



LONG-TERM CARE (LTC) USER GUIDE

FOR COMMUNITY SERVICE WAIVER PROGRAMS



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

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Learning Objectives

After learning the material in the *Long-Term Care User Guide for Community Services Waiver Programs*, you will be able to:

- Understand the Medicaid team roles.
- Identify National Provider Identifier (NPI)/Atypical Provider Identifier (API) requirements.
- Understand the use of the LTC Online Portal and resources to navigate the Online Portal.
- Understand medical necessity (MN) and the MN determination process.
- Submit Medical Necessity and Level of Care (MN/LOC) Assessments.
- Understand and complete the Long-Term Care Medicaid Information (LTCMI) section, field by field.
- Submit Individual Service Plan (ISP) forms.
- Understand the provider workflow process.
- Understand how to correct or inactivate assessments—and the consequences of doing so.
- Understand how to print completed and blank assessments.
- Identify assessment statuses and how to resolve issues.
- Understand Resource Utilization Group (RUG) training requirements.
- Explain how to report Medicaid waste, abuse, and fraud.
- Identify additional resources.

Medicaid Team

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

- **Centers for Medicare & Medicaid Services (CMS)** – The federal agency within the United States Department of Health and Human Services that is responsible for the administration of Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).
- **Individual(s)** – A person enrolled in a Medicaid, CHIP, or Medicaid waiver program. May also be referred to as “member(s).”
- **Managed care organization (MCO)** – State-contracted entity that has been given delegated authority to provide Medicaid services such as acute and long-term care/services and supports to enrolled managed care members eligible for these services.
- **Program provider** – An entity that provides services under a contract with the Texas Health and Human Services Commission (HHSC). For the purposes of this user guide, a program provider is any entity that completes and submits an MN/LOC or ISP using the LTC Online Portal, including an MCO.
- **Texas Health and Human Services Commission (HHSC)** – State agency that provides administrative oversight of Texas Health and Human Services programs including Medicaid and the Children’s Health Insurance Plan (CHIP). HHSC delivers most Medicaid and CHIP services through MCOs. MCOs operate under programs such as the State of Texas Access Reform (STAR) and the State of Texas Access Reform PLUS (STAR+PLUS). Examples of Medicaid services delivered through STAR+PLUS are long-term services and supports (LTSS) for eligible older persons and people with physical, intellectual, and developmental disabilities.
- **Texas Medicaid & Healthcare Partnership (TMHP)** – Contracted by the state as the claims administrator to process claims for providers under traditional Medicaid. TMHP processes and approves claims for traditional long-term care (LTC). TMHP does not pay LTC claims; this is done by the comptroller. Responsibilities also include the following:
 - Determination of MN
 - Provision of provider education and technical assistance with TMHP portals and applications (e.g., the LTC Online Portal and TexMedConnect).
 - Timely processing of claims for services not covered by Medicaid managed care (except for services covered by the STAR+PLUS premium).
 - Represent HHSC at fair hearings
 - Production of yearly program manuals, quarterly *LTC Provider Bulletins*, and bi-weekly Remittance and Status (R&S) Reports
 - Oversight of the TMHP Call Center/Help Desk, Monday through Friday, 7:00 a.m.–7:00 p.m., Central Time, excluding holidays

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

The Health Insurance Portability and Accountability Act (HIPAA) established the NPI as the 10-digit standard unique identifier for health care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in HIPAA-covered transactions.

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

Atypical providers are providers that do not provide health care and therefore do not qualify to receive a NPI. Examples of services atypical providers provide include transportation, home and vehicle modifications, and respite services. An atypical provider identifier (API) is assigned to these providers in lieu of an NPI, to bill for those services.

It is important that the NPI or API is included in MN/LOC Assessment submissions field S2d. NPI or API is required on claims and assessment submissions using the following methods:

- LTC Online Portal
- TexMedConnect
- Third-party software vendor

To obtain an NPI, go to <https://nppes.cms.hhs.gov/NPPES>. To obtain an API, go to <https://hhs.texas.gov/doing-business-hhs/medicaid-provider-enrollment>.

The LTC Online Portal

The LTC Online Portal is used to submit, monitor, and manage MN/LOC Assessments. You can also submit **HI1700-1 HCBS STAR+PLUS Waiver Individual Service Plan (ISP)** forms.

Benefits of Using the LTC Online Portal

- Web-based application available 24 hours a day, 7 days a week.
- TMHP provides LTC Online Portal technical support by phone at **800-626-4117**, from 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday—excluding holidays.
- Audits are in place to verify the validity of data entered.
- Error messages flag entries that must be resolved before submission.
- Providers can monitor the status of their assessments using Form Status Inquiry (FSI) or Current Activity.
- Allows providers to submit additional information.

LTC Online Portal Security

Security clearance and access to needed LTC Online Portal features are based on the role of the user, allowing them to complete the tasks associated with their job requirements. The options available on the blue navigational bar are based on the security profile assigned to each user. Therefore, some options on the blue navigational bar may not be available for all users.

To utilize the LTC Online Portal, providers and MCOs must request access to the LTC Online Portal. Your agency may already have an account. You may need to contact your agency's administrator for user access. An administrator account is not required for LTC Online Portal access but it is strongly recommended to have multiple administrator accounts in case one administrator is unavailable.

The administrator account is the primary user account for a provider number.

The administrator account provides the ability to create and add/remove permissions (access to LTC Online Portal features) for other user accounts on the same provider number, according to the user's responsibilities.

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

If you do not have an account, you can create one by following the steps outlined in the *Long-Term Care (LTC) User Guide for Online Portal Basics, General Information, and Program Resources*. To do so, you will need to have your:

- **Provider number** – This nine-digit number (normally starts with 00) is assigned by HHSC when the provider signs the contract to provide HHS Program services.
- **Vendor number** – This four-digit number is assigned by HHSC when the provider signs the contract to submit assessments on the LTC Online Portal.

- **Vendor password** – Providers must call the Electronic Data Interchange (EDI) Help Desk at **888-863-3638, option 4**, to obtain a vendor password. The Help Desk is available Monday through Friday, 7:00 a.m.–7:00 p.m. Note that it may take 3-5 business days to receive the password, which is randomly generated by TMHP.

LTC Online Portal Resources

For information on how to navigate the LTC Online Portal, including how to create an administrator account, refer to the *Long-Term Care (LTC) User Guide for Online Portal Basics, General Information and Program Resources*.

Medical Necessity and Level of Care 3.0 Assessment

MN/LOC Assessments are submitted to determine MN for people in the community and for Medicaid reimbursement.

There are three reasons to submit an MN/LOC 3.0 Assessment:

- A0310A = 01. Initial Assessment
- A0310A = 03. Annual Assessment
- A0310A = 04. Significant Change in Status Assessment (SCSA), submitted due to changes in the medical condition of the person when one of the following conditions are met:
 - Authorized by the HHSC case manager; OR
 - For people receiving Community First Choice (CFC) services from an MCO.

Note: A SCSA does not apply for the Program for All-Inclusive Care for the Elderly (PACE). For STAR+PLUS, the SCSA is completed but not submitted on the LTC Online Portal unless eligibility for STAR+PLUS HCBS is being established and the member receives CFC services. If the member receives CFC services, the MCO submits the SCSA on the LTC Online Portal.

Significant Change in Status Assessment Submission Guidelines

The LTC Online Portal will accept SCSA submissions only when there is a record of previously approved MN found within the past 365 calendar days for the member.

If there is no approved MN within the past 365 calendar days, the SCSA will not be accepted on the LTC Online Portal, and the following error message will be displayed:

• The SCSA cannot be accepted. No previous MN on file for client within past 365 days. Please submit Initial or Annual assessment.

The LTC Online Portal will not accept SCSA submissions if the latest approved MN Assessment found for a member is within the 365 calendar day limit and is set to one of the following pending statuses:

- **Pending Review**
- **Pending Denial (need more information)**

In the above circumstance, the following error message will be displayed:

• The SCSA cannot be accepted. The final decision has not been made on your previously submitted Initial or Annual assessment for this client. You may save this SCSA as a draft for submission at a later date.

All assessments must be submitted through the LTC Online Portal.

Note: MCOs complete the SCSA but do not submit it on the LTC Online Portal unless eligibility for STAR+PLUS HCBS program is being established and the member receives CFC services. If the member does not receive CFC

services, the MCO prints and keeps it in the member's records. If the member receives CFC services, the MCO submits it on the LTC Online Portal.

How to Submit a Medical Necessity and Level of Care Assessment

- 1) Login to the LTC Online Portal.
- 2) Click the **Submit Form** link located in the blue navigational bar.
- 3) Choose **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the Type of Form drop-down box.

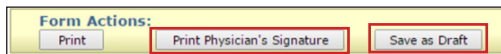
The screenshot shows the 'Submit Form' page in the TMHP system. The 'Form Select' section has a 'Type of Form' dropdown menu set to 'Waiver 3.0: Medical Necessity and Level of Care Assessment' and a 'Vendor Number' dropdown menu set to 'for Provider Number'. The 'Recipient' section contains the following text: 'To prepopulate recipient information please provide one of the following combinations of information. Medicaid/CSHCN ID or Social Security Number AND Last Name or Social Security Number AND Date of Birth or Date of Birth AND Last Name AND First Name'. Below this text are input fields for 'Medicaid Number', 'SSN', 'Date of Birth' (with a date picker), 'First Name', and 'Last Name'. An 'Enter Form' button is located at the bottom right of the form.

- 4) To auto-populate a member's information in the MN/LOC Assessment, enter one of the following combinations of information:
 - Medicaid number
or
 - Social Security number (SSN) *and* last name
or
 - SSN *and* date of birth
or
 - Date of birth *and* last name *and* first name

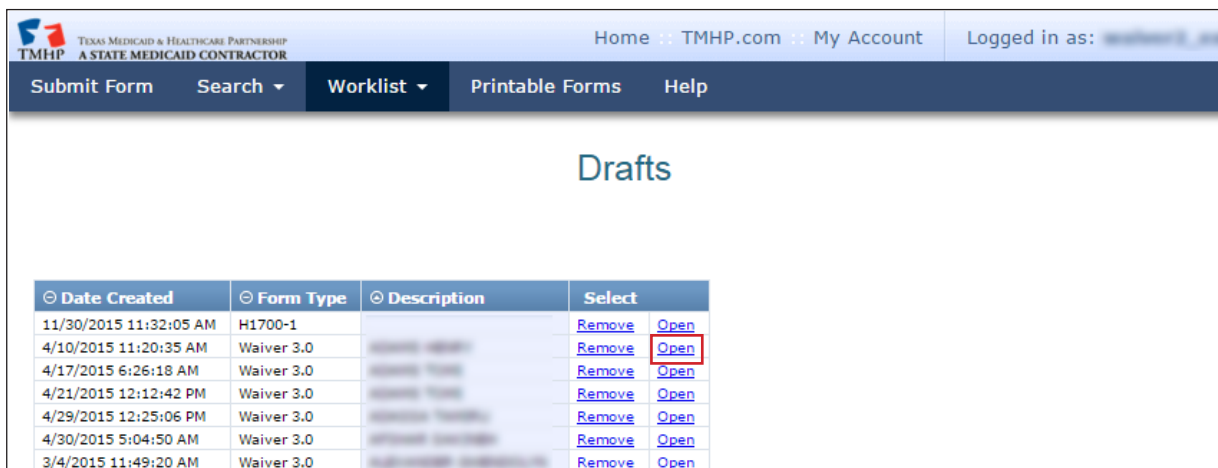
Note: All demographic information (except gender) is auto-populated when one of the aforementioned data items is entered. Refer to the demographic information located in Section A and the LTCMI of the MN/LOC Assessment section.
- 5) Click the **Enter Form** button.
- 6) Click the tabs (Section A, Section B, etc.) and enter the assessment information.

For Initial Assessments only, the following is required:

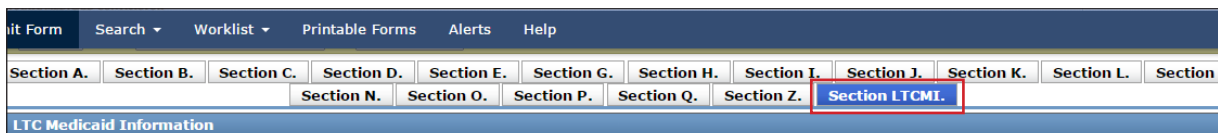
- 1) Click the **Print Physician's Signature** button, print the signature page, and obtain the MD/DO signature.
- 2) Click the **Save as Draft** button to save the MN/LOC Assessment to be recalled later.



