submit a correction of the date as needed. • If the date is correct, but the form is under the incorrect contract, inactivate the form and resubmit with the proper contract. • If there is not an active contract for the transaction date, the submission will have to be held until the contract has been approved.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0076: This admission assessment cannot be processed because the Entry Date is earlier than the Service Authorization begin date. Verify the Entry Date and correct it as needed, or submit an earlier 3618/3619 admission. If the 3618/3619 admission and MDS Entry Date are correct, contact Provider Claims Services for assistance.	MDS (Admit)	The submitted MDS admission Entry Date is earlier than the Service Authorization begin date on the recipient's file. - Verify the entry date, and submit a modification to the CMS database as needed. - If an earlier 3618 or 3619 admission is needed, submit a matching admission and discharge pair, and then resubmit the rejected MDS admission. - If the 3618 or 3619 admission date and the MDS Entry Date are correct, call HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.
NF-0077: This admission modification cannot be processed because the new Full Medicare period would create an overlap with an existing Service Authorization. Verify the Full Medicare periods and Service Authorizations already established and submit any additional modifications.	3619 (Admit Mod)	The adjusted days of full Medicare on this correction would create an overlap with Service Authorizations already in the recipient's file if this correction is processed as submitted. - Review the Medicare remittances for this Spell of Illness to determine the full Medicare and Medicare Part A Coinsurance dates. - Pull a MESAV, and compare the Service Authorizations on file and the full Medicare Qualifying Stay dates to the remittance dates. The system has determined that the additional Qualifying Stay dates would create an overlap with existing Service Authorizations. Also, consider the Qualifying Stays reported on the processed 3619s. These dates create full Medicare periods, which do not appear on the MESAV. - Submit any additional 3619 corrections to adjust begin or end dates to allow this admission correction to be processed.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0078: This admission cannot be processed because the earliest Qualifying Stay date is too old, compared to the transaction date. Verify the Qualifying Stay dates and correct them as needed. If the Qualifying Stay dates are correct, contact Provider Claims Services for assistance.	3619 (Admit)	The difference between the earliest Qualifying Stay date and the transaction date is too great for this admission to be processed automatically. • Review the Medicare remittances for this Spell of Illness to determine the full Medicare and Medicare Part A Coinsurance dates. • If the dates on the form are correct, contact Provider Claims Services, and request that the form be processed manually. Confirmation will be made that the Spell of Illness does not exceed 80 days. Call HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.
NF-0080: This admission cannot be processed because it would cancel the individual's Enrollment with a different provider. Verify the effective date and correct it as needed. If the date is correct, contact Provider Claims Services for assistance.	3618 (Admit)	This 3618 admission would cancel the previous provider's Service Authorization rather than "auto discharge" the recipient from the previous provider. • Review the facility's records to determine the recipient's admission and discharge dates. • If the 3618 admission's transaction date is correct, contact the prior facility, and request that they review their admissions and discharges. • If the prior facility agrees to make adjustments, allow processing time, and resubmit your rejected admission.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

NF-0081: This admission cannot be processed because the individual is already admitted into your facility as of the submitted admission date. Verify current Service Authorizations on file and submit the needed 3618/3619 discharge prior to the submitted admission date, to allow this 3619 admission to process.	3619 (Admit)	The recipient has an ongoing Service Authorization for your facility (processed 3618 or 3619 admission).
		• Review the facility's records to determine which discharge is prior to this admission.
		• Pull a MESAV, and review the Service Authorizations to determine the authorized services. If the MDS for the recipient has not been processed, services will not be authorized.
		• If the recipient has an ongoing Service Authorization with a begin date prior to the rejected admission:
		  • If the current Service Authorization is for full Medicaid (Code 1), a 3618 discharge must be processed prior to resubmission of the rejected 3619 admission.
		  • If the current Service Authorization is for Medicare Part A Coinsurance (Code 3), a 3619 discharge must be processed prior to resubmission of the rejected 3619 admission.
		• If the recipient does not have Service Authorizations on the MESAV, use the statuses on the LTC Online Portal to determine which forms have been processed. Remember, authorizations will be displayed only if the MDS has also been processed.
		  • If the most recently processed form is a 3618 admission prior to the rejected 3619 admission, a 3618 discharge must be processed prior to resubmission of the rejected 3619 admission.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
NF-0082: This form cannot be processed because the submitted Provider Number is not valid for the requested service as of the form effective date. Adjust the effective date or resubmit once the requested service has been added to the contract.	3618, 3619	The effective date of this form is outside the provider's contract dates for the requested service. **Note:** The effective date of a discharge is the Date of Above Transaction minus one day. **Exception:** *F*or a 3618 discharge marked Deceased, use the Date of Above Transaction instead because HHSC pays for the date of death. • Confirm the transaction date for the rejected form, and submit a correction of the date as needed. • If the requested service is not active on the contract for the transaction date, contact the HHSC Intellectual and Developmental Disability (IDD) PASRR Unit at PASRR.support@hhsc.state.tx.us. The submission will have to be held until the contract has been updated to include the requested service.
PS-3001: This therapy assessment cannot be processed because the submitted Provider No. is not valid as of the Date of Assessment. Correct the therapy Date of Assessment or contact the HHS IDD PASRR Unit to inactivate this assessment, then submit a new NFSS form with the correct Provider No.	NFSS (Therapy Assessment)	The therapy Date of Assessment is outside the provider's contract dates. • Confirm the Date of Assessment for the rejected therapy assessment, and submit a correction of the date as needed. • If the date is correct, but the form is under the incorrect contract, contact the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us. Then submit a new NFSS form with the proper contract. • If there is not an active contract for the Date of Assessment, the submission will have to be held until the contract has been approved.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
PS-3003: This CMWC/DME assessment cannot be processed because the submitted Provider No. is not valid as of the Date of Assessment. Correct the CMWC/DME Date of Assessment or contact the HHS IDD PASRR Unit to inactivate this assessment, then submit a new NFSS form with the correct Provider No.	NFSS (CMWC/DME Assessment)	The customized manual wheelchair (CMWC)/durable medical equipment (DME) Date of Assessment is outside the provider's contract dates. • Confirm the Date of Assessment for the rejected CMWC/DME assessment, and submit a correction of the date as needed. • If the date is correct, but the form is under the incorrect contract, contact the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us. Then submit a new NFSS form with the proper contract. • If there is not an active contract for the Date of Assessment, the submission will have to be held until the contract has been approved.
PS-3004: This CMWC/DME item cannot be processed because the submitted Provider No. is not valid as of the Therapist's Certification Date. Correct the CMWC/DME Therapist's Certification Date or contact the HHS IDD PASRR Unit to inactivate this service, then submit a new NFSS form with the correct Provider No.	NFSS (CMWC/DME item)	The CMWC/DME therapist's certification date is outside the provider's contract dates. • Confirm the therapist's certification date for the rejected CMWC/DME item, and submit a correction of the date as needed. • If the date is correct, but the form is under the incorrect contract, contact the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us. Then submit a new NFSS form with the proper contract. • If there is not an active contract for the therapist's certification date, the submission will have to be held until the contract has been approved.
PS-3005: This therapy assessment cannot be processed because the submitted Provider No. is not valid for the requested service as of the Date of Assessment. Correct the therapy Date of Assessment or submit when the service becomes effective for the Provider No.	NFSS (Therapy Assessment)	The therapy Date of Assessment is outside the provider's contract dates for the requested service. • Confirm the therapy Date of Assessment and submit a correction of the date as needed. • If the requested service is not active on the contract for the Date of Assessment, contact the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us. The submission will have to be held until the contract has been updated to include the requested service.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
PS-3007: This CMWC/DME assessment cannot be processed because the submitted Provider No. is not valid for the requested service as of the Date of Assessment. Correct the CMWC/DME Date of Assessment or submit when the service becomes effective for the Provider No.	NFSS (CMWC/DME Assessment)	The CMWC/DME Date of Assessment is outside the provider's contract dates for the requested service. • Confirm the CMWC/DME Date of Assessment and submit a correction of the date as needed. • If the requested service is not active on the contract for the Date of Assessment, contact the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us. The submission will have to be held until the contract has been updated to include the requested service.
PS-3008: This CMWC/DME item cannot be processed because the submitted Provider No. is not valid for the requested item as of the Therapist's Certification Date. Correct the CMWC/DME Therapist's Certification Date or submit when the item becomes effective for the Provider No.	NFSS (CMWC/DME item)	The CMWC/DME therapist's certification date is outside the provider's contract dates for the requested item. • Confirm the CMWC/DME therapist's certification date, and submit a correction of the date as needed. • If the requested item is not active on the contract for the therapist's certification date, contact the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us. The submission will have to be held until the contract has been updated to include the requested item.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
PS-3009: This therapy assessment cannot be processed because the individual does not have a Daily Care Service Authorization for the submitted Provider No. as of the Date of Assessment. Correct the therapy Date of Assessment or submit the necessary 3618 admission form and/or MDS assessment.	NFSS (Therapy Assessment)	There is no Daily Care Service Authorization that covers the therapy Date of Assessment. • Pull a MESAV, and review the Service Authorizations to determine if the recipient has a Daily Care Service Authorization that covers the therapy Date of Assessment. If the 3618 admission and MDS assessment for the recipient have not been processed, services will not be authorized. • If a covering Daily Care Service Authorization is found and the Date of Assessment is incorrect, update it, and resubmit. • If a covering Daily Care Service Authorization is not found, use the LTC Online Portal to determine the status of the 3618 admission and MDS assessment. • If the 3618 admission is not processed, determine why the form was rejected. Correct the current 3618 admission, or inactivate the rejected 3618, and submit a new 3618 admission. • If the 3618 is processed, determine whether there is an associated MDS assessment. If processing of the MDS failed, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI, and submit it. • After the covering 3618 admission and MDS assessment have been processed, resubmit the therapy assessment. • If the 3618 admission and MDS assessment were both processed but there is no covering Daily Care Service Authorization, call HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

