Long-Term Care (LTC)

User Guide for Community Services Waiver Programs

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

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Contents

Learning Objectives

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

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

Medicaid Team

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

- **Centers for Medicare & Medicaid Services (CMS)** – The federal agency within the United States Department of Health and Human Services that is responsible for the administration of Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP).
- **Individual/Individuals** – A person enrolled in a Medicaid, CHIP, or Medicaid waiver program. May also be referred to as "member/members".
- **Managed Care Organization (MCO)** – State-contracted entity that has been given delegated authority to provide acute and long-term services to enrolled managed care members eligible for these services.
- **Program Provider** – An entity that provides services under a contract with the Texas Health and Human Services Commission (HHSC). For the purposes of this User Guide, a program provider is any entity that completes and submits a MN/LOC or ISP using the LTC Online Portal, including a MCO.
- **Texas Health and Human Services Commission (HHSC)** – State agency that provides administrative oversight of Texas Health and Human Services programs including Medicaid and the Children's Health Insurance Plan (CHIP). HHSC delivers most Medicaid and CHIP services through health plans. Medicaid managed care health plans operate under programs such as the State of Texas Access Reform (STAR) and the State of Texas Access Reform PLUS (STAR+PLUS). Medicaid services include, but are not limited to, long-term services and supports (LTSS) for older persons and people with physical, intellectual, and developmental disabilities. Medicaid and CHIP eligibility is determined by HHSC's Access and Eligibility Services (AES) staff.
- **Texas Medicaid & Healthcare Partnership (TMHP)** – Contracted by the state as the claims administrator to process claims for providers under traditional Medicaid. TMHP processes and approves claims for traditional LTC. TMHP does not pay LTC claims; this is done by the comptroller. Responsibilities also include the following:
  - Determination of MN
  - Provider education such as conducting training sessions for providers, which includes technical assistance on the LTC Online Portal and TexMedConnect online applications
  - Provide timely processing of claims (except for services covered by the STAR+PLUS premium) and represent HHSC at Fair Hearings
  - Provide yearly program manuals, quarterly *LTC Provider Bulletins*, and twice weekly Remittance and Status (R&S) Reports
  - Maintain the TMHP Call Center/Help Desk, Monday through Friday, 7:00 a.m.–7:00 p.m., Central Time, excluding holidays
- **Texas State Legislature** – The state legislature allocates budgetary dollars for Texas Medicaid.

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

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

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

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

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

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

The LTC Online Portal

The LTC Online Portal is used to submit, monitor, and manage MN/LOC Assessments.

Benefits of Using 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 telephone at **800-626-4117**, **Option 3**, from 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday – excluding holidays.
- Edits are in place to verify the validity of data entered.
- Provides error messages that flags entries that must be resolved before submission.
- Providers have the ability to monitor the status of their assessments by using Form Status Inquiry (FSI) or Current Activity.
- Allows providers to submit additional information.

LTC Online Portal Security

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

To utilize the LTC Online Portal, providers (and managed care organizations) must request access to the LTC Online Portal. Your agency may already have an account. You may need to contact your agency's administrator for user access. An administrator account is required for LTC Online Portal access, but it is strongly recommended to have multiple administrator accounts, in case one administrator is unavailable.