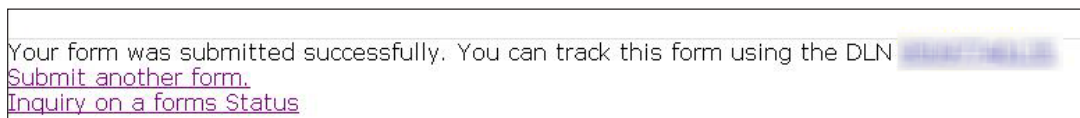
- 3) Once the physician's signature has been obtained, click the **Drafts** link in the blue navigational bar.
- 4) Click the **Open** link.



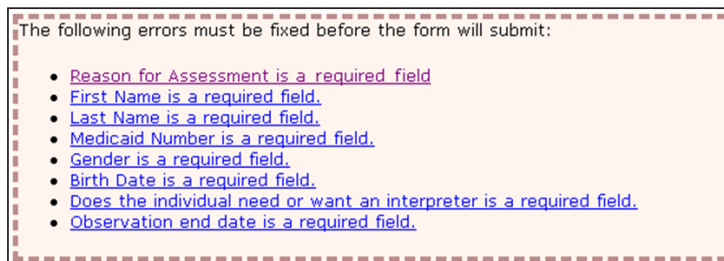
- 5) Click the **Section LTCMI** tab. Check the box indicating the physician's signature is on file.



- 6) Click the **Submit Form** button.
 - a) If the assessment is submitted successfully, a DLN will be assigned and the following message will be displayed:



- b) If an assessment is not successfully submitted, an error message will appear at the top of the screen. The provider must resolve the error(s) to ensure that the assessment will be submitted successfully. The error message will prompt the provider as to how to resolve the error or save to draft for research and correction at a later date. If the provider is unable to resolve the error, they may contact TMHP for assistance.



MN/LOC 3.0 Assessment Sections

The following are the MN/LOC 3.0 Assessment sections:

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

- Section A: Identification Information
- Section B: Hearing, Speech, and Vision
- Section C: Cognitive Patterns
- Section D: Mood
- Section E: Behavior
- Section G: Functional Status
- Section H: Bladder and Bowel
- Section I: Active Diagnoses
- Section J: Health Conditions
- Section K: Swallowing/Nutritional Status
- Section L: Oral/Dental Status
- Section M: Skin Conditions
- Section N: Medications
- Section O: Special Treatments, Procedures, and Programs
- Section P: Restraints and Alarms
- Section Q: Participation in Assessment and Goal Setting
- Section Z: Assessment Administration
- Section LTCMI: LTC Medicaid Information

Detailed explanations of the MN/LOC Assessment sections can be found at the following locations:

- Go to www.tmhp.com/programs/ltc/forms, and click the **Medical Necessity and Level of Care 3.0 Assessment Instructions** link found under the Community Waivers Programs heading.
- Click the **Help** link in the blue navigational bar, and click the **Medical Necessity and Level of Care 3.0 Assessment Instructions** link.

Blank MN/LOC Assessments can be found at the following locations:

- Go to www.tmhp.com/programs/ltc/forms, and click the **Medical Necessity and Level of Care 3.0 Assessment** link found under the Community Waivers Programs heading.
- Click the **Printable Forms** link in the blue navigational bar, and click the **Waiver 3.0 MN and LOC** link.

Long Term Care Medicaid Information (LTCMI)

This is what the LTCMI section looks like.

mit Form		Search	Worklist	Printable Forms	Alerts	Help					
Section A.	Section B.	Section C.	Section D.	Section E.	Section G.	Section H.	Section I.	Section J.	Section K.	Section L.	Section M.
		Section N.	Section O.	Section P.	Section Q.	Section Z.	Section LTCMI.				
LTC Medicaid Information											
S1. Medicaid Information											
S1a.	Medicaid Client Indicator	1. Medicaid									
S1b.	Individual Address										
S1c.	City										
S1d.	State										
S1e.	ZIP Code										
S1f.	Phone										
S2. Claims Processing Information											
S2a.	DADS Vendor/Site ID Number										
S2b.	Provider Number										
S2c.	Service Group	3. CBA									
S2d.	NPI Number										
S2e.	Region										
S2f.	Purpose Code										
S2g.	HHA License #										
S2h.	HHA License # Expiration Date	mm/dd/yyyy									
S3. Primary Diagnosis											
	Primary Diagnosis ICD Code	Primary Diagnosis ICD Description									
S3a.		S3b.									
S5. Licenses											
Certification: To the best of my knowledge, I certify to the accuracy and completeness of this information.											
S5a.	HHA RN Last Name										
S5b.	HHA RN License #										
S5c.	HHA RN License State										
S5d.	DADS RN Last Name										
S5e.	DADS RN License #										
S5f.	DADS RN License State										
S5g.	DADS RN Signature Date	mm/dd/yyyy									
S5h.	PACE RN Last Name										
S5i.	PACE RN License #										
S5j.	PACE RN License State										
S5k.	HMO RN Last Name										
S5l.	HMO RN License #										
S5m.	HMO RN License State										
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 individual functioning?										
S6h.	Enter the number of times this individual 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 Individual or Caregiver										

S7. Physician's Evaluation & Recommendation	
S7a.	Did an MD/DO certify that this individual requires nursing facility services or alternative community based services under the supervision of an MD/DO? <input type="text"/>
S7b.	Did a military physician providing healthcare according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual? <input type="text"/>
S7c.	MD/DO Last Name <input type="text"/>
S7d.	MD/DO License # <input type="text"/>
S7e.	MD/DO License State <input type="text"/>
Indicate Physician Signature on file by checking box (Required for Initial Assessments) <input type="checkbox"/>	
The following MD/DO information is required if MD/DO is not licensed in Texas.	
S7f.	MD/DO First Name <input type="text"/>
S7g.	MD/DO Address <input type="text"/>
S7h.	MD/DO City <input type="text"/>
S7i.	MD/DO State <input type="text"/>
S7j.	MD/DO ZIP Code <input type="text"/>
S7k.	MD/DO Phone <input type="text"/>
S9. Medications	
List all medications that the individual 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 individual is taking no medications OR the medications listed below are correct	
Add Meds	
S10. Comments	
<div style="border: 1px solid gray; height: 100px;"></div>	
S11. Advance Care Planning	
S11a.	Does the individual/caregiver report having a legally authorized representative? <input type="text"/>
S11b.	Does the individual/caregiver report having a Directive to Physicians and Family or Surrogates? <input type="text"/>
S11c.	Does the individual/caregiver report having a Medical Power of Attorney? <input type="text"/>
S11d.	Does the individual/caregiver report having an Out-of-Hospital Do Not Resuscitate Order? <input type="text"/>
S12. LAR Address	
Required if individual/caregiver 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"/>
S12f.	ZIP Code <input type="text"/>
S12g.	Phone <input type="text"/>

Submit Form

S1. Medicaid Information

- S1a. Medicaid Client Indicator
 - This field will be auto populated.
- S1b. Individual Address
 - Required
 - Enter the street address where the member is presently living.
 - The member's address is used for mailing MN letters.
- S1c. City
 - Required

- Enter the city where the member is presently living.
- S1d. State
 - Required
 - Choose the state where the member is presently living from the drop-down box.
 - The member's address is used for mailing MN letters.
- S1e. ZIP Code
 - Required
 - Enter the ZIP Code where the member is presently living.
 - The member's address is used for mailing MN letters.
- S1f. Phone
 - Optional
 - Enter the member's contact telephone number, if known.
- **S2. Claims Processing Information**
 - S2a. HHSC Vendor/Site ID Number
 - This field will be auto populated based on the user's logon security credentials and cannot be changed.
 - S2b. Provider Number
 - This field will be auto populated and cannot be changed.
 - S2c. Service Group
 - Required
 - Choose from the drop-down box:
 - 3. CBA
 - 11. PACE
 - 17. CWP
 - 19. STAR+PLUS
 - 23. CFC
 - S2d. NPI Number
 - Required
 - This field will be auto populated and cannot be changed.

- This is where API would be included if you're using an API number. API is "D", two zeros, then the provider number.
- S2e. Region
 - Required
 - Choose from the drop-down box:
 - 01 (Lubbock)
 - 02 (Abilene)
 - 03 (Arlington)
 - 04 (Tyler)
 - 05 (Beaumont)
 - 06 (Houston)
 - 07 (Austin)
 - 08 (San Antonio)
 - 09 (Midland / Odessa)
 - 10 (El Paso)
 - 11 (Edinburg)
- S2g. Home Health Agency (HHA) License #
 - Required
 - If you work for a HHA:
 - Enter the HHA License number. HHA License # is no more than 7 numeric digits.
 - If you do not work for a HHA:
 - Enter all zeros.
- S2h. HHA License # Expiration Date
 - Required
 - Enter the license expiration date of the HHA License number. If you entered all zeros in field S2g, this field will deactivate.
 - HHA License # Expiration Date must be in mm/dd/yyyy format.
- **S3. Primary Diagnosis**
 - S3a. Primary Diagnosis International Classification of Diseases (ICD) Code

- Required
 - Enter a valid ICD code for the person's primary diagnosis. Use your best clinical judgment.
- S3b. Primary Diagnosis ICD description
 - Optional
 - This field will be auto populated after S3a was inputted.
 - Click the **magnifying glass** and the description will be auto populated based on the primary diagnosis ICD code.
- **S4. For HHSC use only**
 - When a successfully submitted LTCMI is printed, field S4b will show the calculated RUG value.
Note: The RUG value also appears at the top of each page on all successfully submitted MN/LOC Assessments.
- **S5. Licenses**

Note: S5d through S5g are not listed here because they are no longer used.

- S5a. HHA RN Last Name
 - Conditional
 - This is a required field for Service Group (SG) 23 CFC.
 - Enter the last name of the RN completing the assessment.
- S5b. HHA RN License #
 - Conditional
 - This is a required field for SG 23 CFC.
 - Enter the license number of the RN.
 - Licenses issued in Texas will be validated against the Texas Board of Nursing (BON). Compact licenses will be validated with the issuing state's nursing board.
 - This number is validated to ensure RUG training requirements have been met.
- S5c. HHA RN License State
 - Conditional
 - This is a required field for SG 23 CFC.
 - Choose the state in which the RN is licensed from the drop-down box.
- S5h. PACE RN Last Name
 - Conditional

- This is a required field for SG 11 PACE.
- Enter the last name of the RN completing the assessment.
- S5i. PACE RN License #
 - Conditional
 - This is a required field for SG 11 PACE.
 - Enter the license number of the RN.
 - Licenses issued in Texas will be validated against the Texas BON. Compact licenses will be validated with the issuing state's nursing board.
 - This number is validated to ensure RUG training requirements have been met.
- S5j. PACE RN License State
 - Conditional
 - This is a required field for SG 11 PACE.
 - Choose the state in which the RN is licensed from the drop-down box.
- S5k. HMO RN Last Name
 - Conditional
 - This is a required field for SG 19 STAR+PLUS.
 - Enter the last name of the RN completing the assessment.
- S5l. HMO RN License #
 - Conditional
 - This is a required field for SG 19 STAR+PLUS.
 - Enter the license number of the RN.
 - Licenses issued in Texas will be validated against the Texas BON. Compact licenses will be validated with the issuing state's nursing board.
 - This number is validated to ensure RUG training requirements have been met.
- S5m. HMO RN License State
 - Conditional
 - This is a required field for SG 19 STAR+PLUS.
 - Choose the state in which the RN is licensed from the drop-down box.
- **S6. Additional MN Information**

- S6a. Tracheostomy Care
 - Conditional
 - This field is only required and available for data entry if O0100E, Tracheostomy care, is checked *and* the person is 21 years of age or younger.
 - Choose from the drop-down box:
 - Less than once a week
 - 1 to 6 times a week
 - Once a day
 - Twice a day
 - 3 – 11 times a day
 - Every 2 hours
 - Hourly/continuous
- S6b. Ventilator/Respirator
 - Conditional
 - This field is only required and available for data entry if O0100F, ventilator or respirator, is checked. It does not enable for BiPap or CPAP.
 - Choose from the drop-down box:
 - Less than once a week
 - 1 to 6 times a week
 - Once a day
 - Twice a day
 - 3 – 11 times a day
 - 6 – 23 hours
 - 24-hour continuous
- S6c. Number of hospitalizations in the last 90 days
 - Required
 - Record the number of times the person 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 person visited the emergency room (ER) without an overnight stay in the last 90 days (or since last assessment if less than 90 days).
 - Enter 0 (zero) if no ER visits.
 - Valid range includes 0 – 90.
 - S6e. Oxygen Therapy
 - Conditional
 - This field is only required and available for data entry if O0100C, Oxygen therapy, is checked.
 - Choose from the drop-down box:
 - Less than once a week
 - 1 to 6 times a week
 - Once a day
 - Twice a day
 - 3 – 11 times a day
 - 6 – 23 hours
 - 7 – 24-hour continuous
 - S6f. Special Ports/Central Lines/PICC
 - Optional
 - Use this field to indicate if the member 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.
 - Choose from the drop-down box:
 - N = none present
 - Y = 1 or more implantable access system or CVC
 - U = unknown
 - S6g. At what developmental level is the person functioning?
 - Conditional

- This is a required field for all assessments for members 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 member is 21 years of age or older.
- Choose from the drop-down box:
 - Unknown or unable to assess
 - < 1 Infant
 - 1 – 2 Toddler
 - 3 – 5 Pre-School
 - 6 – 10 School age
 - 11 – 15 Young Adolescence
 - 16 – 20 Older Adolescence
- S6h. Enter the number of times this person has fallen in the last 90 days.
 - Required
 - Record number of times the member has fallen in the last 90 days. Enter 0 (zero) if there are no falls.
 - Each fall should be counted separately. So, if the member has fallen multiple times in one day, count each fall individually.
 - Valid range includes 0 – 999.
- S6i. In how many of the falls listed in S6h above was the person physically restrained prior to the fall?
 - Conditional
 - This is a required field only if S6h indicates the member has fallen.
 - Valid range includes 0 with a maximum being the number entered in S6h.
 - Enter 0 if no falls when the member was physically restrained prior to the fall.
- S6j. In the falls listed in S6h above, how many had the following contributory factors?
 - Required
 - 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.)
 - Conditional
 - This field is required only if S6h indicates the member has fallen.
 - Valid range includes 0 with a maximum being the number entered in S6h.