PS-3011: This CMWC/DME assessment cannot be processed because the individual does not have a Daily Care Service Authorization for the submitted Provider No. as of the Date of Assessment. Correct the CMWC/DME Date of Assessment or submit the necessary 3618 admission form and/or MDS assessment.	NFSS (CMWC/DME Assessment)	There is no Daily Care Service Authorization that covers the CMWC/DME Date of Assessment.
		• Pull a MESAV, and review the Service Authorizations to determine whether the recipient has a Daily Care Service Authorization that covers the CMWC/DME Date of Assessment. If the 3618 admission and MDS assessment for the recipient have not been processed, services will not be authorized.
		• If a covering Daily Care Service Authorization is found, and the Date of Assessment is incorrect, update it, and resubmit.
		• If a covering Daily Care Service Authorization is not found, use the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.
		  • If the 3618 admission is not processed, determine why the form was rejected. Correct the current 3618 admission, or inactivate the rejected 3618, and submit a new 3618 admission.
		  • If the 3618 is processed, determine whether there is an associated MDS assessment. If processing of the MDS failed, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI, and submit it.
		  • After the covering 3618 admission and MDS assessment have processed, resubmit the CMWC/DME assessment.
		• If the 3618 admission and MDS assessment have both been processed but there is no covering Daily Care Service Authorization, call HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

PS-3012: This CMWC/DME item cannot be processed because the individual does not have a Daily Care Service Authorization for the submitted Provider No. as of the Therapist's Certification Date. Correct the CMWC/DME item Therapist's Certification Date or submit the necessary 3618 admission form and/or MDS assessment.	NFSS (CMWC/DME item)	There is no Daily Care Service Authorization that covers the CMWC/DME item therapist's certification date.
		• Pull a MESAV, and review the Service Authorizations to determine whether the recipient has a Daily Care Service Authorization that covers the CMWC/DME item therapist's certification date. If the 3618 admission and MDS assessment for the recipient have not been processed, services will not be authorized.
		• If a covering Daily Care Service Authorization is found and the therapist's certification date is incorrect, update it, and resubmit.
		• If a covering Daily Care Service Authorization is not found, use the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.
		  • If the 3618 admission is not processed, determine why the form was rejected. Correct the current 3618 admission, or inactivate the rejected 3618, and submit a new 3618 admission.
		  • If the 3618 is processed, determine whether there is an associated MDS assessment. If processing of the MDS failed, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI, and submit it.
		  • After the covering 3618 admission and MDS assessment have been processed, resubmit the CMWC/DME item.
		• If the 3618 admission and MDS assessment have both been processed but there is no covering Daily Care Service Authorization, call HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
PS-3013: This therapy assessment cannot be processed because a different Provider No. for the same Vendor No. has a Daily Care Service Authorization as of the Date of Assessment. Adjust the therapy Date of Assessment or contact the HHS IDD PASRR Unit to inactivate this assessment, then submit a new NFSS form with the correct Provider No.	NFSS (Therapy Assessment)	This therapy assessment has been submitted using the incorrect provider number. The facility has had a change of ownership, and the therapy assessment needs to be submitted using the provider number that was active on the therapy Date of Assessment. - Confirm the Date of Assessment for the rejected therapy assessment, and submit a correction of the date as needed. - If the date is correct, but the form is under the incorrect contract, contact the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us. Then submit a new NFSS form with the proper contract. - If there is not an active contract for the Date of Assessment, the therapy assessment will have to be held until the contract has been approved.
PS-3015: This CMWC/DME assessment cannot be processed because a different Provider No. for the same Vendor No. has a Daily Care Service Authorization as of the Date of Assessment. Adjust the CMWC/DME Date of Assessment or contact the HHS IDD PASRR Unit to inactivate this assessment, then submit a new NFSS form with the correct Provider No.	NFSS (CMWC/DME Assessment)	This CMWC/DME assessment has been submitted using the incorrect provider number. The facility has had a change of ownership, and the CMWC/DME assessment needs to be submitted using the provider number that was active on the CMWC/DME Date of Assessment. - Confirm the Date of Assessment for the rejected CMWC/DME assessment, and submit a correction of the date as needed. - If the date is correct, but the form is under the incorrect contract, contact the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us. Then submit a new NFSS form with the proper contract. - If there is not an active contract for the Date of Assessment, the CMWC/DME assessment will have to be held until the contract has been approved.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

