LONG-TERM CARE (LTC) USER GUIDE

FOR COMMUNITY SERVICES WAIVER PROGRAMS

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

Contents

Learning Objectives

After learning the material in the *Long-Term Care (LTC) 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 how to use the LTC Online Portal.

- Navigate the resources on the LTC 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 fraud, waste, and abuse.

- 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 LTC services and supports to enrolled managed care members eligible for these services. MCOs operate under programs such as the State of Texas Access Reform (STAR) and the State of Texas Access Reform PLUS (STAR+PLUS). An example of Medicaid services delivered through STAR+PLUS is long-term services and supports (LTSS) for eligible older persons and people with physical, intellectual, and developmental disabilities.

- **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 (HHS) programs including Medicaid and CHIP. HHSC delivers most Medicaid and CHIP services through MCOs.

- **Texas Medicaid & Healthcare Partnership (TMHP)** – Contracted by the state as the claims administrator, along with HHSC, to process claims for providers under traditional Medicaid. TMHP processes and approves claims for traditional LTC. TMHP does not pay LTC claims; this is done by the comptroller. Responsibilities also include the following:

  - Determination of MN (with the exception of STAR Kids)

  - 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 (with the exception of STAR Kids)

  - 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 a.m.–7 p.m., Central Time, excluding holidays

NPI/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 an NPI. Examples of services that atypical providers provide include transportation, home and vehicle modifications, and respite services. An API is assigned to these providers instead of an NPI, to bill for those services.

An 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, STAR Kids Screening and Assessment Instrument (SK-SAI), and STAR Kids Individual Service Plan (SK-ISP). You can also submit H1700-1 Home and Community Based Services (HCBS) STAR+PLUS Waiver Individual Service Plan (ISP) forms.

Benefits of Using the LTC Online Portal

- The LTC Online Portal is a 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 a.m. to 7 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.

- It 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. Various LTC Online Portal features are displayed on the blue navigational bar located within the portal. Some features include the ability to edit or submit certain forms. 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.

Providers and MCOs must request access to use 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. It also 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 and would like to access the LTC Online Portal, 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 a.m.–7 p.m. **Note:** It may take three to five business days to receive the password, which is randomly generated by TMHP.

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 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 MN 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."
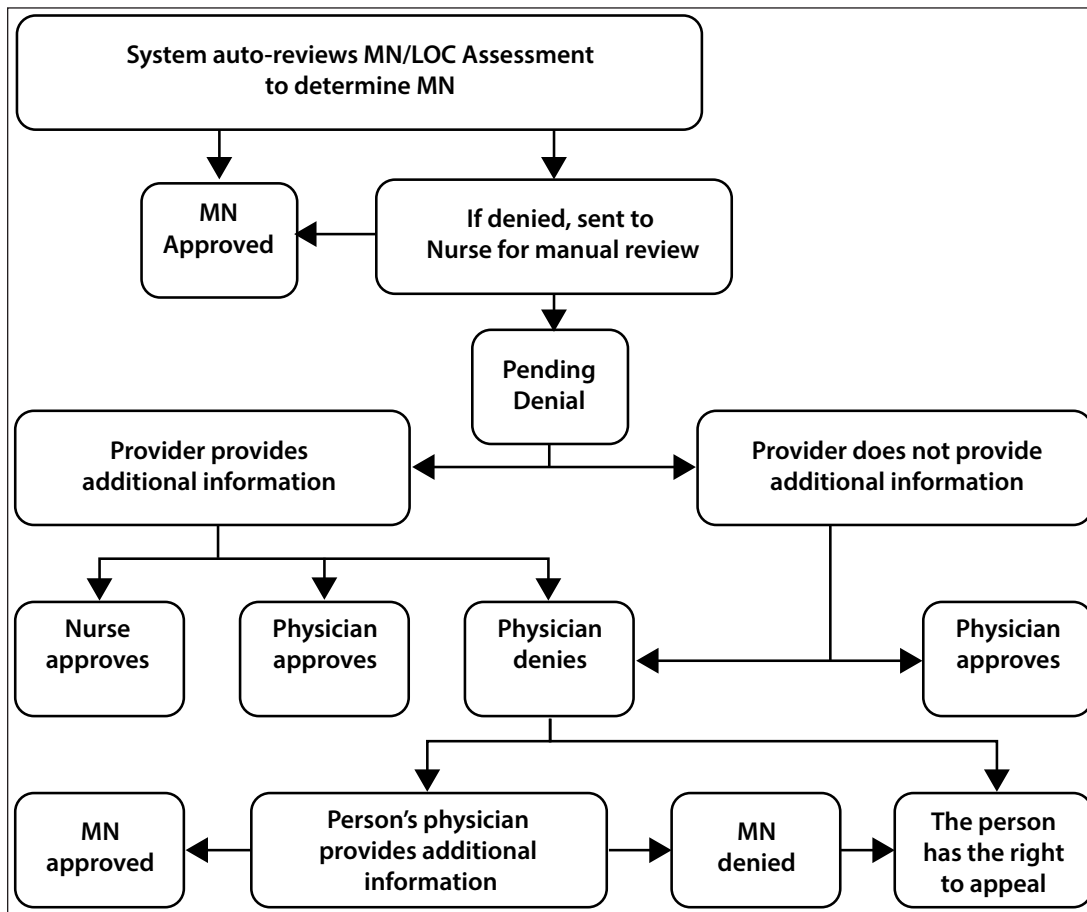
General Qualifications for Medical Necessity Determinations

In accordance with 26 TAC §554.2401, MN is the prerequisite for participation in the Medicaid (Title XIX) LTC program. Further, the section outlines that to verify that MN 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


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┌─────────────────────────────────────┐
│ System auto-reviews MN/LOC Assessment│
│         to determine MN              │
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This flowchart provides a high-level overview of the process used for determination of MN.

