



**Long-Term Care (LTC) User Guide
for Nursing Facility Forms 3618/3619 and
Minimum Data Set/Long-Term Care Medicaid
Information (MDS/LTCMI)**



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Learning Objectives

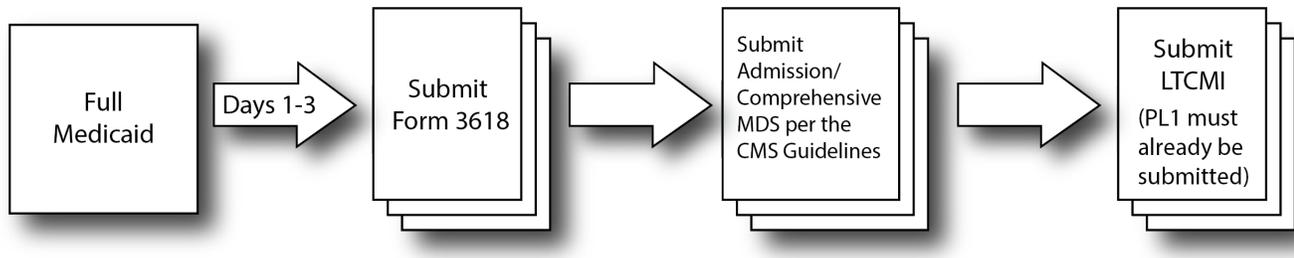
After reading this Long-Term Care (LTC) User Guide for Nursing Facility Forms 3618/3619 and Minimum Data Set/Long-Term Care Medicaid Information (MDS/LTCMI), you will be able to:

- Identify the forms and screenings to be submitted and their sequencing, including when and how to submit them.
- Understand the Long-Term Care Medicaid Information (LTCMI) section submission process.
- Understand and differentiate between the Minimum Data Set (MDS) purpose code E and M.
- Understand the provider workflow process which includes dividing into two sections: corrections and updates in provider workflow.
- Understand how to correct, modify, counteract, or inactivate forms or assessments - and the consequences of doing so.
- Identify form and assessment statuses and how to resolve issues.
- Recognize how to prevent Medicaid waste, abuse, and fraud.
- Understand that complying with Health Insurance Portability and Accountability Act (HIPAA) is YOUR responsibility. You should seek legal representation when needed, and consult the manuals or speak to your Texas Medicaid & Healthcare Partnership (TMHP) Provider Representative when you have questions.
- Identify additional resources for assistance.

Sequencing of Documents

The Preadmission Screening and Resident Review (PASRR) Level 1 Screening Form (PL1) must always be submitted prior to admission, regardless of payor source. Refer to the Overview of PASRR Processes section of the *Long-Term Care (LTC) User Guide for Preadmission Screening and Resident Review (PASRR)* for details.

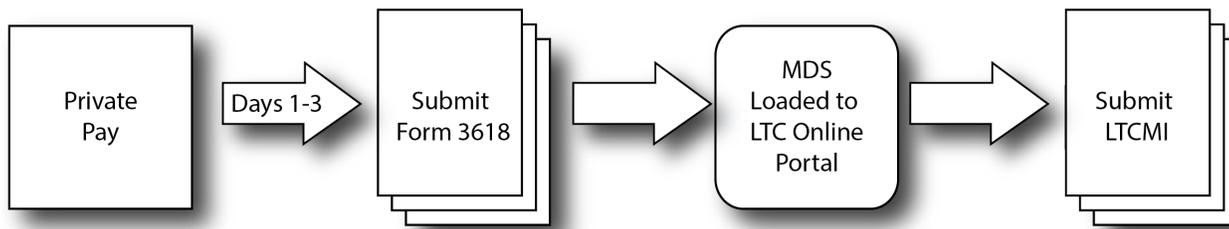
Admission as a Full Medicaid Recipient



This flow chart displays the admission process for a person as a Full Medicaid recipient.

- Nursing facilities (NFs) are required to initiate the HHSC Medicaid Eligibility application process to ensure validations occur with the Medicaid ID, Medicaid Eligibility, and the Applied Income.
- A facility must submit a Form 3618 for a person who has full Medicaid or is applying for Medicaid coverage within 72 hours of admission.
- Federal Claims Management Services *Resident Assessment Instrument (RAI) User's Manual* requires completion of an admission/comprehensive MDS within 14 days of admission (MDS 3.0: A0310A=01). Submit the MDS to Claims Management Services in accordance with the *RAI User's Manual*.
- Federal Claims Management Services guidelines allow providers up to 14 days to transmit MDS 3.0 assessments. Note that waiting will cause a delay in Medical Necessity (MN) determination and payment if the assessment is being used to establish Medicaid state payment.
- Complete the MDS LTCMI on the LTC Online Portal within the covering quarter of the MDS (PL1 must have already been submitted). MDS 3.0 = Z0500B + 91 days
Note: *The above timeliness guidelines reflect the requirements of Texas Medicaid only. For Centers for Medicare & Medicaid Services (CMS) timeliness guidelines, refer to the RAI User's Manual available at the following link: Federal MDS 3.0 site: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp*
- Complete a quarterly assessment within 92 days of the Admission MDS unless a Significant Change in Status Assessment (SCSA) was completed prior to this.

Recipient Transitioning to Full Medicaid



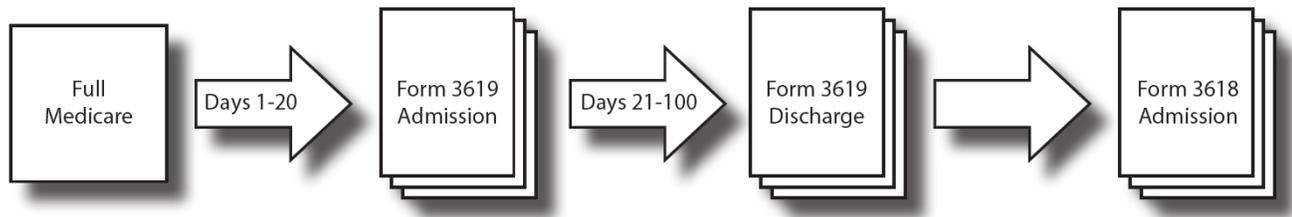
This flow chart displays the process for a private-pay person transitioning to Full Medicaid. Submission should occur upon notification of application for Medicaid.

- A facility should submit a 3618 Admission indicating admission from private pay.
- Once the 3618 has been submitted, any MDS assessment will be loaded onto the LTC Online Portal within 24 to 48 hours.
- Remember that the MDS LTCMI must be completed and submitted before TMHP can process the assessment.

If TMHP is unable to retrieve the assessment from CMS because the person's Medicaid number or Social Security number (SSN) on the assessment is different from the current Form 3618 Admission, the provider will have to submit an MDS modification to allow the LTC Online Portal to retrieve the assessment. Modifications should be submitted to CMS in accordance with the *RAI User's Manual*.

Note: *If the last name on the assessment is not identical to the last name on the Medicaid Identification card, there will be a conflict. Correct the assessment to match the Medicaid Identification card if the card is correct. If the name on the Medicaid Identification card is incorrect, contact the appropriate Medicaid Eligibility worker to make name corrections so that there is an exact match.*

Full Medicare Transitioning to Medicaid



This flow chart displays the process of a person that is Full Medicare and transitioning to Full Medicaid.

- Full Medicare reimburses for the first 20 days.
- The facility must submit a 3619 Admission on day 21 (within 72 hours) of Medicare payment to begin Medicare Coinsurance up to a maximum of 80 days. The entire Medicare stay cannot exceed 100 days.
- The facility must submit a 3619 Discharge on the 101st day or the day of discharge from Medicare Coinsurance and a 3618 Admission on the same day to admit the person to Full Medicaid.
- The 3619 Discharge and 3618 Admission changing to Full Medicaid will be the same date unless the person physically went out of the facility.
- The facility may submit an LTCMI on an MDS assessment for an person who will be transitioning from Medicare to Medicaid. However, the LTCMI cannot be submitted prior to the 3619 Admission. The provider has two options for submitting the LTCMI. It can be done prior to the resident discharging off of Medicare or waiting until the resident is considered Full Medicaid.

Current Resident Admitted to Hospice

- Submit a Form 3618 or 3619, as appropriate, discharging the person to Hospice Care.
- CMS states a SCSA should be submitted on a resident who admits to Hospice. The MDS 3.0 LTCMI should include the Hospice provider number and Hospice Care should be indicated in O0100K2.
- Indicate Hospice Care in 3.0: O0100K2.
- Hospice provider number must be entered on the LTCMI.
- Hospice provider submits Forms 3071 and 3074.

Form 3618 or 3619 Discharge must be signed and electronically submitted within 72 hours of Hospice election date.



Submit an MDS with A0310A=04 (Significant Change in Status Assessment) with a check in O0100K2 indicating Hospice Care.



Complete Long-Term Care Medicaid Information (LTCMI) S1d. Hospice provider number.



Form 3071 and 3074 submitted by Hospice provider.

Current Hospice Residents

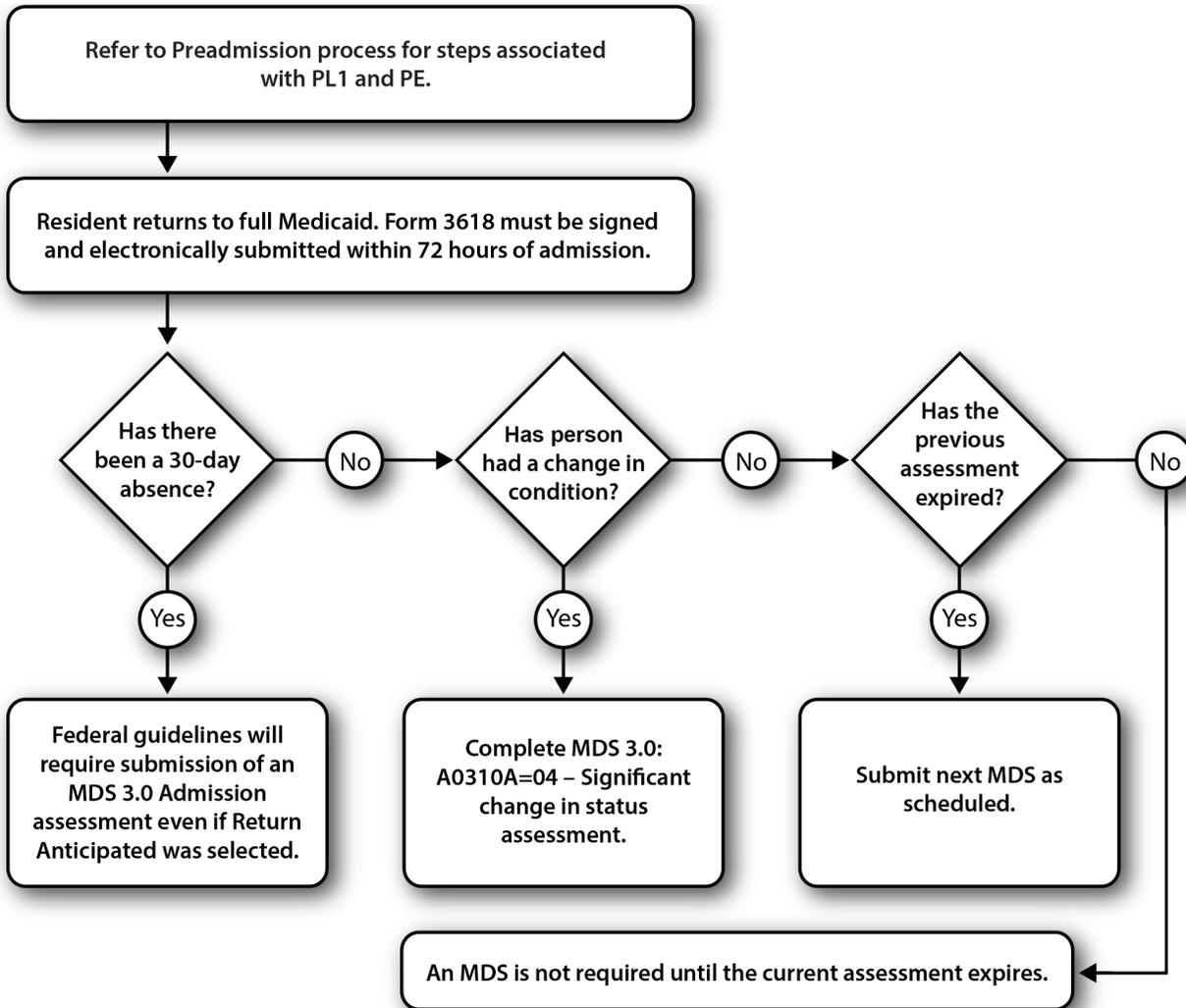
Once an MDS SCSA is submitted, the nursing facility (NF) should continue the MDS cycle for people in Hospice. In addition to indicating Hospice Care on the assessment, the hospice provider number on the LTCMI will be required to allow the hospice provider to view assessments submitted with their provider numbers. The hospice provider number entered on the LTCMI will be validated and must contain a valid hospice provider number to be accepted onto the LTC Online Portal.

Hospice providers can view (on the LTC Online Portal) MDS assessments submitted on their behalf – based on the hospice provider number that is indicated in the LTCMI S1d (Hospice Provider Number S1d must be completed correctly to view those assessments).

Hospice nurses are not required to sign off on the assessment for the people in hospice. Providers can print and sign their assessment prior to submitting. The assessment should be signed by the NFs RN MDS Assessment Coordinator.

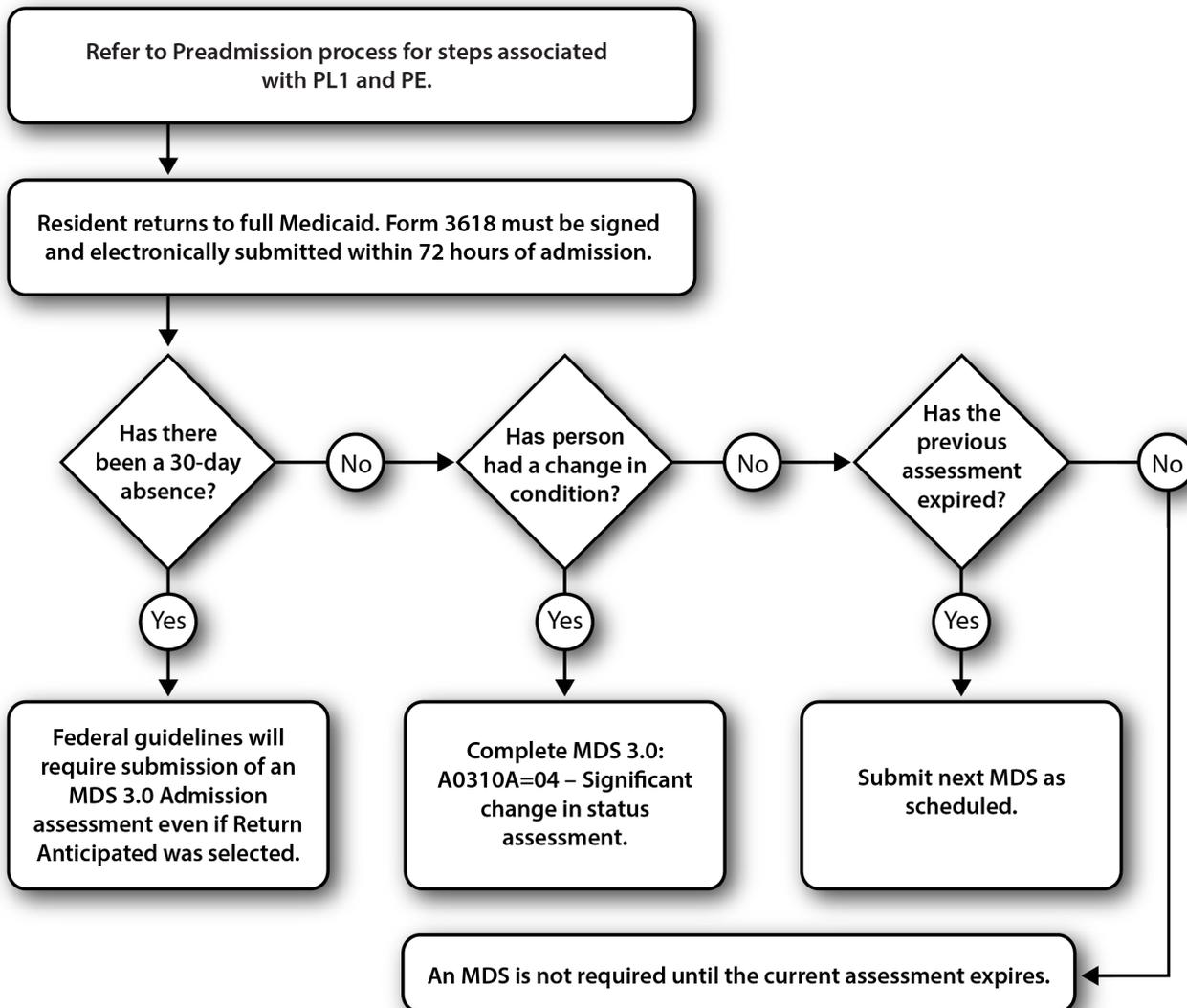
Resident Returns (Prior Discharge - Return Not Anticipated)

- Follow the PASRR process to start over with a new PL1 AND a new PASRR Evaluation (PE), if a new PE is warranted.
- Submit a 3618 Admission by day three (admitting to full Medicaid).
- Complete an Admission MDS assessment by day 14.
- Complete a quarterly assessment within 92 days of the Admission MDS unless a SCSA was completed prior to this.