PS-3017: This therapy assessment cannot be processed because the individual is enrolled with a different provider as of the Date of Assessment. Correct the therapy Date of Assessment or submit the necessary 3618 admission form and/or MDS assessment.	NFSS (Therapy Assessment)	There is a Daily Care Service Authorization for a different provider that covers the therapy Date of Assessment.
		• Pull a MESAV, and review the Service Authorizations to determine whether the recipient has a Daily Care Service Authorization that covers the therapy Date of Assessment. If the 3618 admission and MDS assessment for the recipient have not been processed, services will not be authorized.
		• If a covering Daily Care Service Authorization is found and the Date of Assessment is incorrect, update it, and resubmit.
		• If a covering Daily Care Service Authorization is not found, use the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.
		  • If the 3618 admission is not processed, determine why the form was rejected. Correct the current 3618 admission, or inactivate the rejected 3618, and submit a new 3618 admission.
		  • If the 3618 is processed, determine whether there is an associated MDS assessment. If processing of the MDS failed, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI, and submit it.
		  • After the covering 3618 admission and MDS assessment have been processed, resubmit the therapy assessment.
		• If the 3618 admission and MDS assessment both processed but there is no covering Daily Care Service Authorization, call HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

PS-3019: This CMWC/DME assessment cannot be processed because the individual is enrolled with a different provider as of the Date of Assessment. Correct the CMWC/DME Date of Assessment or submit the necessary 3618 admission form and/or MDS assessment.	NFSS (CMWC/DME Assessment)	There is a Daily Care Service Authorization for a different provider that covers the CMWC/DME Date of Assessment.
		
		• Pull a MESAV, and review the Service Authorizations to determine whether the recipient has a Daily Care Service Authorization that covers the CMWC/DME Date of Assessment. If the 3618 admission and MDS assessment for the recipient have not been processed, services will not be authorized.
		• If a covering Daily Care Service Authorization is found and the Date of Assessment is incorrect, update it, and resubmit.
		• If a covering Daily Care Service Authorization is not found, use the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.
		  • If the 3618 admission is not processed, determine why the form was rejected. Correct the current 3618 admission, or inactivate the rejected 3618, and submit a new 3618 admission.
		  • If the 3618 is processed, determine whether there is an associated MDS assessment. If processing of the MDS failed, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI, and submit it.
		  • After the covering 3618 admission and MDS assessment have been processed, resubmit the CMWC/DME assessment.
		• If the 3618 admission and MDS assessment were both processed but there is no covering Daily Care Service Authorization, call HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action

PS-3020: This CMWC/ DME item cannot be processed because the individual is enrolled with a different provider as of the Therapist's Certification Date. Correct the Therapist's Certification Date or submit the necessary 3618 admission form and/or MDS assessment.	NFSS (CMWC/DME item)	There is a Daily Care Service Authorization for a different provider that covers the CMWC/DME therapist's certification date.
		• Pull a MESAV, and review the Service Authorizations to determine whether the recipient has a Daily Care Service Authorization that covers the CMWC/DME therapist's certification date. If the 3618 admission and MDS assessment for the recipient have not been processed, services will not be authorized.
		• If a covering Daily Care Service Authorization is found and the therapist's certification date is incorrect, update it, and resubmit.
		• If a covering Daily Care Service Authorization is not found, use the LTC Online Portal to determine the status of the 3618 admission and MDS assessment.
		  ○ If the 3618 admission is not processed, determine why the form was rejected. Correct the current 3618 admission, or inactivate the rejected 3618, and submit a new 3618 admission.
		  ○ If the 3618 is processed, determine whether there is an associated MDS assessment. If processing of the MDS failed, compare the 3618 processed date to the rejection date of the MDS. If the 3618 admission was processed after the MDS was rejected, resubmit the rejected MDS. If the MDS was never submitted, complete the LTCMI, and submit it.
		  ○ After the covering 3618 admission and MDS assessment have been processed, resubmit the CMWC/DME item.
		• If the 3618 admission and MDS assessment were both processed but there is no covering Daily Care Service Authorization, call HHSC LTC Provider Claims Services at 512-438-2200, option 1, for assistance.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
PS-3022: This CMWC/DME item cannot be processed because the individual was not at least 21 years of age as of the Therapist's Certification Date. Correct the Therapist's Certification Date or contact HHS MEPD for assistance correcting the individual's Birth Date in their records.	NFSS (CMWC/DME item)	The recipient was not at least 21 years of age as of the therapist's certification date. • If the birth date is incorrect on the form, contact the person or their legally authorized representative (LAR) and ask them to contact HHSC Medicaid for the Elderly and People with Disabilities (MEPD) to request that the error be corrected in the system. Resubmit the CMWC/DME item after the individual or LAR has confirmed that the information has been corrected by HHSC.
PS-3044: This therapy assessment cannot be processed because the individual does not have a successfully processed MDS assessment for the submitted Provider No. as of the Date of Assessment.	NFSS (Therapy Assessment)	• Correct the therapy date of assessment, or submit the necessary MDS assessment.
PS-3045: This therapy service must be manually processed by HHSC.	NFSS (Therapy Assessment)	• Email the HHSC IDD PASRR Unit at PASRR.support@hhsc.state.tx.us for assistance.
PS-3046: This CMWC/DME assessment cannot be processed because the individual does not have a successfully processed MDS assessment for the submitted Provider No. as of the CMWC/DME Date of Assessment.	NFSS (CMWC/DME Assessment)	• Correct the CMWC/DME date of assessment, or submit the necessary MDS assessment.

Provider Message (Displayed in History)	Form or Assessment	Suggested Action
PS-3047: This CMWC/DME item cannot be processed because the individual does not have a successfully processed MDS assessment for the submitted Provider No. as of the Therapist's Certification Date.	NFSS (CMWC/DME item)	• Correct the CMWC/DME item therapist's certification date, or submit the necessary MDS assessment.

Note: For Response Codes PS-3044, PS-3046, and PS-3047, contact Provider Claims Services for additional assistance.