1) 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 nurse has five business days to review assessments and dtermine MN. The assessment will be set to status *Pending Review* on the FSI search results.

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.
Note: The assessment will only appear in Current Activity for 14 days.

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. For Medically Dependent Children Programs (MDCP) or STAR Kids Community First Choice (SK-CFC) MN determination, the provider should call a HHSC nurse.

4) If the nurse determines that MN has been met, the assessment is approved.

5) If the nurse still cannot determine any licensed nursing need, the member's assessment is sent to the physician for an MN determination.

6) If the physician determines that MN has been met, the assessment is approved.

7) If the MN is denied by the 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 or in Section A of the SK-SAI. 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 14 business days of the date of the denial letter by faxing or calling either TMHP or HHSC, with additional information. Alternatively, a licensed nurse familiar with the member may provide additional information by calling and speaking with a TMHP or HHSC nurse. Any additional documentation must be sent by fax and in writing.

9) If the physician or nurse determines that MN has been met, the assessment is approved.

10) If the 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 physician for review, and steps 7 through 11 will apply.

12) The member may initiate the appeal process when notified by an HHSC case manager, using the Form 2065D, that MN has been denied by the 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 or HHSC nurses or by fax. Any additional documentation must be sent by fax and in writing.

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. The assessment will only appear in Current Activity for 14 days.

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 12 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. STAR Kids complaint, appeal and fair hearing procedures can be found in section 7000 of the STAR Kids Handbook. They are available at these three links: https://www.hhs.texas.gov/handbooks/fair-fraud-hearings-handbook, https://www.hhs.texas.gov/handbooks/starplus-handbook/4000-complaints-internal-mco-appeals-state-fair-hearings and https://www.hhs.texas.gov/handbooks/star-kids-handbook/7000-complaint-appeal-fair-hearing-procedures.

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

  - 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 3.0 Assessment

1) Log into 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.

4) Select the appropriate vendor number from the Vendor Number drop-down box.

5) To autofill 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 autofilled when one of the aforementioned data items is entered. Refer to the demographic information located in Section A and the LTCMI section of the MN/LOC Assessment.

6) Click the **Enter Form** button.

7) 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 Medical Doctor/Doctor of Osteopathic Medicine (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, using the Worklist drop-down, 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 Document Locator Number (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 as draft for research and correction at a later date. If the provider is unable to resolve the error, they may contact TMHP for assistance.

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

- Reason for Assessment is a required field
- First Name is a required field.
- Last Name is a required field.
- Medicaid Number is a required field.
- Gender is a required field.
- Birth Date is a required field.
- Does the individual need or want an interpreter is a required field.
- Observation end date is a required field.

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 the [Long-Term Care Forms web page](), and click the **Medical Necessity and Level of Care 3.0 Assessment Instructions** link found under the Community Waiver Programs heading.

- Click the **Help** link in the LTC Online Portal 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 the [Long-Term Care Forms web page](), and click the **Medical Necessity and Level of Care 3.0 Assessment** link found under the Community Waiver Programs heading.

- Click the **Printable Forms** link in the LTC Online Portal 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.

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?	▼
S7b.	● Did a military physician providing healthcare according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual?	▼
S7c.	● MD/DO Last Name	
S7d.	● MD/DO License #	
S7e	● MD/DO License State	▼
	Indicate Physician Signature on file by checking box (Required for Initial Assessments)	☐

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

S7f.	● MD/DO First Name	
S7g.	● MD/DO Address	
S7h.	● MD/DO City	
S7i.	● MD/DO State	▼
S7j.	● MD/DO ZIP Code	
S7k.	MD/DO Phone	

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.

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

Add Meds

S10. Comments

S11. Advance Care Planning

S11a.	● Does the individual/caregiver report having a legally authorized representative?	▼
S11b.	● Does the individual/caregiver report having a Directive to Physicians and Family or Surrogates?	▼
S11c.	● Does the individual/caregiver report having a Medical Power of Attorney?	▼
S11d.	● Does the individual/caregiver report having an Out-of-Hospital Do Not Resuscitate Order?	▼

S12. LAR Address

Required if individual/caregiver has reported having a legally authorized representative.

S12a.	LAR First Name	
S12b.	LAR Last Name	
S12c.	Address	
S12d.	City	
S12e.	State	▼
S12f.	ZIP Code	
S12g.	Phone	

Submit Form

- **S1. Medicaid Information**
  - S1a. Medicaid Client Indicator
    - This field will be autofilled.
  - 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 autofilled based on the user's logon security credentials and cannot be changed.
  - S2b. Provider Number
    - This field will be autofilled 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 autofilled 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 an HHA:
    - Enter the HHA License number. HHA License # is no more than seven numeric digits.
  - If you do not work for an 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 autofilled after S3a was inputted.
    - Click the **magnifying glass** and the description will be autofilled 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 registered nurse (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 through 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.

☑ **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.

H1700-1/Individual Service Plan (ISP) Form

What is the ISP Form?

The H1700-1/ISP form is used for STAR+PLUS HCBS members. 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 autofill with information from a member's MN/LOC.

- Form statuses can be tracked using the FSI feature.