- S6j2 - Medication(s)
 - Conditional
 - This field is required only if S6h indicates the member has fallen.
 - Valid range includes 0 with a maximum being the number entered in S6h.
- S6j3 - Major Change in Medical Condition (Myocardial Infarction [MI/Heart Attack], Cerebrovascular Accident [CVA/Stroke], Syncope [Fainting], etc.)
 - Conditional
 - This field is required only if S6h indicates the member has fallen.
 - Valid range includes 0 with a maximum being the number entered in S6h.
- S6j4 - Poor Balance/Weakness
 - Conditional
 - This field is required only if S6h indicates the member has fallen.
 - Valid range includes 0 with a maximum being the number entered in S6h.
- S6j5 - Confusion/Disorientation
 - Conditional
 - This field is required only if S6h indicates the member has fallen.
 - Valid range includes 0 with a maximum being the number entered in S6h.
- S6j6 - Assault by Individual or Caregiver
 - Conditional
 - This field is required only if S6h indicates the member has fallen.
 - Valid range includes 0 with a maximum being the number entered in S6h.
- **S7. Physician's Evaluation & Recommendation**
 - S7a. Did an MD/DO certify that this person requires nursing facility services or alternative community-based services under the supervision of an MD/DO?
 - Conditional
 - To meet the requirements for these community programs, the member must require nursing facility services or alternative community-based services under the supervision of an MD or DO. Submission of the assessment will not be allowed on the LTC Online Portal if **No** is selected.
 - This is a required field for the Initial Assessment. This field is optional for Annual and SCSA Assessments.
 - Choose from the drop-down box:

- No
- Yes
- S7b. Did a military physician providing health care according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual?
 - Required
 - If the licensed physician providing health care to this member is practicing in a health-care facility of the Department of Defense (DOD), a civilian facility affiliated with the DOD, or any other location authorized by the Secretary of Defense, and is not licensed by the State of Texas, answer **Yes** for this item.
 - Choose from the drop-down box:
 - No
 - Yes
- S7c. MD/DO Last Name
 - Required
 - Enter the last name of the MD/DO.
Note: The physician listed in sections S7c, S7d, and S7e is the physician on record that receives the MN determination letter.
- S7d. MD/DO License #
 - Required
 - Enter the license number of the MD/DO.
 - This number is validated against the appropriate State Medical Board file.
 - Physicians are not required to complete the RUG training.
Note: The physician's licensing information is a vital piece of information. Therefore, the physician's license number is required on all MN/LOC submissions, regardless of the Reason for Assessment (A0310A).
- S7e. MD/DO License State
 - Required
 - Choose the state in which the MD/DO is licensed from the drop-down box.
 - Indicate Physician Signature on file by checking the box.
 - The box under the License State is required to be checked for Initial Assessments. It is optional for Annual and SCSA Assessments.
 - Fields S7f through S7j are required information if the MD/DO is not licensed in Texas.

- Enter the address and telephone number of the facility in which the physician providing the evaluation and recommendation practices in S7g-S7k. ***This information will be used to mail MN determination letters.***
- S7f. MD/DO First Name
 - Conditional
 - This field is required if the MD/DO is not licensed in Texas.
 - Enter the first name of the member's MD/DO.
 - This information is used to mail MN determination letters.
- S7g. MD/DO Address
 - Conditional
 - This field is required if the MD/DO is not licensed in Texas.
 - Enter the street address of the member's MD/DO.
 - This information is used to mail MN determination letters.
- S7h. MD/DO City
 - Conditional
 - This field is required if the MD/DO is not licensed in Texas.
 - Enter the city of the member's MD/DO mailing address.
 - This information is used to mail MN determination letters.
 - If a city has a hyphen in the city name, replace the hyphen with a space.
 - If a city has an apostrophe in the city name, enter the city name without the apostrophe.
- S7i. MD/DO State
 - Conditional
 - This field is required if the MD/DO is not licensed in Texas.
 - Choose the state of the member's MD/DO mailing address from the drop-down box.
 - This information is used to mail MN determination letters.
- S7j. MD/DO ZIP Code
 - Conditional
 - This field is required if the MD/DO is not licensed in Texas.
 - Enter the ZIP Code of the member's MD/DO mailing address.

- This information is used to mail MN determination letters.
- S7k. MD/DO Phone
 - Optional
 - This field is optional if the MD/DO is not licensed in Texas.
 - Enter the telephone number of the member’s MD/DO.
 - This information is used to contact MD/DO if necessary.
- **S9. Medications**
 - 30-Day Look-back
 - Medication Certification. I certify this person is taking no medications *or* the medications listed below are correct.
 - Required
 - Check the Medication Certification box to verify that the member has no medications *or* that the member has medications and they are listed correctly in the medication table to include name, dose, route of administration (RA), frequency (Freq), and as necessary – number of doses (PRN-n).
 - When a medication is added, the information that is required to be entered is:
 - Medication Name and Dose Ordered
 - Route of Administration
 - Frequency
 - PRN - Number of doses (required if the frequency chosen is PRN)

S9. Medications				
List all medications that the individual received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.				
<input checked="" type="checkbox"/> Medication Certification: I certify this individual is taking no medications OR the medications listed below are correct				
Medication Name and Dose Ordered	Route of Administration	Frequency	PRN-n of doses	
DEPAKOTE 125MG	1: by mouth (PO)	3D: (TID) three times daily		Delete
ARTANE 2MG	1: by mouth (PO)	3D: (TID) three times daily		Delete
MVI WITH FLUORIDE	1: by mouth (PO)	1D: (QD or HS) once daily		Delete
VITAMINE E 200IU	1: by mouth (PO)	1D: (QD or HS) once daily		Delete
DUONEB 1 VIAL	8: inhalation	1D: (QD or HS) once daily		Delete

Add Meds

- **S10. Comments**
 - Optional
 - The comments field allows up to 1,500 characters to be entered. It is essential to include signs and symptoms that present an accurate picture of the member’s condition. The Comments section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:
 - Pertinent medical history
 - Ability to understand medications

- Ability to understand changes in condition
- Abnormal vital signs
- Previous attempts at outpatient management of medical condition
- Results of abnormal lab work
- **S11. Advanced Care Planning**
 - Advance-care planning means planning ahead for how the member wants to be treated if ill or near death. Sometimes when members 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.
 - Advance-care planning is a five-step process that should be discussed with the member, which includes:
 1. Thinking about what they would want to happen if they could not talk or communicate with anyone.
 2. Finding out about what kind of choices they will need to make if they become very ill at home, in a nursing home, or in a hospital.
 3. Talking with their family and doctor about how they want to be treated.
 4. Filling out papers that spell out what they want if they are in an accident or become sick.
 5. Telling people what they have decided.
 - S11a. Does the individual/caregiver report having a legally authorized representative?
 - Required
 - Legally Authorized Representative (LAR) is a person authorized by law to act on behalf of a member, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.
 - Choose from the drop-down box:
 - 0. No
 - 1. Yes
 - S11b. Does the individual/caregiver report having a Directive to Physicians and Family or Surrogates?
 - Required
 - Directive to Physician is a document that communicates a member's wishes about medical treatment at some time in the future when they are unable to make their wishes known because of illness or injury.
 - Choose from the drop-down box:
 - 0. No
 - 1. Yes

- S11c. Does the individual/caregiver report having a Medical Power of Attorney?
 - Required
 - Choose from the drop-down box:
 - 0. No
 - 1. Yes
- S11d. Does the individual/caregiver report having an Out-of-Hospital Do Not Resuscitate Order?
 - Required
 - What is an Out-of-Hospital Do Not Resuscitate Order (OOHDNR)?
 - This form is for use when a member is not currently admitted to a hospital. It tells health-care workers, including Emergency Medical Services (EMS) workers, *not* to do some things if the member stops breathing or their heart stops. If a member 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 member 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.
 - Choose from the drop-down box:
 - 0. No
 - 1. Yes
- **S12. Legally Authorized Representative Address**

Note: In the future, this information may be used to send MN determination letters to the LAR when it is indicated on the assessment.

 - S12a. LAR First Name
 - Conditional
 - This is a required field if S11a is indicated as 1. Yes, Does the person report having a legally authorized representative?
 - Enter the first name of the LAR.
 - S12b. LAR Last Name
 - Conditional
 - This is a required field if S11a is indicated as 1. Yes, Does the person report having a legally authorized representative?
 - Enter the last name of the LAR.
 - S12c. Address
 - Conditional

- This is a required field if S11a is indicated as 1. Yes, Does the person report having a legally authorized representative?
- Enter the street address of the LAR.
- S12d. City
 - Conditional
 - This is a required field if S11a is indicated as 1. Yes, Does the person report having a legally authorized representative?
 - Enter the city of the LAR.
 - If a city has a hyphen in the city name, replace the hyphen with a space.
 - If a city has an apostrophe in the city name, enter the city name without the apostrophe.
- S12e. State
 - Conditional
 - This is a required field if S11a is indicated as 1. Yes, Does the person report having a legally authorized representative?
 - Enter the state of the LAR.
- S12f. ZIP Code
 - Conditional
 - This is a required field if S11a is indicated as 1. Yes, Does the person report having a legally authorized representative?
 - Enter the ZIP Code of the LAR.
- S12g. Phone
 - Optional
 - Enter the contact telephone number for the LAR, if it is known.

H1700/Individual Service Plan (ISP) Form

What is the ISP Form?

The H1700-1/ISP form is used for STAR+PLUS HCBS. This form is submitted on the LTC Online portal. Before an ISP can be submitted for a member, they must have an MN/LOC in *Processed/Complete* or *CS Processed Complete* status.

Note: If the MN/LOC is not in one of the above statuses the ISP should not be submitted. MCOs should work with their regional Program Support Unit (PSU) team to resolve MN/LOC errors they are unable to fix.

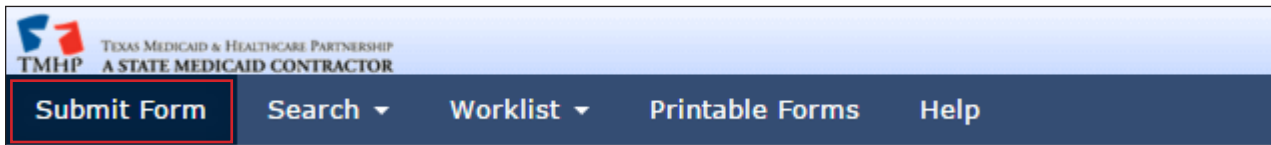
Features of Submitting ISP Forms on the LTC Online Portal

- Many fields auto populate with information from a member's MN
- Track forms with Form Status Inquiry
- 24/7 availability

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

Submitting an ISP

- 1) When the blue navigational bar is displayed, click the [Submit Form](#) link.



- 2) You may need to reenter your security credentials.

- 3) From the Type of Form drop-down menu, select **H1700-1 HCBS STAR+PLUS Waiver Individual Service Plan**.