Document Statuses

Providers can retrieve the statuses of their documents by using FSI or Current Activity on the LTC Online Portal. The following are statuses that a provider may see, along with their definitions:

- AI Check Inactive: Applied income validation was attempted nightly for up to six months and failed, or the request was canceled. The provider may restart the assessment after the reason for the failed validation has been resolved by the Medicaid Eligibility worker by clicking the **Reactivate Form** button.

- AI Confirmed: Applied income is confirmed.

- AI Pending: Applied income verification is pending.

- Appealed: A person has appealed the MN determination, and the provider has provided more information for consideration. Assessment is now awaiting TMHP doctor review, or a fair hearing has been requested.

- Approved: NFSS PTID is approved by the HHSC PASRR reviewer. The MDS or Preadmission PE is approved for MN determination.

- Awaiting LTC Medicaid Information: MDS has been retrieved by TMHP from CMS. If an LTCMI is submitted, the assessment will be processed by HHSC.

- Awaiting PE: A PL1 Screening Form has been submitted, but the PE for the person has not been submitted.

- Coach Pending More Info: HHSC Provider Claims Services is awaiting additional information from the NF. See the Form or PTID History trail for notes.

- Coach Review: HHSC Provider Claims Services is reviewing.

- Corrected: Forms are moved into a corrected status when the form is corrected by another form. View the History trail to find the child DLN. No further actions are allowed on a form or assessment in Corrected status.

- Denial Overturned: Denial of the PTID has been overturned, or PTID has been approved at a fair hearing.

- Denial Upheld: Denial of the PTID has been upheld, or PTID has been denied at a fair hearing.

- Denied: The NFSS PTID is denied by an HHSC PASRR reviewer for an assessment, service, or item request. The MDS or Preadmission PE is denied for MN determination.

- Denied No FH: The request for specialized services is denied. The resident or LAR has the option to request a fair hearing.

- Documented/Complete: An assessment PTID is marked with this status if a previous assessment has been successfully processed at HHSC within 180 days. This status applies only to assessment PTIDs, and the assessment is not billable.

- FH Expired: The period for requesting a fair hearing has expired.

- Form Complete: This is the only status that a PASRR Specialized Services (PSS) form can be in.

- Form Inactivated: The assessment or form has been inactivated. No further actions are allowed on the form or assessment.

- Form Submitted: A form has been successfully submitted on the LTC Online Portal.

- ID Confirmed: The Medicaid ID is confirmed.

- ID Invalid: Medicaid ID validation has failed. The form or assessment cannot be processed until the Medicaid ID has been corrected. Contact a Medicaid Eligibility worker to verify the person's name, SSN, and Medicaid ID. A new form or assessment must be submitted with correct information. The name entered must match the name shown on the person's Medicaid ID card.

- Inactivated: The PTID has been inactivated by HHSC PASRR reviewer.

- Incomplete: The EDI form submission is incomplete. After five days in Pending Submission, the status is systematically set to Incomplete. An X12 275 was not received within five days.

- Invalid/Complete: HHSC processing deemed this form, assessment, or PTID invalid. See the Form or PTID History trail for details.

- Invalid Form Sequence: This status applies only for Forms 3618 and 3619. The Form 3618/3619 sequence is invalid. For example, Form 3618 needs to be submitted before the MDS can be accepted.

- Item Not Received: The CMWC or DME item has not been certified by the NF in 365 days.

- Item Transferred: The CMWC or DME item has been transferred to another nursing facility.

- ME Check Inactive: Medicaid eligibility validation was attempted nightly for six months and failed, or the request was canceled. The provider may restart the assessment after the reason for the failed validation has been resolved by the Medicaid Eligibility worker by clicking the **Reactivate Form** button.

- ME Pending: Medicaid eligibility is pending verification.

- Med ID Check Inactive: Medicaid ID validation was attempted nightly for six months and failed, or the request was canceled. The provider may restart the assessment after the reason for the failed validation has been resolved by the Medicaid Eligibility worker by clicking the **Reactivate Form** button.

- Medicaid ID Pending: Medicaid ID validation is pending. Validation attempts occur nightly until deemed valid or invalid, or until six months have expired, whichever comes first. Contact the Medicaid Eligibility worker to verify the person's name, SSN, and Medicaid ID. This status will also apply to private-pay residents whose assessments are successfully but unnecessarily submitted on the LTC Online Portal. The assessment will be suspended for six months, and if the person never applies for Medicaid, the status will be set to Med ID Check Inactive.

- Negative PASRR Eligibility: The PL1 Screening Form or PE did not indicate that the person has a diagnosis of mental illness, intellectual disability, or developmental disability.

- NF Placement Process Exhausted: This PL1 Screening Form status occurs when a person has not been placed in an NF or alternate setting within 90 days of a PE submission.

- Out of State MD/DO License Invalid: The out of state MD or DO license is confirmed to be invalid.

- Out of State MD/DO License Valid: The out of state MD or DO license is confirmed to be valid.

- Out of State RN License Invalid: The state that issued the compact license has indicated that the compact registered nurse (RN) license is invalid.

- Out of State Therapist License Invalid: The therapist on the PTID is not licensed in Texas.

- Overturned Doctor Review: The assessment was denied MN, and then the provider supplied more information. The assessment is pending.

- PCS Documented/Complete: Provider Claims Services has successfully completed processing the assessment's PTID. An assessment in this status is not billable.

- PCS Processed/Complete: The form, assessment, or PTID has been successfully processed by PCS.

- PE MN Denied: This status is displayed on the MDS, and it indicates that MN has not been met on the Preadmission PE. View the History trail for detailed status and information about the denial of MN.

- Pending Applied Income: Applied income validation is pending. Validation attempts occur nightly until applied income is found, the request canceled, or six months have expired, whichever comes first. Contact the Medicaid Eligibility worker.

- Pending Denial: The PTID is pending additional information for approval.

- Pending Denial (needs more information): The TMHP nurse did not find the assessment to qualify for MN. The provider has 21 calendar days to submit additional information for consideration.

- Pending Doctor Review: MN determination is pending TMHP doctor review.

- Pending Fair Hearing: A fair hearing has been requested by the person or NF.

- Pending MD/DO License Verification: MD or DO credentials are pending verification.

- Pending Medicaid Eligibility: Medicaid eligibility validation is pending. Validation attempts occur nightly until eligibility is found, the request is canceled, or six months have expired, whichever comes first.

- Pending More Info: HHSC Provider Claims Services needs more information before further processing can occur. See the Form History trail or PTID History for further details on the information required.

- Pending NF Receipt: The CMWC or DME is pending receipt and certification by the NF.

- Pending Placement: The person has not been placed in a nursing facility. In the PL1 Screening Form "NF Choices" section, no NF has indicated "Admitted To", nor has the person been placed in an alternate setting.

- Pending Placement in NF - PE Confirmed: When the PL1 Screening Form is in this status, the NF is required to review the associated PE (which identifies the Recommended Specialized Services for the person) and certify whether it is able or unable to serve the person.