- The portal is available 24 hours a day, seven days a week.
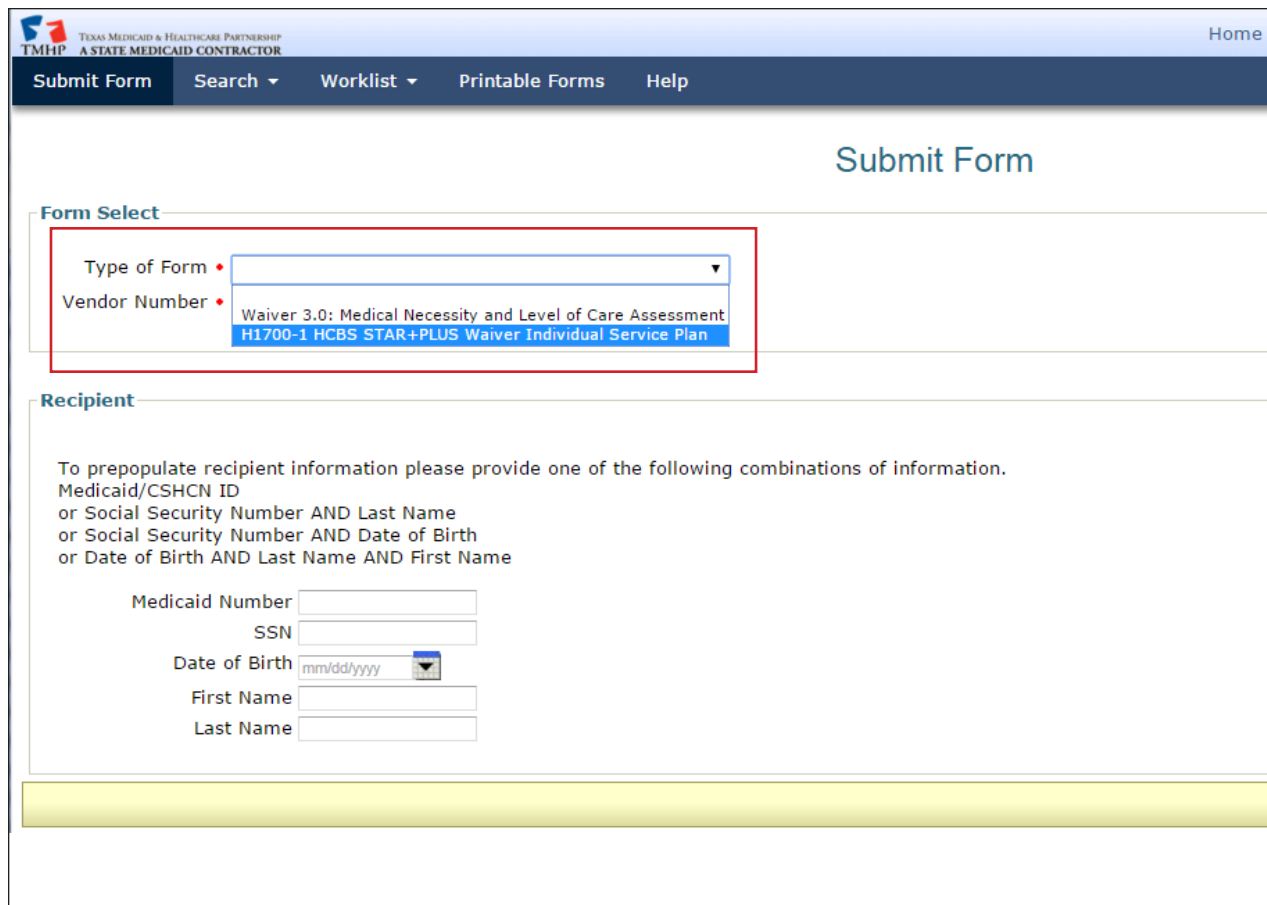
TMHP provides LTC Online Portal technical support by telephone at 800-626-4117, from 7 a.m.–7 p.m., Central Time, Monday through Friday–excluding holidays.

Entering the ISP

1) When the blue navigational bar is displayed, click the **Submit Form** link. You may need to reenter your security credentials.
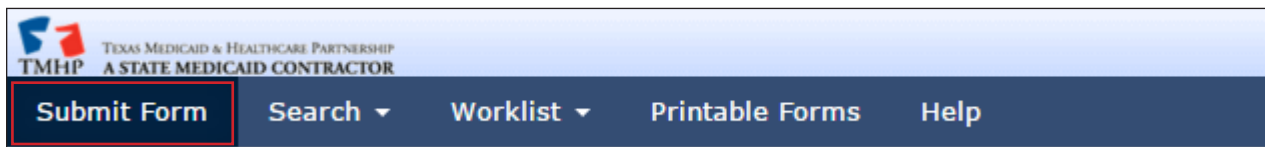
2) From the Type of Form drop-down menu, select **H1700-1 HCBS STAR+PLUS Waiver Individual Service Plan**.

3) Select the appropriate vendor or provider number, if applicable.

4) Enter the member's Medicaid number in the Medicaid Number field.

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

The form may take a moment to populate fields from the person's most recent MN/LOC Assessment in a finalized status. Autofilled fields are not editable. These fields are tinted gray.

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.

3) In the Applicant/Member section of the form, verify that the Medicaid number is correct. It is a required field.
   Note: The Applicant/Member section of the ISP form will be autofilled using information from their recent MN/LOC Assessment in a finalized status.

4) Check the **ME-Waiver** box, if applicable, for the person.

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 autofill based on the ISP From Date field.
   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, 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.

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.

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 autofill.

14) Add new Service Categories, as necessary.

    Note: To add additional Service Categories, click the **Add Service** button and repeat steps 10-13. 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 reenter the information.

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

    Note: Total Estimated Waiver Cost autofills. 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 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 on the blue navigational bar. Submitted ISPs are displayed on the Current Activity screen of the LTC Online Portal for 14 calendar days. After 14 calendar days, submitted ISPs must be searched for manually using FSI.

Submitting ISP Forms by Multiple Users

Occasionally, multiple users 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.