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

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

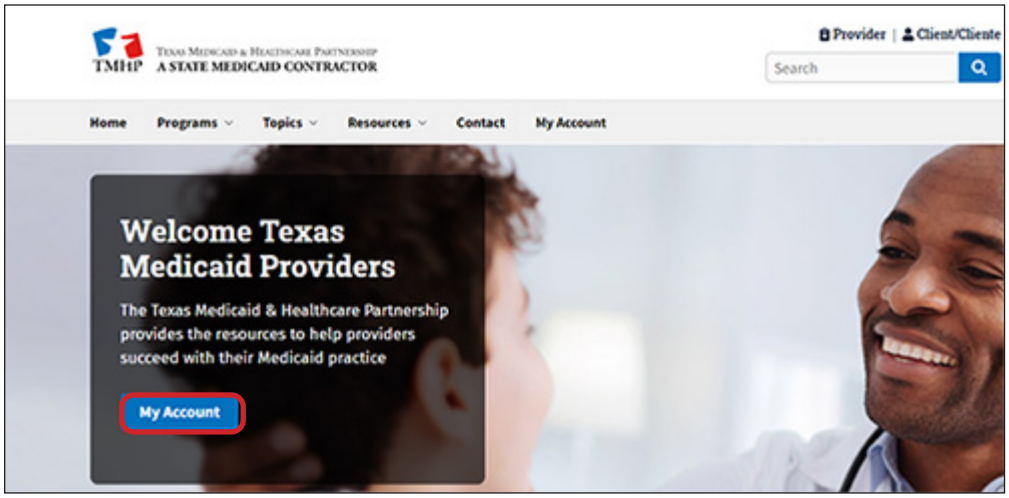
If you already have an administrator or user account, go to www.tmhp.com/programs/ltc. Click the **LTC Online Portal** button to sign in.

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

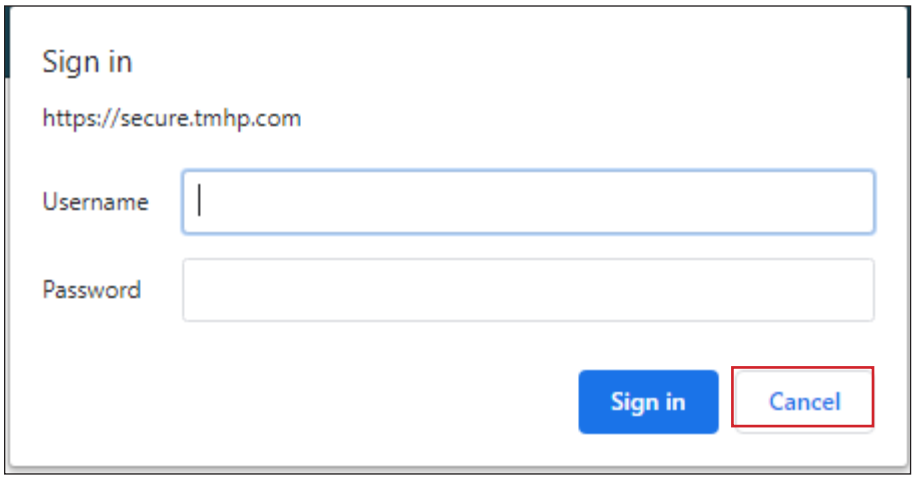
- **Provider number** – This is assigned by HHSC when the provider signs the contract to provide HHS Program services.
- **Vendor number** – This four-digit number is assigned by HHSC when the provider signs the contract to submit assessments on the LTC Online Portal.
- **Vendor password** – Providers must call the Electronic Data Interchange (EDI) Help Desk at **888-863-3638, Option 4**, to obtain a vendor password. The Help Desk is available Monday through Friday, 7:00 a.m. – 7:00 p.m. Note that it may take three to five business days to receive the password, which is randomly generated by TMHP.