- Pending Review: MN determination is pending TMHP nurse review because the assessment was not approved through the automated MN determination process.

- Pending RN License Verification: The RN license number is pending verification from the Texas Board of Nursing (BON) or the licensing state from which the compact license was issued.

- Pending State Confirmation: The PTID is pending confirmation by the HHSC PASRR reviewer.

- Pending State Review: The PTID is pending review by the HHSC PASRR reviewer.

- Pending Submission: The EDI submission is incomplete. Submission of X12 275 is awaited for up to five calendar days to complete form submission in the LTC Online Portal.

- PL1 Inactive: This PL1 Screening Form status indicates that the person is deceased or has been discharged.

- Processed/Complete: The form, assessment, or PTID on the NFSS form has been processed and is complete. Please check the MESAV.

- Provider Action Required: The form, assessment, or PTID needs to be reviewed by the provider because it was rejected by HHSC Service Authorization System (SAS) Processing. Refer to the form or assessment History trail or PTID History for the specific error message.

- PTID Submitted: The NFSS PTID is successfully submitted on the LTC Online Portal.

- Recert - Reference Only: The assessment PTID for a therapy recertification has successfully completed processing.

- SAS Request Pending: The form or assessment has passed all validations (Medicaid ID, Medicaid eligibility, applied income, etc.) and will be sent from TMHP to HHSC for processing. For the NFSS, both the Form and the PTID has passed all workflow validations and will be sent to HHSC for processing. Allow two to four business days for the next status change.

- Submit to SAS: PTID information is submitted to HHSC SAS system.

- Submitted: The form or assessment has been submitted.

- Submitted to manual workflow: The form or assessment needs to be reviewed by HHSC Provider Claims Services because the form or assessment was rejected by SAS. Refer to the form or assessment History trail for additional information.

- Submitted to PASRR Unit: The PTID is submitted to the HHSC PASRR Unit for review and completion.

- Submitted to PCS: The form, assessment, or PTID is submitted to HHSC Provider Claims Services for review and completion.

Nonemergency Ambulance

If you need to transport a person receiving fee-for-service (FFS) Medicaid by ambulance for a doctor appointment or other nonemergency reason, there are some important things to know. For the most up-to-date and detailed information, refer to the *Texas Medicaid Provider Procedures Manual (TMPPM), Vol. 1*, section 5, "Fee-for-Service Prior Authorizations."

Medicaid payment for ambulance transportation may be made only for people receiving FFS Medicaid whose condition at the time of transport is such that ambulance transportation is medically necessary. For example, it is insufficient that a person merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transportation. In each of those instances, the condition of the person must be such that transportation by any other means is medically contraindicated.

Ambulance transports must be limited to those situations where the transportation of the person is less costly than bringing the service to the person.

Note: Authorization requests for services administered by a person's MCO must be submitted to the person's MCO according to the guidelines that are specific to the plan under which the person is covered.

Prior Authorization Requirements

Prior authorization is not a guarantee of payment. Even if a procedure has been prior authorized, reimbursement can be affected for a variety of reasons [for example the person is ineligible on the date of service (DOS), or the claim is incomplete]. Providers must verify a person's eligibility status before providing services.

In most instances, prior authorization must be approved before the service is provided. Prior authorization for urgent services that are provided after business hours, on a weekend, or on a holiday may be requested on the next business day. TMHP considers providers' business hours as Monday through Friday, from 8:00 a.m. to 5:00 p.m., Central time. Prior authorization requests that do not meet these deadlines may be denied.

To avoid unnecessary denials, the request for prior authorization must contain correct and complete information, including documentation of MN. The documentation of MN must be maintained in the person's medical record. The requesting NF may be asked for additional information to clarify or complete a request for prior authorization.

Refer to TMPPM, Vol. 1, section 6, "Claims Filing," subsection 6.1.4, "Claims Filing Deadlines" for the TMHP-approved holidays.

According to Texas Administrative Code (TAC) 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided for a person receiving Medicaid to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the person's home after discharge from a hospital when the person has a medical condition such that the use of an ambulance is the only appropriate means of transportation (when alternate means of transportation are medically contraindicated).

According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a person in circumstances not involving an emergency.

The HRC states that a provider of nonemergency ambulance transport is entitled to payment from the nursing facility, health-care provider, or other responsible party that requested the service if payment under the Medical Assistance Program is denied because of lack of prior authorization and the ambulance provider submits a copy of the claim for which payment was denied.

The TMHP Ambulance Unit reviews the prior authorization request to determine whether the person's medical condition is appropriate for transport by ambulance. Incomplete information may cause the request to be suspended until the submission of additional medical information or be denied.

The following information assists TMHP in determining the appropriateness of the transport:

- An explanation of the person's physical condition that establishes the MN for transport. The explanation must clearly state the person's conditions that require transport by ambulance.

- The necessary equipment, treatment, or personnel used during the transport.

- The origination and destination points of the person's transport.

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When a person's condition changes, such as the development of a need for oxygen or additional monitoring during transport, the prior authorization request must be updated.

Prior Authorization Types and Definitions

One-time, Nonrepeating
One-time, nonrepeating requests are reserved for those people who require a one-time transport. The request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), RN, or discharge planner with knowledge of the person's condition. Stamped or computerized signatures and dates are not accepted. Without a signature and date, the form is considered incomplete.

Recurring
Recurring requests, up to 60 days, are reserved for those people whose transportation needs are not anticipated to last longer than 60 days. The request must be signed and dated by a physician, PA, NP, or CNS. Stamped or computerized signatures and dates are not accepted. Without a signature and date, the form is considered incomplete. The request must include the approximate number of visits needed for repeated transport (for example, dialysis, radiation therapy).

Note: Refer to the Non-emergency Ambulance Prior Authorization Request form in the TMPPM, Vol. 2, Ambulance Services Handbook.

Prior Authorization Process

To obtain prior authorization, NFs must submit a completed Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-emergency Ambulance Prior Authorization Request form by fax to the TMHP Ambulance Unit at 512-514-4205. Prior authorization can also be requested through the TMHP website at www.tmhp.com.

The Non-emergency Ambulance Prior Authorization Request form must not be modified. If the form is altered in any way, the request may be denied. The form must be filled out by the NF or by a member of the physician's staff who is most familiar with the person's condition. The ambulance provider must not assist in completing any portion of this form.

Note: Refer to the [Non-emergency Ambulance Prior Authorization Request](#) form in the TMPPM, Vol. 2, Ambulance Services Handbook.

A request for a one-day transport may be submitted on the next business day following the transport in some circumstances; however, every attempt should be made to obtain prior authorization before the transport takes place. Authorization requests for one-day transports submitted beyond the next business day will be denied.