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.

SK-SAI

What is the SK-SAI?

STAR Kids is a managed care program that meets the needs of children and young adults 20 years-of age or younger who receive Medicaid services from a number of different programs.

The people enrolled in STAR Kids and their families will receive assistance through the STAR Kids program. Through service coordination, some of the identified needs of the people will be addressed by connecting them to services and qualified providers. MCOs, in collaboration with the family, will assess each person's needs using the SK-SAI, and an ISP will be created.

The SK-SAI provides a standardized care needs assessment that is comprehensive, holistic, consumer-directed, evidence-based, and considers social and medical issues to prioritize the person's needs.

Unlike other assessments processed by TMHP, the SK-SAI will include auto MN criteria for the individuals being assessed. The LTC Online Portal automatically approves MN when certain criteria are met. If the LTC Online Portal cannot approve the SK-SAI based on the auto MN criteria, then the assessment must be reviewed by clinical staff to determine MN.

Letters

Like all assessments where MN is determined, letters are mailed out if the form reaches certain statuses. HHSC has five letters for the SK-SAI. Two of these letter types are mailed to the person or their LAR, and three letter types are mailed to the person's doctor.

HHSC will mail out the following letters:

- Client/Doctor Denial Letter – This letter will be generated and mailed once the SK-SAI goes into an MN Denied status, which occurs once the HHSC physician denies MN.

- Client/Doctor Overturn Approval Letter – This letter will be generated and mailed if an SK-SAI has MN approved after initially having MN denied.

HHSC will not send a letter to the MCO. However, the MCO should recognize the form status based on systematic notifications returned to the MCO. In other words, the MCO should be aware of the status of the assessment.

TMHP Online Portal

STAR Kids and STAR Health MCOs can view the SK-SAI for retention, determination of MN (if applicable) and RUG levels.

Screening And Assessment Instrument

The STAR Kids screening and assessment process will help identify the complexity and intensity of a person's physical, medical, mental, social, developmental, and behavioral needs. The process will also help identify personal

preferences and goals. Findings from the STAR Kids screening and assessment process will also be used by HHSC to identify trends and provide insight on conditions, outcomes, how services are being used, and the quality of care.

The SK-SAI can be pulled up by performing a Power Search. Once the proper SK-SAI has been found, you can view any part of the assessment. No changes to the form can be made online.

You can view the Current Status of the SK-SAI in the upper left hand of the page above the yellow bar.

The form can be in one of the following statuses:

- *Appealed Doctor Review*

- *Corrected*

- *Denial Inventory*

- *Doctor Overturn Denied*

- *FH Appeal Denied*

- *FH Doctor Appeal Denied*

- *Form Inactivated*

- *ID Invalid*

- *Invalid/Complete*

- *Med ID Check Inactive*

- *Medicaid ID Pending*

- *MN Approved*

- *MN Denied*

- *Overturn Doctor Review Expired*

- *Overturned Doctor Review*

- *Pending Denial*

- *Pending Doctor Review*

- *Pending Fair Hearing*

- *Pending More Info*

- *Pending Nurse Review*

- *Processed/Complete*

The RUG and MN status are displayed beside the Current Status above the yellow bar. You can also click **Return to Search Results** to go back to the display of the results of your power search.

The SK-SAI includes three modules: the Core Module, the Nursing Care Assessment Module (NCAM), and the Medically Dependent Children Programs (MDCP) Module.

The Core tab shows basic demographics and other personal information about the person, as well as information about the person's behavioral and cognitive issues and needs.

The NCAM covers any complex condition that the person might have and the nursing task that are needed that are associated with the conditions.

The MDCP Module covers items related to mental and physical needs of the person.

Add Note

The Add Note feature may be used to add additional MN information that was not captured upon original submission. Information is added to the History trail of the assessment, not to the assessment itself. Any information added here by the MCO SC will need to be followed up with faxed documentation for verification.

After entering information into the Add Note box, click the **Save** button. The information is then added to the History trail of the assessment, not to the assessment itself. Once the note is saved, the content from the box will appear at the bottom of the history trail.

Print

You can also print the SK-SAI form from this page by clicking **Print** at the top of your form.

The SK-SAI form will then be displayed in PDF format, and the print commands can be followed from there.

DLN		Individual Identification	
Current Status	Processed/Complete	RUG	CA1

STAR Kids Screening and Assessment Instrument (SK-SAI) Form
STAR Kids Screening and Assessment Instrument - Core

SECTION A. IDENTIFICATION INFORMATION

1. Date of Assessment Conducted With The Individual/LAR

1 0	—	0 1	—	2 0 2 1
Month		Day		Year

2. Reason For Assessment

0. Initial   [0]
1. Re-assessment
2. Significant change in condition re-assessment
3. Minor correction to recent assessment
4. Major correction to recent assessment

3. Legal Name

(First Name)	(Middle Initial)	(Last Name)	(Suffix)

4. Gender

1. Male   2. Female   9. Unknown   [1]

5. Birthdate

0 2	—	0 8	—	2 0 0 8
Month		Day		Year

6. Ethnicity And Race

0. No   1. Yes

Ethnicity a. Hispanic or Latino   [0]

Race   b. American Indian or Alaska Native [0]   c. Asian [0]   d. Black or African American [0]

e. Native Hawaiian or other Pacific Islander [0]   f. White [1]   g. Other [0]   h. Prefer not to identify [0]

g. Other (specify):

Testing Other Description

7. Participants In Assessment

Name	Relationship to Individual
Jane Doe	Self
John Doe	Husband
Jemma Doe	Daughter

7. Participants In Assessment continued on next page

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SK-ISP Form

What is the SK-ISP Form?