The screenshot shows the 'Submit Form' web application. At the top, there is a navigation bar with 'Submit Form', 'Search', 'Worklist', 'Printable Forms', and 'Help'. The main heading is 'Submit Form'. Below this, there are two main sections: 'Form Select' and 'Recipient'.

Form Select

Type of Form • [Dropdown menu]
Vendor Number • [Dropdown menu]
Waiver 3.0: Medical Necessity and Level of Care Assessment
H1700-1 HCBS STAR+PLUS Waiver Individual Service Plan

Recipient

To prepopulate recipient information please provide one of the following combinations of information.
Medicaid/CSHCN ID
or Social Security Number AND Last Name
or Social Security Number AND Date of Birth
or Date of Birth AND Last Name AND First Name

Medicaid Number [Text field]
SSN [Text field]
Date of Birth [Date picker (mm/dd/yyyy)]
First Name [Text field]
Last Name [Text field]

- 4) Select the appropriate vendor or provider number, if applicable.
- 5) Enter the member's Medicaid number in the Medicaid Number field.

6) Click the **Enter Form** button in the bottom right corner of the screen. The form will appear.

HCBS STAR+PLUS Waiver Individual Service Plan

Current Status: Unsubmitted

Form Actions

Print **Save as Draft**

Managed Care Organization

Provider No.

MCO Name

• Service Coordinator

Plan Code

• County

Applicant/Member

Group Code

The form may take a moment to populate fields from the person’s most recent MN/LOC Assessment in a finalized status. Auto populated fields are not editable.

Required fields are indicated by a red dot.

The form sections of the ISP are:

- MCO Information
- Applicant/Member Information
- Individual Service Plan Event
- Individual Service Plan Services

Completing the H1700 / ISP Form Fields

- 1) Complete the Service Coordinator field.
- 2) Select the correct county from the County drop-down menu.

The screenshot shows the 'Managed Care Organization' section of the form. It includes the following fields:

- Provider No. (text input)
- MCO Name (text input)
- Service Coordinator (text input)
- Plan Code (text input)
- County (dropdown menu with 'Select' selected and a list of counties including Aransas, Bee, Brooks, and Calhoun visible)

Below this section is the 'Applicant/Member' section, which includes a 'Group Code' field with the value '19'.

- 3) In the Applicant/Member section of the form, verify that the Medicaid number is correct. It is a required field. **Note:** Applicant/Member section of the ISP form will be auto populated using information from their recent MN/LOC Assessment in a finalized status.
- 4) Check the **ME-Waiver** box, if applicable, for the person.

The screenshot shows the 'Applicant/Member' section of the form. It includes the following fields:

- Group Code (text input with value '19')
- ME-Waiver (checkbox, checked)
- Medicaid No. (text input, highlighted with a red box)
- First Name (text input)
- Middle Initial (text input)
- Last Name (text input)
- Date of Birth (text input)

Note: The Type Authorization indicates whether the current ISP will be submitted as an Initial ISP or a Reassessment. This field automatically determines this based on the dates entered below and whether or not the person has an existing ISP on file. If the ISP has been out of date for 120 days, it resets to an Initial Assessment. Backdating is possible; this makes it possible to submit the ISP as a Reassessment instead of an Initial Assessment. Backdating must go back far enough to fall within the 120 day Reassessment window, and appropriate SAS registration codes (example: Service Group 19/Service Code 13) must be filed for backdated months, and Service Group 19/Service Code 12 should be completed for upcoming months.

- 5) Enter the **ISP From Date**. This is a required field. You can complete the ISP From Date field using the interactive calendar. The ISP From Date must be the first day of the selected month. The ISP expires one calendar year after the ISP From Date. The **ISP To Date** cannot be edited and will auto populate based on the ISP From Date field.
- 6) Choose the appropriate option from the required **Enrolled From** drop-down menu.
- 7) Check the **MFPD** box if the applicant/member qualifies for a Money Follows Person Demonstration.
- 8) Choose the appropriate option from the required **Living Arrangement after Entry into SPW** field.

Individual Service Plan Event

Effective Date: 04/30/2015

Type Authorization: Initial Reassessment

ISP From Date: 05/01/2015

ISP To Date: 4/30/2016

Enrolled From: Select

MFPD:

Living Arrangement after Entry into SPW: Select

Individual Service Plan Services

Delivery Option	Service Category	Est. Annual Service Units	Cost
	Alone		
	With Other Waiver		
	Assisted Living		
	Adult Foster Care		
	With Family		

- 9) The final section on the ISP form is titled Individual Service Plan Services. This is a required section. You must enter at least one service to submit the ISP.
- 10) To enter a service:
 - a) Use the drop-down menu to select the appropriate option in the Delivery Option column.
 - b) Based on your selection, a new drop-down menu will populate in the required Service Category column. Use it to select the correct Service Category.
Note: Once a Service Category has been selected, it will no longer be available on the Service Category list when adding additional Service rows.
- 11) Complete the required Estimated Annual Service Units column.
- 12) Complete the required Rate column.
- 13) The Estimated Annual Cost column will auto populate.

14) Add new Service Categories as necessary.

Note: To add additional Service Categories, click the **Add Service** button and repeat the steps above. When multiple Service rows exist, a new column will appear on the right hand side of the screen and each Service row will have a **Delete Service** button. Clicking the **Delete Service** button will instantly delete that Service row. If you accidentally delete a Service row, you will need to click the **Add Service** button and re-enter the information.

Delivery Option	Service Category	Est. Annual Service Units	Rate	Est. Annual Cost	
Agency	Occupational Therapy (S9129, U3, U3)	100.00	\$100.00	\$10,000.00	Delete Service
Agency	Physical Therapy (S9131, U3, U3)	100.00	\$100.00	\$10,000.00	Delete Service
CDS	Protective Supervision (S5125, U3, U5, 99, UC)	100.00	\$100.00	\$10,000.00	Delete Service

Add Service

Total Est. Waiver Cost \$30,000.00

Ventilator Use None

RUG CA1

Annual Cost Limit \$80,118.00

Submit Form

15) Select an option from the required **Ventilator Use** drop-down menu.

Note: Total Estimated Waiver Cost auto-populates. If the Total Estimated Waiver Cost exceeds the Annual Cost Limit, a new checkbox titled Over Annual Cost Limit override with GR approval will appear. If this box is present, it must be selected before the form can be submitted. Note that this will automatically flag the ISP for review by Health and Human Services Commission (HHSC) staff.

16) Click the **Submit Form** button at the bottom right of the screen.

Note: If the ISP is flagged for review by HHSC staff, it can be tracked using the FSI or Power Search tools on the blue navigational bar. Additionally, submitted ISPs may be found for 14 calendar days by clicking the Current Activity link on the blue navigational bar.

Submitting Individual ISP forms by Multiple Users

Occasionally, multiple users may need to input data on an ISP form prior to submission. This can be accomplished by using the **Save as Draft** function at the top of the form.

- 1) Fill out as many fields on the ISP form as possible using the steps described above.

- 2) Instead of clicking **Submit Form**, scroll back to the top of the form and click the **Save as Draft** button.

The screenshot displays the 'HCBS STAR+PLUS Waiver Individual Service Plan' form. At the top, it shows the 'Current Status: Unsubmitted'. Below this is a 'Form Actions' section with two buttons: 'Print' and 'Save as Draft'. The 'Save as Draft' button is highlighted with a red box. The form is divided into two main sections: 'Managed Care Organization' and 'Applicant/Member'. The 'Managed Care Organization' section includes fields for 'Provider No.', 'MCO Name', 'Service Coordinator', 'Plan Code', and 'County' (set to 'Karnes'). The 'Applicant/Member' section includes fields for 'Group Code' (19), 'ME-Waiver' (checkbox), 'Medicaid No.', 'First Name', and 'Middle Initial'.

- 3) The ISP will now be available on the Drafts page.
- 4) Other users linked to that contract may now access the ISP form by clicking the **Drafts** link on the blue navigational bar.
- 5) Once the form is completed, it can be submitted by following the steps described above.

Medical Necessity and the MN Determination Process

Definition of Medical Necessity

Texas Administrative Code (TAC), Title 26, Part 1, Chapter 554 includes state rules governing licensed only nursing facilities and Medicaid nursing facilities. 26 TAC §554.101(80) defines Medical Necessity as:

“A determination, made by physicians and registered nurses who are employed by or contract with the state Medicaid claims administrator, that a recipient requires the services of a licensed nurse in an institutional setting to carry out a physician’s planned regimen for total care. A recipient’s need for custodial care in a 24-hour institutional setting does not constitute medical necessity.”

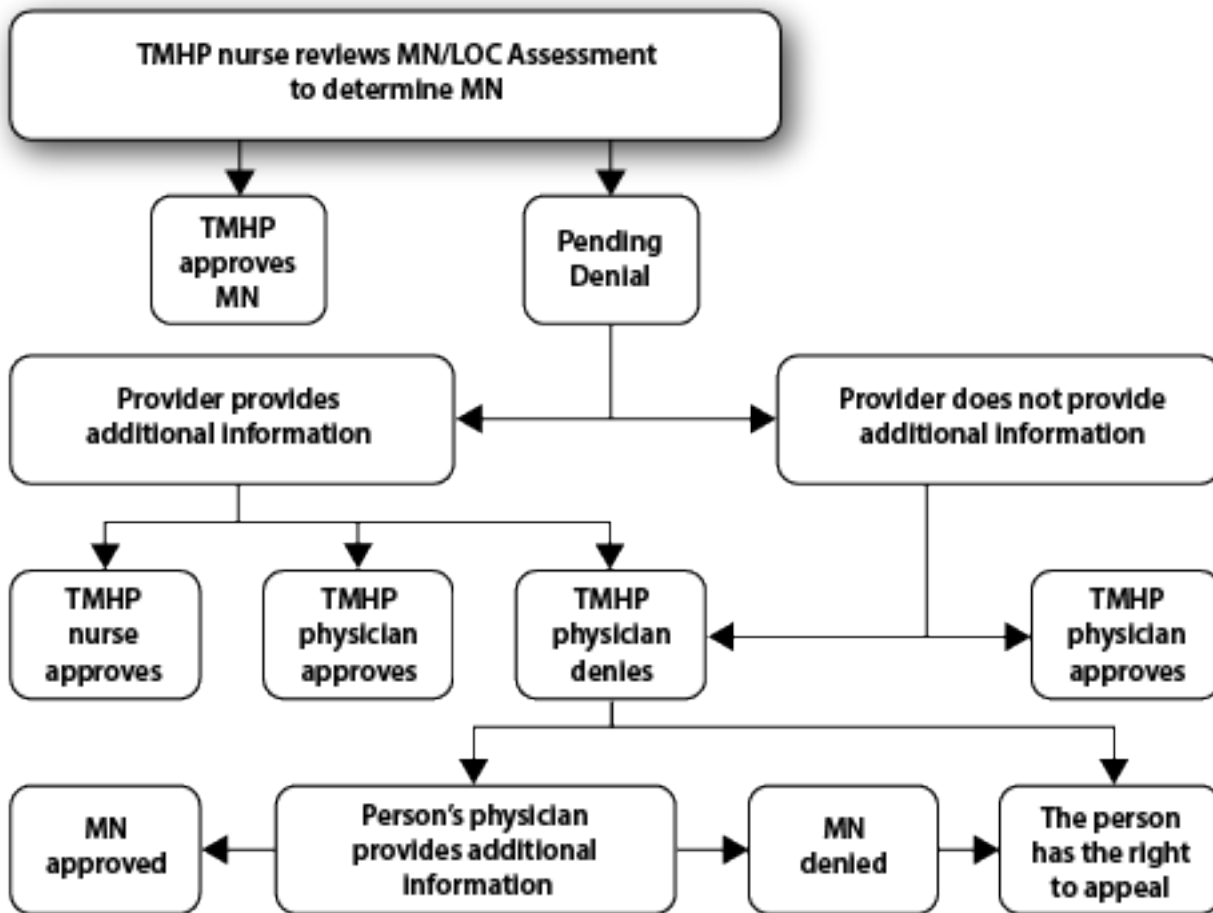
General Qualifications for Medical Necessity Determinations

In accordance with 26 TAC §554.2401, Medical Necessity is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. Further, the section outlines that to verify that Medical Necessity exists, a member must meet the following requirements:

- 1) The person must demonstrate a medical condition that:
 - a) Is of sufficient seriousness that the person’s needs exceed the routine care which may be given by an untrained person.
 - b) Requires licensed nurses’ supervision, assessment, planning, and intervention that are available only in an institution.
- 2) The person must require medical or nursing services that:
 - a) Are ordered by the physician.
 - b) Are dependent upon the person’s documented medical conditions.
 - c) Require the skills of a registered nurse or licensed vocational nurse.
 - d) Are provided either directly by or under the supervision of a licensed nurse in an institutional setting.
 - e) Are required on a regular basis.