Resident Returns (Prior Discharge - Return Anticipated)

- Follow the PASRR process to start over, with a new PL1 AND a new PE if a new PE is warranted.
- Submit a 3618 within 72 hours of admission.
- If the person returns after a 30-day absence, an MDS 3.0 Admission assessment will be due even if the Discharge indicated Return Anticipated.
- If the person was admitted to another nursing facility, an Admission assessment is required.
- If there has been a change in condition, submit a SCSA.
- If the previous MDS assessment is less than 92 days old—has not expired—and the person has not had a change in condition, no additional assessment is required.
- If the previous MDS assessment has expired, complete the next scheduled assessment, per the federal guidelines.



Forms to be Submitted

Form 3618 - Resident Transaction Notice

Purpose of Form 3618

Form 3618 is used when the person is in a **Full Medicaid** or **Medicaid Pending** status (refer to flow chart in the Sequencing of Documents section of this User Guide). A 3618 submission informs Medicaid Eligibility workers about transactions and status changes and provides Texas Health and Human Services Commission (HHSC) with information to initiate or close service authorizations or adjust provider payments.

Form 3618 is to be submitted for admissions, discharges, and death. Form 3618 must be submitted on the LTC Online Portal. The person must reside in a valid, Medicaid-contracted bed. If Form 3618 is submitted, it is assumed that the person is in a contracted bed. MDS Discharge Tracking and Re-Entry Tracking forms (3.0: A0310F) are not used by Texas Medicaid.

Providers submit Form 3618 when the person is being classified as Full Medicaid. This can occur upon initial admission or can follow a Medicare stay; it can also follow a change in payor source from private pay. If the form is submitted for a change from private pay, Medicare, or Hospice to Medicaid, this is the indicator for TMHP to retrieve MDS Assessments for that person for Medicaid processing. Providers are not required to submit a new MDS to CMS upon change to Medicaid if the cycle is already established. Once the Form 3618 has been submitted, the most recent MDS assessment that meets the necessary criteria will be loaded onto the LTC Online Portal and set to status **Awaiting LTC Medicaid Information**.

For a Medicaid recipient to begin Full Medicaid Provider Payment, the following must apply:

- The person must have Medicaid Financial Eligibility. Form 3618 will not be processed until the person is determined to be eligible.
- The MN must be approved on the MDS and Resource Utilization Group (RUG) calculated.
- Medicaid Eligibility Service Authorization Verification (MESAV) must be updated to reflect the processing of Form 3618 and the MDS RUG.

Note: *The MDS must be submitted to CMS in accordance with the RAI User's Manual whether the person is under Medicare, Medicaid, or private pay status. MDS submissions to CMS are not dependent upon the payor source.*

Form 3618 must be signed and submitted by the facility administrator within 72 hours of the person's Admission to, or Discharge from, the Medicaid Vendor System to be considered timely.

A facility administrator may authorize a person to sign the form in their absence. The authorization must be in writing and on file at the facility. The administrator date signed check box is required for Forms 3618 and 3619.

If the facility is temporarily without an administrator, a signature is still required. Note in the comment section of Form 3618 that the facility is without an administrator at this time, and enter 999999 in field 13 for the State Board License No.

Note: *Nursing facilities are reminded that a Form 3618 Discharge must be submitted after a person is classified as Hospice and continues to reside in the facility. If the person is classified as Hospice upon admission, Form 3618 should not be submitted. Hospice providers should only submit Forms 3071/3074. If the person is Medicare for a non-related condition and classified as SNF (Skilled Nursing Facility) by the Hospice provider, Form 3619 is appropriate. Nursing facilities should inactivate any Forms 3618/3619 rejected to the Provider Action Required workflow submitted in error for full Hospice persons.*

Repercussions of Submitting Form 3618 Late

- Payment to the facility will be delayed or denied.
- Personal needs allowance for people receiving Supplemental Security Income (SSI) will be delayed.
- Can delay the Medicaid Eligibility certification for a person applying for Medicaid.
- Failure to submit Form 3618 can restrict the person to a limited number of prescriptions.
- The facility may be subject to sanctions (such as vendor hold) as a result of contractual noncompliance.

How to Submit Form 3618

- 1) Log in to the LTC Online Portal.
- 2) Click the **Submit Form** link located in the blue navigational bar.
- 3) Type of Form: Choose **3618: Resident Transaction Notice** from the drop-down box.
- 4) Click the **Enter Form** button.
- 5) Enter all required information as indicated by the red dots.
 - Enter at least one of the following numbers: Medicaid Recipient No., Social Security No., or Medicare or RR Retirement Claim No.
 - If an Admission from hospital, enter the hospital admission date in the field provided between location and Date of Above Transaction.
 - If an Admission from private pay, enter the physical admission date in the field provided next to Private pay.
 - Deceased indicates that the person was pronounced dead in the facility.
 - Location indicates where the person is admitting from or discharging to.
 - Date of Above transaction will be the actual admission or discharge date.
 - The Last Name must match exactly what is shown on the Medicaid card.

Note: *Validation is performed on the Medicaid/SSN/Medicare number and the Last Name of the person. If the Medicaid/SSN/Medicare number and Last Name do not match, processing will not occur. The form will be set to status **ID Invalid**. Validations are against the Medicaid Eligibility*

file. Check the person's Medicaid card or the MESAV and compare to the entry being made. If the Medicaid card is incorrect, contact the Medicaid Eligibility Worker. The correction information must be submitted. After the form is submitted, only corrections to the First Name or Medicare ID Number fields are allowed. The Last Name, SSN, and Medicaid ID Number fields cannot be corrected. Incorrect entries require inactivation and a new submission. Also note that the discharge type Return Anticipated or Return Not Anticipated has an effect on the person's MDS RUG cycle. Discharge type Return not Anticipated ends the person's current RUG records. This should match the MDS Tracking Form.

6) From here you have two choices:

a) Click the **Submit Form** button to submit the form.

or

b) Click the **Save as Draft** button to store the form for future use, but not submit it. The form does not have to be complete to save the draft.

Note: *If the form is successfully submitted, a Document Locator Number (DLN) will be assigned and the LTC Online Portal will show Your form was submitted successfully. If there are errors, they will be displayed in a box at the top of the screen. These errors will need to be resolved before the form can be successfully submitted. Once all errors are resolved, click the **Submit Form** button again to submit the form.*

Your form was submitted successfully. You can track this form using the DLN 
[Submit another form.](#)
[Inquiry on a forms Status](#)

3618 - RESIDENT TRANSACTION NOTICE

Current Status: Name: DLN:0

Form Actions:

Provider Information
 HENSHAW MEDICAL CENTER
 1101 NORTH 10TH STREET
 GAITHERSBURG, MD 20878
 Vendor Number: 9047
 Provider Number: 000004200
 NPI Number: 106340 0027

Recipient Information

1. Medicaid Recipient No. <input type="text"/>	4. Name	Recipient's Last Name <input type="text"/> Recipient's First Name <input type="text"/> Recipient's Middle Initial <input type="text"/> Recipient Name Suffix <input type="text"/>	5. Address
2. Social Security No. <input type="text"/>			Address <input type="text"/>
3. Medicare or RR Retirement Claim No. <input type="text"/>			City <input type="text"/>
			State <input type="text"/>
			ZIP <input type="text"/>

Transaction Information

Service Group <input type="text"/>	Discharge Type <input type="text"/>
Transaction <input type="text"/>	Date of Physical Admission to Private Pay <input type="text"/>
Location <input type="text"/>	
If Newly Admitted From/Discharged To Hospital, Enter Date <input type="text"/>	
Date of Above Transaction <input type="text"/>	

Comments

Administrator Information
 I certify that, to the best of my knowledge, the date in Item 11 (Date of Above Transaction) is for services provided, and the date is not included in the 100% Medicare Part A reimbursement time frame.

Administrator	State Board License No <input type="text"/> Administrator Last Name <input type="text"/> Administrator First Name <input type="text"/> Is Administrator Signature on Form? <input type="checkbox"/> Date Signed <input type="text"/>
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History

Note: A Form 3618, admitting the person to Full Medicaid, or a Form 3619 (Medicare Coinsurance) must be submitted prior to submission of the MDS LTCMI (to be discussed later).

Form 3619 - Medicare/Skilled Nursing Facility Patient Transaction Notice

Purpose of Form 3619

Form 3619 is for people who fall under the Medicare Coinsurance category and provides information about the status of a Medicaid applicant or recipient. It provides information to Medicaid for the Elderly and People with Disabilities (MEPD) worker about the status of a Medicare Coinsurance applicant or person. Form 3619 provides HHSC with information to initiate, close, or adjust Medicare Skilled Coinsurance payments. The dates of qualifying stay are tracked by HHSC. Traditional Medicare will pay for up to 100 days stay in an SNF. After the first 20 days, the facility must look to private pay, third-party insurance, or Medicaid to pay the deductible portion of the remaining days.

Occasionally, Medicare-/Medicaid-eligible people may be discharged and readmitted under the same Medicare authorization. These people are eligible for up to 100 days of skilled nursing care per spell of illness and may use their days in several short-term stays or in one long stay.

Form 3619 establishes the 20 qualifying days of full Medicare coverage. Form 3619 Admission must be completed on the 21st day to begin Medicare Coinsurance. Before submitting Form 3619 Admission, the person must have already spent 20 days of Full Medicare Coverage in a skilled nursing bed, though the stay does not have to be in the same facility. The administrator must sign and submit the form within 72 hours of the person's Admission to or Discharge from Medicare Coinsurance to be considered timely. In hospitals acting as temporary Texas Medicaid nursing homes, the person responsible, such as the Director of Nurses (DON), may sign as the administrator; the 72-hour deadline will still apply.

Facility administrators may authorize a person to sign the form in their absence. The authorization must be in writing and on file at the facility. The administrator date signed check box is required for Forms 3618 and 3619. If the facility is temporarily without an administrator, a signature is still required. Note in the comment section of Form 3619 that the facility is without an administrator at this time, and enter 999999 for the State Board License No.

When Medicaid provides the rest of the payment, this is called Medicare Coinsurance. For Medicare Coinsurance to begin, the person must meet the following requirements:

- Medicaid financial eligibility
- Have an Admission Form 3619 on file
- Have a qualifying stay of 20 days of full Medicare coverage (not the three-day acute care hospitalization stay)

The Dates of Qualifying Stay fields allow for two separate time frames. However, the dates may be broken up into multiple stays but will need to total 20 days. If the dates entered on the form equal less than 20 days, the provider must add comments to the form explaining the reason for this. Once the comments are added, the form may be submitted. If additional sets of dates are needed to document the qualifying stay, the provider must enter a comment that additional forms are being submitted for the form to be accepted into the LTC Online Portal with less than 20 days. A second Form 3619 must be completed using the same date of above transaction to supply the additional set(s) of dates. This form will also require a comment because it will not document a full 20 days of Qualifying Stay.

If the person has a Medicare Replacement (also known as Medicare Advantage plan or Medicare Health Maintenance Organization [HMO]), the full coverage requirement may vary. Include the following information in the Comments section of the Form 3619:

- Medicare Replacement
- Name of the insurance carrier
- Number of Coinsurance payment days allowed
- Daily Coinsurance payment amount

Repercussions of Submitting Form 3619 Late

- Payment to the facility will be delayed or denied.
- The facility may be subject to sanctions (such as vendor hold) as the result of contractual noncompliance.

How to Submit Form 3619

- 1) Log in to the LTC Online Portal.
- 2) Click the **Submit Form** link located in the blue navigational bar.
- 3) Type of Form: Choose **3619: Medicare/SNF patient Transaction Notice** from the drop-down box.
- 4) Click the **Enter Form** button.
- 5) Enter all required information as indicated by the red dots.
 - Enter at least one of the following: Medicaid Recipient No., Social Security No., or Medicare or RR Retirement Claim No.
 - Indicate either an admission or discharge transaction. Medicaid does not pay for Date of Death on Medicare Coinsurance people.
 - Location indicates where the person is admitting from or discharging to.
 - Date of Above transaction will be the actual admission or discharge date.
 - Enter the Qualifying stay dates equal to 20 days. If Full Medicare is more than two time periods use multiple forms with the same Date of Above Transaction to submit the 20 days of Full Coverage.
 - The Last Name must match exactly what is shown on the Medicaid card.
Note: *Validation is performed on the Medicaid/SSN/Medicare number and the Last Name of the person. If the Medicaid/SSN/Medicare number and Last Name do not match, processing will not occur. The form will be set to status **ID Invalid**. Validations are against the Medicaid Eligibility file. Check the person's Medicaid card or the MESAV and compare to the entry being made. If the Medicaid card is incorrect, contact the Medicaid Eligibility Worker. The correction information must be submitted. As noted previously, after the form is submitted, no corrections to the Last Name, SSN, or Medicaid ID Number fields are allowed. Incorrect entries require inactivation and a new submission.*
- 6) From here you have two choices:
 - a) Click the **Submit Form** button to submit the form.
or
 - b) Click the **Save as Draft** button to store the form for future use, but not submit it. The form does not have to be complete to save the draft.

Note: *If the form is successfully submitted, a DLN will be assigned and the LTC Online Portal will show Your form was submitted successfully. If there are submission errors, they will be displayed in a box at the top of the screen. These errors will need to be resolved before the form can be successfully submitted. Once all errors are resolved, click the **Submit Form** button again to submit the form.*

***Important:** Validation is performed on the Medicaid/SSN/Medicare number and the Last Name of the person. If the Medicaid/SSN/Medicare number and Last Name do not match, processing will not occur. The form will be set to status **ID Invalid**. Validations are against the Medicaid Eligibility file. Check the person's Medicaid card or the MESAV and compare to the entry being made. If the Medicaid card is incorrect, contact the Medicaid Eligibility Worker. The correction information must be submitted. As noted previously, after the form is submitted, no corrections to the Last Name, SSN, or Medicaid ID Number fields are allowed. Incorrect entries require inactivation and a new submission.