A request for a recurring transport must be submitted before the person is transported by ambulance. After a prior authorization request has been approved, if the person's condition deteriorates or the need for equipment changes so that additional procedure codes must be submitted for the transport, the requesting NF must submit a new Non-emergency Ambulance Prior Authorization Request form.

TMHP responds to nonemergency transport prior authorization requests within two business days of receipt of requests for 60 days or less. NFs should submit all requests for a prior authorization number (PAN) in sufficient time to allow TMHP to issue the PAN before the date of the intended transport. The requesting NF must contact the transporting ambulance provider with the PAN and the dates of service that were approved.

TMHP reviews all of the documentation it receives. An online prior authorization request submitted through the TMHP website is responded to with an online approval or denial. Alternately, a letter of approval or denial is faxed to the requesting NF. The person is notified by mail if the authorization request is denied or downgraded. Reasons for denial include documentation that does not meet the criteria of a medical condition that is appropriate for transport by ambulance, or the person is not Medicaid-eligible for the dates of services requested. The person may appeal prior authorization request denials by contacting TMHP Client Notification at 800-414-3406. Providers may not appeal prior authorization request denials.

A nonemergency transport will be denied when a claim is submitted with a prior authorization request form that is completed and signed after the service is rendered. In addition, a prior authorization request form that is completed and signed after the service is rendered will not be accepted on appeal of the denial.

Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a person's Medicaid coverage is before the eligibility add date, which is the date the person's Medicaid eligibility is added to TMHP's eligibility file.

For people with retroactive eligibility, prior authorization requests must be submitted after the person's add date and before a claim is submitted to TMHP.

For services that are provided to people receiving FFS Medicaid during their retroactive eligibility period (the period from the effective date to the add date), providers must obtain prior authorization within 95 days of the person's add date and before a claim is submitted for those services to TMHP.

If a person's Medicaid eligibility is pending, a PAN must be requested before a nonemergency transport. Initially, this request will be denied for Medicaid eligibility. When Medicaid eligibility is established, the NF requestor has

95 days from the date on which the eligibility was added to TMHP's files to contact the TMHP Ambulance Unit and request that authorization be considered.

Documentation of MN

Retrospective review may be performed to ensure that documentation supports the MN of the transport.

Documentation to support MN must include one of the following:

* The person is bed-confined before, during, and after the trip, and alternate means of transport is medically contraindicated and would endanger the person's health (in the case of injury, surgery, or the use of respiratory equipment). The functional, physical, and mental limitations that have rendered the person bed-confined must be documented.
  Note: "Bed-confined" is defined as the inability to stand, ambulate, and sit in a chair or wheelchair.

* The person's medical or mental health condition is such that alternate means of the transport is medically contraindicated and would endanger the person's health (in the case of injury, surgery, or the use of respiratory equipment).

* The person is a direct threat to self or others, which requires the use of restraints (chemical or physical) or trained medical personnel during transport for the safety of the person and the staff (for example when the person is suicidal). When physical restraints are needed, documentation must include but is not limited to the following:

  * Type of restraint

  * Time frame of the use of the restraint

  * The person's condition

Note: The standard straps used in an ambulance transport are not considered a restraint.

People Receiving Medicare and Medicaid

NFs should simultaneously request prior authorization for the nonemergency transport from TMHP for a person receiving Medicaid Qualified Medicare Beneficiary (MQMB) services in the event that the service requested is denied by Medicare as a noncovered service.

Note: Persons receiving QMB services are not eligible for Medicaid benefits. NFs can contact Medicare for the Medicare prior authorization guidelines.

Reminders

- The LTC Online Portal has 24/7 availability to submit and track documents.

- Monitor document statuses regularly on the LTC Online Portal.

- Access your documents using FSI or Current Activity.

- Print and sign documents prior to submission.

- Use the TMHP website to access training materials and other resources. LTC program information can be found on the TMHP website at www.tmhp.com/programs/ltc.

Preventing Medicaid Waste, Abuse, and Fraud

The Code of Federal Regulations [42 CFR §455.2](#) defines Medicaid fraud as "an intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law."

How to Report Waste, Abuse, and Fraud

Reports may be made through the following website: https://oig.hhs.texas.gov/report-fraud-waste-or-abuse. This website also gives instructions on how to submit a report, as well as how to submit additional documentation that cannot be transmitted over the internet. The website also provides information on the types of waste, abuse, and fraud to report to the Office of Inspector General (OIG).

If you are not sure whether an action is waste, abuse, or fraud of Texas Medicaid, report it to OIG, and let the investigators decide. If you are uncomfortable about submitting a report online, call the Recipient Fraud and Abuse reporting phone number, 800-436-6184.

HIPAA Guidelines and Provider Responsibilities

Providers must comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. As a provider, it is *your* responsibility to comply with HIPAA, to seek legal representation when needed, to consult the appropriate manuals, or to speak to your TMHP provider representative when you have questions.

Resource Information

Types of Calls to Refer to TMHP

Call TMHP at **800-626-4117**, option 1, about the following:

- NF form completion, including the PL1 Screening Form and NFSS form

- Rejection codes on the forms and PTIDs

- Management of the Provider Action Required status

- Having the form restarted through the system if the Medicaid, Social Security, or Medicare number and the name match the person's Medicaid ID card and the form is set to ID Invalid status

- PL1 Screening Form submission error messages and the NFSS Form and PTID error messages

- PL1 Screening Form and PE status questions

Call TMHP at **800-626-4117**, option 2, about the following:

- MN determination on MDS

- MN determination on PE

Call TMHP at **800-626-4117**, option 3, about the following:

- TMHP LTC Online Portal and TexMedConnect account setup

Call TMHP at **800-626-4117**, option 4, about the following:

- Electronic Visit Verification (EVV)

Call TMHP at **800-626-4117**, option 5, about the following:

- Fair Hearings

Call TMHP at **800-626-4117**, option 6, about the following:

- Third-party Liability (TPL)/Other Insurance (OI)

Types of Calls to Refer to HHSC PCS

Call HHSC PCS at **512-438-2200, option 1**, about the following:

- Denials or pending denials of people who have established prior permanent MN, after verifying that MDS 3.0 Field A0700. Medicaid Number, contains a nine-digit number rather than "+" or "N."

- A 3618/3619 admission submitted under the wrong contract. That process must have a counteracting discharge submitted, and the provider must call to request that HHSC PCS set the incorrect form to Invalid/Complete status. A third form for the same Date of Above Transaction cannot be submitted until the forms with the incorrect contract have been set to status Invalid/Complete.

- Resolution of forms in Manual Workflow.

- Assistance with Processed/Complete forms that do not appear on the MESAV.