Note: MN is not the only prerequisite to qualify for LTC Medicaid Community Services Waiver Programs.

Medical Necessity Determination Process



This flowchart provides a high-level overview of the process used for determination of MN.

- 1) The TMHP nurse has 5 business days to review assessments and determine MN. TMHP systems automatically review specific criteria on the assessments. If the criteria are appropriately met, the assessment is automatically approved. If not, the provider will see the form has failed Auto MN Approval displayed in the History trail of the assessment. The assessment will then be sent to a nurse for manual MN review. The assessment will be set to status **Pending Review** on the FSI search results. However, the last message showing in the History trail will be “The Form has failed Auto MN Approval.”
- 2) Once reviewed, the assessment is either approved because it meets MN or set to status **Pending Denial (need more information)** (which means that additional information is needed) for up to 21 calendar days. FSI or Current Activity will allow the provider to view the status of an assessment during the MN determination process.
- 3) The provider may supply additional information clarifying nursing/medical needs through the Add Note feature on the LTC Online Portal or by calling TMHP and speaking with a TMHP nurse.
- 4) If the TMHP nurse determines that MN has been met, the assessment is approved.

- 5) If the TMHP nurse still cannot determine any licensed nursing need, the member's assessment is sent to the TMHP physician for an MN determination.
- 6) If the TMHP physician determines that MN has been met, the assessment is approved
- 7) If the MN is denied by the TMHP physician, notification of denied MN is sent to the member and the physician of record, as specified in Section LTCMI of the MN/LOC Assessment, by mail. The provider will have access to the status of the assessment by FSI or Current Activity on the LTC Online Portal.
- 8) The attending physician may respond within 10 business days of the date of the denial letter by faxing or calling TMHP with additional medical information. Alternatively, a licensed nurse familiar with the member may provide additional information by calling and speaking with a TMHP nurse.
- 9) If the TMHP physician or nurse determines that MN has been met, the assessment is approved.
- 10) If the TMHP physician determines that MN has not been met, the assessment remains in a **Denied** status.
- 11) If the provider does not provide additional information clarifying nursing or medical needs within the 21 calendar days of **Pending Denial (need more information)** status, the assessment is sent to the TMHP physician for review, and steps 7 – 11 will apply.
- 12) The member may initiate the appeal process when notified by a HHSC case manager, using the Form 2065-C, that MN has been denied by the TMHP physician. If a hearing is requested, additional information may be submitted at any time by the provider or by the member's physician either by a telephone call to the TMHP nurses or by fax.

Note: At any point, providers can check the status of the assessment and the MN determination for the assessment by utilizing the LTC Online Portal FSI or Current Activity features.

Request for Fair Hearing

A fair hearing is an informal, orderly, and readily available proceeding held before an impartial HHSC enterprise hearing officer. At the hearing, a person receiving services/applicant (appellant), or their representative, including legal counsel, may present the case as they wish to show that any action, inaction, or agency policy affecting the case should be reviewed.

The person or the person's responsible party may request a fair hearing on behalf of the person within 90 days from the notice of adverse action date. If a PACE participant receives a letter denying MN and giving them the right to request a fair hearing, the person must request a fair hearing within twelve days of the date of the letter for Medicaid payment to continue until the fair hearing decision. Medicaid payment will continue if the person was already receiving services.

Form 4803, Acknowledgement and Notice of Fair Hearing, serves as a notice of the fair hearing. It is sent to the appellant to acknowledge the receipt of a request for a hearing and to set a time, date, and place for the hearing. Form 4803 will be sent to all known parties and required witnesses at least ten calendar days in advance of the hearing.

The fair hearing is held at a reasonable place and time. They are normally scheduled in the order in which requests are received and are usually held by teleconference.

Appellants may present their own case, or bring a friend, relative, or attorney to present their case. HHSC enterprise does not pay attorney fees. Appellants may request additional time to prepare for their case by contacting the hearing officer.

Appellants may request an interpreter at no cost. However, appellants must notify the hearing officer at least two days before the hearing if they are going to require an interpreter.

Before and during the hearing, appellants and their representatives have the right to examine the documents, records, and evidence that HHSC will use. To see medical evidence before the hearing, the appellant must make a written request to the hearing officer. The appellant may bring witnesses and present facts and details about the case. The appellant may also question or disagree with any testimony or evidence that is presented by the department.

Appellants have the right to know all the information the hearing officer examines in making the decision. The laws and policies which apply to the appellant's case and the reasons for HHSC's action will be explained.

The hearing officer will issue a final written order. The decision by the hearing officer is HHSC's final administrative decision. If the appellant believes the hearing officer did not follow applicable policy and procedures, the appellant can submit a request for administrative review within 30 days of the date of the decision. The appellant submits the request for administrative review to the hearing officer, who will forward the request to the appropriate legal office for review.

HHSC's Fair and Fraud Hearings Handbook provides guidance on the appeal process for applicants, clients, client representatives, program representatives and hearings officers. STAR+PLUS complaint, internal MCO appeal, and state fair hearing information can be found in section 4000, Complaints, Internal MCO Appeals, and State Fair Hearings, of the STAR+PLUS Handbook. They are available at these two links: <https://www.hhs.texas.gov/handbooks/fair-fraud-hearings-handbook> and <https://www.hhs.texas.gov/handbooks/starplus-handbook/4000-complaints-internal-mco-appeals-state-fair-hearings>.

Assessment Statuses

Providers can monitor the status of a submitted MN/LOC Assessment by utilizing FSI or Current Activity on the LTC Online Portal. The status is shown within the FSI or Current Activity results; or, once a specific assessment is selected, the status can be located at the top of the page or at the bottom of the assessment in the History trail. The following are statuses that a provider may see, and their definition:

- **Appealed:** The assessment does not meet MN and the member, or their representative, has requested a fair hearing.
- **Approved:** The assessment meets MN. Assessments that are MN approved will only stay in this status momentarily. They will automatically move to the next status in the workflow. This status is not searchable using FSI.
- **Corrected:** The assessment has been corrected by the submitting provider. A new DLN is assigned to the corrected assessment and will be reflected in the history trail. No further actions are allowed on assessments with a status of **Corrected**.
- **Denied:** The assessment does not meet MN.
- **Escalated Needs Review:** The assessment was escalated for further review.
- **Form Inactivated:** The assessment was withdrawn by the submitting provider. No further action will be allowed on this assessment.
- **ID Invalid:** Medicaid ID validation failed. Contact the Medicaid Eligibility Worker to verify the member's name, SSN, and Medicaid ID. A new assessment must be submitted with the correct information.
- **Invalid/Complete:** The assessment has been deemed invalid. The reason can be found in the History trail. A new assessment must be submitted with the correct information.
- **Med ID Check Inactive:** Medicaid ID validation has failed or the request to validate the Medicaid ID was canceled. The LTC Portal attempts to validate a Medicaid ID nightly until deemed valid, invalid, or after six months, the request expires, whichever comes first. Contact the Medicaid Eligibility Worker to verify the person's name, SSN, and Medicaid ID. The provider may restart the assessment once the reason for failed validation has been resolved by the Medicaid Eligibility Worker by clicking the **Reactivate Form** button on the Form Action Toolbar and then selecting the **Change Status** button on the page that displays.
- **Medicaid ID Pending:** Medicaid ID validation is pending. Contact the Medicaid Eligibility Worker to verify the person's name, SSN, and Medicaid ID.
- **Out of State MD/DO License Invalid:** TMHP has performed a manual check on the out-of-state license and determined it to be invalid. If the information on the assessment is incorrect, the provider can submit a correction within 14 calendar days of an original submission to correct the wrong information.
- **Out of State MD/DO License Valid:** TMHP has performed a manual check on the out-of-state license and determined it to be valid. The assessment will continue through the workflow.
- **Out-of-State RN License Invalid:** TMHP has performed a manual check on the out-of-state license and determined it to be invalid. This often happens because the provider entered the wrong state. If the information on the assessment is incorrect, the provider can submit a correction within 14 calendar days of submission to fix the wrong information.

- **Overtured Doctor Review:** The provider has supplied additional information for an assessment that was denied MN. The assessment is pending TMHP doctor review for MN determination.
- **Overtured Doctor Review Expired:** The assessment was denied MN, and no additional information was submitted for review within the allowable 14 business days following the MN denial.
- **Pending Denial (need more information):** A TMHP nurse has reviewed the assessment and determined that it does not meet MN. The provider has up to 21 calendar days to give additional information for further consideration either by telephone or by using the Add Note feature on the LTC Online Portal. The TMHP nurse did not find the assessment to be qualified for MN. The provider has 21 calendar days to submit additional information for consideration.
- **Pending MD/DO License Verification:** The MD/DO License number is pending manual verification by TMHP for licenses that are issued from states other than Texas. TMHP will validate the MD/DO License number entered in field S7d of the LTCMI, and set assessment status to either **Out of State MD/DO License Valid** or **Out of State MD/DO License Invalid**. If the status is set to **Out of State MD/DO License Valid**, the assessment will continue to process through the workflow.
- **Pending More Info:** This status appears when the form is in the CS Workflow, and HHSC is waiting for more information from the provider. Information required may be found within the assessment History trail.
- **Pending Review:** The assessment is waiting for a TMHP RN to manually review it for MN.
- **Pending RN License Verification:** The RN License number is pending manual verification by TMHP from the Texas BON or the licensing state from which the compact license was issued.
- **Processed/Complete:** The assessment has been processed and complete. This is the final status of the form and it happens after MN has been met. Check Medicaid Eligibility and Service Authorization Verification (MESAV).
- **Provider Action Required:** The assessment must be reviewed by the provider due to the assessment being rejected by Service Authorization System (SAS). Refer to the assessment History trail for the specific error message. The error message must be resolved before further processing of assessment will occur.
- **SAS Request Pending:** The assessment has passed all TMHP validations and will be sent from TMHP to HHSC-LTC for SAS processing. Allow 2 to 4 business days for the next status change.
- **Submitted to CS manual workflow:** The assessment has been submitted to HHSC due to the assessment being rejected by SAS. Refer to the assessment History trail for additional information. HHSC will review this assessment within 10 business days. While the assessment is being reviewed, no action is required from the provider.

Provider Workflow Process

Provider workflow allows providers to independently manage their assessments when processing errors in the Medicaid system occur. The assessments moving through the provider workflow require the provider to take action for the issue to be resolved. The benefit to the provider is a shorter resolution time since providers can resolve their own errors.

In summary, assessments are sent to the provider workflow when the assessment is set to the status ***Provider Action Required***.

Assessments reach this status if:

- The assessment was not successfully processed.
- An error occurred during the nightly batch processing.

The provider workflow is the responsibility of the provider to monitor and manage. System processing errors, including rejection messages, are found within the History trail of the assessment, and the assessment is set to status ***Provider Action Required***. Once an assessment is set to status ***Provider Action Required***, the assessment will require provider action before processing on that particular assessment continues.

If a system error occurs, the error will be displayed in the History trail of the assessment. The assessment is set to status ***Provider Action Required***.

Finding Assessments with Provider Action Required Status

To find the items in your provider workflow (i.e., those items with system processing errors to be resolved by the provider):

- 1) Click or hover over the **Search** link in the blue navigational bar.
- 2) Click **Form Status Inquiry** in the drop-down menu.

- Choose Type of Form: **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the drop-down box.

The screenshot shows the 'Form Status Inquiry' page. At the top, there is a navigation bar with 'Submit Form', 'Search', 'Worklist', 'Printable Forms', and 'Help'. The page title is 'Form Status Inquiry'. Below the title, there is a 'Form Select' section. In this section, the 'Type of Form' dropdown menu is highlighted with a red box and contains the text 'Waiver 3.0: Medical Necessity and Level of Care Assessment'. Below it, there is a 'Vendor Number' field with a dropdown arrow and the text 'for Provider Number'. The 'Form Status Inquiry' section below contains several input fields: DLN, Last Name, Form Status (dropdown), SSN, From Date (dropdown with '12/30/2015'), Purpose Code (dropdown), Reason for Assessment (dropdown), Medicaid Number, and First Name. There is also a 'To Date' field (dropdown with '01/29/2016').

- Enter the From Date and To Date range in the fields allocated. These are required fields.
- Form Status: Choose **Provider Action Required** from the drop-down box.

This screenshot shows the same 'Form Status Inquiry' page as the previous one, but with the 'Form Status' dropdown menu open. The dropdown list contains various status options, and 'Provider Action Required' is highlighted with a red box. The 'From Date' field is now set to '02/08/2016'. The 'To Date' field is also set to '02/08/2016'. A 'Search' button is visible at the bottom right of the form area.