How to Create an LTC Online Portal Administrator Account

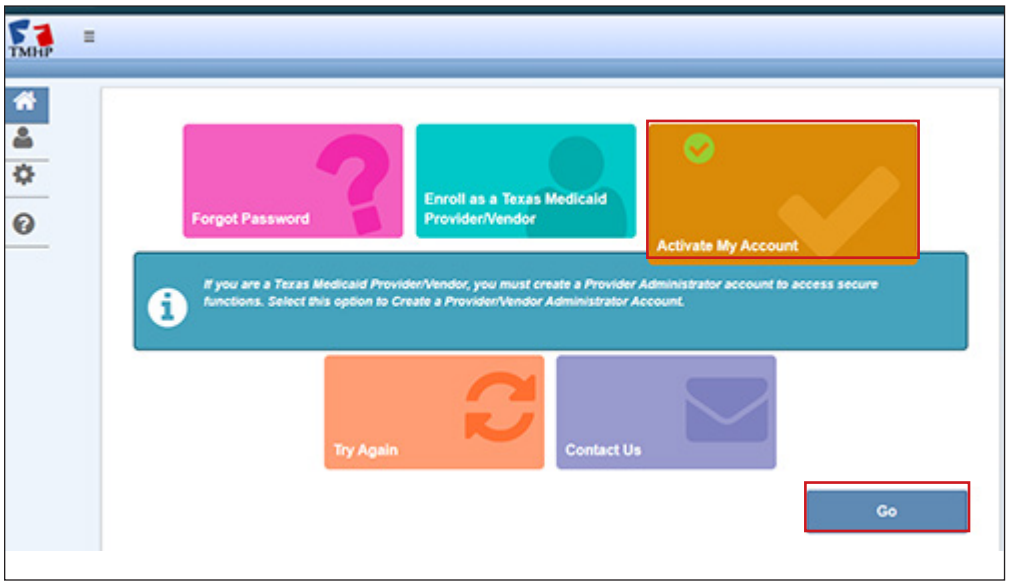
1) Go to www.tmhp.com.
2) Click the **My Account** button.



3) You will be prompted to sign in. If you do not have a username and password, click the **Cancel** button.