Helpful Contact Information

TMHP

Client Notification 800-414-3406

Electronic Data Interchange (EDI) Help Desk 888-863-3638

General Customer Service...800-925-9126

LTC Department...800-727-5436 or 800-626-4117

    General Inquiries, MDS not in the LTC Online Portal, LTCMI Questions, Claim Forms,
    Claim Submission, R&S Report, PL1 Screening Form, and PE .... Option 1

    Medical Necessity (MN) .... Option 2

    Technical Support .... Option 3

    Fair Hearings .... Option 5

    LTC Other Insurance Information and Updates.. Option 6

LTC Department (fax) 512-514-4223

Medicaid Hotline..800-252-8263

HHSC

HHSC General Information 512-438-3011

Community Services Contracts Unit Support... 512-438-3550

Community Services Contracts Voice Mail (Contract Applications,
Reenrollments, and Reporting Changes, such as address and telephone number).................... 512-438-3550

Consumer Rights & Services Hotline 800-458-9858

    Complaint for LTC Facility/Agency .... Option 2

    Information About a Facility .... Option 4

    Provider Self-Reported Incidents .... Option 5

Survey Documents/HHSC Literature .... Option 6

Criminal History Checks 512-438-2363

Facility Licensure/Certification (Reporting Changes, such as Service Area and
Medical Director)..512-438-2630

HHSC Ombudsman Office Medicaid Benefits..877-787-8999

Home and Community Support Services Unit (Hospice Regulatory Requirements) 512-438-3161

Hospice Policy (Medicaid, Program Support, and Special Services Unit)........................hospicepolicy@hhs.texas.gov

Institutional Services Contracting...512-438-2546

Medicaid Fraud 800-436-6184

Medication Aide Program 512-231-5800

NF Administrator Program..512-231-5800

NF Policy..512-438-3161

Nurse Aide Registry..800-452-3934

Nurse Aide Training 512-231-5800

PASRR Unit Policy Questions..PASRR.support@hhsc.state.tx.us

Provider Claims Services Hotline..512-438-2200

NF and Hospice (service authorizations, MESAV updates, and inability
to determine rate key) .... Option 1

Personal Needs Allowance Payments (PNA) .... Option 2

Deductions and Holds... Option 3

Provider Recoupment and Holds, including torts and trusts and annuities .... Option 4

Home and Community-based Services (HCS) .... Option 5

Texas Home Living (TxHmL)... Option 5

Rehabilitation Therapy and Specialized Services .... Option 6

Rate Analysis Help Line...512-730-7404

Regulatory Services 512-438-2625

Resource Utilization Groups (RUGs) Information

Nurse Specialist (Reconsideration & RUGs)...512-491-2074

Texas State University RUG Training Information and Online Course Questions 512-245-7118

Informational Websites

Texas Medicaid & Healthcare Partnership (TMHP): https://www.tmhp.com/

- HIPAA information: https://www.tmhp.com/hipaa-privacy-statement

- Long-Term Care (LTC) Program: https://www.tmhp.com/programs/ltc

- NF LTCMI and PASRR information: https://www.tmhp.com/programs/ltc

- LTC Provider News Archives: https://www.tmhp.com/news?program_id=56

Health and Human Services Commission (HHSC): https://hhs.texas.gov/

All HHSC provider information can be found at https://www.hhs.texas.gov/providers/long-term-care-providers. Please choose your particular provider type for available online resources:

- Consumer Rights and Services (includes information about how to make a complaint): https://www.hhs.texas.gov/services/your-rights/complaint-incident-intake

- Hospice: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/hospice

- Local Mental Health Authority Search: https://hhs.texas.gov/services/mental-health-substance-use/mental-health-substance-use-resources/find-your-local-mental-health-or-behavioral-health-authority

- Nursing Facility: https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf

- Nursing Facility MDS Coordinator Support Site: https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf/texas-minimum-data-set

- Office of Inspector General (OIG): https://oig.hhs.texas.gov/report-fraud-waste-or-abuse

- PASRR: https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/preadmission-screening-resident-review-pasrr/pasrr-nursing-facilities

- Provider Letters: https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf#comms

- Resources for HHSC Service Providers: https://www.hhs.texas.gov/providers/long-term-care-providers

- HHSC Regions: https://www.hhs.texas.gov/about/contact-us/community-services-regional-contacts

- Vendor Drug Program: https://www.txvendordrug.com/providers

Other Resources:

- Centers for Medicare & Medicaid Services: www.cms.gov

- Department of State Health Services: www.dshs.state.tx.us

- National Provider Identifier (NPI): https://nppes.cms.hhs.gov/NPPES (to obtain an NPI)

- Texas Administrative Code: www.sos.state.tx.us/tac/index.shtml

- Texas Medicaid Provider Procedures Manual: https://www.tmhp.com/resources/provider-manuals/tmppm

- Texas State RUG Training: www.txstate.edu/continuinged/CE-Online/RUG-Training

- Federal MDS 3.0: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Appendix A: Medicaid Eligibility Verification – Resident with Medicaid Eligibility

Medicaid Eligibility Verification – Resident with Medicaid Eligibility

Does not apply to PASRR

Assessment Reviewed for Medical Necessity (MN)

↓ MN Approved

ID Invalid ← *ID Invalid* — **Request/Validate Medicaid ID** — *ID Pending* → **Medicaid ID Pending** → **Medicaid ID Check Inactive**

NF confirms SSN/Medicaid/Medicare #s and first four letters of last name match. If yes, contact TMHP to restart form. If no, NF submits correction.

Medicaid ID Check Inactive ↓ **Provider Reactivates**

↓ *ID Confirmed*

Request/Validate Medicaid Eligibility (ME) — *Pending ME* → **Pending ME** → **ME Check Inactive**

ME Check Inactive ↓ **Provider Reactivates**

Resident may not have correct NF coverage. If no, new application needs to be filed.

↓ *ME Confirmed*

SAS Request Pending ← *AI Confirmed* — **Request/Validate Applied Income Check** — *Pending AI* → **Pending AI** → **AI Check Inactive**