3619 - Medicare/SNF Patient Transaction Notice

Current Status: Name: _____ DLN:0

Form Actions:

Provider Information

Vendor Number: _____
 Provider Number: _____
 NPI Number: _____

Recipient Information

1. Medicaid Recipient No. _____ 4. Name
 2. Social Security No. _____ • Recipient Last Name _____
 3. Medicare or RR Retirement Claim No. _____ • Recipient First Name _____
 Recipient Middle Initial _____
 Recipient Name Suffix _____

5. Address
 Address _____
 City _____
 State _____
 ZIP _____

Transaction Information

• Service Group _____
 • Transaction _____
 • Location _____
 • Date of Above Transaction _____

Dates Of Qualifying Stay

Enter an explanation in the "Comments" section if less than 20 days of "Qualifying Stay" are entered on this form. If additional sets of dates are needed, a second Form 3619 must be completed using the same "Date of Above Transaction" in order to supply the additional set(s) of dates.

• Stay 1 From _____
 • Stay 1 To _____
 Stay 2 From _____
 Stay 2 To _____

Comments

Administrator Information

I certify that, to the best of my knowledge, the date in Item 11 (Date of Above Transaction) is for services provided, and the date is not included in the 100% Medicare Part A reimbursement time frame.

Administrator
 • State Board License No. _____
 • Administrator Last Name _____
 Administrator First Name _____
 • Is Administrator Signature on Form?
 • Date Signed _____

Submit Form 3619 for:

- Medicare Coinsurance Admission
- Medicare Coinsurance Discharge

Form 3619 Discharge is needed if the Coinsurance is no longer due to the NF (e.g., the person discharged from the NF, Medicare benefits are exhausted or denied, or the person is deceased).

In addition, type the following information in the Comments section of Form 3619:

- Medicare Replacement
- Name of the insurance carrier
- Number of Coinsurance payment days allowed under the Medicare replacement policy
- Daily Co-payment amount

Forms 3618 and 3619 Submission Validation Rules and Edits

Based on information entered in certain fields and on the sequence in which the form is being submitted, validation, or front-end edits, will occur and may result in an error. The form will not be accepted until all errors are resolved. The system messages will display at the top of the LTC Online Portal submission page. If you do not receive the DLN number-assigned page after clicking the **Submit Form** button, there are errors that need to be resolved. The errors will be displayed at the top of the page, and you may need to scroll to the top of the page to see the errors.

An example of a validation, or front-end edit, occurs when the Date of Above Transaction is more than one year old or more than or equal to five years old. A front-end edit may also require the provider to enter additional information depending upon the message received.

Sequencing validation edits are based on three levels: Form Type, Transaction, and Date of Above Transaction.

- Form type – admission 3618 must be discharged with a 3618 before submitting a 3619 and the reverse.
- Transactions must alternate between admission and discharge.
- Date of Above Transaction should be chronological unless submitting a form effective retroactively.
- Retroactive forms should be submitted in pairs creating or filling a gap of time.

Forms set to the following statuses are excluded from consideration in meeting form sequencing requirements: **Corrected, Invalid/Complete, Invalid Form Sequence, ID Invalid, Form Inactivated, Med ID Check Inactive, ME Check Inactive, or AI Check Inactive.**

The errors will display at the time of a 3618 or 3619 form submission. There are different errors dependent upon the form type, therefore, the error messages below have been categorized by form type.

- 1) **System Message.** This is the specific error message that will be displayed in the LTC Online Portal at time of submission.
- 2) **System Message Clarification.** Further clarification of the LTC Online Portal error message including a basic example of the situation.
- 3) **System Message Resolution.** Assistance with resolving the error.

When a form is missing, providers will need to submit the missing form for the erroring form to pass validations.

The provider has two options regarding the submissions:

- If a submission displays a message that a form is missing, the provider can save the form as a draft. Submit the missing form, and then retrieve the draft and submit to complete both transactions.
- If the submission displays a message stating that a form is missing, that form can be adjusted to submit the missing form and then, using Use as template, the original form can be submitted now that the edit has been resolved.

The submission of the missing form and the erroring form can occur the same day. The missing form will need to be submitted and then the erroring form should be submitted. Providers do not need to wait for the missing form to process overnight.

Form 3618 Resident Transaction Notice Edits

Edit Description

System Message (displayed at time of submission)	System Message Clarification	System Message Resolution (assistance for resolving error)
<p>Last form submitted was an admission. Please supply discharge form prior to this admission.</p>	<p>Rejection of New Admission for missing Previous Discharge.</p> <p>New admission follows an admission for same contract i.e., 11-12-2008 admission (no discharge) 12-16-2008 admission submitted.</p>	<p>Submit a discharge prior to this admission.</p> <p>Attempting to submit two 3618 admissions in a row, missing a 3618 discharge. Submit the missing discharge then submit the 3618 admission.</p> <p>Scenarios: 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/20/08. 3618 admit submitted for person A, provider A, transaction date = 10/21/08. Submission is not allowed without a prior discharge.</p> <p>3618 admit exists in Corrected status for person A, provider A, transaction date = 10/20/08. 3618 admit submitted for person A, provider A, transaction date = 10/21/08. Submit allowed (Previous admit in Corrected status so not considered).</p>

System Message (displayed at time of submission)	System Message Clarification	System Message Resolution (assistance for resolving error)
<p>Last form submitted was a discharge. Please supply admission form prior to this new discharge.</p>	<p>Rejection of New Discharge for missing Previous Admission.</p> <p>New discharge follows a discharge for same contract i.e., 11-1-2008 discharge (no admission) 12-1-2008 discharge submitted.</p>	<p>Submit an admission prior to this discharge.</p> <p>Attempting to submit two 3618 discharges in a row, missing a 3618 admission. Submit the missing admission then submit the 3618 discharge.</p> <p>3618 discharge exists in Processed/Complete status for person A, provider A, transaction date = 10/19/08. 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/19/08. 3618 admit submitted for person A, provider A, transaction date = 10/21/08. Submission is allowed because of multiple matching date of above transaction on prior form.</p> <p>3618 admit exists in ME Check Inactive status for person A, provider A, transaction date = 10/20/08. 3618 admit submitted for person A, provider A, transaction date = 10/21/08. Submit allowed (Previous admit in ME Check Inactive status so not considered).</p>

System Message (displayed at time of submission)	System Message Clarification	System Message Resolution (assistance for resolving error)
<p>Same contract: An admission has already been received for the Date of Above Transaction. OR Different contract: An admission from another provider has already been received for the Date of Above Transaction.</p>	<p>Rejection of New Admission for Same Date of Above Transaction.</p> <p>New admission has same Date of Above Transaction as an admission already received i.e., 11-1-2008 admission 11-1-2008 admission.</p>	<p>Same contract: Possibly attempting to submit a duplicate form. OR Different contract: A different provider has previously submitted an admission for the same Date of Above Transaction date. One provider is in error. Contact other provider.</p> <p>Scenarios: 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/1/08. 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/21/08. 3618 admit submitted for person A, provider A, transaction date = 10/1/08. Submit not allowed because date already in Processed/Complete.</p> <p>3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/1/08. 3618 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/21/08. 3618 admit submitted for person A, provider B, transaction date = 10/1/08. Submit not allowed because date already in Processed/Complete for another provider.</p>

System Message (displayed at time of submission)	System Message Clarification	System Message Resolution (assistance for resolving error)
<p>Same contract: A discharge has already been received for the Date of Above Transaction. OR Different contract: A discharge from another provider has already been received for the Date of Above Transaction.</p>	<p>Rejection of New Discharge for Same Date of Above Transaction. New discharge has same Date of Above Transaction as a discharge already received i.e., 11-1-2008 discharge 11-1-2008 discharge.</p>	<p>Same contract: Possibly attempting to submit a duplicate form. OR Different contract: A different provider has previously submitted a discharge for the same Date of Above Transaction date. One provider is in error. Contact other provider.</p>
<p>Date of Above Transaction is over one year old, do you want to continue?</p>	<p>When submitting a form that is between one and five years old, providers will receive this warning message. The provider will have an option to select OK or Cancel before the form will continue to process.</p>	<p>If a provider submits a Date of Above Transaction that is equal to or more than five years old, the form will not be accepted onto the LTC Online Portal. Additionally, forms with a future date in the Date of Above Transaction field will not be accepted onto the LTC Online Portal.</p>

System Message (displayed at time of submission)	System Message Clarification	System Message Resolution (assistance for resolving error)
<p>Previous form was a 3619. A 3619 discharge or 3618 admission (as appropriate) must be submitted before a 3618 discharge can be submitted. Applicable for same or different contract.</p>	<p>Rejection of 3618 Discharge following a 3619. 3618 discharge received following a 3619 regardless of contract.</p>	<p>Submit either a 3619 discharge or 3618 admission (as appropriate) prior to this 3618 Discharge.</p> <p>Scenarios:</p> <p>3619 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/20/08. 3618 admit submitted for person A, provider A, transaction date = 10/21/08. Submit not allowed.</p> <p>3619 discharge exists in Processed/Complete status for person A, provider A, transaction date = 10/20/08. 3618 discharge submitted for person A, provider A, transaction date = 10/21/08. Submit not allowed.</p> <p>3619 admit exists in Processed/Complete status for person A, provider A, transaction date = 10/19/08. 3619 discharge exists in Processed/Complete status for person A, provider A, transaction date = 10/19/08. 3618 discharge submitted for person A, provider A, transaction date = 10/21/08. Submit not allowed.</p>

Form 3619 Medicare/SNF Patient Transaction Notice Edits

Edit Description

System Message (displayed at time of submission)	System Message Clarification	System Message Resolution (assistance for resolving error)
Last form submitted was an admission. Please supply discharge form prior to this new admission.	<p>Rejection of New Admission for missing Previous Discharge.</p> <p>New admission follows an admission for same contract i.e., 11-1-2008 admission (no discharge) 12-1-2008 admission submitted.</p>	<p>Submit a discharge form prior to this admission.</p> <p>Attempting to submit two 3619 admissions in a row, missing a 3619 discharge. Submit the missing discharge then submit the 3619 admission.</p>
Last form submitted was a discharge. Please supply admission form prior to this new discharge.	<p>Rejection of New Discharge for missing Previous Admission.</p> <p>New discharge follows a discharge for same contract i.e., 11-1-2008 discharge (no admission) 12-1-2008 discharge submitted.</p>	<p>Submit an admission form prior to this discharge.</p> <p>Attempting to submit two 3619 discharges in a row, missing a 3619 admission. Submit the missing admission then submit the 3619 discharge.</p>
<p>Same contract: An admission has already been received for the Date of Above Transaction.</p> <p>OR</p> <p>Different contract: An admission from another provider has already been received for the Date of Above Transaction.</p>	<p>Rejection of New Admission for Same Date of Above Transaction.</p> <p>New admission has same Date of Above Transaction as an admission already received i.e., 11-1-2008 admission 11-1-2008 admission.</p>	<p>Same contract: Possibly attempting to submit a duplicate form.</p> <p>OR</p> <p>Different contract: A different provider has previously submitted an admission for the same Date of Above Transaction date. One provider is in error. Contact other provider.</p>
<p>Same contract: A discharge has already been received for the Date of Above Transaction.</p> <p>OR</p> <p>Different contract: A discharge from another provider has already been received for the Date of Above Transaction.</p>	<p>Rejection of New Discharge for Same Date of Above Transaction.</p> <p>New discharge has same Date of Above Transaction as a discharge already received i.e., 11-1-2008 discharge 11-1-2008 discharge.</p>	<p>Same contract: Possibly attempting to submit a duplicate form.</p> <p>OR</p> <p>Different contract: A different provider has previously submitted a discharge for the same Date of Above Transaction date. One provider is in error. Contact other provider.</p>

System Message (displayed at time of submission)	System Message Clarification	System Message Resolution (assistance for resolving error)
<p>Previous form was a 3618. A 3618 discharge or 3619 admission (as appropriate) must be submitted before a 3619 discharge can be submitted.</p>	<p>Rejection of 3619 Discharge following a 3618.</p> <p>3619 discharge received following a 3618 (regardless of contract on form).</p>	<p>Submit either a 3618 discharge or 3619 admission (as appropriate) prior to this 3619 Discharge.</p>
<p>Date of Above Transaction is over one year old, do you want to continue?</p>	<p>When submitting a form that is between one and five years old, providers will receive this warning message. The provider will have an option to select OK or Cancel before the form will continue to process.</p>	<p>If a provider submits a Date of Above Transaction that is equal to or more than five years old, the form will not be accepted onto the LTC Online Portal. Additionally, forms with a future date in the Date of Above Transaction field will not be accepted onto the LTC Online Portal.</p>
<p>Please provide a reason in the comments field why the Dates of Qualifying Stay for this client do not equal 20.</p>	<p>The Dates of Qualifying Stay must add up to exactly 20 non-duplicative days. If the Dates of Qualifying Stay do not equal 20, a comment is required in the Comments field.</p>	<p>Correct the Dates of Qualifying Stay to equal 20.</p> <p>If the dates do not equal 20 days because additional space is needed, add a comment to the form indicating that additional forms are being submitted to capture the full 20 days.</p> <p>If the person has a Medicare replacement policy, indicate the following information in the comments:</p> <ul style="list-style-type: none"> • Medicare replacement • Name of the insurance carrier • Number of co-pay days allowed • Daily co-pay amount

MDS Assessments

The LTC MDS is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all recipients in a Medicare- or Medicaid-certified LTC facility. The MDS contains items that measure physical, psychological, and psychosocial functioning. The items in the MDS give a multidimensional view of the person's functional capacities and helps staff to identify health problems.

Assessments that providers may submit to CMS and for Medicaid payment include:

- Admission assessment (required by day 14).
- Quarterly review assessment.
- Annual assessment.
- Significant change in status assessment.
- Significant correction to prior comprehensive assessment.
- Significant correction to prior quarterly assessment.
- Inactivation.
- Modification.

MDS 3.0 assessments that are accepted by CMS are retrieved by TMHP nightly, loaded onto the LTC Online Portal, and set to status **Awaiting LTC Medicaid Information**. Once the LTCMI has been successfully completed and submitted on the LTC Online Portal, the MN determination process will begin.

MDS 3.0 Admission assessments are effective based on the Entry Date entered into field A1600. System processing will start the Level record either based on the Entry Date or the completion date (Z0500B) minus 30 days, whichever is later.

Note: *If the begin date of the Level record needs to be adjusted because the timeframe between Entry Date and the completion date is over 30 days, you must call HHSC LTC Provider Claims Services 512-438-2200, Option 1, for the additional days.*

All other assessment types will be effective based on the completion date (Z0500B).

All assessments without a Purpose Code are valid for 92 days from the completion date. Expiration dates on the MESAV also include a 31-day grace period for the next submission.

An MDS 3.0 Admission assessment is valid in three situations:

- 1) For a first physical admission into a NF, an Admission assessment is valid. Regardless of whether the person is private pay, Medicare, or Medicaid, the provider should complete an Admission assessment for a first physical Omnibus Budget Reconciliation Act (OBRA) admission within 14 calendar days of admission to the NF. For Texas Medicaid, if a resident is active in a NF and discharges to another NF for even one day, then returns to the original NF, the readmission to the original NF is considered a first physical admission. As soon as another provider is introduced, the prior NF's MDS cycle for the person is ended and must be restarted if the person returns to the

original NF. Discharging to the person's home, to Hospice, to another Medicaid service (community services), or to the hospital is not discharging to another NF.

- 2) If the resident discharges from a NF and the Form 3618 discharge type indicates Return Not Anticipated, a new Admission assessment is required if the person readmits to the NF. Remember that the Form 3618 is expected to match the MDS discharge tracking form also submitted for this person. The MDS discharge tracking form would indicate Discharge – Return Not Anticipated. Although CMS rules allow the use of the Reason for Assessment on the discharge tracking form for any person whose first physical admission to the NF is less than 14 days, a provider should NOT use this reason for assessment if the person's stay is being paid for by Texas Medicaid. This is because if the provider does not complete an OBRA Admission assessment as completely as possible, even if the person is in the provider's building for only one day, the provider will not have an MDS assessment for billing purposes. If the Form 3618 or MDS tracking form discharge type is marked incorrectly, the discharge type can be corrected.
- 3) If the resident is physically discharged from the facility for over 30 days – regardless of reason or location – CMS requires an Admission assessment. For example, if the discharge to the hospital was marked Return Anticipated, and the person is in the hospital over 30 days, a new MDS 3.0 Admission assessment is due. The Entry Date should be the new admission to the facility after the discharge that was over 30 days. If the Entry Date is submitted with a date prior to the discharge, a modification will be required to adjust the date so the assessment is valid for the dates after readmission.