The SK-ISP form is used for children and young adults with disabilities receiving services in the STAR Kids program. The SK-ISP includes information about a person's preferences, goals, service needs, and plans for obtaining services. These forms can be submitted online using the LTC Online Portal.

Before an ISP can be submitted for a person, they must have an SK-SAI on file in status *Processed/Complete* with MN approved.

Benefits of Submitting SK-ISP Forms on the TMHP Portal

- Many fields are autofilled with information from a person's SK-SAI.

- Track forms with Form Status Inquiry.

- The portal can be accessed 24 hours a day, 7 days a week.

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

Creating and Submitting an SK-ISP

There are two different ways to create and submit an SK-ISP form:

- Using the **Submit Form** link on the blue navigational bar

- Using the Create ISP feature on the person's existing SK-SAI form
  Note: Remember, the person must already have an SK-SAI form before an SK-ISP can be submitted.

Creating and Submitting an SK-ISP using Submit Form

1) From the blue navigational bar, click the **Submit Form** link.
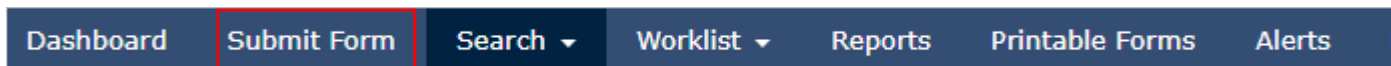
2) You may need to reenter your security credentials.

3) From the Type of Form drop-down menu, select **STAR Kids Individual Service Plan (SK-ISP)**.

4) Select the appropriate vendor or provider number, if applicable.

5) Enter the person'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.

The form may take a moment to populate fields from the person's SK-SAI. You will not be able to edit the autofilled fields, which are tinted gray. Required fields are indicated by a red dot.

The form sections of the SK-ISP are:

- MCO Organization Information.

- Applicant/Member Information.

- Individual Service Plan Event.

- Individual Service Plan Services.

Complete the form using the instructions in the "Completing the SK-ISP Form Fields" section of this user guide.

Creating and Submitting the SK-ISP Form from the SK-SAI Form

To create an SK-ISP form from the person's existing SK-SAI, open the SK-SAI, and click the **Create SK-ISP** button on the Form Actions Bar:

Then complete the form using the instructions in the "Completing the SK-ISP Form Fields" section.

Completing the SK-ISP Form Fields

1) Complete the **Service Coordinator** field.

2) Select the correct county from the County drop-down menu.

Note: Most of the Applicant/Member section of the SK-ISP form will be autofilled using information from the SK-SAI on file for that person.

3) In the Applicant/Member section of the form, verify that the Medicaid number is correct. It is a required field.

4) Check the **ME-Waiver** box, if applicable, for the person.
Note: Initial forms for ME-Waiver will automatically trigger review by HHSC staff.

5) In the Individual Service Plan Event section, the Type Authorization will automatically indicate whether the current SK-ISP will be submitted as an Initial SK-ISP or a Reassement.
Note: This field automatically determines whether the SK-ISP is an Initial or a Reassessment based on the dates entered below and whether or not the person has an existing SK-ISP on file. If the SK-ISP has been out of date for 120 days, it resets to an Initial assessment. Backdating is possibleso that you can submit the SK-ISP as a Reassessment instead of an Initial Assessment. Backdating must go back far enough to fall within the 120-day reassessment window.

6) Enter the ISP From Date. You can complete the ISP From Date field using the interactive calendar. The ISP From Date must be the first day of a selected month. For Initial forms, the portal will autofill the first day of the following month.
The SK-ISP expires one calendar year after the ISP From Date. The ISP To Date cannot be edited and will autofill based on the editable ISP From Date field. For a reassessment, the ISP From Date will default to the day after the previous ISP To Date.
Note: The final section on the SK-ISP form is titled "Individual Service Plan Services." This is a required section. You must enter at least one service to submit the SK-ISP.

7) To enter a service:

- Use the drop-down menu to select the appropriate option in the Delivery Option column.

- 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.

8) Complete the required Estimated Annual Service Units column.

9) Complete the required Rate column.

10) The Estimated Annual Cost column will autofill.

11) 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 mistakenly delete a Service row, click the **Add Service** button and reenter the information.

Note: 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. Checking the box will automatically flag the SK-ISP for review by HHSC staff.

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

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

How to Save a Form as a Draft

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

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

3) The SK-ISP will now be available on the Drafts page.

4) Other users linked to that contract may access the SK-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.
   Note: The TMHP Portal only supports single SK-ISP form submissions. For users attempting to submit SK-ISP forms in batches, use the existing batch transaction process with one of the following naming conventions: SK-ISP.*.txt; SK-ISP.*.dat; or SK-ISP.*.zip.

How to Inactivate a Form

If HHSC Program Services Unit (PSU) staff set the form status to *MCO Action Required*, an MCO user should then inactivate the form using the following steps:

1) Log in to the LTC Online Portal.

2) Locate the form you want to inactivate using the **Form Status Inquiry**, **Current Activity**, or **Power Search** links in the blue navigational bar.

   a) If using FSI or Power Search, you may search for the SK-ISP using SSN, Medicaid number, or DLN. Click the **Search** button, then click the **View Detail** link.

   b) If using Current Activity, click the **DLN number** in the SK-ISP column.

3) To be eligible for inactivation, the form must be set to status *MCO Action Required* or *Pending PSU Review*.

4) Click the **Form Inactivate** button on the yellow Form Actions bar.

5) The status will be set to *Form Inactivated*, and a note will be added to the form's History trail.