AI Check Inactive ↓ **Provider Reactivates**

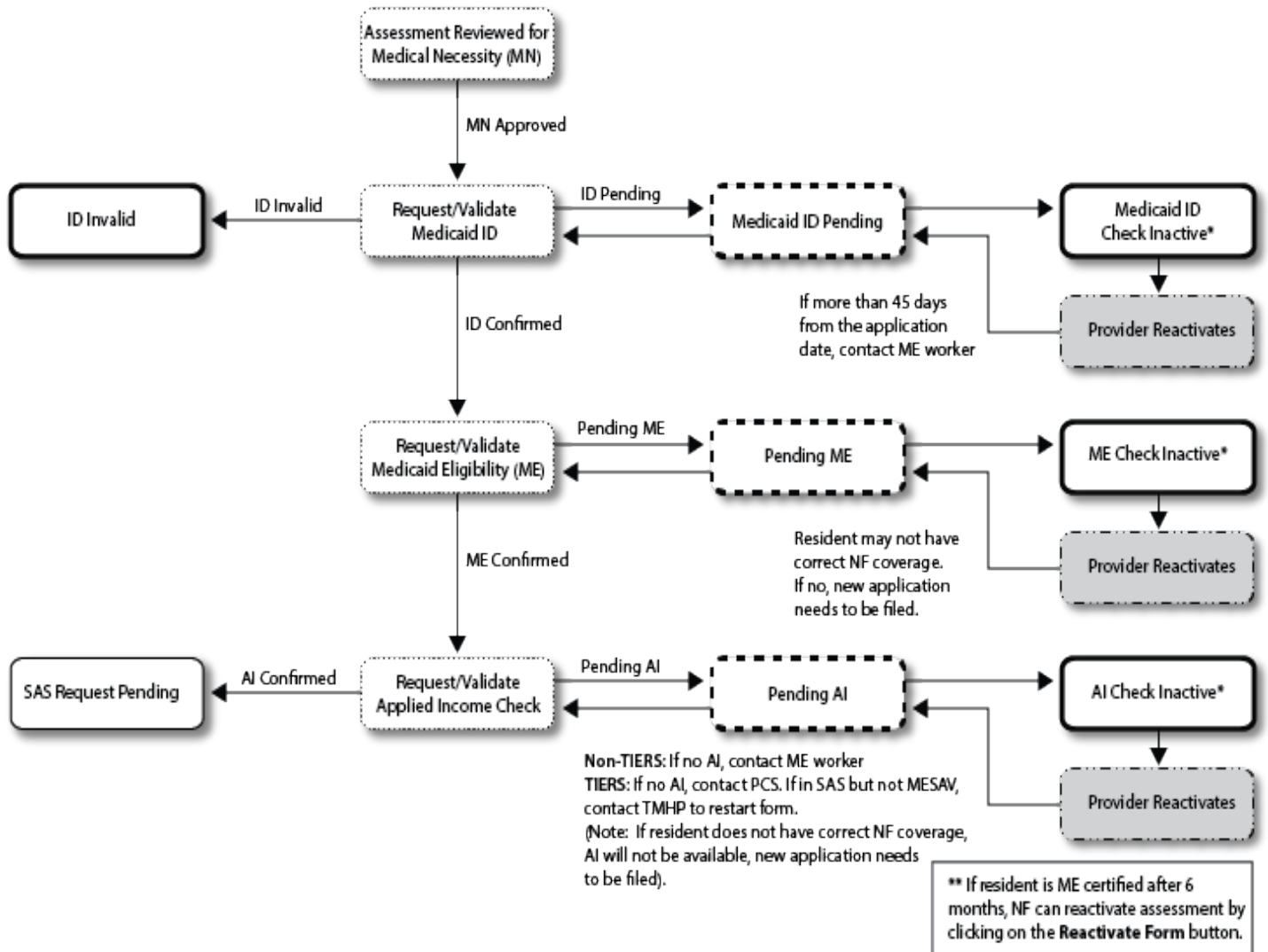If resident is ME certified after 6 months, NF can reactivate assessment by clicking on the **Reactivate Form** button.

Appendix B: Medicaid Eligibility Verification – Resident with Pending Medicaid Eligibility

Medicaid Eligibility Verification – Resident with Pending Medicaid Eligibility

Does not apply to PASRR

Appendix C: Acronyms, Terms, and Abbreviations

- A0310A: Reason for Assessment (MDS 3.0)

- A1600: Admission or Entry Date (MDS 3.0)

- A2300: Assessment Reference Date

- BON: Texas Board of Nursing

- CHOW: Change of ownership

- CMS: Centers for Medicare & Medicaid Services

- CNS: Clinical nurse specialist

- CPR: Cardiopulmonary resuscitation

- DLN: Document locator number

- DOS: Date of service

- EDI: Electronic Data Interchange

- EMS: Emergency medical services

- ER: Emergency room

- FFS: Fee-for-service

- FSI: Form Status Inquiry

- HHSC: Texas Health and Human Services Commission

- HIPAA: Health Insurance Portability and Accountability Act of 1996

- HMO: Health maintenance organization

- HRC: Human Resource Code

- ICF/IID: Intermediate care facility for individuals with intellectual disability

- IDD: Intellectual and developmental disabilities

- IDT: Interdisciplinary team

- IG: HHSC inspector general

- LA: Local authority (This is a general term that can include the LIDDA, LMHA, or LBHA.)

- LAR: Legally authorized representative

- LBHA: Local behavioral health authority

- LIDDA: Local intellectual and developmental disability authority

- LMHA: Local mental health authority

- LTC: Long-term care

- LTCMI: Long-Term Care Medicaid Information. The LTCMI is the replacement for the federal MDS Section S and contains items for Medicaid state payment. After your MDS assessments have been transmitted to CMS, TMHP will retrieve all assessments that meet the retrieval criteria and assign a DLN. The assessment will be set to *Awaiting LTC Medicaid Information* status.

- MCO: Managed care organization

- MDS: Minimum Data Set

- MEPD: Medicaid for the Elderly and People with Disabilities

- MESAV: Medicaid Eligibility Service Authorization Verification

- MN: Medical necessity

- MQMB: Medicaid Qualified Medicare Beneficiary

- NFSS: Authorization Request for PASRR Nursing Facility Specialized Services

- NP: Nurse practictioner

- NPI: National Provider Identifier

- OES: Office of Eligibility Services

- OIG: Office of the Inspector General

- PA: Physician assistant

- PAN: Prior authorization number

- PC: Purpose code

- PDF: Portable Document Format

- PE: PASRR Evaluation (Level II)

- PL1: PASRR Level 1 Screening

- PASRR: Preadmission Screening and Resident Review, a federal mandate that requires the state of Texas to screen all persons suspected of having mental illness (MI), intellectual disabilities (ID), or developmental disabilities (DD) prior to admission into a certified nursing facility. The screening must be submitted to TMHP on the LTC Online Portal.

- PMN: Permanent MN

- PNA: Personal Needs Allowance

- PRN: Pro re nada or "as needed"

- PSS: PASRR specialized services

- PTID: PASRR transaction ID

- QTSO: QIES Technical Support Office

- RA: Route of administration

- RAI: Resident Assessment Instrument; includes instructions on how to complete the MDS assessment

- RE: Referring entity

- RAVEN: Resident Assessment Validation and Entry, free MDS data entry software that offers users the ability to enter and transmit assessments to CMS. CMS provides this free MDS data entry software. Providers can download the free software from the CMS website.

- RN: Registered nurse

- RUG: Resource Utilization Group

- SAS: Sevice Authorization System

- SCSA: Significant Change in Status Assessment

- SNF: Skilled nursing facility

- SSI: Supplemental Security Income

- TMHP: Texas Medicaid & Healthcare Partnership

- TAC: Texas Administrative Code

- Z0500B: Date RN assessment coordinator signed as complete (MDS 3.0)