Validating the Appropriateness of an Admission Assessment

If the Entry Date of an MDS assessment overlaps with an established MDS for the same NF, the coding of Admission assessment is most likely in error.

One of the considerations in validating an Admission assessment is the relationship between the Entry Date and the completion dates. An Admission assessment should be completed within 14 days of the Entry Date. CMS and HHSC will accept the assessment if the timeframe is longer, but the provider must validate whether an Admission assessment is the appropriate reason for assessment. If the Entry Date is two years prior to the completion date, this assessment probably should not be an Admission assessment.

If the Admission assessment is needed because the resident had a Form 3618 discharge indicating Return Not Anticipated, the Entry Date should be the new readmission date, not an admission prior to the discharge. If the provider already submitted the assessment with the Entry Date prior to the discharge date, a modification must be transmitted to the state MDS database to adjust the Entry Date to the readmission date following the discharge.

Swing bed providers are required to submit MDS 3.0 assessments A0200 Type of Provider coded as 2. Swing Bed. MDS 3.0 assessments for swing bed providers include assessments listed in items A0310B, A0310C, A0310D, and A0310F. These assessments are submitted to CMS; however, they are not retrieved by TMHP. Swing bed providers must complete the appropriate MDS 3.0 OBRA-required Comprehensive or Quarterly assessments listed in item A0310A in accordance with the MDS 3.0 *RAI User's Manual*,

if services provided are eligible for Medicaid reimbursement. OBRA-required assessments listed in A0310A that meet TMHP guidelines are retrieved by TMHP and the associated LTCMI will have field S1c (Service Group) auto populated to equal ten (10) based on the vendor/provider number provided upon login.

MDS Discharge Tracking and Re-Entry Tracking forms (3.0: A0310F) are used by CMS, but are not retrieved and loaded onto the LTC Online Portal. The 3618 and 3619 are used by the state for Medicaid processing of recipient movement.

If the resident expires on the day the MDS Quarterly is due and there is no level of service for the date of death, the MDS Quarterly must be submitted to receive payment for the date of death.

To receive a RUG payment when a resident expires prior to completion of an Admission assessment, the Admission assessment must be completed and submitted to CMS with the information that is available. If CMS cannot calculate a RUG because the Admission assessment is incomplete or has errors, CMS will still assign a RUG value of BC1, which is the default rate. If the Admission assessment meets medical necessity and the resident has Medicaid eligibility for the days of services, payment can be made for the RUG value calculated by CMS.

Submission and Retrieval of MDS Assessment

Providers should use their current method for submission to CMS, either through jRAVEN or another third-party software package. Validate the acceptance of the MDS 3.0 assessment using the validation report process from CMS.

TMHP receives assessments nightly. Only assessments that meet the following criteria will be loaded onto the LTC Online Portal:

- Reason for Assessment
 - Admission assessment: A0310A=01.
 - Quarterly review assessment: A0310A=02.
 - Annual assessment: A0310A=03.
 - Significant change in status assessment: A0310A=04.
 - Significant correction to prior comprehensive assessment: A0310A=05.
 - Significant correction to prior quarterly assessment: A0310A=06.
- National Provider ID (MDS 3.0: A0100A) should be entered to locate assessments set to status **Awaiting LTC Medicaid Information**.
- Medicaid Number (MDS 3.0: A0700) contains + or a nine-digit numeric value.

Note: *Once accepted by CMS, it may be up to 48 business hours before the MDS 3.0 assessment is accessible on the LTC Online Portal for data entry in **Awaiting LTC Medicaid Information** status.*

Note: *The effective date of quarterly review assessments with a date after the 30-day submission period, can be adjusted by contacting HHSC Provider Claim Services (PCS) directly to make the adjustment.*

Assessments loaded onto the LTC Online Portal are assigned a DLN and set to status **Awaiting LTC Medicaid Information**.

Providers must log in to the LTC Online Portal and use Form Status Inquiry (FSI) or Current Activity to find the submitted MDS assessment set to status **Awaiting LTC Medicaid Information**. Complete the LTCMI and submit.

The MDS assessment must be accepted by the LTC Online Portal and have an LTCMI completed to begin the MN determination process. Periodically review the status of the MDS assessment for MN and Medicaid Processing using FSI or Current Activity.

When an MDS assessment is set to status **PE MN Denied** but the MN determination on the PE has been overturned, the NF can change the status of the MDS assessment. For more information, see the MDS set to status **PE MN Denied** section of this User Guide.

Note: *Providers should follow the federal MDS 3.0 RAI User's Manual for submission of an assessment. If the provider follows the federal guidelines for submission, and completes the LTCMI on the LTC Online Portal, there will not be a lapse in Texas Medicaid coverage.*

MDS Dually-Coded Assessments

Dually-coded assessments will be retrieved and loaded onto the LTC Online Portal nightly if the retrieval criteria above are present. If the assessment fails due to the Medicaid ID/Recipient name, the provider should refer to the MDS 3.0 RAI User's Manual, Chapter five for further instructions and guidelines for submitting modifications to key resident identifying information fields. The MDS 3.0 RAI User's Manual can be found under Downloads on the CMS website:

www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage.

Dually-coded assessments can be submitted as multiple combinations. If the person has been established with MDS RUG's for the facility, then discharges to the hospital and returns to Medicare, the assessment can be dually-coded for the appropriate Medicaid assessment due and the proper Medicare assessment due. An assessment for an established person admitting to Medicare can be coded as a Medicaid Quarterly and a Medicare five-day assessment. If an assessment is coded for a Medicaid Admission assessment and a Medicare five-day assessment and the person has a current RUG already established, the Medicaid admission RUG will not be used unless the person was out over 30 days or discharged as Return Not Anticipated. If the RUG is wanted for Medicaid, it will require inactivating the assessment at CMS and resubmitting with a different Medicaid reason for assessment.

Long-Term Care Medicaid Information (LTCMI)

LTCMI is the replacement for the federal MDS Section S and contains state-specific items for Medicaid payment. Providers must access the LTC Online Portal and retrieve their MDS assessments to successfully complete the LTCMI. Providers should complete the LTCMI section as soon as possible to submit the MDS assessment into TMHP's workflow for review within the anticipated quarter time frame. The anticipated quarter is within 92 days of the date the RN Assessment Coordinator signed the MDS assessment as complete (Z0500B). This is known as the 92-day timeliness rule.

Submission of LTCMI

To enter the LTCMI, the provider must log in to the LTC Online Portal and access their assessments set to status **Awaiting LTC Medicaid Information** using FSI or Current Activity. The LTCMI must be completed with all required data and be successfully submitted on the LTC Online Portal.

Note: *The LTC Online Portal allows a 60-day grace period for submission of the LTCMI for Change of Ownership (CHOW) and new owners. Facilities have 60 days from the day the first MDS LTCMI is submitted on the LTC Online Portal with the new provider number to submit any additional MDS assessments in **Awaiting LTC Medicaid Information** status, whether within the 92-day submission window or not, without requiring a Purpose Code (PC) E.*

LTCMI Rejections

The LTCMI may be rejected for a variety of issues. If an LTCMI has been rejected, it may be due to one of the following issues listed in this section.

If a PASRR Level 1 Screening Form (PL1) has not been submitted prior to the submission of the LTCMI, and there is no PL1 found on the LTC Online Portal for this person, the LTCMI will not be accepted on the LTC Online Portal. Attempting to submit the LTCMI without a PL1 Screening Form will result in an error message stating: PASRR Screening (PL1) not found. A PL1 is required before an MDS LTCMI can be submitted; you may save the LTCMI and submit after PL1 is submitted.

If a PL1 has been submitted with an assessment date that is prior to the assessment date of the LTCMI being submitted, and the Vendor/Provider numbers in Section D of the PL1 do not match the MDS LTCMI Vendor/Provider numbers of the NF, the LTCMI will not be accepted on the LTC Online Portal. Attempting to submit the LTCMI without a matching PL1 will result in an error message stating: PASRR Screening (PL1) not found for this Nursing Facility. A PL1 is required before MDS LTCMI can be submitted; you may save the LTCMI and submit after PL1 is submitted.

For Preadmission PASRR Positive persons with an active PL1, the LTC Online Portal will not accept the LTCMI without an associated PASRR Evaluation (PE). Attempting to submit the LTCMI without a PE will result in an error message stating: PASRR Evaluation (PE) not found. A PE is required before MDS LTCMI can be submitted. Please contact your Local Authority to perform the PASRR Evaluation; you may save the LTCMI and submit after PE is submitted.

In addition, when a PE is required for the admission process, an MDS LTCMI cannot be submitted prior to MN Determination on the PE. The initial MDS assessment will inherit the MN determination from the PE, if the MDS assessment effective date is within 30 days (plus or minus) of the date of assessment of the PE. Attempting to submit the LTCMI prior to MN determination will result in an error message stating: MDS LTCMI cannot be submitted prior to Medical Necessity (MN) Determination on the PASRR Evaluation; you may save the LTCMI and submit after MN on PE is complete.

If the LTCMI is rejected because the latest Interdisciplinary Team (IDT) meeting on the latest PASRR Comprehensive Service Plan (PCSP) submitted for the person that is associated with the NF was not submitted on the LTC Online Portal within the last year, the NF will be able to save the LTCMI and resubmit it after successful submission of IDT meeting. The error message will read: An Interdisciplinary Team (IDT) meeting submission is not found on the LTC Online Portal, or it was found

but the IDT meeting date is more than one year ago. An IDT meeting submission is required before the MDS LTCMI can be submitted. You may save the LTCMI, and submit it again after the IDT meeting is submitted on the PCSP form.

The LTC Online Portal will not reject the MDS LTCMI for missing an IDT meeting submission under the following circumstances:

- The PL1 is inactive (the person has been transferred, is deceased, or discharged).
- A positive PE for this person at this NF was not found on the LTC Online Portal.
- The person is in the Hospice Program (Service Group 8) as of the current date or the MDS Assessment Effective Date. Indication of Hospice will be checked both in the MDS (Section O and LTCMI) and Claims Management System.
- The NF has undergone a CHOW and the system finds that the IDT (with the IDT meeting date within the past year) was submitted on the pre-CHOW PCSP form.

Providers have the ability to save the LTCMI and attempt resubmission once the PL1 Screening Form, PE, or IDT meeting have been submitted on the LTC Online Portal.

Finding Assessments Using Form Status Inquiry

- 1) Click the **Submit Form** link located in the blue navigational bar.
- 2) Choose **Form Status Inquiry** link from the drop-down menu.
- 3) Type of Form: Choose one of the following options from the drop-down box:
 - MDS 3.0: Minimum Data Set (Comprehensive)

- MDSQTR 3.0: Minimum Data Set (Quarterly)

Note: The following is an example of an MDS 3.0 Comprehensive assessment.

The screenshot displays the 'Form Status Inquiry' interface. At the top, under 'Form Select', the 'Type of Form' is set to 'MDS 3.0: Minimum Data Set (Comprehensive)' and the 'Vendor Number' is set to 'for Provider Number'. Below this, the 'Form Status Inquiry' section contains several input fields: 'DLN', 'Last Name', 'Form Status' (with a dropdown menu open showing a list of statuses), 'SSN', 'From Date', 'Purpose Code', 'Reason for Assessment', 'Medicaid Number', 'First Name', and 'To Date' (set to 5/20/2013). A 'Search' button is located at the bottom right of the form.

- 4) Form Status: Choose **Awaiting LTC Medicaid Information** from the drop-down box.
- 5) Enter a date range for the period for which you are searching. The system default for the search is within the past month; however, the date range must include the period in which the assessment was submitted.
Note: It may take up to 48 business hours after submission to CMS before the MDS 3.0 assessment is accessible on the LTC Online Portal for data entry in **Awaiting LTC Medicaid Information** status.
- 6) Click the **Search** button and the search results will display.
- 7) Click the **View Detail** link to display the details of the assessment.

Resource Utilization Group (RUG) Value

The RUG is used for MDS 3.0 to classify relative direct care resource requirements for people in an NF and to determine the rate of payment for Nursing Facility Daily Care and Hospice Room and Boarding fees. Once a person’s assessment is open, the RUG value can be found next to the DLN.

The screenshot shows the MDS 3.0 form interface. At the top, it says "MINIMUM DATA SET (MDS) – Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING Nursing Home Comprehensive (NC) Item Set". Below this, there is a yellow bar with "Current Status: Awaiting LTC Medicaid Information Name: [REDACTED] DLN: [REDACTED] RUG: CA1". The "RUG: CA1" is circled in red. Below the yellow bar are buttons for "Print", "Save LTCMI", and "Populate LTCMI". At the bottom, there is a grid of sections labeled Section A through Section Z, with Section RUG highlighted.

If You Cannot Locate Your MDS Using FSI or Current Activity

After confirming the requested date range, be sure to verify all of the following:

- MDS was accepted (not rejected) by CMS by way of your validation report.
- A valid Medicaid number or + was entered in field A0700.
- A0700 does not contain an ‘N.’
- A0310A has a response of 01, 02, 03, 04, 05, or 06.
- A0310A does not contain a 99.
- The Name on the MDS is exactly the same as the person’s Medicaid ID card.
- The NPI entered in field A0100A matches the Vendor/Provider information on the MESAV for that person.

Using FSI to Identify People with Specific PASRR Conditions

Nursing facilities can use FSI to identify people with specific PASRR conditions. This can assist NFs in identifying the number of people in the facility who are IDD only, MI only, IDD and MI, or PASRR Negative.

The LTC Online Portal will:

- Derive and store the PASRR condition of people in an NF, as indicated by the latest active PE for the person at the time of the most recent MDS LTCMI submission. *(An active PE is one that is not set to status **Pending Form Completion** or **Form Inactivated**.)
- Provide the capability to export the person-based search results to Microsoft Excel™.
- Provide a capability to search for people in the facility based on their PASRR condition, by selecting an option from the drop-down box in the FSI.
- Display a list of people when searching by a PASRR condition listed in the PASRR Eligibility Type drop-down box of the FSI.

To use FSI this way you must select MDS 3.0: Minimum Data Set (Comprehensive) or MDSQTR 3.0: Minimum Data Set (Quarterly) from the FSI Type of Form drop-down box.

- 1) Click the **Search** link on the blue navigational bar.
- 2) Choose **Form Status Inquiry** from the drop-down menu.
- 3) Type of Form: Choose one of the following options from the drop-down box:
 - MDS 3.0: Minimum Data Set (Comprehensive)
 - MDSQTR 3.0: Minimum Data Set (Quarterly)
- 4) Vendor Number: Choose the submitter Vendor Number/Provider Number from the drop-down box.
- 5) Choose one of the following from the PASRR Eligibility Type drop-down box:
 - IDD Only
 - MI Only
 - IDD and MI

- Click the **Search** button. The search will return records for all current people who meet the criteria. Current people are determined by fields B0650. Individual is deceased or has been discharged? and B0655. Deceased/Discharged Date of the PL.