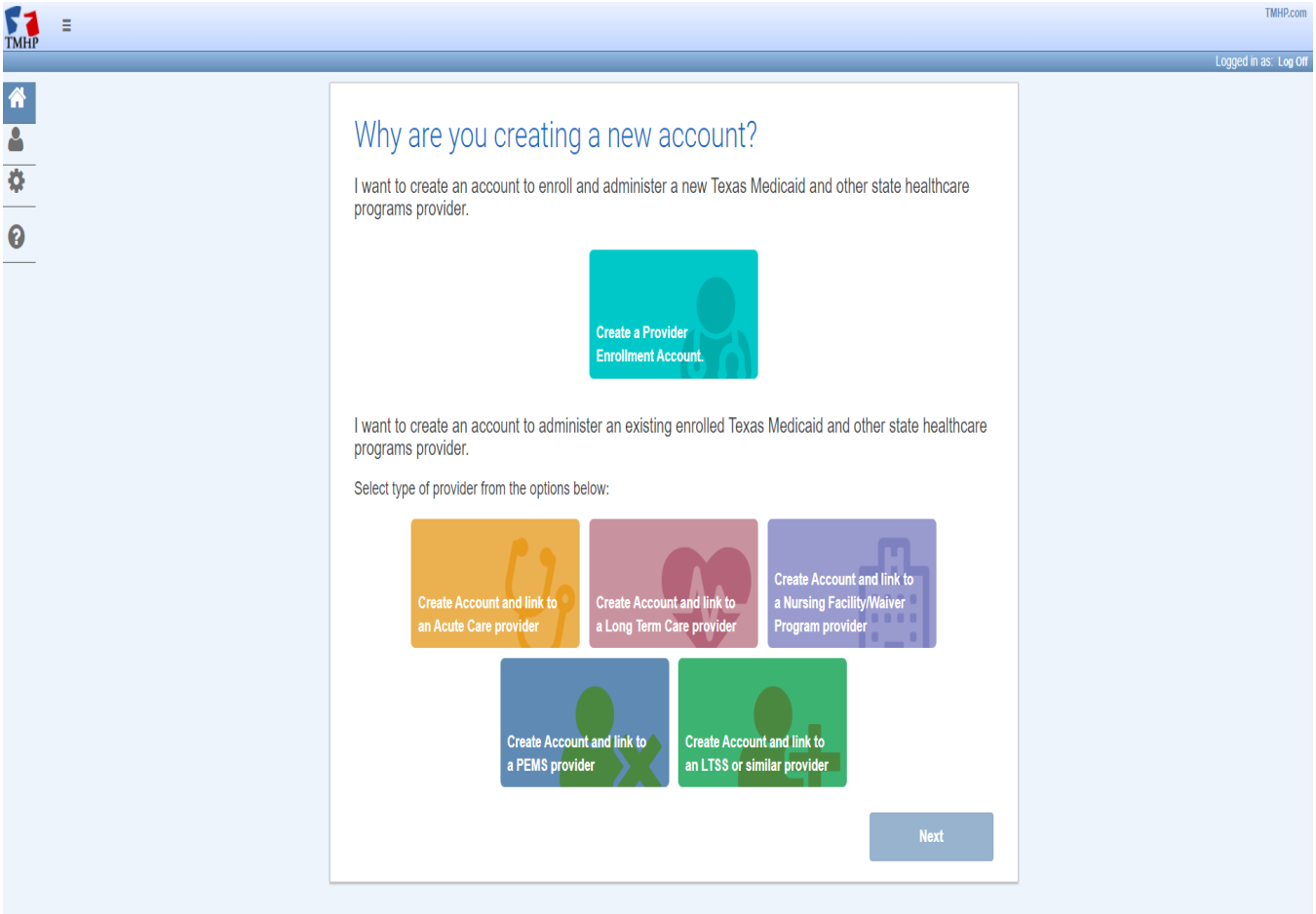


4) Click the **Activate My Account** button, then click the **Go** button.

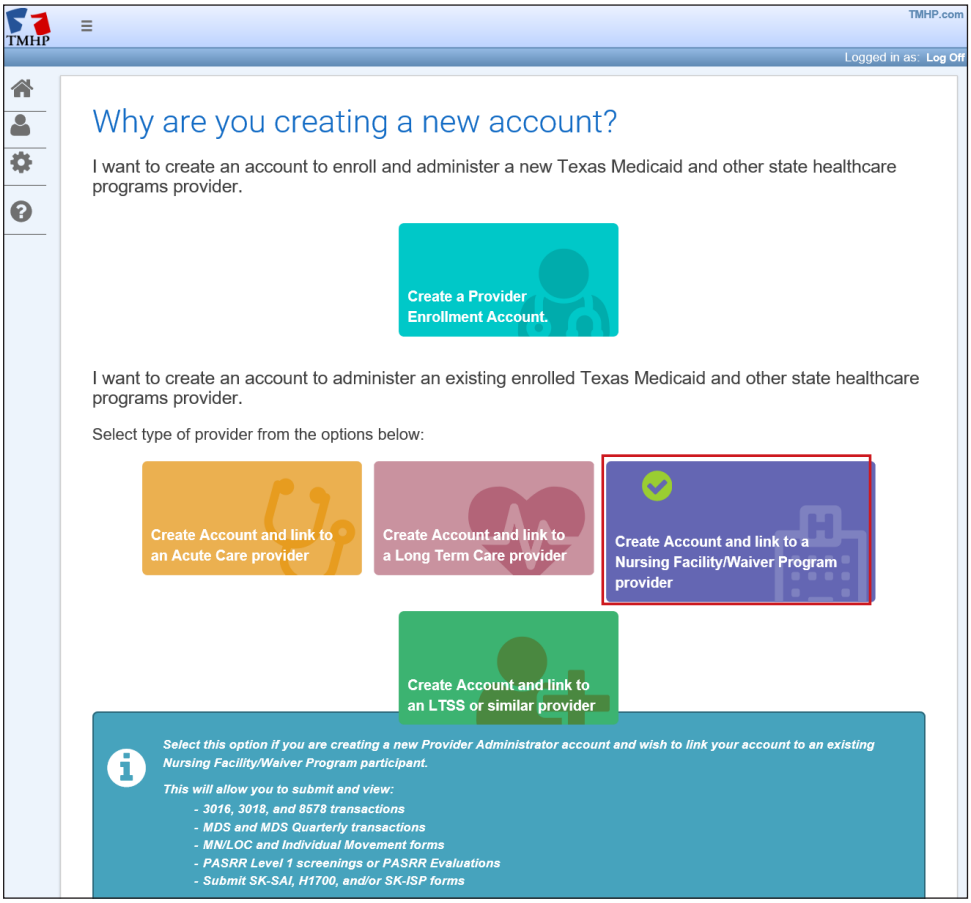


5) From here you have a few options:

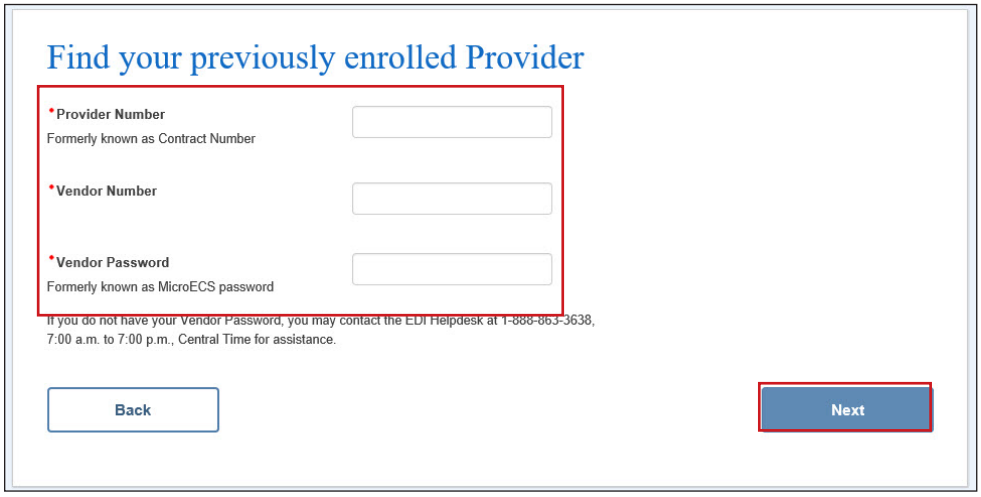
a) If you are not currently a Texas Medicaid provider, you will be prompted to enroll in Texas Medicaid. To enroll as a Texas Medicaid provider, visit the Doing Business with HHS section of the HHS.texas.gov website for more information.



b) To create a new TMHP User Account with an existing provider/vendor account, click the **Create a Provider Enrollment Account** box or click the **Create Account and link to a Nursing Facility/Waiver Program provider** box. This option will allow you to submit 3618s, 3619s, MDS, MDS Quarterly, MN/LOC, 8578s, Individual Movements, PASRR Level 1 Screenings, or PASRR Evaluations.