Note: A form is no longer eligible to be inactivated once it is set to status *Processed/Complete, PSU Processed/Complete, Form Inactivated, Transferred*, or *PSU Invalid/Complete*. Forms will be automatically inactivated after 45 days in status *MCO Action Required*.

How to Resubmit a Form

1) Inactivate the form using the steps above.

2) Click the **Use as Template** button on the yellow Form Actions bar.

3) Edit the form as necessary using the process described in this user guide.

4) Click the **Submit** button at the bottom right of the screen to submit the form.

How to Terminate a Form

MCO users may not terminate their own forms.

Forms set to status *Processed/Complete* or *PSU Processed/Complete* can be terminated by PSU staff at HHSC.

SK-ISPs Reassessment or Overdue Report

MCO staff can pull the SK-ISPs for Reassessment or Overdue Report from the LTC Online Portal. Portal administrators will need to create a non-admin user account for themselves to add MCO Reports Access.

- If only reports access is needed for this new user account, MCO Reports Access can be the only option selected.

- To access the report, portal administrators need to log in to the LTC Online Portal using this new non-admin user account's user name.

1) To start, Click **Reports** on the blue navigational bar.

2) The reports page will be displayed. Click the arrow beside the Select Report box. Select the SK-ISPs for Reassessment or Overdue Report from the drop-down menu.

Reports	Printable Forms	Help		

Select Report	Historical Reports	
SK-ISPs for Reassessment or Overdue	SKISPReassessmentOrOverDue_Current	Display Report

3) After selecting the SK-ISPs for Reassessment or Overdue Report, you can then choose the Historical Report type. Click the **Display Report** button.

Reports	Printable Forms	Help		

Select Report	Historical Reports	
SK-ISPs for Reassessment or Overdue	SKISPReassessmentOrOverDue_Current	Display Report

4) Your search results will open and be displayed in a separate window. The report will display in a Microsoft Excel spreadsheet. The SK-ISPs for Reassessment or Overdue report is used to determine who has an expired SK-ISP, or to note when the current SK-ISP is going to expire and a new SK-ISP has not yet been submitted. The ISP To Date of the most recent **Processed/Completed** or **PSU Processed/Complete** SK-ISP is used to determine when the SK-ISP is going to expire. The SK-ISPs are due to expire within three months, beginning on the first day of the current month. The SK-ISP will be included on the report as long as the ISP To Date is at least one day prior to the date the report is being run and is in a status of either **Processed/Completed** or **PSU Processed/ Complete.**

SK-ISPs For Reassessment or Overdue Report as of 11/30/2019

Service Area	Name	Medicaid ID	Plan Code	Expiring ISP DLN	ISP Expiration Date
Tarrant			K1		2/28/2018
Tarrant			K1		7/31/2018
Tarrant			K1		8/31/2018
Tarrant			K1		8/31/2018
Tarrant			K1		8/31/2018
Tarrant			K1		9/30/2018
Tarrant			K1		1/31/2019
Tarrant			K1		1/31/2019
Tarrant			K1		3/31/2019
Tarrant			K1		5/31/2019
Tarrant			K1		6/30/2019
Tarrant			K1		6/30/2019
Tarrant			K1		6/30/2019
Tarrant			K1		7/31/2019

Note: Example: A person has an SK-ISP with a date range 1/1/2021–12/31/2021. An SK-ISP has not yet been created for 1/1/2022–12/31/2022. If the report is run on 1/31/2022 (report is generated on the last day of each month), the expiring DLN will be included in the report, with the ISP Expiration Date column showing the last day the person is eligible to receive services as of the report run date.

Assessment Statuses

Providers can monitor the status of a submitted MN/LOC Assessment by using 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 definitions:

- *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 Online 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.

- *Overturned Doctor Review:* The provider has supplied additional information for an assessment that was denied MN. The assessment is pending doctor review for MN determination.

- *Overturned 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.

- *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 the 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 assessment 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 completed. This is the final status of the assessment 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 the 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 two to four 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 ten 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 LTC Online Portal 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.

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.

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

4) Select the appropriate vendor number from the Vendor Number drop-down box.

5) Enter the From Date and To Date range in the fields allocated. These are required fields.

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

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

From Date *	12/30/2015 ▼	To Date *	01/29/2016 ▼	
				Search

8) 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.

9) Click the **View Detail** link to open the assessment.

10) 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	1/4/2013 3:20:11 PM
1/4/2015 3:20:11 PM	**TMHP** : Medicaid ID 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.

11) Find the *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	1/4/2013 3:20:11 PM
1/4/2015 3:20:11 PM	**TMHP** : Medicaid ID 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

12) Find the rejection message in the white line just below *Provider Action Required*.

13) 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.

14) 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:

a) Click the **OK** button to Inactivate, and the assessment will set to status *Form Inactivated*.

b) 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 only be used after a provider has been instructed to do so by HHSC. 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.

  From here, you have two choices:

a) Click the **Cancel** button to cancel the request, keeping the assessment set to the status *Provider Action Required*.

b) Click the **Change Status** button to move the assessment out of the status *Provider Action Required*.

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

16) 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.	SCSAt	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.	SCSA	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.	SCSAt	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: A0310a=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 (PCS) for assistance.
GN-9010	This form must be manually processed by DADS.		Contact PCS 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	The submitted Diagnosis International Classification of Diseases (ICD) Code is not valid. Correct the Diagnosis Codes on the LTCMI section or Section I as needed using the **Correct this form** button. 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 * If PACE, contact program staff by telephone at 512-487-3450.

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 using FSI or Current Activity.

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.

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.