Form Select

Type of Form
 Vendor Number for Provider Number

Form Status Inquiry

DLN
 Last Name
 Form Status
 SSN --
 From Date
 Purpose Code
 Reason for Assessment
 PASRR Eligibility Type

Medicaid Number
 First Name
 To Date

6 record(s) returned.
[Export Data to Excel](#)

Last Name	First Name	PASRR Eligibility Type	Medicaid #	SSN	Medicare #	Vendor Number	Provider Number	Admission Date
BANKS	WENDY	2. MI Only	614339912	488242021	488242021	7087	000017872	4/14/2014
BATTLE	JOHN	2. MI Only	611862788	488743024	488743024	7087	000017872	5/31/2014
BLOOM	LINDA	2. MI Only	257287982	487237982		7087	000017872	12/11/2011
BROOKS	MALIN	2. MI Only	610991228	488891008	488891008	7087	000017872	5/2/2013
BURKE	ELIAS	2. MI Only	617877628	432881278	432881278	7087	000017872	7/17/2013
SMALL	HEATHER	2. MI Only	78889982	486213078		7087	000017872	4/23/2014

Note: The PASRR Eligibility Type field will appear on the FSI page to Local Authorities (LAs) who have authority to select an MDS 3.0 or MDSQTR 3.0 assessment; however, LAs/ will not be able to obtain FSI search results using the PASRR Eligibility Type field.

How to Submit Long-Term Care Medicaid Information (LTCMI)

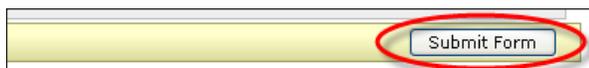
Once you have found and opened the assessment set to status **Awaiting LTC Medicaid Information** using FSI or Current Activity:

- 1) Click the Section LTCMI tab.

- 2) Enter data into remaining fields that are not auto populated. At this time, you will have the option to manually enter information or click the **Populate LTCMI** button and modify data as necessary. **Note:** To ensure that the LTCMI can be submitted after completion, first check for the **Submit Form** button at the bottom of the screen. If the assessment is being used (locked) by another user, the **Submit Form** button will not be available (displayed). Additionally, a message will display in the upper right of the screen: This form is being viewed by another user and cannot be changed.

- 3) From here you have two choices:

- a) Click the **Submit Form** button located at the bottom right of the screen, if ready to submit for processing.



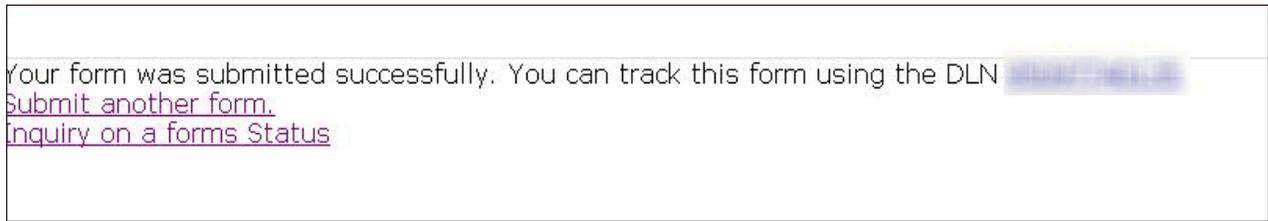
or

- b) Click the **Save LTCMI** button located in the yellow Form Actions bar, if you would like to save the LTCMI prior to submission. The saved LTCMI will remain in status **Awaiting LTC Medicaid Information**.

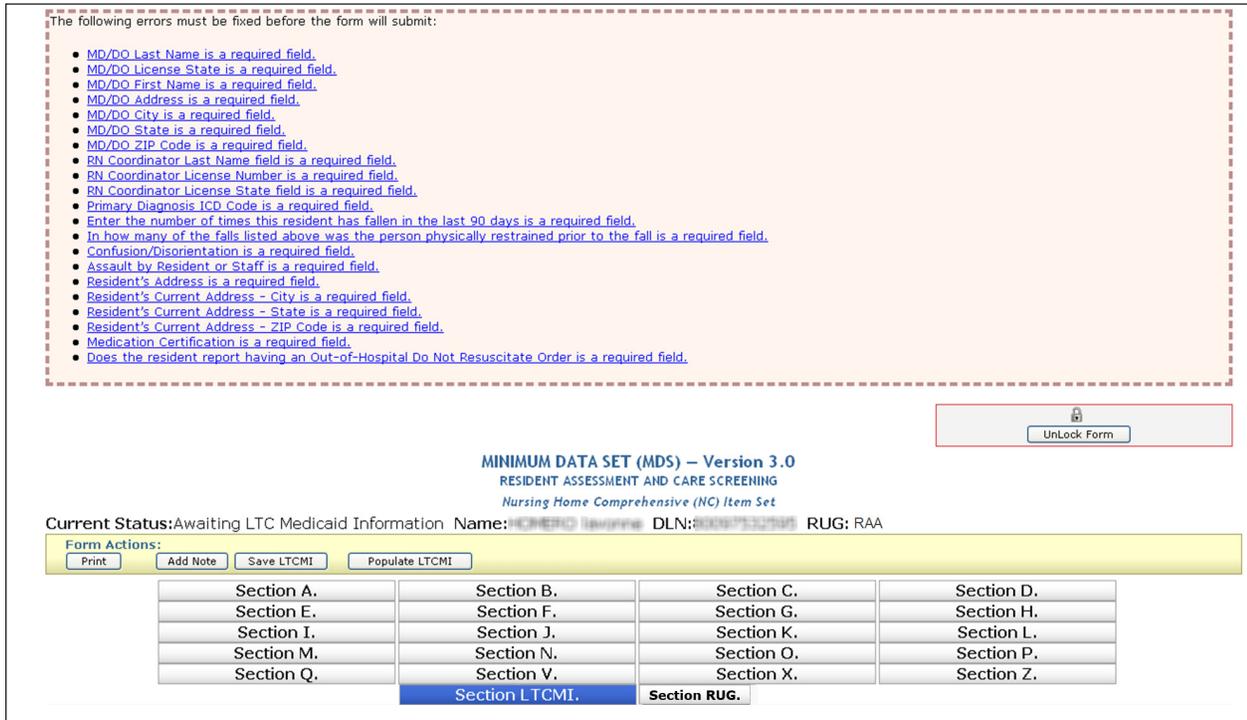
Reminder: The LTCMI will not be saved to Drafts.

- Negative Successful submission will display the DLN and the message: Your form was submitted

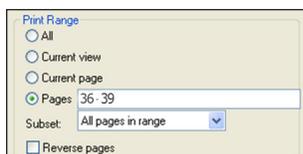
successfully.



- 4) Unsuccessful submission will result in error messages being displayed at the top of the page (scroll to the top of the page to see the errors).



- 5) To print the submitted LTCMI for your records, open the document and click the **Print** button located in the yellow Form Actions bar.
- Printer: Choose the appropriate printer name from drop-down box.
 - Print Range: Click the Pages radio button.
 - Enter the pages to print. As an example, pages for the LTCMI for the MDS 3.0 Comprehensive are 41-44. Pages for the LTCMI for the MDS 3.0 Quarterly are 36-39.



- Click the **OK** button.

Circumstances for LTCMI Submission

Nursing facilities are directed to complete the LTCMI when seeking full Medicaid reimbursement (when a person is moving to full Medicaid or continuation of Medicaid payment). The LTCMI is not required for Medicare recipients or Coinsurance.

Note: *HHSC recommends completing the LTCMI if the person could possibly become eligible for Full Medicaid during the time period the assessment represents. The LTCMI cannot be submitted until an admission, either Form 3618/3619, has been submitted.*

LTCMI Fields

Important: *Ensure that the information entered in the LTCMI does not conflict with information entered in the MDS assessment.*

MINIMUM DATA SET (MDS) – Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

🔒

Current Status: Awaiting LTC Medicaid Information **Name:** [REDACTED] **DLN:** [REDACTED] **RUG:** SE2

Form Actions:

Section A.	Section B.	Section C.	Section D.
Section E.	Section F.	Section G.	Section H.
Section I.	Section J.	Section K.	Section L.
Section M.	Section N.	Section O.	Section P.
Section Q.	Section V.	Section X.	Section Z.
Section LTCMI.		Section RUG.	

Section LTC Medicaid Information

S1. Claims Processing Information

S1a. DADS Vendor/Site ID Number

S1b. Provider Number

S1c. Service Group

S1d. Hospice Provider Number

S1e. Purpose Code

S1f. Missed Assessment or Prior Start Date

S1g. Missed Assessment or Prior End Date

S2. PASARR Information

S2a. To your knowledge, does the resident have an intellectual disability?

S2b. To your knowledge, does the resident have a developmental disability?

S2c. To your knowledge, does the resident have a condition of mental illness according to the PASARR guidelines?

S2d. Is the resident a danger to himself/herself?

S2e. Is the resident a danger to others?

S2f. Are specialized services indicated?

S3. Physician's Evaluation & Recommendation

S3a. Does the MD/DO have plans for the eventual discharge of this resident?

S3b. Rehabilitative Potential

S3c. Did an MD/DO certify that this resident requires/continues to require nursing facility care?

S3d. MD/DO Last Name

S3e. MD/DO License #

S3f. MD/DO License State

S3g. MD/DO Military Spec Code #

The following MD/DO information is required if MD/DO is **not** licensed in Texas.

S3h. MD/DO First Name

S3i. MD/DO Address

S3j. MD/DO City

S3k. MD/DO State

S3l. MD/DO ZIP Code

S3m. MD/DO Phone

S4. Licenses

Provider Certification: On behalf of this facility, I certify to the completeness of the MDS Assessment.

S4a. RN Coordinator Last Name

S4b. RN Coordinator License #

S4c. RN Coordinator License State

S5. Primary Diagnosis

S5a. Primary Diagnosis ICD Code **S5b.** Primary Diagnosis ICD Description

S6. Additional MN Information

S6a. Tracheostomy Care

S6b. Ventilator/Respirator

S6c. Number of hospitalizations in the last 90 days

S6d. Number of emergency room visits in the last 90 days

S6e. Oxygen Therapy

S6f. Special Ports/Central Lines/PICC

S6g. At what developmental level is the resident functioning?

S6h. Enter the number of times this resident has fallen in the last 90 days.

S6i. In how many of the falls listed above was the person physically restrained prior to the fall?

S6j. In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.)

S6j1. Environmental (debris, slick or wet floors, lighting, etc.)

S6j2. Medication(s)

S6j3. Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.)

S6j4. Poor Balance/Weakness

S6j5. Confusion/Disorientation

S6j6. Assault by Resident or Staff

S8. Resident's Current Address

S8a. Resident's Address

S8b. City

S8c. State

S8d. ZIP Code

S8e. Phone

S9. Medications

List all medications that the resident received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.

Medication Certification: I certify this resident is taking no medications OR the medications listed below are correct

[Add Meds](#)

S10. Comments

S8. Resident's Current Address	
S8a. Resident's Address	<input type="text"/>
S8b. City	<input type="text"/>
S8c. State	<input type="text" value=""/>
S8d. ZIP Code	<input type="text"/>
S8e. Phone	<input type="text"/>
S9. Medications	
<ul style="list-style-type: none"> List all medications that the resident received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly. <input type="checkbox"/> Medication Certification: I certify this resident is taking no medications OR the medications listed below are correct	
Add Meds	
S10. Comments	
<div style="border: 1px solid gray; height: 50px;"></div>	
S11. Advance Care Planning	
S11a. Does the resident report having a legally authorized representative?	<input type="text" value="1. Yes"/>
S11b. Does the resident report having a Directive to Physicians and Family or Surrogates?	<input type="text" value=""/>
S11c. Does the resident report having a Medical Power of Attorney?	<input type="text" value=""/>
S11d. Does the resident report having an Out-of-Hospital Do Not Resuscitate Order?	<input type="text" value=""/>
S12. LAR Address	
Required if resident has reported having a legally authorized representative.	
S12a. LAR First Name	<input type="text"/>
S12b. LAR Last Name	<input type="text"/>
S12c. Address	<input type="text"/>
S12d. City	<input type="text"/>
S12e. State	<input type="text" value=""/>
S12f. ZIP Code	<input type="text"/>
S12g. Phone	<input type="text"/>
History	
Awaiting LTC Medicaid Information	1/3/2009 2:00:21 PM
<input type="button" value="Submit Form"/>	

Information fields on the LTCMI are divided by section as follows:

S1. Claims Processing Information

S1a. HHS Vendor/Site ID Number.

- This field is auto populated based on the Provider Identifier (NPI) number in field A0100A.
- This field is not correctable.
- If A0100A NPI is not correct on the MDS, then the NPI must be fixed at the CMS level.

S1b. Provider Number.

- This field is auto populated based on the NPI number in field A0100A.
- This field is not correctable.
- If an NPI has more than 1 provider number associated with it, be sure the correct provider number is selected from the drop-down box.

S1c. Service Group.

- This field is auto populated based on the user's log in credentials.
- This field is not correctable on the TMHP LTC Online portal.

S1d. Hospice Provider Number.

- Conditional.
- This field is required if 00100K. Hospice care column 2 While a Resident is checked.
- Enter the Medicaid Hospice provider number assigned by HHSC. Entering the Hospice provider number in this field will allow the Hospice provider to view the assessment submitted on their behalf by the NF. This number will be validated and must contain a valid Hospice provider number to be accepted onto the LTC Online Portal. If not valid, the provider will receive an error message stating: Hospice Provider Number is invalid.

S1e. Purpose Code.

- Optional.
- E. Missed Assessment
- M. Coverage Code must be P
- Providers should verify that the MESAV Coverage Code is P prior to submitting a Purpose Code M.
- This field is not removable once a Purpose Code has been selected and the assessment has been successfully submitted on the TMHP LTC Online Portal.

S1f. Missed Assessment or Prior Start Date (The first date the facility was not paid).

- Conditional.
- This field is required if S1e. Purpose Code = E or M.
- This would be the first missed assessment date (Check MESAV for gaps).
- Enter the date in mm/dd/yyyy format of the missed assessment start date.
- Start Date cannot be prior to September 1, 2008.
- Field is correctable.

S1g. Missed Assessment on Prior End Date (The last date the facility was not paid).

- Conditional.
- This field is required if S1e. Purpose Code = E or M.
- This would be the last missed assessment date (Check MESAV for gaps).
- Enter the date in mm/dd/yyyy format of the missed assessment or 3-month prior Retro Eligibility (Coverage code must be P) end date.
- Date cannot be greater than date of submission (i.e., today's date).
- End date cannot be prior to the Start Date.
- Field is correctable.

- These dates are used to locate a gap of time. If a gap is not found within the range provided, the assessment will not be processed. Providers can submit a MDS Purpose Code E with a missed assessment date range greater than 92 days. This allows providers to submit one MDS Purpose Code E to cover large gaps in dates.

S2. PASRR Information

S2a. To your knowledge, does the resident have an intellectual disability?

- Required.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

S2b. To your knowledge, does the resident have a developmental disability?

- Required.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

S2c. To your knowledge, does the resident have a condition of mental illness according to the PASRR guidelines?

- Required.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

S2d. Is the resident a danger to himself/herself?

- Required.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

If unknown, then reply with 0. No.

S2e. Is the resident a danger to others?

- Required.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

If unknown, then reply with 0. No.

S2f. Are specialized services indicated?

- Disabled.
 - This field is disabled. Click the Determine Specialized Services button to calculate and populate a value in S2f.

S3. Physician's Evaluation & Recommendation

S3a. Does the MD/DO have plans for the eventual discharge of this resident?

- Conditional.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

This field is required if Admission assessment, SCSA, or Recovery of Lost Payment (Purpose Code E).

S3b. Rehabilitative Potential.

- Conditional.
- Choose from the drop-down box:
 - 1. good
 - 2. fair
 - 3. minimal

This field is required if Admission assessment, SCSA, or Recovery of Lost Payment (Purpose Code E).

S3c. Did an MD/DO certify that this resident requires/continues to require Nursing Facility care?

- Conditional.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

This field is required if Admission assessment, SCSA, or Recovery of Lost Payment (Purpose Code E).

S3d. MD/DO Last Name.

- Required.
- Enter the last name of the MD/DO.

S3e. MD/DO License #.

- Conditional.

- This field is required if S3g. MD/DO Military Spec Code # is not populated.
- Enter the license number of the MD/DO.
- This number is validated against the Texas Medical Board file.