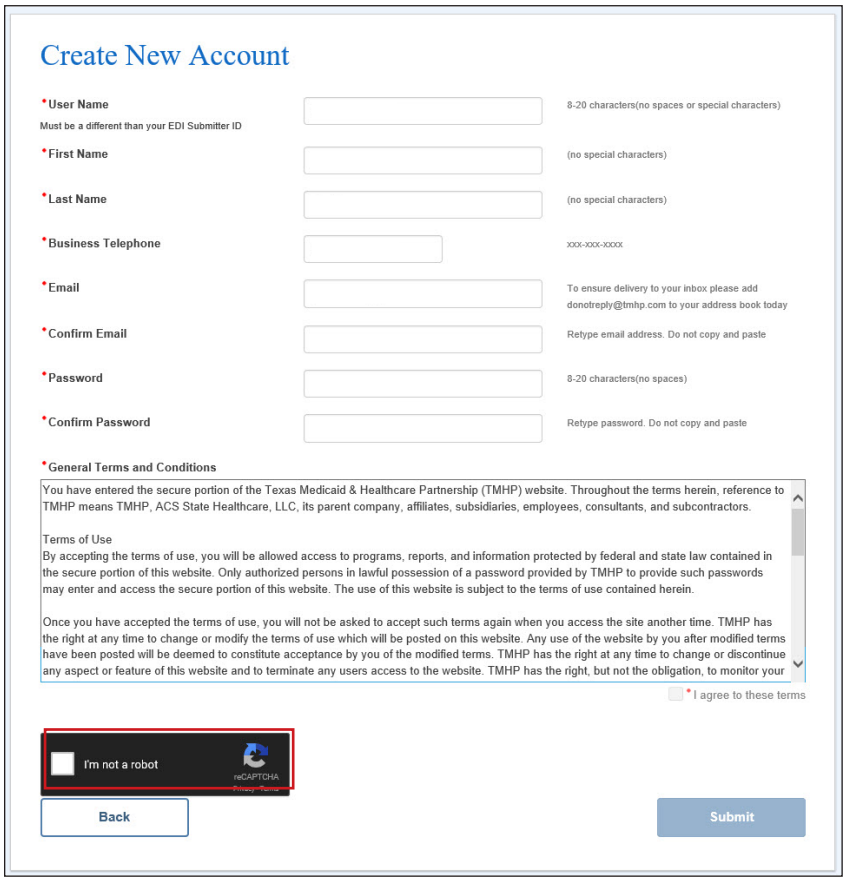
6) Enter your Provider Number, Vendor Number, and Vendor Password, then click the **Next** button.



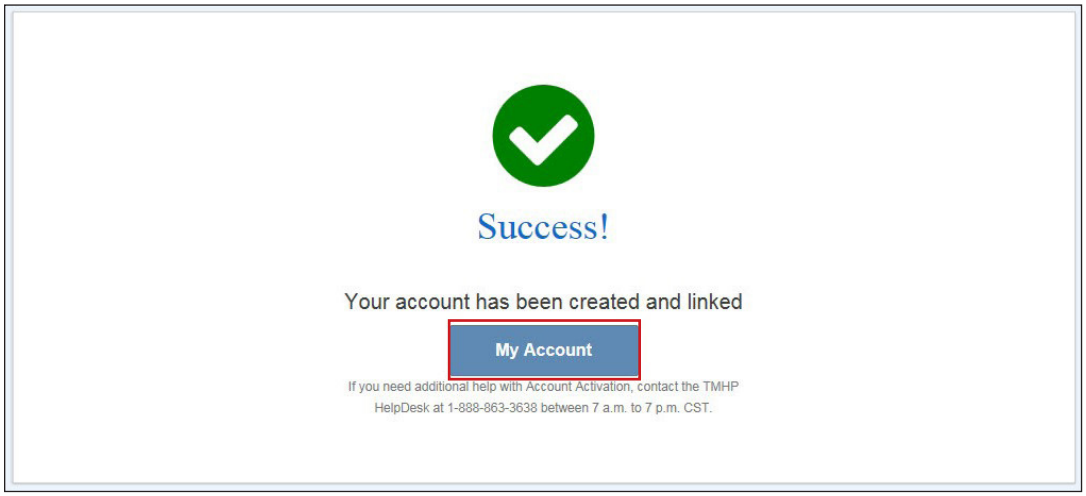
7) To create a new account, you will fill in all the required fields as indicated by the red dots.

8) Check the **I agree to these terms** box at the bottom of the screen under the General Terms and Conditions if you agree to the terms. You won't be able to agree to these terms until you have scrolled through all of the General Terms and Conditions.