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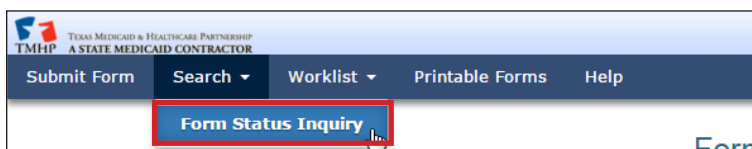
3) Type of Form: Choose **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the drop-down box.

4) 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, Purpose Code, and Reason for Assessment.

5) Click the **Search** button.

6) Click the **View Detail** link of the requested assessment.

7) Click the **Correct this form** button.

8) Complete only the fields needing correction.

9) 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 ▓▓▓▓

🔒
UnLock Form

MEDICAL NECESSITY AND LEVEL OF CARE ASSESSMENT - Version 3.0

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

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

Form Actions:
| Print | Print Physician's Signature | Use as template | Correct this form | Add Note | Inactivate Form |

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.

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** link on the blue navigational bar.

3) Click the **Form Status Inquiry** or **Current Activity** link, respectively.

4) Click the **View Detail** link.
   Note: If you choose to use FSI, you must perform a search first before seeing 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**.

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. Texas State University can take from four to seven 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.distancelearning.txst.edu/continuing-education/rugs-training.html

Reminders

- The LTC Online Portal is available 24 hours a day, 7 days a week to submit and track assessments.

- Use 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. For questions for STAR Kids assessments, call the HHSC Nurse Line at 833-259-9089. To add a note, 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.

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 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.
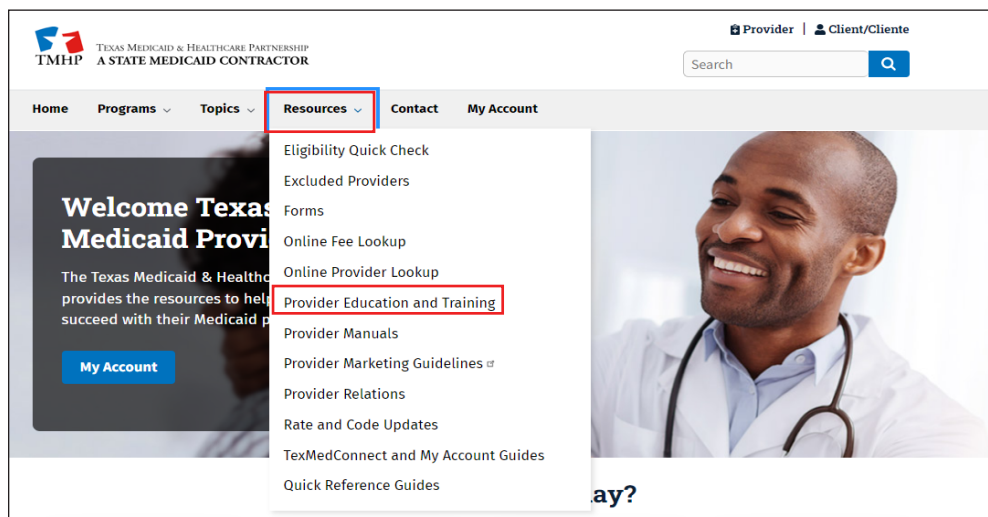
Resource Information

TMHP Call Center/Help Desk

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

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

PACE Program Contacts..512-487-3450

HHSC OMD Waiver Call Center - Waiver Eligibility/HHSC Nurse Line for SK-SAI Assessments...........833-259-9089

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.