- 6) Click the **Search** button located on the bottom right of the screen to submit the Inquiry.

The screenshot shows a search interface with two date pickers: 'From Date' set to 12/30/2015 and 'To Date' set to 01/29/2016. Below these is a yellow search bar with a 'Search' button highlighted by a red box.

- 7) All Waiver 3.0 Medical Necessity and Level of Care Assessments that are set to status **Provider Action Required** will display.

Note: For confidentiality purposes, the assessment details (Medicaid #, etc.) have been hidden in the User Guide.

The screenshot shows the 'Form Status Inquiry' page. It includes a navigation bar with 'Submit Form', 'Search', 'Worklist', 'Printable Forms', and 'Help'. The main content area has a 'Form Select' section with a dropdown for 'Type of Form' (set to 'Waiver 3.0: Medical Necessity and Level of Care Assessment') and a 'Vendor Number' field. Below is a 'Form Status Inquiry' section with input fields for 'DLN', 'Last Name', 'Form Status', 'Medicaid Number', and 'First Name'.

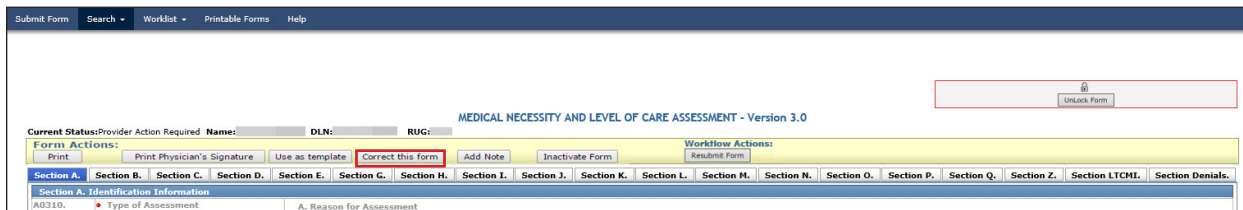
- 8) Click the **View Detail** link to open the assessment.
- 9) Scroll to the bottom of the page to view the History trail.

History	
Form Submitted	1/1/2015 7:44:32 PM
Pending Review	1/1/2015 7:44:34 PM
1/1/2015 7:44:34 PM	TMHP : The Form has failed Auto MN Approval
Approved	1/4/2015 3:20:07 PM
Medicaid ID Pending	1/4/2015 3:20:09 PM
1/4/2015 3:20:09 PM	TMHP : Medicaid ID request submitted
ID Confirmed	1/4/2015 3:20:11 PM
1/4/2015 3:20:11 PM	TMHP : Medicaid ID [redacted] confirmed for this client
SAS Request Pending	1/4/2015 3:20:11 PM
1/4/2015 3:20:11 PM	TMHP : The request is being processed by DADS. Please allow 2-4 business days for the next status change.
Provider Action Required	1/5/2015 4:44:44 AM
1/5/2015 4:44:44 AM	TMHP : CS-0004: This assessment cannot be processed because the Annual assessment has been submitted more than 132 days after the end of the last Service Plan. Submit an Initial assessment.

- 10) Find **Provider Action Required** status on the far left.

Pending Review	1/1/2015 7:44:34 PM
1/1/2015 7:44:34 PM	TMHP : The Form has failed Auto MN Approval
Approved	1/4/2015 3:20:07 PM
Medicaid ID Pending	1/4/2015 3:20:09 PM
1/4/2015 3:20:09 PM	TMHP : Medicaid ID request submitted
ID Confirmed	1/4/2015 3:20:11 PM
1/4/2015 3:20:11 PM	TMHP : Medicaid ID [redacted] confirmed for this client
SAS Request Pending	1/4/2015 3:20:11 PM
1/4/2015 3:20:11 PM	TMHP : The request is being processed by DADS. Please allow 2-4 business days for the next status change.
Provider Action Required	1/5/2015 4:44:44 AM

- 11) Find the rejection message in the white line just below **Provider Action Required**.
- 12) Perform the necessary research to resolve the error. For more information on the error messages, see the Provider Workflow Rejection Messages section of this User Guide.
- 13) Depending on the provider research, a provider has one of three options to move the assessment out of the provider workflow. These are: Correct this form, Inactivate form, or Resubmit form.
 - Correct this form—The **Correct this form** button allows providers to submit a correction within 14 calendar days of the original submission date. The original assessment with a status of **Provider Action Required** will be set to status **Corrected** and will have a parent relationship DLN to the new/child assessment. The new assessment replaces the original assessment.



Most fields can be corrected. Only the following fields cannot be corrected:

Waiver 3.0: MN/LOC Assessment	
A0500c	Individual Name (does not allow changes to last name)
A0600a	Social Security Number
A0600b	Medicare (or comparable railroad insurance number)
A0700	Medicaid Number
A0310a	Type of Assessment/Tracking
Z0500b	Date Assessment Completed
S5a-S5m	Licenses section
S2a	DADS Vendor/Site ID
S2b	Provider Number
S2c	Service Group
S2d	NPI Number

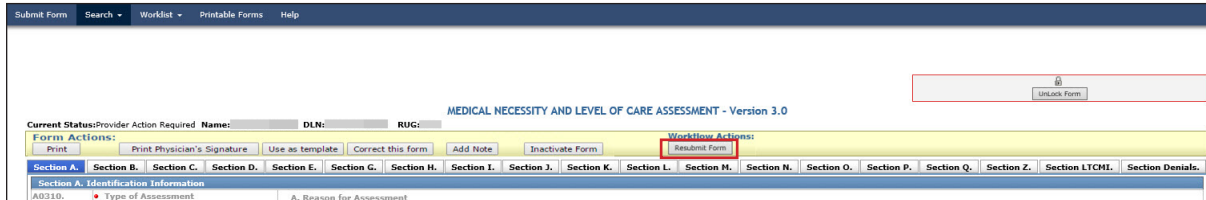
- Inactivate Form—The **Inactivate Form** button will inactivate the assessment. The status of the assessment will then set to status **Form Inactivated**. An example of when the **Inactivate Form** button would be used is when the provider research indicates the assessment being submitted is a duplicate.

- If the provider clicks the **Inactivate Form** button, the provider will see the following confirmation window:

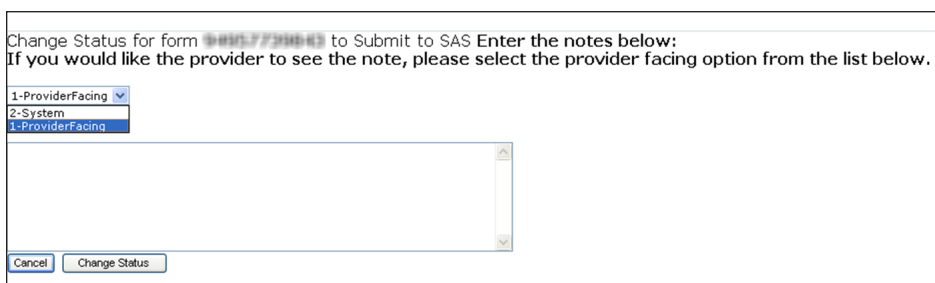
From here, you have two choices:

- Click the **OK** button to Inactivate, and the assessment will set to status **Form Inactivated**.
- or
- Click the **Cancel** button to cancel the Inactivation request, keeping the assessment set to status **Provider Action Required**.

- Resubmit Form. The **Resubmit Form** button will set the assessment to status **SAS Request Pending**. The assessment will process during the nightly system processing. Check the status of the assessment the next day to determine if the assessment processed successfully. The assessment will be set to status **Processed/Complete** if successfully processed. The **Resubmit Form** button will only be used after a provider has been instructed to do so by HHSC.



If the provider clicks the **Resubmit Form** button, the following screen will appear, allowing the provider to add any comments:



The provider can choose one of the following options:

- **1-ProviderFacing:** This option allows comments entered to be seen by both state staff and the provider.
 - **2-System:** This option allows comments entered by the provider to be seen only by internal state staff. The comments will not be seen by the provider.
- In either case, the comments will be seen in the History trail of the assessment and are for informational purposes only. These comments will *not* be used in the system processing of the assessments. The provider may choose to enter comments. Entering comments is optional.
- a) Click the **Cancel** button to cancel the request, keeping the assessment set to the status **Provider Action Required**.
 - or
 - b) Click the **Change Status** button to move the assessment out of the status **Provider Action Required**.
- 14) Once one of the actions have been completed (Correct this form, Inactivate form, or Resubmit Form) the status of the form or assessment will no longer be set to status **Provider Action Required**. Processing will continue based upon action chosen.
 - 15) Repeat all of the steps for finding Wavier 3.0: Medical Necessity and Level of Care Assessments set to status **Provider Action Required** until there are no results found.

Provider Workflow Rejection Messages

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

The table contains four columns:

- 1) **Message Number**—This is the specific error message that will be displayed in the portal.
- 2) **System Message**—This provides further clarification of the portal error message, including a basic example of the situation.
- 3) **Associated with Reason for Assessment**—This explains what type of assessment can result in the error.

Waiver 3.0: MN/LOC Assessment
A0310a = 01. Initial Assessment.
A0310a = 03. Annual Assessment.
A0310a = 04. Significant change in status assessment (SCSA).

- 4) **Suggested Action**—The most likely Workflow Action Button to be used.

Rejected Message Descriptions

Message Number	System Message (Displayed in History)	Associated with Reason for Assessment	Suggested Action
CS-0001	CS-0001: The request cannot be processed because an existing Initial Assessment has already been processed.	Initial	Inactivate the Initial Assessment and submit an Annual Assessment, or a SCSA as appropriate or contact your regional PSU Representative.
CS-0003	CS-0003: The request cannot be processed because the Annual Assessment is being submitted more than 90 days prior to the Service Plan end date. Please resubmit the assessment at the appropriate time.	Annual	Inactivate Form and submit Annual Assessment when within the 90 days.
CS-0004	CS-0004: This assessment cannot be processed because the Annual assessment has been submitted more than 132 days after the end of the last Service Plan. Submit an Initial assessment.	Annual	The request cannot be processed because the Annual Assessment has been submitted more than 132 days after the end of the last Service Plan. Inactivate Annual Assessment and submit an Initial Assessment.

Message Number	System Message (Displayed in History)	Associated with Reason for Assessment	Suggested Action
CS-0005	CS-0005: This assessment cannot be processed because a previous Service Plan cannot be found. Submit an Initial assessment.	Annual	The request cannot be processed because a previous Service Plan cannot be found. Submit an Initial Assessment.
CS-0006	CS-0006: The request cannot be processed because an Initial Assessment for the individual cannot be found.	Significant Change in Status Assessment	Verify data entry or contact your regional PSU Representative.
CS-0011	CS-0011: This assessment cannot be processed because there is not an open Service Plan for the individual. Verify data entry or contact the case manager.	Significant Change in Status Assessment	Inactivate Form.
CS-0012	CS-0012: This assessment cannot be processed because the SCSA assessment is being submitted more than 30 days after the Service Plan end date.	Significant Change in Status Assessment	Inactivate Form.
CS-0020	CS-0020: This assessment cannot be processed because the annual assessment is being submitted more than 90 days prior to the Level of Service end date.	Annual	Inactivate this assessment by clicking the Inactivate Form button and submit an Annual Assessment within 90 days of the Level of Service end date.
CS-0021	CS-0021: This assessment cannot be processed because the annual assessment has been submitted more than 132 days after the end of the last Level of Service record.	Annual	Inactivate this assessment by clicking the Inactivate Form button and submit an Initial Assessment Waiver 3.0: 0310a=01.
CS-0023	CS-0023: This assessment cannot be processed because the individual is enrolled in PACE and has Permanent Medical Necessity. Annual assessments for this individual are not needed. This assessment should be Inactivated.	Annual	Inactivate Form.

Message Number	System Message (Displayed in History)	Associated with Reason for Assessment	Suggested Action
GN-9007	This form must be manually processed by DADS.		Contact Provider Claims Services for assistance.
GN-9010	This form must be manually processed by DADS.		Contact Provider Claims Services for assistance.
GN-9248	GN-9248: This form cannot be processed due to one or more invalid Diagnosis Codes. Correct the Diagnosis Codes and resubmit.	MN/LOC	<p>The submitted Diagnosis International Classification of Diseases (ICD) Code is not valid.</p> <p>Correct the Diagnosis Codes on the LTCMI section or Section I as needed using the Correct this form button.</p> <p>If the Diagnosis Codes are valid: Contact the HHSC regional Claims Management System Coordinator. Select the appropriate region per website link provided to locate the Claims Management System Coordinator contact information. PACE Excluded. https://www.hhs.texas.gov/about/contact-us/community-services-regional-contacts</p> <p>* If PACE, contact program staff by telephone at 512-487-3450.</p>

Corrections

If incorrect data is submitted on the MN/LOC Assessment, the provider can submit a correction within 14 calendar days of the original submission by clicking the **Correct this form** button. However, not all fields allow corrections (A list of fields that cannot be corrected can be found in the [Provider Workflow](#) section).