Note: *An error will occur if the license number does not pass validation. The assessment will not be considered successfully submitted until all errors are resolved.*

Note: *Physicians are not required to complete the RUG training.*

S3f. MD/DO License State.

- Required.
- Choose the license state in which the MD/DO is licensed from the drop-down box.

S3g. MD/DO Military Spec Code #.

- Conditional.
- This field is required if S3e. MD/DO License # is not populated.
- Enter the Military Spec Code number of the MD/DO.

Fields S3h through S3i (MD/DO information) are required if MD/DO is not licensed in Texas.

S3h. MD/DO First Name.

- Conditional.
- This field is required if S3f License State is NOT Texas.
- Enter the first name of the resident's MD/DO.
- This information is used to mail MN determination letters.

S3i. MD/DO Address.

- Conditional.
- This field is required if S3f License State is NOT Texas.
- Enter the street address of the resident's MD/DO.
- This information is used to mail MN determination letters.

S3j. MD/DO City.

- Conditional.
- This field is required if S3f License State is NOT Texas.
- Enter the city of the resident's MD/DO mailing address.
- This information is used to mail MN determination letters.

S3k. MD/DO State.

- Conditional.

- This field is required if S3f License State is NOT Texas.
- Enter the state of the resident's MD/DO mailing address.
- This information is used to mail MN determination letters.

S3l. MD/DO ZIP Code.

- Conditional.
- This field is required if S3f License State is NOT Texas.
- Enter the ZIP code of the resident's MD/DO mailing address.
- This information is used to mail MN determination letters.

S3m. MD/DO Phone.

- Optional.
- This field is optional if S3f License State is NOT Texas.
- Enter the telephone number of the resident's MD/DO.
- This information is used to contact MD/DO if necessary.

S4. Licenses

Provider Certification: On behalf of this facility, I certify to the completeness of the MDS Assessment.

S4a. RN Coordinator Last Name.

- Required.
- Enter the last name of the RN Assessment Coordinator.

S4b. RN Coordinator License #.

- Required.
- Enter the license number of the RN Coordinator.
- Licenses issued in Texas will be validated against the Texas BON (Board of Nursing) or Compact License will be validated with the issuing state's nursing board.

Note: *This number is validated to ensure RUG training requirements have been met. The license numbers supplied at S4b must be RUG trained as offered by Texas State University. The assessment will not be accepted on the LTC Online Portal if the license # is not indicated as having completed the RUG training. The RUG training is online (web-based training) as offered by Texas State University. The training is valid for two years. The name entered in S4a should match the name in section Z0500A.*

Note: *An error will occur if the license number does not pass validation. The assessment will not be considered successfully submitted until all errors are resolved.*

S4c. RN Coordinator License State.

- Required.

- Choose the license state in which the RN Coordinator is licensed from the drop-down box.

S5. Primary Diagnosis

S5a. Primary Diagnosis ICD Code.

- Required.
- Enter a valid ICD code for the person's primary diagnosis. Use your best clinical judgment.

S5b. Primary Diagnosis ICD Description.

- Optional.
- Click the magnifying glass and the description will be auto populated based on the primary diagnosis ICD Code.

S6. Additional MN Information

S6a. Tracheostomy Care.

- Conditional.
- Choose from the drop-down box:
 - 1. Less than once a week.
 - 2. 1 to 6 times a week.
 - 3. Once a day.
 - 4. Twice a day.
 - 5. 3 – 11 times a day.
 - 6. Every 2 hours.
 - 7. 24 hour continuous.
- This field is only required and available for data entry if O0100E. Tracheostomy care column 2 While a Resident is checked AND the resident is 21 years of age or younger.

ENTRY TIP: *This field will be disabled if field O0100E2. Tracheostomy Care is not checked on the MDS. The Provider must submit an MDS Modification if field O0100E2 is not checked and S6a is to be claimed for the add-on rate.*

S6b. Ventilator/Respirator.

- Conditional.
- Choose from the drop-down box:
 - 1. Less than once a week
 - 2. 1 to 6 times a week
 - 3. Once a day
 - 4. Twice a day

- 5. 3 – 11 times a day
- 6. 6 – 23 hours
- 7. 24 - hour continuous
- This field is only required and available for data entry if O0100F Ventilator or respirator column 2 While a Resident is checked. Do not include BiPAP/CPAP.

S6c. Number of hospitalizations in the last 90 days.

- Required.
- Record the number of times the resident was admitted to hospital with an overnight stay in the last 90 days (or since last assessment if less than 90 days). Enter 0 (zero) if no hospital admissions.
- Valid range includes 0 – 90.

S6d. Number of emergency room visits in the last 90 days.

- Required.
- Record the number of times the resident visited the Emergency Room (ER) without an overnight stay in the last 90 days (or since the last assessment if less than 90 days). Enter 0 (zero) if no ER visits.
- Valid range includes 0 – 90.

S6e. Oxygen Therapy.

- Conditional.
- Choose from the drop-down box:
 - 1. Less than once a week
 - 2. 1 to 6 times a week
 - 3. Once a day
 - 4. Twice a day
 - 5. 3 – 11 times a day
 - 6. 6 – 23 hours
 - 7. 24 - hour continuous
- This is a required field that is only available for data entry if O0100C Oxygen therapy column 2 While a Resident is checked.

S6f. Special Ports/Central Lines/PICC.

- Optional.
- Choose from the drop-down box:
 - 0. N = none present.

- 1. Y = 1 or more implantable access system or CVC.
- 2. U = unknown.

NOTE: Use this field to indicate if the resident has any type of implantable access system or central venous catheter (CVC). This includes epidural, intrathecal, or venous access or Peripherally Inserted Central Catheter (PICC) devices. This does NOT include hemodialysis or peritoneal dialysis access devices.

S6g. At what developmental level is the resident functioning?

- Conditional.
- Choose from the drop-down box:
 - ‘–‘Unknown or unable to assess
 - 1. < 1 Infant
 - 2. 1 – 2 Toddler
 - 3. 3 – 5 Pre-School
 - 4. 6 – 10 School age
 - 5. 11 – 15 Young Adolescence
 - 6. 16 – 20 Older Adolescence
- This is a required field for all assessments on people who are 20 years of age and younger (based on birth date minus date of submission [TMHP Received date]).
- This field is not available for data entry if the person is 21 years of age or older.

S6h. Enter the number of times this resident has fallen in the last 90 days.

- Required.
- Record the number of times the person has fallen in the last 90 days. Enter 0 (zero) if no falls.
- Each fall should be counted separately. If the resident has fallen multiple times in one day, count each fall individually.
- Valid range includes 0 (zero) – 999. Leading zeroes may be included or omitted from the submitted value. A decimal point and decimal values may not be included on the LTC Online Portal.

S6i. In how many of the falls listed above was the person physically restrained prior to the fall?

- Conditional.
- This is a required field if S6h indicates the person has fallen.
- Valid range includes 0 (zero) with a maximum being the number entered in S6h.

S6j. In the falls listed in S6h above, how many had the following contributory factors? (More

than one factor may apply to a fall. Indicate the number of falls for each contributory factor).

- Conditional.
- S6j1 through S6j6 are required only if S6h indicates the person has fallen.
- Valid range includes 1 (one) with a maximum being the number entered in S6h.
 - S6j1. Environmental (debris, slick or wet floors, lighting, etc.).
 - S6j2. Medication(s).
 - S6j3. Major Change in Medical Condition (Myocardial Infarction [MI/Heart. Attack], Cerebrovascular Accident [CVA/Stroke], Syncope [Fainting], etc.).
 - S6j4. Poor Balance/Weakness.
 - S6j5. Confusion/Disorientation.
 - S6j6. Assault by Resident or Staff.

S7. For HHS Only - RUG

S7b. For HHS Only - RUG

- When the LTCMI is printed S7b will show the calculated RUG value.

S8. Resident's Current Address

S8a. Resident's Address.

- Required.
- Enter the street address where the person is presently living.
- This information is used to mail MN determination letters.

S8B. City.

- Required.
- Enter the city where the person is presently living.
- This information is used to mail MN determination letters.

S8c. State.

- Required.
- Enter the state where the person is presently living.
- This information is used to mail MN determination letters.

S8d. ZIP Code.

- Required.
- Enter the ZIP code where the person is presently living.
- This information is used to mail MN determination letters.

S8e. Phone.

- Optional.
- Enter the contact telephone number for the person if known. If the person is residing in an NF and no other direct contact telephone number is known, enter the telephone number of the NF.

S9. Medications

Medication Certification checkbox.

- Required.
- Providers are required to check the Medication Certification checkbox to certify that the person is taking no medications or the medication listed are correct.
- S9. Medications.
 - S9 (1.) Medication Name and Dose Ordered. Free-form text.
 - Identify and record all medications that the person received in the last 30 days. Also identify and record any medications that may not have been given in the last 30 days, but are part of the person's regular medication regimen (e.g., monthly B-12 injections). Do not record PRN medications that were not administered in the last 30 days.
 - S9 (2.) RA (Route of Administration). Select from the list of options.
 - Determine the Route of Administration (RA) used to administer each medication. The MAR and the physician's orders should identify the RA for each medication. Record the RA in column 2.
 - S9 (3.) Freq (Frequency). Select from the list of options.
 - Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3.
 - S9 (4.) PRN-n (number of doses) as necessary—number of times in last 30 days.

Note: *Pro Re Nata (PRN) means "as needed" in Latin. The PRN-n column is only completed for medications that have a frequency as PR. Record the number of times in the past 30 days that each medication coded as PR was given. Stat medications are recorded as a PRN medication. Remember, if a PRN medication was not given in the past 30 days, it should not be listed here.*

- Section N on MDS 3.0 assessments reflects the number of medications and section S9 allows for more detailed information to be submitted (i.e., name of medications).

S10. Comments

- Optional.
- Enter up to 500 characters if needed. It is essential that you include signs and symptoms that present an accurate picture of the person's condition.
- The comment section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:
 - Pertinent medical history.

- Ability to understand medication.
- Ability to understand changes in condition.
- Abnormal vital signs.
- Previous attempts at outpatient management of medical condition.
- Results of abnormal lab work.

S11. Advance Care Planning

Advance care planning means planning ahead for how the person wants to be treated if ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die they are not able to talk or to let others know how they feel.

S11a. Does the resident report having a legally authorized representative?

- Required.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

NOTE: A Legally Authorized Representative (LAR) is a person authorized by law to act on behalf of a person with regard to a matter, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.

S11B. Does the resident report having a Directive to Physicians and Family or Surrogates?

- Required.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

NOTE: In states other than Texas, this document may be referred to as a Living Will. Directive to Physician/Living Will is a document that communicates a resident's wishes about medical treatment at some time in the future when he or she is unable to make their wishes known because of illness or injury.

S11c. Does the resident report having a Medical Power of Attorney?

- Required.
- Choose from the drop-down box:
 - 0. No
 - 1. Yes

S11d. Does the resident report having an Out-of-Hospital Do Not Resuscitate Order?

- Required.

- Choose from the drop-down box:
 - 0. No
 - 1. Yes

NOTE: *This form is for use when a person is not in the hospital. It lets the person tell health-care workers, including Emergency Medical Services (EMS) workers, NOT to do some things if the person stops breathing or their heart stops. If a person does not have one of these forms filled out, EMS workers will ALWAYS give the person Cardiopulmonary Resuscitation (CPR) or advanced life support even if the advance care planning forms say not to. A person should complete this form as well as the Directive to Physicians and Family or Surrogates and the Medical Power of Attorney form if they do NOT want CPR.*

S12. LAR Address

Legally Authorized Representative (LAR) Address is required if S11a. Does the resident report having a legally authorized representative? Is indicated as 1. Yes.

S12a. LAR First Name.

- Conditional.
- This field is required if field S11a = 1. Yes.
- Enter the first name of the Legally Authorized Representative.

S12b. LAR Last Name.

- Conditional.
- This field is required if field S11a = 1. Yes.
- Enter the last name of the Legally Authorized Representative.

S12c. Address.

- Conditional.
- This field is required if field S11a = 1. Yes.
- Enter the street address of the Legally Authorized Representative.

S12d. City.

- Conditional.
- This field is required if field S11a = 1. Yes.
- Enter the city of the Legally Authorized Representative.

S12e. State.

- Conditional.
- This field is required if field S11a = 1. Yes.

- Enter the state of the Legally Authorized Representative.

S12f. ZIP Code.

- Conditional.
- This field is required if field S11a = 1. Yes.
- Enter the ZIP Code of the Legally Authorized Representative.

S12g. Phone.

- Optional.
- This field is optional if field S11a = 1. Yes.
- Enter the contact telephone number for the Legally Authorized Representative, if known.

MDS Purpose Code E (Missed Assessment)

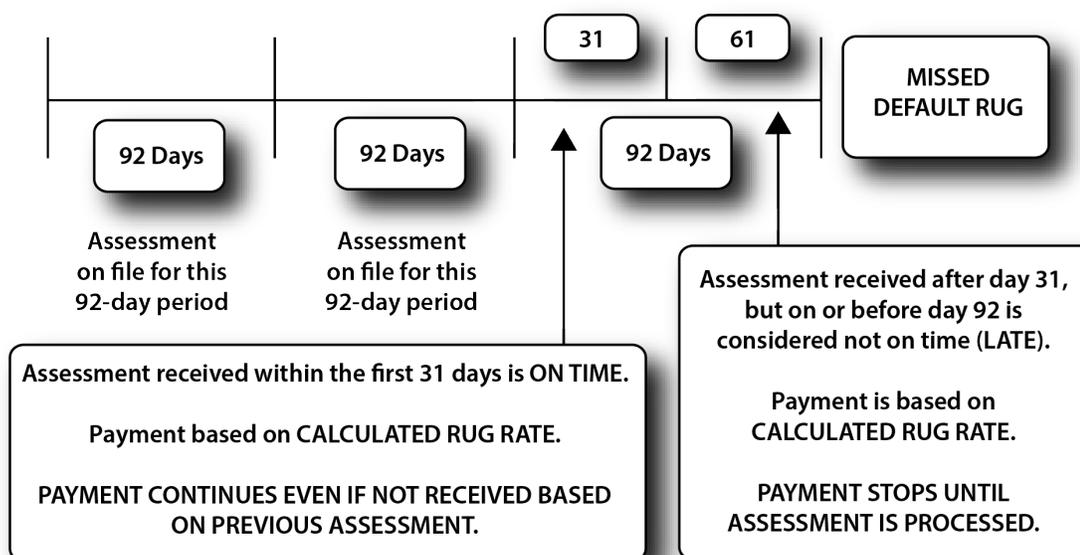
Purpose Code E should be used for a missed assessment.

According to 26 Texas Administrative Code (TAC) §554.2413:

- (3) Missed MDS assessment—An MDS assessment that is received by the state Medicaid claims administrator outside the time period that the MDS assessment covers.
- (g) Missed MDS assessments. When the state Medicaid claims administrator receives a missed MDS assessment, HHSC pays the nursing facility a default RUG rate for the entire period of the missed MDS assessment if the recipient meets financial eligibility for Medicaid, except as provided in paragraph (2) of this TAC subsection.

Note: An *On-Time MDS assessment* is an MDS assessment that is submitted in accordance with the federal MDS submission schedule and the state Medicaid claims administrator within 31 days of the completion date. A *Late MDS assessment* is an assessment with a Z0500B (MDS 3.0) date after the 31-day submission period, but within the 92 days the assessment represents.

If a new person is admitted to the facility and the Admission assessment is submitted more than 91 days after Z0500B (MDS 3.0) of that Admission assessment, the Admission assessment will have to be submitted as a PC E. Payment for this gap will be made at the PC E default rate. MDS Purpose Code E is used to recover missed assessment time frames. A missed assessment occurs when an MDS is not submitted within the anticipated quarter time frame. The anticipated quarter is the 92-day anticipated MDS assessment quarter following the 92-day span of the current MDS assessment. A missed assessment can also occur if the Admission assessment is not submitted within 92 days of the assessment date. Purpose Code E can only be submitted on the Admission assessment, Annual assessment, or Quarterly review assessment. The PC E must be submitted within 365 days from the last uncovered day.