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.
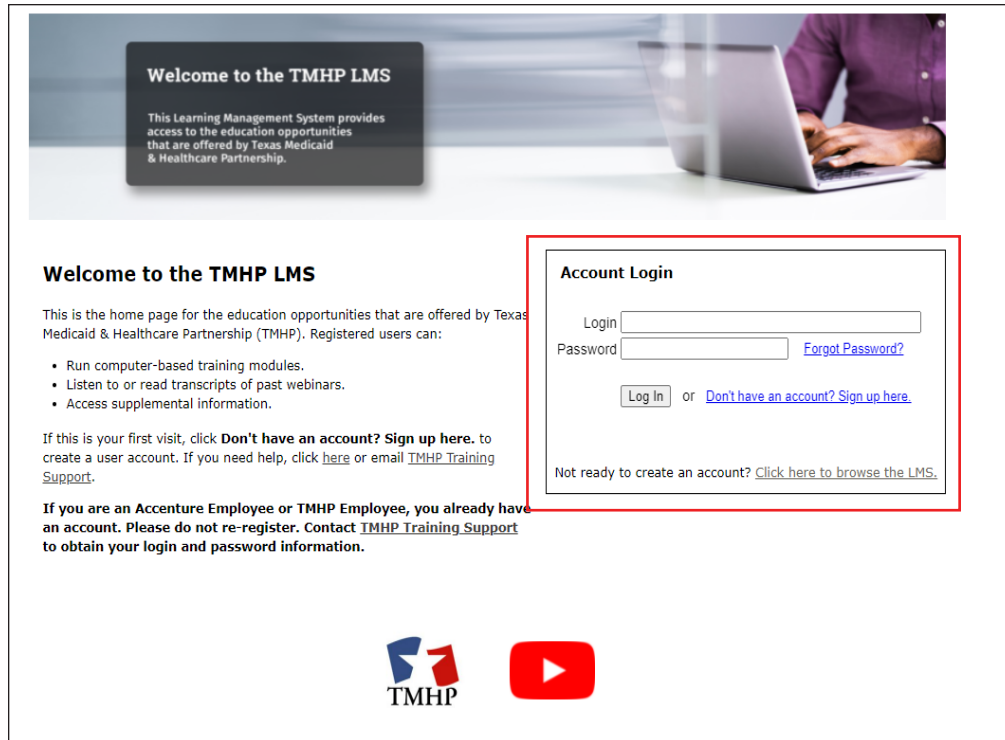
4) Scroll down the main page and click **Webinars**.
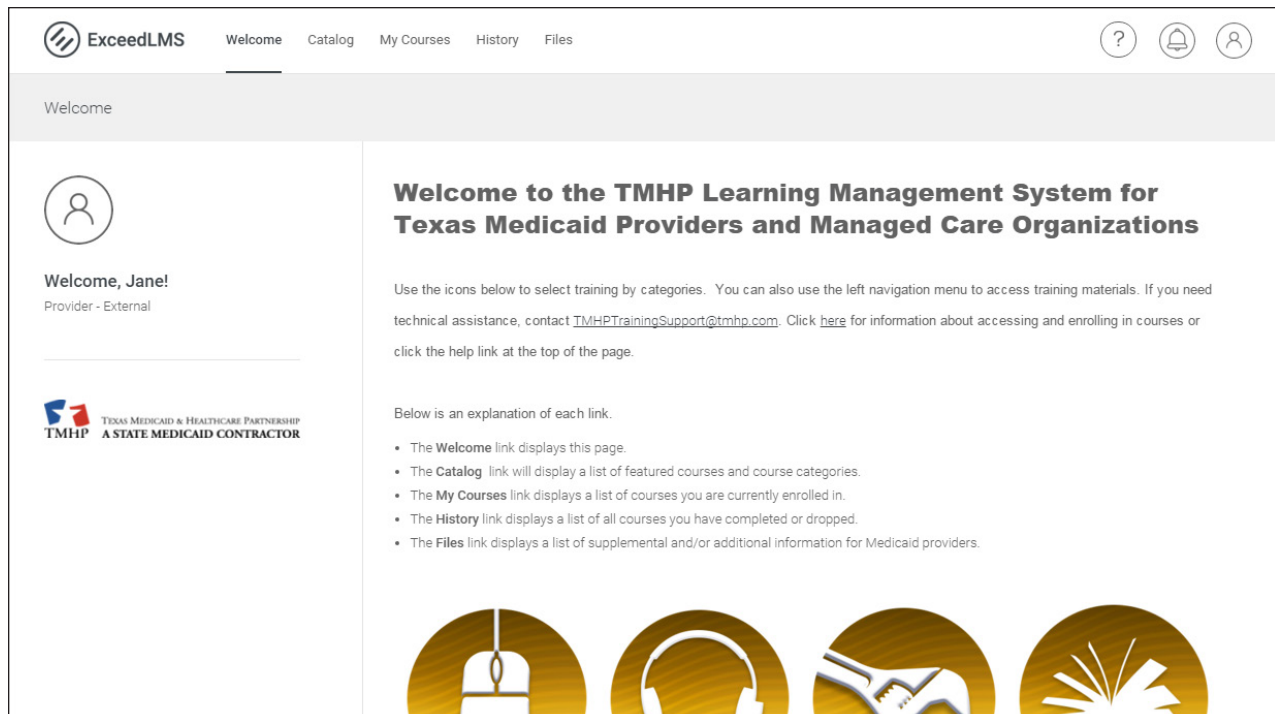
5) Scroll until you find the correct webinar recording. Click on the icon.
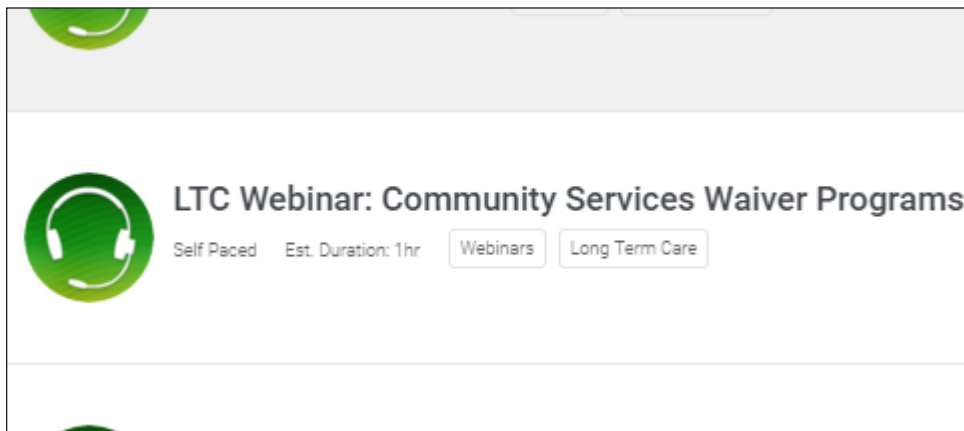
6) Click **Get Started** to view the replay.

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

- Medicaid Basics CBT

- LTC Online Portal Basics CBT

- TexMedConnect for LTC Providers CBT

Informational Websites

Website	Link
Centers for Medicare & Medicaid Services	www.cms.gov
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	https://www.distancelearning.txst.edu/continuing-education/rugs-training.html
Texas Administrative Code	www.sos.state.tx.us/tac/
Texas Department of State Health Services	http://www.dshs.texas.gov/
Texas Medicaid & Healthcare Partnership	www.tmhp.com
Texas HHS Aging Services	https://hhs.texas.gov/services/aging
Texas HHS Disability Services	https://hhs.texas.gov/services/disability
Texas HHS Long Term Care Providers	https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers
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
PCS	Provider Claims Services
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
SK-ISP	STAR Kids Individual Service Plan
SK-SAI	STAR Kids Screening and Assessment Instrument
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, that 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 age 21 years and older who have a disability, elderly age 65 years or older, and women with breast or cervical cancer. STAR+PLUS provides members with health care, long-term services and support, and service coordination.