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



10) Click the **Submit** button to create your account and link it to a nursing facility/waiver provider. Click the **My Account** button to be directed to your account.
Note: *The user name and password are used for future log ins to your account. Please make a note of it for your records.*

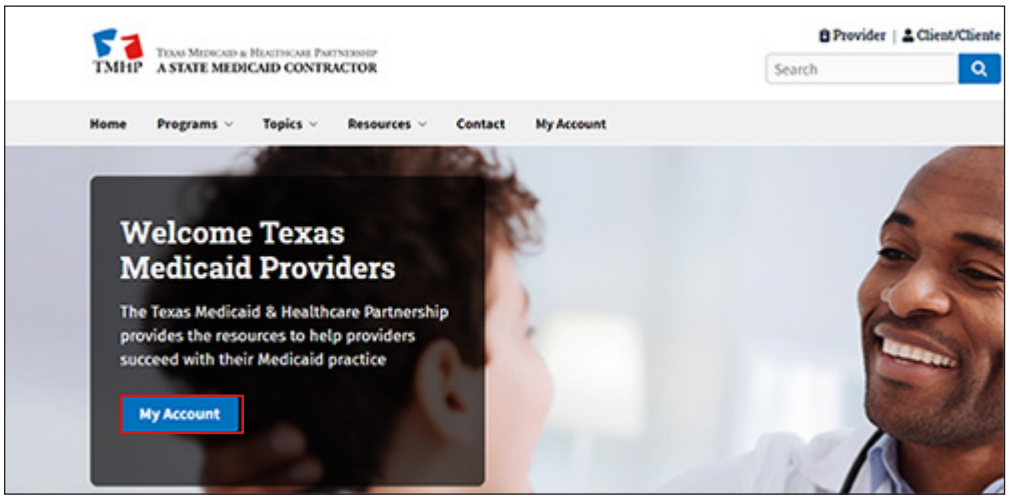


My Account

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

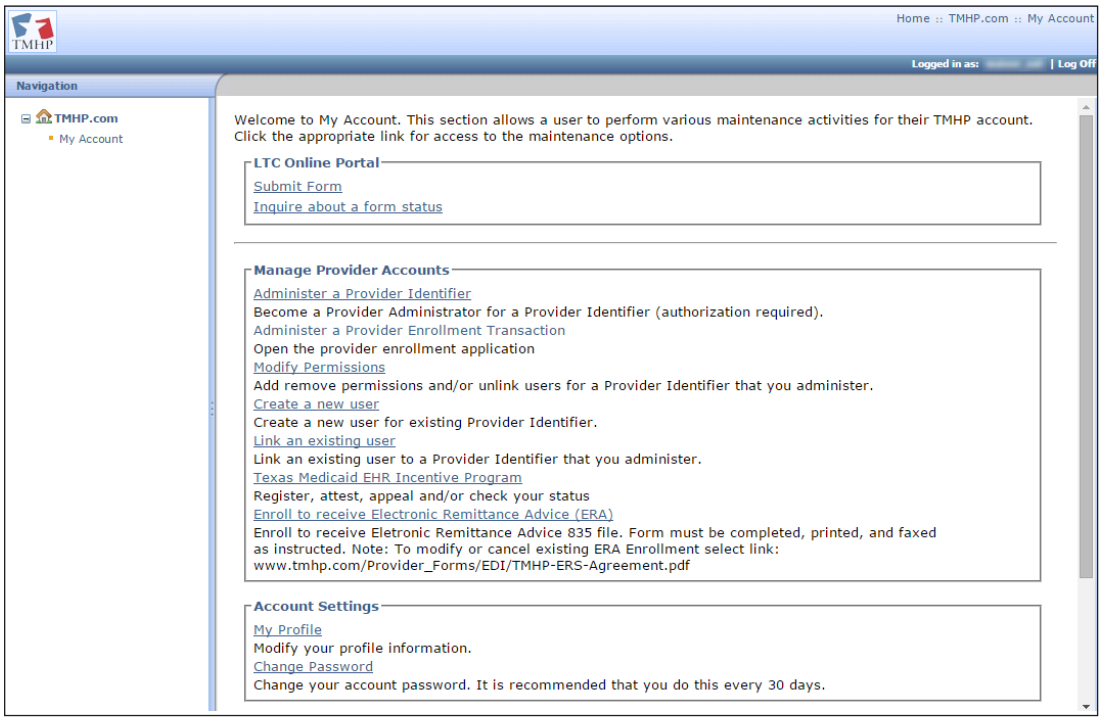
To access My Account:

1) Go to www.tmhp.com.
2) Click **My Account**.