NF Provider Tips for When to Submit an MDS PC E

The following provides information to help NF providers determine when to submit an MDS PC E. A PC E can only be submitted on an MDS Admission, Annual, or Quarterly assessment.

There typically are two situations when an MDS PC E should be submitted:

- 1) **RUG Gap.** Once the person has been established as a RUG recipient, a PC E will be needed if the next MDS assessment submission completely misses the anticipated assessment quarter. Each Z0500B (MDS 3.0) establishes a 92-day period (Z0500B + 91 days), so the next assessment should be completed and submitted within the 92-day anticipated MDS assessment quarter following the 92-day span of the current MDS assessment.
 - The RUG of the current assessment will expire 31 days after the covering quarter (Z0500B + 91 days) unless the next MDS assessment has been successfully completed. HHSC cannot pay for services on days when a RUG has expired.
 - The next MDS assessment will not be considered missed if it has a Z0500B date within the anticipated MDS assessment quarter and the LTCMI is completed on the LTC Online Portal within 91 days of the new MDS assessment Z0500B date.
 - If the new MDS assessment is submitted after the expiration of the RUG on file but within the anticipated quarter, the gap following the 31 days and prior to the new Z0500B date will automatically be filled with the new calculated RUG.
 - If the new MDS is not submitted within the anticipated quarter or the LTCMI is not completed within 91 days of the Z0500B date, a gap will be created following the 31 days until the Z0500B date of the new assessment. Payment for this gap will be made at the PC E default rate. To fill the gap, submit an Admission, Annual, or Quarterly MDS assessment including the LTCMI by completing:
 - The S1e field on the LTCMI completed as the PC E.
 - The Missed or Prior Assessment Start Date (S1f).
 - The Missed or Prior Assessment End Date (S1g).
Note: *To submit a PC E for a one-day gap, the Missed Assessment Start Date and the Missed Assessment End Date must be the same.*
- 2) **Missed MDS.** If an LTCMI is submitted more than 91 days after the Z0500B date of the assessment, the assessment will have to be submitted as a PC E. Payment for this gap will be made at the PC E default rate. Submit the assessment, including the LTCMI, by completing:
 - The S1e field on the LTCMI completed as the PC E.
 - The Missed or Prior Assessment Start Date (S1f).
 - The Missed or Prior Assessment End Date (S1g).

Prior to adding a Purpose Code to an LTCMI, validate if payment has been made based on the MDS. Entering a Purpose Code, Start and End date cancels any prior services dates the assessment represented. If necessary, submit an off-cycle MDS 3.0 assessment to submit a Purpose Code E or M.

Note: *Once an MDS LTCMI has been completed as a PC E, any future modifications or corrections must also be completed as a PC E.*

PC E Start and End Date Limitations (MDS 3.0)

Only applicable for MDS 3.0 Admission, Quarterly review, and Annual assessments

- Start date cannot be prior to September 1, 2008.

The following errors must be fixed before the form will submit:

- [Missed Assessment or Prior Start Date must be on or after 09/01/2008.](#)

- End date cannot be prior to the Start Date.

- [Missed Assessment or Prior Start Date must be on or before Missed Assessment or Prior End Date.](#)

MDS Purpose Code M

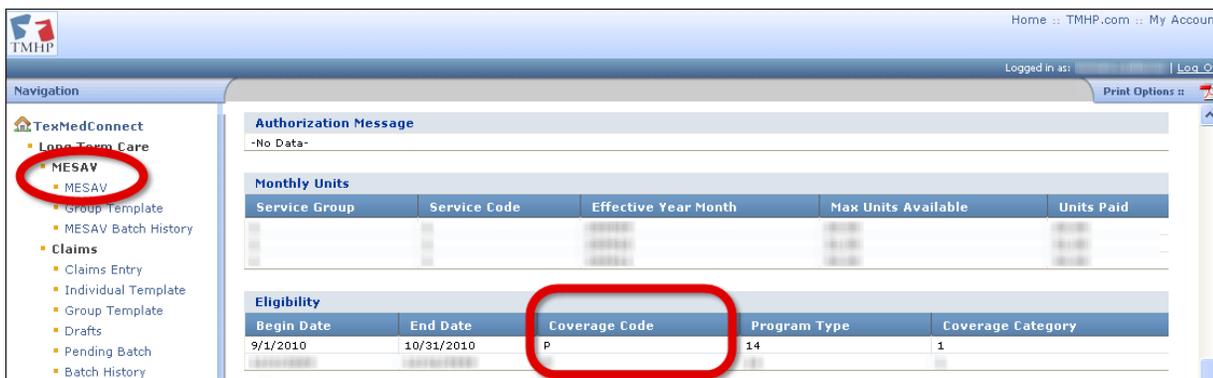
The Purpose Code M is used when Prior Medicaid Eligibility has been established. Prior eligibility can begin up to three months prior to certification of Medicaid. Purpose Code M can only be submitted on the Admission assessment, Annual assessment, or Quarterly review assessment.

Missed Assessment Start and End Dates are used by the provider to identify the Prior Medicaid period. The MESAV must reflect a Medicaid coverage type of P (prior eligibility).

Note: A Purpose Code M can only fill a gap for which prior eligibility has previously been established. Payment is made at the full calculated RUG rate. Check MESAV to ensure eligibility code of P or TP11 BEFORE the submission of a PC M.

The LTCMI section should include:

- S1e = M (Purpose Code) Coverage Code must be P.



- S1f = Missed Assessment or Prior Start Date (This is the prior eligibility start date).
- S1g = Missed Assessment or Prior End Date.

The correction of an existing LTCMI Purpose Code to an E or M invalidates the original time frame. If the LTCMI is changed to indicate a PC E or PC M and the assessment had been part of the person's cycle, the original time frame is voided (e.g., set to status **Corrected**) and only the PC E or M dates will be covered.

More information on Purpose Code E and M can be found at:

www.HHS.state.tx.us/providers/communications/2009/letters/IL2009-27.pdf

The following information is an excerpt from the Information Letter (referenced above).

What is a Purpose Code M and How Do You Complete a Purpose Code M?

Purpose Code M – an MDS submitted, if three months prior to application, is granted after the person is certified for Medicaid. When there is an application for Medicaid, the person's financial eligibility is considered and reviewed based on the month of application. If the person is determined to be

Medicaid-eligible, the worker does a consideration on the three months prior to the application to determine if the person may have been financially eligible at an earlier date. The Purpose Code M was designed to allow the provider to submit a MDS Purpose Code M to cover those three months so the payment could be made at a RUG value rather than the default PC E rate. The retroactive Medicaid is shown on the MESAV as a TP 14 Coverage Code P or TP 11 which are retroactive TP13 SSI coverage.

To fill a period approved by the financial worker for dates prior to the application, the provider has two options:

- 1) Submit an off-cycle MDS quarterly assessment including the LTCMI by completing:
 - The S1e field on the LTCMI completed as the PC M.
 - The start date of the approved prior period (S1f).
 - The end date of the approved prior period (S1g).
- 2) Modify an earlier MDS that has not been used for the Medicaid cycle and complete the LTCMI as a PC M by completing:
 - The S1e field on the LTCMI completed as the PC M.
 - The start date of the approved prior period (S1f).
 - The end date of the approved prior period (S1g).

Note: To submit a PC M for one day, the Missed Assessment Start Date and the Missed Assessment End Date must be the same.

PC M Start and End Date Limitations (MDS 3.0)

Only applicable for MDS 3.0 Admission, Quarterly review, and Annual assessments

- Start date cannot be prior to September 1, 2008.

The following errors must be fixed before the form will submit:

- [Missed Assessment or Prior Start Date must be on or after 09/01/2008.](#)

- End date cannot be prior to the Start Date.

- [Missed Assessment or Prior Start Date must be on or before Missed Assessment or Prior End Date.](#)

Corrections and Updates

Corrections can be made to certain fields on LTCMI, Forms 3071, 3074, 3618, and 3619. Providers should not correct assessments that are already in status **Processed/Complete**. This may result in payment ceasing.

Note: Forms 3618 and 3619 or the LTCMI section of a MDS assessment that have been set to status **Form Inactivated** at any time in the assessment's history will not allow corrections to the form or assessment. The **Correct this form** or **Update Form** buttons will not be displayed in the yellow Form Actions bar on any form that cannot be corrected or updated. This includes submission of these forms or assessments by a third-party software vendor for your facility. PL1 Screening Forms cannot be submitted by a third-party software vendor.

LTCMI Corrections

Corrections to the LTCMI section data can be submitted directly on the LTC Online Portal.

Note: If no PC (Purpose Code) is identified in field S1e., it may be corrected to reflect either an E or M. A PC M may be corrected to a PC E. However, after an assessment is classified as a PC E, the entry in field S1e cannot be corrected. Once an assessment is classified as a PC E, field S1e. is not correctable.

Prior to correcting/adding a PC on an LTCMI, validate if payment has been made based on the MDS. Entering a PC Start and End date cancels any prior service dates the assessment represented. If necessary, submit an off-cycle MDS 3.0 assessment to submit a PC E or M.

To submit LTCMI corrections:

- 1) Log in to the LTC Online Portal.
- 2) Use either **Form Status Inquiry** or **Current Activity** to access the document with which you wish to work.
 - a) If using FSI, you may search for an MDS using SSN, Medicaid Number, or DLN. Click the **Search** button, then click the **View Detail** link.
 - b) If using Current Activity, click the **DLN** link.
- 3) Click the **Correct this form** button.

The screenshot shows the 'MINIMUM DATA SET (MDS) – VERSION 3.0' interface. At the top, it displays 'RESIDENT ASSESSMENT AND CARE SCREENING' and 'Nursing Home Comprehensive (NC) Item Set'. Below this, the 'Current Status' is 'Processed/Complete' and the resident's name is 'GEORGE GUEVARA'. The 'Form Actions' bar is highlighted in yellow and contains three buttons: 'Print', 'Correct this form' (circled in red), and 'Add Note'. Below the bar is a grid of buttons for sections A through Z, with 'Section LTCMI.' and 'Section RUG.' at the bottom.

4) Click the Section LTCMI tab and complete only the fields needing correction.

MINIMUM DATA SET (MDS) – VERSION 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Current Status: Name: **HINE POLJA** RUG: RAA
Parent DLN: **0000000000**

Form Actions:

Section A.	Section B.	Section C.	Section D.
Section E.	Section F.	Section G.	Section H.
Section I.	Section J.	Section K.	Section L.
Section M.	Section N.	Section O.	Section P.
Section Q.	Section V.	Section X.	Section Z.

Section LTCMI. **Section RUG.**

Section LTC Medicaid Information

S1. Claims Processing Information

S1a. DADS Vendor/Site ID Number

S1b. Provider Number

S1c. Service Group

S1d. Hospice Contract Number

S1e. Purpose Code

S1f. Missed Assessment or Prior Start Date

S1g. Missed Assessment or Prior End Date

S2. PASARR Information

S2a. To your knowledge, does the resident have an intellectual disability?

S2b. To your knowledge, does the resident have a developmental disability?

S2c. To your knowledge, does the resident have a condition of mental illness according to the PASARR guidelines?

5) Click the **Submit Form** button.

6) The original assessment (parent) is set to status **Corrected** and the new assessment (child) DLN is assigned, creating a parent/child DLN relationship. The new child assessment replaces the parent assessment. However, if the parent assessment is in status **Processed/Complete** or **PCS Processed/Complete**, it will not move to **Corrected** status until the child form is in status **Processed/Complete** or **PCS Processed/Complete**.

Current Status: Name: **HINE POLJA** RUG: RAA
Parent DLN: **0000000000**

Form Actions:

History	
Form Submitted	10/8/2010 10:59:57 AM
10/8/2010 10:59:57 AM	TMHP : This form was submitted as a correction for DLN 0000000000

Note: Corrections are processed overnight. Providers must wait until the following day to see changes.

Form 3618 and 3619 Corrections

NF providers must submit Forms 3618 and 3619 corrections directly on the LTC Online Portal.

Correctable Fields on Forms 3618 and 3619

- Administrator Signature Date
- Administrator License Number
- Comment Section
- Date of Above Transaction
- Dates of Qualifying Stay (Form 3619)
- Discharge Type
- Location
- Medicare ID
- Recipient Address
- Recipient First Name
- Recipient Middle Initial
- Recipient Name Suffix
- Service Group

The entries in the correctable fields can be changed even if the form has been processed into the system. For example, if a person receiving Medicare transfers to Medicaid on the fifth of the month and then it is discovered that the transfer was actually on the eighth of the month instead, two corrections should be submitted. The original Form 3619 discharge and Form 3618 admission must be corrected to the eighth rather than submitting new forms. Even if the original forms are processed, corrections can be submitted.

TMHP places the original form in a status of **Corrected** and gives the new form a DLN creating a Parent/Child DLN relationship.

If a form contains incorrect information in a field that cannot be corrected and the form is set to the status **Processed/Complete**, a counteracting form will need to be submitted. If the form is not set to a **Processed/Complete** status, inactivate the form and resubmit with the correct information. Refer to the Counteracting Forms section of this User Guide for additional information.

Correction to Forms 3618 or 3619

- 1) Log in to the LTC Online Portal.
- 2) Click the **Search** link in the blue navigational bar.
- 3) Choose **Form Status Inquiry** from the drop-down menu.
- 4) Search for Form 3618 or 3619 using the person's SSN, Medicaid Number, First and Last Name, or DLN.
- 5) Click the **Search** button.
- 6) Click the **View Detail** link.
Click the **Correct this form** button.

The screenshot shows the '3618 - RESIDENT TRANSACTION NOTICE' form. At the top right, there is an 'UnLock Form' button. Below the title, the current status is 'Medicaid ID Pending' and the name is 'MARGA GAYLEN'. The form is divided into several sections: 'Form Actions' (with buttons for Print, Use as template, Correct this form, Add Note, and Inactivate Form), 'Provider Information' (for HENRIK MEDICAL CENTER), 'Recipient Information' (with fields for Medicaid Recipient No., Social Security No., Medicare or RR Retirement Claim No., Name, and Address), 'Transaction Information' (with dropdowns for Service Group, Transaction, Location, Discharge Type, and Date of Physical Admission to Private Pay), and 'Comments'.

7) Correct the information in the fields needing correction.

Vendor Number: 99-63		Provider Number: 0000000000		NPI Number: 99-63-99999	
Recipient Information					
1. Medicaid Recipient No.	<input type="text"/>	4. Name	<ul style="list-style-type: none"> Recipient's Last Name <input type="text"/> Recipient's First Name <input type="text"/> Recipient's Middle Initial <input type="text"/> Recipient Name Suffix <input type="text"/> 	5. Address	Address <input type="text"/> City <input type="text"/> State <input type="text"/> ZIP <input type="text"/>
2. Social Security No.	<input type="text"/>				
3. Medicare or RR Retirement Claim No.	<input type="text"/>				
Transaction Information					
<ul style="list-style-type: none"> Service Group <input type="text"/> Transaction Location <input type="text"/> 		1. Nursing Facility 1. Admission From 2. Nursing Facility	Discharge Type <input type="text"/> Date of Physical Admission to Private Pay <input type="text"/>		
If Newly Admitted From/Discharged To Hospital, Enter Date		<input type="text"/>			
<ul style="list-style-type: none"> Date of Above Transaction <input type="text"/> 					
Comments					
<input type="text"/>					
Administrator Information					
I certify that, to the best of my knowledge, the date in Item 11 (Date of Above Transaction) is for services provided, and the date is not included in the 100% Medicare Part A reimbursement time frame.					
Administrator	<ul style="list-style-type: none"> State Board License No. <input type="text"/> Administrator Last Name <input type="text"/> Administrator First Name <input type="text"/> Is Administrator Signature on Form? <input checked="" type="checkbox"/> Date Signed <input type="text"/> 				

8) Click the **Submit Form** button.