Examples of incorrect data that can be corrected include:

- Member gender
- Member diagnosis

If corrections to the MN/LOC Assessment are needed, providers must access the assessment utilizing FSI or Current Activity.

When to Correct Assessments

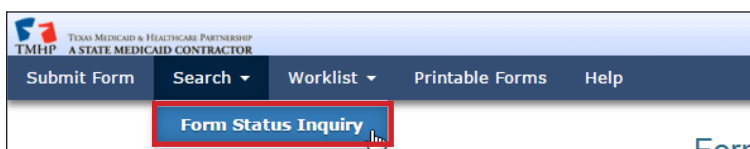
MN/LOC Assessments can only be corrected during the 14 calendar day time period following the original submission date.

Who May Submit the Correction?

A correction does not have to be submitted by the original submitter, but it has to be from the same vendor/provider number. Regardless of the current status of an MN/LOC Assessment, corrections will not be allowed to assessments that have at any time been set to status *Form Inactivated*, *Invalid/Complete*, *SAS Request Pending*, or *Corrected*. The **Correct this form** button will not be displayed in the yellow Form Actions bar on any assessment that cannot be corrected. Corrections are processed overnight, and providers must wait until the following day to see changes.

How to Submit a Correction

- 1) Click or hover over the [Search](#) link on the blue navigational bar.
- 2) Click the [Form Status Inquiry](#) link from the drop-down box.



- Type of Form: Choose **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the drop-down box.

- Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: DLN, Last Name, First Name, SSN, Medicaid Number, Form Status, From Date, To Date, Purpose Code, and Reason for Assessment.
- Click the **Search** button.
- Click the **View Detail** link of the requested assessment.

6 record(s) returned.

[Export Data to Excel](#)

	DLN	TMHP Received Date	SSN	Medicaid #	Medicare #	First Name	Last Name	ISP From Date	ISP To Date	Status	RUG	RN Signature Date	Purpose Code	Provider Number	Vendor Number	County	Reason For Assessment
View Detail		1/18/2016								Corrected	PA1	1/6/2016					03. Annual assessment
View Detail		1/18/2016								Pending Review	PA1	1/6/2016					03. Annual assessment
View Detail		1/18/2016								Form Inactivated	PA1	1/6/2016					03. Annual assessment
View Detail		1/18/2016								Pending Review	SE2	1/6/2016					01. Initial assessment
View Detail		1/18/2016								Pending Review	PA1	1/4/2016					03. Annual assessment
View Detail		1/19/2016								Out of State RN License Invalid		1/7/2016					03. Annual assessment

- Click the **Correct this form** button.

- Complete only the fields needing correction.
- Click the **Submit Form** button.

10) The original assessment (parent) is set to status **Corrected** and the new assessment (child) DLN is assigned, creating the parent/child DLN relationship. The new child assessment replaces the parent assessment.

History	
Form Submitted	1/18/2016 9:59:56 AM
Pending Review	1/18/2016 9:59:59 AM
1/18/2016 9:59:59 AM	TMHP : The Form has failed Auto MN Approval
Corrected	1/18/2016 3:55:47 PM
1/18/2016 3:55:47 PM	TMHP : Form has been corrected by DLN [redacted]

UnLock Form

MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT - Version 3.0

Current Status: Pending Review Name: _____ DLN: _____ RUG: PA1

Parent DLN: [redacted]

Note: Waiver corrections are allowed within 14 days from the original submission.

Form Actions:

Inactivations

Assessments may need to be inactivated when fields cannot be corrected as needed (e.g., Medicaid # or Individual Name). MN/LOC Assessments can be inactivated through the LTC Online Portal by first retrieving the assessment using FSI or Current Activity. Once the assessment is inactivated, it will be set to status **Form Inactivated**. The assessment cannot be reactivated; however, it can still be used as a template.

When to Inactivate?

There are no time limitations on performing an inactivation. Providers may perform an inactivation when an assessment needs to stop processing in the workflow, if an assessment needs to be canceled after processing is complete, or when fields cannot be corrected as needed (e.g., Medicaid # or Individual Name).

Who May Inactivate?

Inactivations may be performed based on the vendor or contract owner who submitted the assessment originally. None of the HHSC or TMHP teams (CS Workers or CS Team Leads) may inactivate forms. CS contacts may be found at: <https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts>. TMHP may submit an inactivation on an MN/LOC Assessment.

The screenshot shows the TMHP LTC Online Portal interface. At the top, there is a navigation bar with 'Submit Form', 'Search', 'Worklist', 'Printable Forms', and 'Help'. The main content area displays the title 'MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT - Version 3.0'. Below the title, there is a 'Current Status: Pending Review' and fields for 'Name', 'DLN', and 'RUG:PA1'. A note states: 'Note: Waiver corrections are allowed within 14 days from the original submission.' A 'Form Actions' bar contains buttons for 'Print', 'Print Physician's Signature', 'Use as template', 'Correct this form', 'Add Note', and 'Inactivate Form' (which is highlighted with a red box). Below the actions bar are tabs for sections A through M. Section A, 'Identification Information', is expanded, showing fields for 'Type of Assessment' (A0310) and 'Legal Name of Individual' (A0500). The 'Reason for Assessment' dropdown is set to '03. Annual assessment'.

Note: When inactivating MN/LOC 3.0 Assessments, a note must be entered identifying why the form or screening was inactivated. This note will be added to the History trail.

How to Inactivate an Assessment

- 1) Login to the LTC Online Portal.
- 2) Click or hover over the **Search** or **Worklist** links on the blue navigational bar.
- 3) Click the **Form Status Inquiry** or **Current Activity** link, respectively.
- 4) Click the **View Detail** link.
- 5) Click the **Inactivate Form** button.
- 6) A pop-up window will ask “Are you sure you want to Inactivate this form?” If so, click **Ok** and enter a note to explain the reason for inactivation.
- 7) When the Change Status window appears, enter a note for the inactivation and click the **Change Status** button. The assessment will be set to status ***Form Inactivated*** and cannot be reactivated.

Resource Utilization Group (RUG) Training Requirements

A RUG level is the measure of a person's care needs. The TMHP automated system uses a mathematical algorithm established by CMS to determine the RUG. This algorithm is used in all cases to automatically generate a RUG level based on the information entered by the nurse in the RUG fields of the MN/LOC Assessment. HHSC uses this systematic approach for community-based programs to categorize the care needs of the person and establish the service plan cost limit. The RUG level determination is totally objective; neither HHSC nor the TMHP nurse reviewing the MN/LOC determines the RUG level.

Below are examples of RUG levels:

- 1) Extensive Services (SE3, SE2, and SE1)
- 2) Rehabilitation All Levels (RAD, RAC, RAB, and RAA)
- 3) Special Care (SSC, SSB, and SSA)
- 4) Clinically Complex with/without Depression (CC2, CC1, CB2, CB1, CA2, and CA1)
- 5) Cognitive Impairment with/without Nursing Rehab (IB2, IB1, IA2, and IA1)
- 6) Behavior Problem with/without Nursing Rehab (BB2, BB1, BA2, and BA1)
- 7) Physical Function with/without Nursing Rehab (PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, and PA1)

Each RUG level has a corresponding cost limit for the associated STAR+PLUS HCBS program. The cost limit is considered when developing the person's plan of care. It is a percentage of the reimbursement rate that would have been paid for that same person to receive nursing facility services for a year.

RUG training is required for registered nurses to complete MN/LOC Assessments. Validation of completion of RUG training occurs at the time the MN/LOC is submitted on the TMHP LTC Online Portal. Texas State University, in cooperation with HHSC's Office of the Inspector General (OIG), has made this training available through the university's Office of Continuing Education's online course programs. RUG training is valid for two years, then it must be renewed by completing the online RUG training through the Texas State University online training. Texas State University can take from 4 to 7 business days to process and report completions of RUG training to TMHP, depending on current volume of enrollments and completions.

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

<https://www.txstate.edu/continuinged/CE-Online/RUG-Training.html>

Reminders

- LTC Online Portal is available 24 hours a day, 7 days a week to submit and track assessments.
- Utilize FSI and Current Activity. These features provide an up-to-date status for submitted assessments.
- Print and sign the assessment prior to submission.
- Provide pertinent information in the Comments section.
- Submit additional information within 21 calendar days on the LTC Online Portal when the assessment is set to status ***Pending Denial (need more information)*** or call TMHP at **800-626-4117**. Refer to the Add Note section of this User Guide for instructions on how to do this.
- All RN and MD/DO licenses are validated against the appropriate licensing state board. Updates are received monthly, with MD licenses being updated within the first 10 days of the month and RN licenses being updated in the latter portion of the month (generally between the 20th and 25th). Be advised that delayed licensure renewal may result in a delay in form processing.
- Use the TMHP website at www.tmhp.com/programs/ltc for recent updates and new information.
- This User Guide can be found under the **Help** link located on the blue navigational bar within the LTC Online Portal.

Reporting Medicaid Fraud, Waste, and Abuse

Medicaid fraud is defined by CMS as: “An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.”

How to Report Fraud, Waste, and Abuse

Fraud, waste, and abuse involving HHSC programs such as Medicaid can be reported to HHSC’s Office of the Inspector General (OIG). Reports can be made online through OIG’s website at <https://oig.hhs.texas.gov/report-fraud-waste-or-abuse>, or through the OIG fraud hotline, **800-436-6184**. This website provides 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 fraud, waste, and abuse to report to the OIG.

If you are not sure if an action is fraud, waste, and abuse of Texas Medicaid, report it to OIG and let the investigators decide.

HIPAA Guidelines and Provider Responsibilities

Providers must comply with HIPAA, seek legal representation when needed, and consult the appropriate manuals or a TMHP Provider Representative for guidance, as appropriate.

Resource Information

TMHP Call Center/Help Desk

Telephone.....800-727-5436/800-626-4117

 General Inquiries: Press 1

 Medical Necessity: Press 2

 Technical Support: Press 3

Fax.....512-514-4223

Medicaid Hotline.....800-252-8263

RUG Training Information.....512-245-7118

EDI Help Desk.....888-863-3638, Option 4

Medicaid Fraud.....800-436-6184

Community Services Regional Contacts.....<https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts>

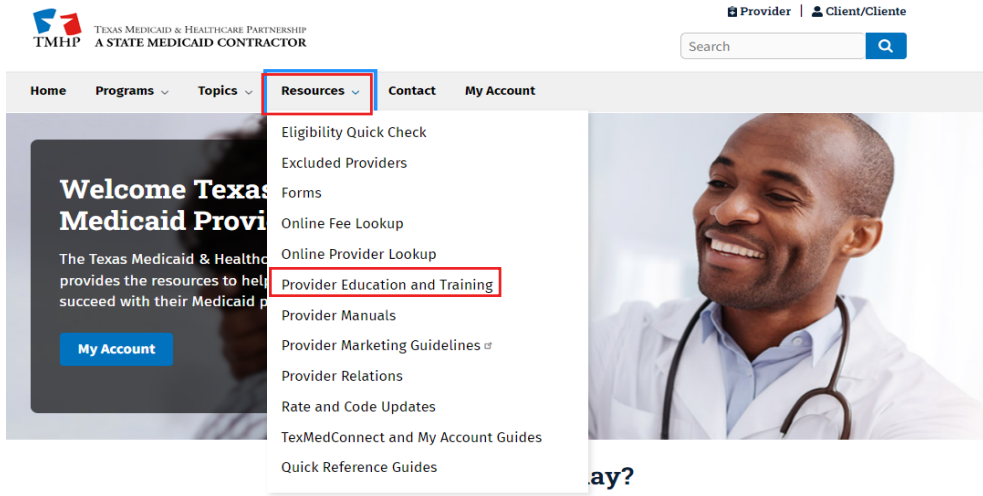
PACE Program Contacts.....512-487-3450

Additional Online Training

Webinar recordings of the LTC Community Services Waiver Programs materials are available on the TMHP Learning Management System (LMS).

Providers can access the above mentioned online training on the TMHP LMS as follows:

- 1) Go to www.tmhp.com, click **Resources**, then **Provider Education and Training**.



2) Click the **Visit the LMS today** link, or access the LMS directly at <http://learn.tmhp.com>.