Note: If the form is successfully submitted, a DLN will be assigned and the LTC Online Portal will show: Your form was submitted successfully. If there are errors, they will be displayed in a box at the top of the screen. These errors will need to be resolved before the form will be successfully submitted. Once all errors are resolved, click the **Submit Form** button again to submit the form.

9) Click the **DLN** link displayed in the Your form was submitted successfully message to return to the form.

10) Click the **Print** button in the yellow Form Actions bar to print the completed form.

Counteracting Forms

A counteracting form is a form submitted indicating the opposite transaction of the incorrect form (admission versus discharge) and with the same date in the Date of Above Transaction field.

Examples:

- A discharge to the hospital is submitted in error because the admission to the hospital was for observation only and no form should have been submitted. If the discharge is processed before the mistake is corrected, submit a counteracting form indicating an admission in the Transaction field and use the same date in the Date of Above Transaction field.
- A Form 3618 admission is submitted, but the person is classified as Medicare. If the admission processes before the mistake is corrected, submit a counteracting form indicating Discharge to NF in the Transaction field and use the same date in the Date of Above Transaction field.
- If an admission is submitted under the wrong contract and it is processed onto the file, a discharge must be submitted for the same incorrect contract, using the same Date of Above Transaction. Once both forms are available on the LTC Online Portal and are set to status **Processed/Complete** or **Provider Action Required**, you must contact HHSC LTC Provider Claims Services. The correct admission cannot be submitted until HHSC has set the status of both forms with the incorrect contract to **Invalid/Complete**.
- It is beneficial to add a note in the comment section of the counteracting form detailing the desired action.

Note: *When submitting a counteracting form for an admission that has payment, recoupment will occur unless additional processing occurs at the same time. Coordinate with HHSC LTC Provider Claims Services to ensure appropriate payment.*

Modifications

NF providers submit all MDS Correction requests to CMS in accordance with the *RAI User's Manual*. Corrections that are classified as a Modification are retrieved by TMHP for processing. In field X0900 on 3.0 corrections, select the reason for modification. TMHP sets the original assessment to status **Corrected** and gives the new assessment a DLN, thus creating a Parent/Child DLN relationship set to status **Awaiting LTC Medicaid Information**. The LTCMI must be completed and submitted at this time. The MN will then be determined.

Note: *You are allowed to submit modifications to an on-time MDS without requiring a PC for up to one year. For Modifications to an MDS assessment that did not originally meet the timeliness rules, a PC E will be required upon submission of the LTCMI.*

Note: *If the parent assessment is in status **Processed/Complete** or **PCS Processed/Complete**, it will not move to **Corrected** status until the child form is in status **Processed/Complete** or **PCS Processed/Complete**.*

You must access the LTC Online Portal to retrieve the new assessment, complete the LTCMI, and submit.

MDS 3.0

For detailed instructions on completing an MDS 3.0 Modification, refer to the MDS 3.0 RAI User's Manual Chapter 5. The User's Manual can be found under Downloads on the CMS website at:

www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Inactivations

MDS Assessment

For MDS Inactivations, NF providers complete the MDS Correction Request Form ensuring field X1050 on 3.0 corrections (reason for inactivation) was completed prior to submitting it to CMS. TMHP will retrieve all successfully submitted MDS Inactivation Requests from CMS for processing. When the inactivation is placed on the LTC Online Portal, TMHP will automatically inactivate the associated LTCMI and the assessment will set to status **Form Inactivated** unless the original assessment has been set to status **Processed/Complete**. However, the LTCMI will not automatically be inactivated on the LTC Online Portal if the assessment had a previous status of **Processed/Complete**, which means it was already processed by the Service Authorization System (SAS). The assessment status will be set to **SAS Request Pending** and will be processed by SAS during the nightly batch routines. Any MDS assessment set to status **Form Inactivated** or **Invalid/Complete** cannot be corrected or resubmitted.

The inactivation request will be submitted against assessments that have been processed. If the assessment can be located and the HHSC Office of Inspector General (OIG) has not addressed the assessment, the assessment will be canceled and any associated payments will be recouped. If the inactivation is submitted on an assessment that has been chosen by OIG, the inactivation will reject with an appropriate error message. If the system fails to identify the assessment, the inactivation will also be rejected and HHSC will manually research it. With each situation a response will be posted on the LTC Online Portal.

Note: Refer to the MDS 3.0 RAI User's Manual, Chapter 5, for detailed instructions on completing an MDS Inactivation. The User's Manual can be found under Downloads on the CMS website at:

www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Note: Providers should only submit an inactivation on dually-coded assessments after attempting to submit a modification by way of CMS. An inactivation will affect Medicare, as well as Medicaid reimbursement.

Forms 3618 and 3619 Inactivations

Use FSI or Current Activity to search for Forms 3618 and 3619 that need to be inactivated. When you find the forms, submit the inactivations on the LTC Online Portal. Once the inactivation is submitted and accepted, the form is set to status **Form Inactivated** and is unavailable for any further action.

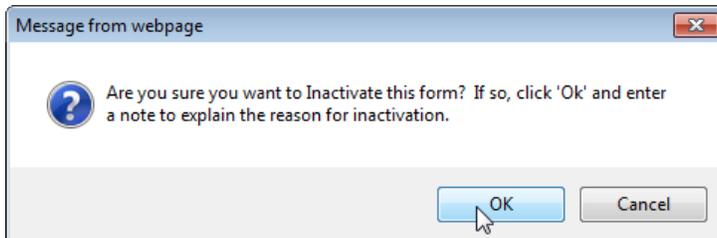
How to Inactivate

- 1) Log in to the LTC Online Portal.
- 2) Search for the form being deactivated using either **Form Status Inquiry** or **Current Activity** link in the blue navigational bar.
 - a) If using FSI, you may search for Form 3618 or 3619 using SSN, Medicaid Number, or DLN. Click the **Search** button, then click the **View Detail** link.

b) If using Current Activity, click the **DLN** link.

3) Click the **Inactivate Form** button.

4) Click the **OK** button when the pop-up window asks: Are you sure you want to Inactivate this form? If so, click OK and enter a note to explain the reason for inactivation.



- 5) When the Change Status window appears, enter a note for the inactivation and click the **Change Status** button. The form or screening will be set to status **Form Inactivated**.

The following Forms 3618 and 3619 cannot be inactivated:

- Forms with a status of **Processed/Complete, Corrected, or Form Inactivated**
- Forms that have been successfully processed
- Forms with the provider workflow message code GN-9004 anywhere in the History trail.

If a provider attempts to inactivate a Form 3618 or 3619 and one of the above circumstances exists, the provider will receive the following error message:

This form has been successfully processed at HHSC and cannot be inactivated. If this form is invalid (should not have been submitted), submit the appropriate form to counteract this form. Otherwise, correct this form and resubmit.

To cancel a form that is set to status **Processed/Complete** and has an error in a non-correctable field or one that should not have been submitted, providers must submit the appropriate counteracting form. Refer to the Counteracting Forms section of this User Guide for additional information.

PASRR Level 1 Screening Inactivations

There is no **Inactivate Form** button for a PL1 Screening Form. If a new PL1 Screening Form is submitted for a person with an existing PL1 Screening Form, the previous PL1 Screening Form and any associated PE will be inactivated automatically. Upon submission of this new PL1 Screening Form, a message will appear prompting you to confirm inactivation of the previous PL1 Screening Form and associated PE.

Other ways to inactivate a PL1 (if the PE has been submitted) is to enter a deceased or discharged date. Or for a PL1 to be set to **PL1 Inactive** status (and does not have a PE submitted), refer to the PASRR Level 1 Screening Updates instructions in the Corrections and Updates section of this User Guide.

Note: *If an inactivation is needed for an NFSS form, contact the HHSC PASRR Unit for assistance.*

RUG Training Requirements

RUG training is intended for long-term care nurses. RUG training is designed to give providers the requirements for completing RUG fields in assessments for Texas Medicaid payment.

Texas State University, in cooperation with the OIG has made this training available through their Office of Continuing Education's online course program.

To register for the RUG training, or for more information visit:

www.txstate.edu/continuinged/CE-Online/RUG-Training.html

RUG training is valid for two years, then it must be renewed by completing the online RUG training offered by Texas State University.

RUG training is required for Registered Nurses (RNs) who sign assessments as complete.

RUG training can take two to seven working days (Monday - Friday, 8:00 a.m. - 5:00 p.m.) for processing and reporting completion of RUG training to TMHP, depending on current volume of enrollments and completions.

Note: *RUG training is valid for a period of two years. The implementation of the MDS 3.0 assessment did not impact the expiration date of your RUG training certificate.*

Preventing Medicaid Waste, Abuse, and Fraud

Medicaid fraud is 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.hhsc.texas.gov/report-fraud>. 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 OIG.

If you are not sure if 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). It is YOUR responsibility to comply with HIPAA, to seek legal representation when needed, and to consult the manuals or 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 forms completion – including PASRR Level 1 Screening Form, PCSP, and NFSS form.
- LA forms completion – including PASRR Level 1 Screening Form, PE, and PCSP.
- Rejection codes on the forms and PTIDs.
- Management of the **Provider Action Required** status.
- If the Medicaid, Social Security, or Medicare number and the name match the person's Medicaid ID card and the form is set to status **ID Invalid**, call TMHP to see what their options are regarding form resubmittal.
- PASRR Level 1 Screening Form, PE, PCSP, and NFSS form submission error messages, and the NFSS PTID and PE PTID error messages.
- PASRR Level 1 Screening Form, PASRR Evaluation, PCSP, and NFSS 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.

Types of Calls to Refer to HHSC IDD PASRR Unit

Call HHSC PASRR Unit at **855-435-7180** or email PASRR.Support@hhsc.state.tx.us about the following:

- Assistance or cooperation from an NF or Local Intellectual or Developmental Disability Authorities (LIDDA)
- Assistance with locating information to perform and submit the PL1 Screening Form and NFSS form
- Assistance with locating screenings and evaluations, people, or additional training resources
- Policy guidance on specialized services and therapist assessments

Types of Calls to Refer to HHSC MI PASRR

Send a message to HHSC MI PASRR at PASRR.Support@hhsc.state.tx.us about the following:

- Assistance or cooperation from a Hospital Referring Entity (RE) or LMHA/LBHA.

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 medical necessity, after verifying MDS 3.0: A0700, Medicaid Number, contains a nine-digit numeric rather than + or N.
- A 3618/3619 admission submitted under the wrong contract - that process must have a counteracting discharge submitted and you must call to request that HHSC PCS set the incorrect form to status **Invalid/Complete**. 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 which do not appear on MESAV.

Types of Calls to Refer to a Local Authority

- For a true preadmission when a person just arrives without paperwork at the NF when not Expedited Admission or Exempted Hospital Discharge
- For a person who just arrives at the NF with a PASRR Negative Letter from the PE and needs help calling the LA
- When the NF needs to follow up after an alert was sent to the LA to perform and submit a PE for a Resident Review
- To invite the LA to participate in the IDT Meeting

Helpful Contact Information

Texas Medicaid & Healthcare Partnership (TMHP)

General Customer Service.....	800-925-9126
Long-Term Care (LTC) Department.....	800-727-5436 / 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	Option 2
Technical Support.....	Option 3
Fair Hearing.....	Option 5
LTC Other Insurance Information and Updates	Option 6
LTC Department (fax).....	512-514-4223
Medicaid Hotline	800-252-8263

Health and Human Services Commission (HHSC)..... 512-438-3011

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
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
Criminal History Checks.....	512-438-2363
Facility Licensure/Certification (Reporting Changes, such as Service Area and Medical Director)	(512) 438-2630
Home and Community Support Services Unit (Hospice Regulatory Requirements)....	512-438-3161
Hospice Policy (Medicaid, Program Support, and Special Services Unit) hospice@hhs.state.tx.us	
Institutional Services Contracting.....	512-438-2546
Medication Aide Program	512-231-5800
Nurse Aide Registry.....	800-452-3934
Nurse Aide Training.....	512-231-5800
NF Administrator Program.....	512-231-5800
NF Policy	512-438-3161
Regulatory Services	512-438-2625
PASRR Unit Policy Questions.....	855-435-7180
Provider Claims Services Hotline	512-438-2200
NF and Hospice (Service authorizations, MESAV updates, and unable to determine Rate Key issues).....	Option 1
Personal Needs Allowance Payments (PNA)	Option 2
Deductions and Holds.....	Option 3
Provider Recoupment and Holds, including torts and trusts and/or annuities	Option 4

Home Community Services.....	Option 5
TX Home Living.....	Option 5
Rehabilitation Therapy and Specialized Services.....	Option 6
HHSC Ombudsman Office Medicaid Benefits	877-787-8999
Medicaid Fraud.....	800-436-6184
Rate Analysis Help Line	512-730-7404
Resource Utilization Groups (RUGs) Information	
Nurse Specialist (Reconsideration & RUGs).....	512-491-2074
Texas State University RUG Training Information	512-245-7118
Texas State University Training Online Course Questions.....	512-245-7118

Informational Websites

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

- HIPAA information: www.tmhp.com/hipaa-privacy-statement
- Long-Term Care Division: www.tmhp.com/programs/ltc
- NF LTCMI and PASRR information is also available at: www.tmhp.com/programs/ltc
- Long-Term Care Provider News Archives: www.tmhp.com/news?program_id=56

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

All HHSC provider information can be found at <https://hhs.texas.gov/doing-business-hhs/provider-portals>. Choose your particular provider type for available online resources:

- Consumer Rights and Services (includes information about how to make a complaint): <https://hhs.texas.gov/about-hhs/your-rights/consumer-rights-services>
- Hospice: <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/hospice>
- Nursing Facility: <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities-nf>
- Nursing Facility MDS Coordinator Support Site: <https://hhs.texas.gov/doing-business-hhs>
- PASRR: <https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-resident-review-pasrr>
- Provider Letters: www.dads.state.tx.us/providers/communications/letters.cfm
- Resources for HHS Service Providers: <https://hhs.texas.gov/doing-business-hhs>
- HHS Regions: <https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts>
- Vendor Drug Program: www.txvendordrug.com/downloads/index.asp

Other

- Centers for Medicare & Medicaid Services: www.cms.gov
- Department of State Health Services: www.dshs.state.tx.us/
- National Provider Identifier (NPI) - To obtain: <https://nppes.cms.hhs.gov/NPPES>
- Texas Administrative Code: www.sos.state.tx.us/tac/index.shtml
- Texas State RUG Training:
www.txstate.edu/continuinged/CE-Online/RUG-Training
- Federal MDS 3.0 site: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Minimum Data Set (MDS) Quick Reference Guide

MDS Telephone Numbers

CMSNet Remote User Support Helpdesk (Verizon).....	888-238-2122
MDS Technical/Report Questions	512-438-2396
MDS Clinical Questions/Training.....	210-619-8010
MDS/RAP/Care Plan Training.....	512-458-1257 / 512-467-2242
CASPER QM/QI Clinical Questions.....	210-619-8010
CASPER QM/QI Report Questions.....	512-438-2396
jRAVEN Help Desk.....	800-339-9313
Swing Bed Automation/Technical.....	800-339-9313
Swing Bed Clinical MDS.....	210-619-8010

MDS Informational Websites

- QIES Technical Support Office (QTSO): www.qtso.com
- For validation report messages and descriptions, see: MDS
- Federal MDS 3.0 site: www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
- MDS Software Specifications: www.cms.gov/MDS20SWSpecs
- MDS/RAP/Care Planning Training: www.txhca.org
- jRAVEN: see Federal MDS 3.0
- Resident Assessment Instrument (RAI) 3.0 Manual:
www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp
- State MDS Policy: www.HHS.state.tx.us/providers/mds/index.cfm
- State MDS Clinical Web Page/The MDS Mentor: www.HHS.state.tx.us/providers/MDS/
- NF MDS Coordinator Support Site: www.HHS.state.tx.us/providers/MDS/