Provider | Client/Cliente

Search



Home Programs Topics Resources Contact My Account

Provider Education and Training

Last updated on 8/7/2020

Welcome to the Provider Education and Training home page. From this page, providers can quickly access the Texas Medicaid & Healthcare Partnership (TMHP) Learning Management System (LMS) and the TMHP YouTube channel, which houses an extensive collection of educational resources. Using these resources, providers can learn more about:

- Medicaid and other state health-care programs and their benefits and limitations
- Provider enrollment, re-enrollment, and revalidation
- Client eligibility tools and requirements
- Claims submission tools and requirements, and the appeals process
- TMHP tools, databases, and systems

TMHP Learning Management System (LMS)

The TMHP LMS is an easy-to-use education portal where providers can learn about all things Texas Medicaid as well as the other programs supported by TMHP. It is available to providers 24 hours a day, seven days a week, and is regularly updated with new and up-to-date training materials. Providers are encouraged to regularly visit the LMS to keep up-to-date with the latest information.

To access the LMS, providers must register and obtain a username. To learn more about creating an account and navigating the LMS, see the following resources:

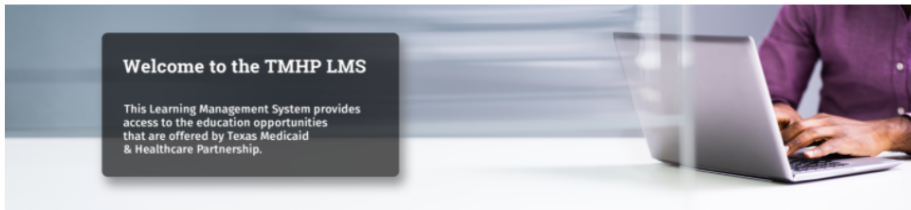
- [Learning Management System \(LMS\) Registration](#)
- [Learning Management System \(LMS\) Job Aid for Providers](#)

Registered users can:

- Access multimedia training content.
- Watch recorded webinars and access associated question and answer (Q&A) documents.
- View Americans with Disabilities Act (ADA)-compliant resources such as job aids, user guides, quick reference guides (QRGs), infographics, webinar transcripts, and other supplemental materials.

[Visit the LMS today.](#)

- 3) Log in to your LMS user account or create a new user account. New visitors to the LMS must create a user account to access the webinar recording.



Welcome to the TMHP LMS

This is the home page for the education opportunities that are offered by Texas Medicaid & Healthcare Partnership (TMHP). Registered users can:

- Run computer-based training modules.
- Listen to or read transcripts of past webinars.
- Access supplemental information.

If this is your first visit, click **Don't have an account? Sign up here.** to create a user account. If you need help, click [here](#) or email TMHP.TrainingSupport.

If you are an Accenture Employee or TMHP Employee, you already have an account. Please do not re-register. Contact [TMHP Training Support](#) to obtain your login and password information.

Account Login

Login

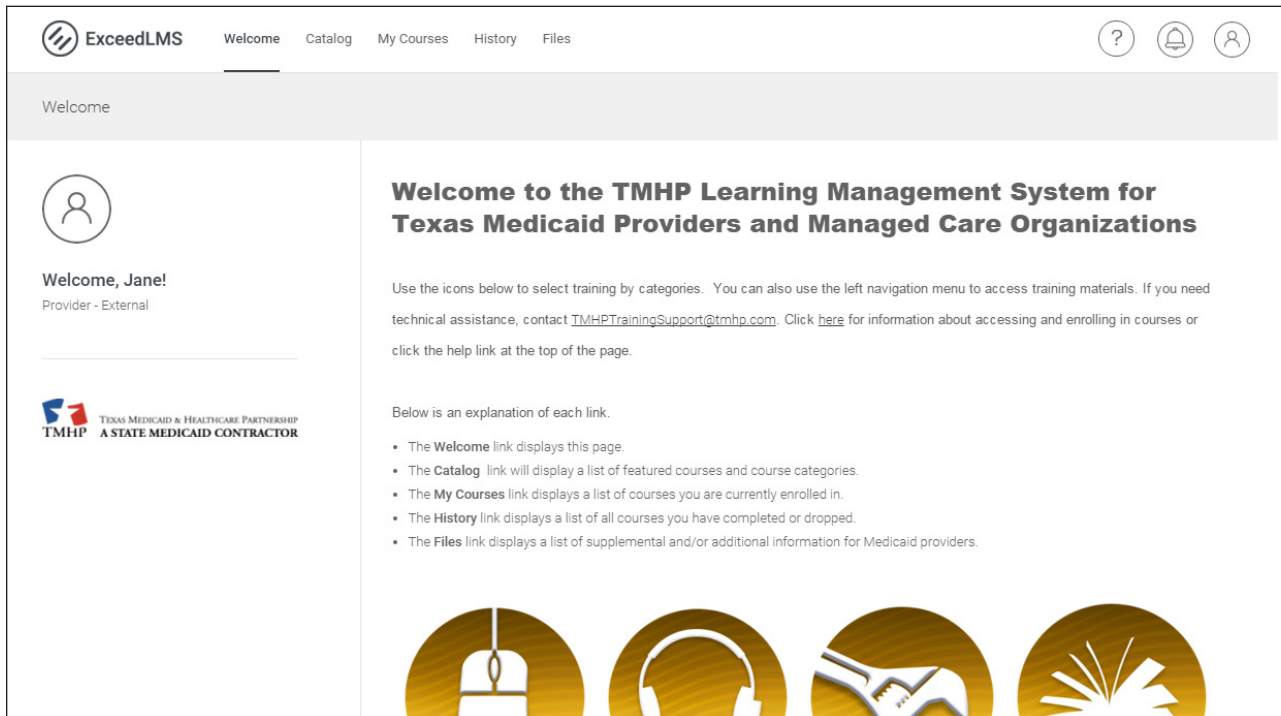
Password [Forgot Password?](#)

or [Don't have an account? Sign up here.](#)

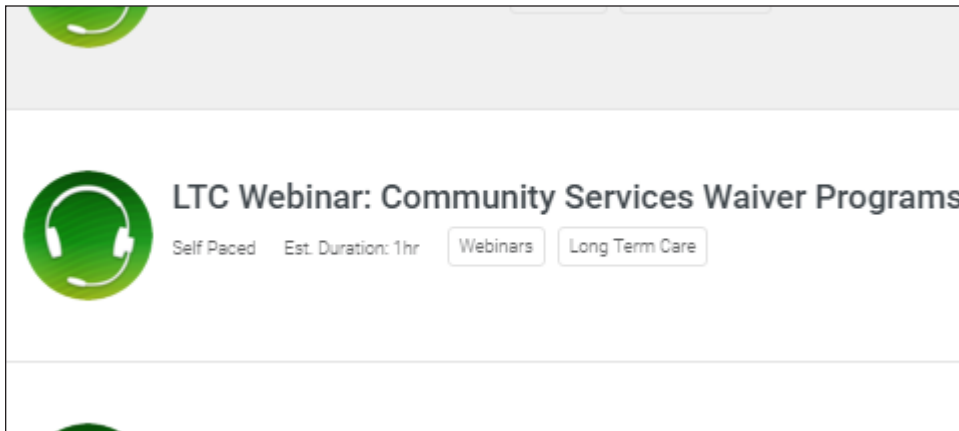
Not ready to create an account? [Click here to browse the LMS.](#)



- 4) Use your cursor to hover over Provider Education in the top menu bar, and click **Webinars**.



5) Scroll until you find the correct webinar recording. Click on the icon.



6) Once you have clicked the **Get Started** button, you will be able to view the replay.

Registered LMS users can access computer-based training, past webinars, and workshop materials 24 hours a day, 7 days a week. These materials include but are not limited to:

- Medicaid Basics CBT
- Recording of latest Medicaid Basics Webinar
- LTC Online Portal Basics CBT
- TexMedConnect for LTC Providers

Informational Websites

Website	Link
Centers for Medicare & Medicaid Services	www.cms.gov
Community Services Policies and Programs	https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers
Consumer Rights and Services (includes information about how to make a complaint)	https://hhs.texas.gov/about-hhs/your-rights/complaint-incident-intake
Health and Human Services Commission	https://hhs.texas.gov/
HHSC Regions	https://hhs.texas.gov/about-hhs/find-us
Long-Term Care Provider Bulletins	https://www.tmhp.com/programs/ltc/long-term-care-ltc-provider-bulletins
Medicaid Fraud	https://oig.hhs.texas.gov/
Medicaid Nursing Facility Program	https://apps.hhs.texas.gov/providers/NF/index.cfm
Medical Necessity and Level of Care 3.0 Assessment and Instructions	www.tmhp.com/programs/ltc/forms
RUG Training	www.txstate.edu/continuinged/CE-Online/RUG-Training.html

Website	Link
Texas Administrative Code	www.sos.state.tx.us/tac/
Texas Department of Aging Services	https://hhs.texas.gov/services/aging
Texas Department of Disability Services	https://hhs.texas.gov/services/disability
Texas Department of State Health Services	http://www.dshs.texas.gov/
Texas Medicaid & Healthcare Partnership	www.tmhp.com
TMHP Long-Term Care Division	www.tmhp.com/programs/ltc
Vendor Drug Program	http://txvendordrug.com/

Acronyms

Acronym	Definition
API	Atypical Provider Identifier
ARD	Assessment Reference Date
BON	Texas Board of Nursing
CFC	Community First Choice
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPR	Cardiopulmonary Resuscitation
CS	Community Services
DD	Developmental Disabilities
DLN	Document Locator Number
DO	Doctor of Osteopathy
EDI	Electronic Data Interchange
EMS	Emergency Medical Services
FSI	Form Status Inquiry
HCSSA	Home and Community Support Services Agency
HHA	Home Health Agency
HHSC	Texas Health and Human Services Commission
HIPAA	Health Insurance Portability and Accountability Act
ICD-10 [®]	International Classification of Diseases Tenth Revision
ICF/IID	Intermediate care facility/facilities for individuals with an intellectual disability or related condition/conditions
ID	Intellectual Disabilities
IDD	Intellectual and Developmental Disabilities
ISP	Individual Service Plan
LTC	Long-Term Care
LTCMI	Long-Term Care Medicaid Information
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MD	Medical Doctor
MDCP	Medically Dependent Children Program
MESAV	Medicaid Eligibility and Service Authorization Verification
MN	Medical Necessity
MN/LOC	Medical Necessity and Level of Care
NF	Nursing Facility
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System

Acronym	Definition
OES	Office of Eligibility Services
OIG	Office of the Inspector General
OOHDNR	Out-of-Hospital Do Not Resuscitate Order
PACE	Program of All-inclusive Care for the Elderly
PDF	Portable Document Format
PRN	Pro re nata (Latin) — as needed
RA	Route of Administration
R&S	Remittance and Status
RN	Registered Nurse
RUG	Resource Utilization Group
SAS	Service Authorization System
SCSA	Significant Change in Status Assessment
SG	Service Group
SSN	Social Security Number
STAR+PLUS	State of Texas Access Reform (STAR) + PLUS
TAC	Texas Administrative Code
THCA	Texas Health Care Association
TMB	Texas Medical Board
TMHP	Texas Medicaid & Healthcare Partnership
UR	Utilization Review

Glossary

§1915(c) Medicaid Waiver - The provision of the Social Security Act that authorizes the Secretary of Health and Human Services to grant waivers of certain Medicaid statutory requirements. This provision allows a state to furnish home and community-based services to Medicaid beneficiaries who need a level of institutional care that is provided in a hospital, nursing facility, or intermediate care facility for persons with intellectual disabilities.

Appeal - The formal process by which an applicant, provider, person, or the applicant or person's parent, guardian, or legally authorized representative requests a review of an adverse action.

CFC - A federal option, called Community First Choice, allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities.

Fair Hearing - An administrative procedure that affords people the statutory right and opportunity to appeal adverse decisions/actions regarding program eligibility or termination, suspension, or reduction of services by the Health and Human Services Commission.

Individual - A person enrolled in a program.

LTSS - Long-term services and supports are services provided to a person in the person's home or other community-based setting that are necessary to allow the person to remain in the most integrated setting possible.

Managed Care - Managed care is a health-care system in which a defined network of health-care providers agree to coordinate and provide health care to a population in exchange for a per-member-per-month capitation payment. HHSC determines which people enroll in managed care, based on specific criteria, such as age and income source.

PACE - Program of All-Inclusive Care for the Elderly provides community-based services to older people who qualify for nursing facility placement. PACE uses a comprehensive care approach, providing an array of services for a capitated monthly fee that is below the cost of comparable institutional care.

STAR+PLUS - STAR+PLUS is a managed care program for adults who have disabilities or are age 65 or older. STAR+PLUS provides members acute care, long-term services and supports, and service coordination.