Note: *You may be prompted to enter your LTC Online Portal user ID and password.*

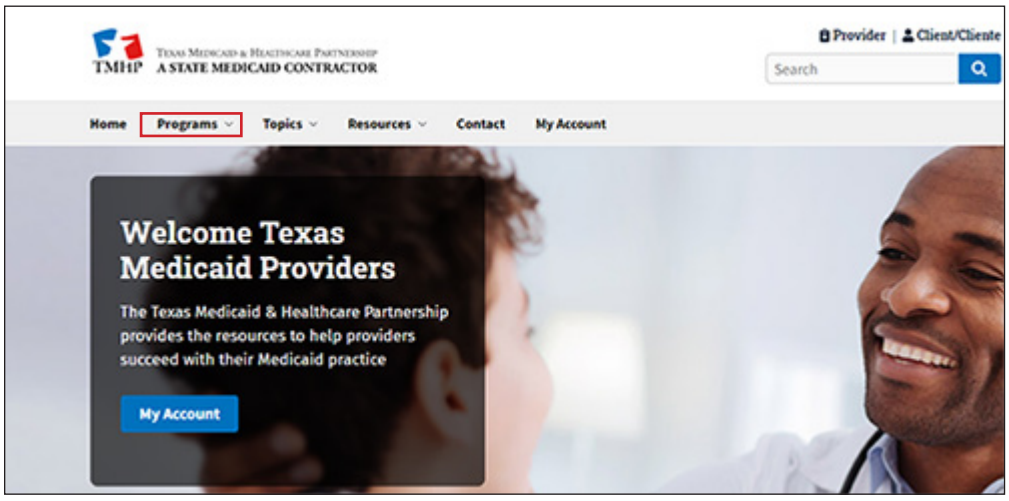
3) The **My Account** page will appear.



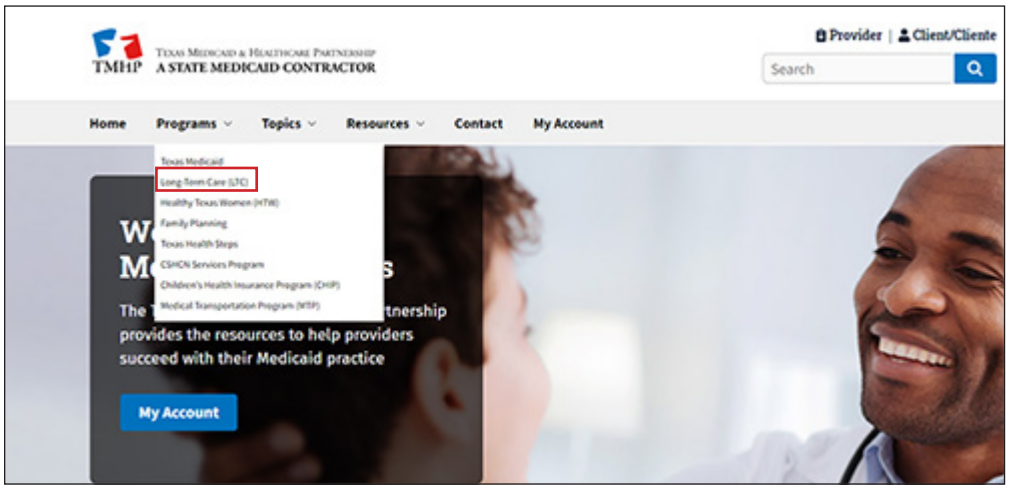
Login to the LTC Online Portal

1) Go to www.tmhp.com.

2) Click **Programs** located at the top of the screen.

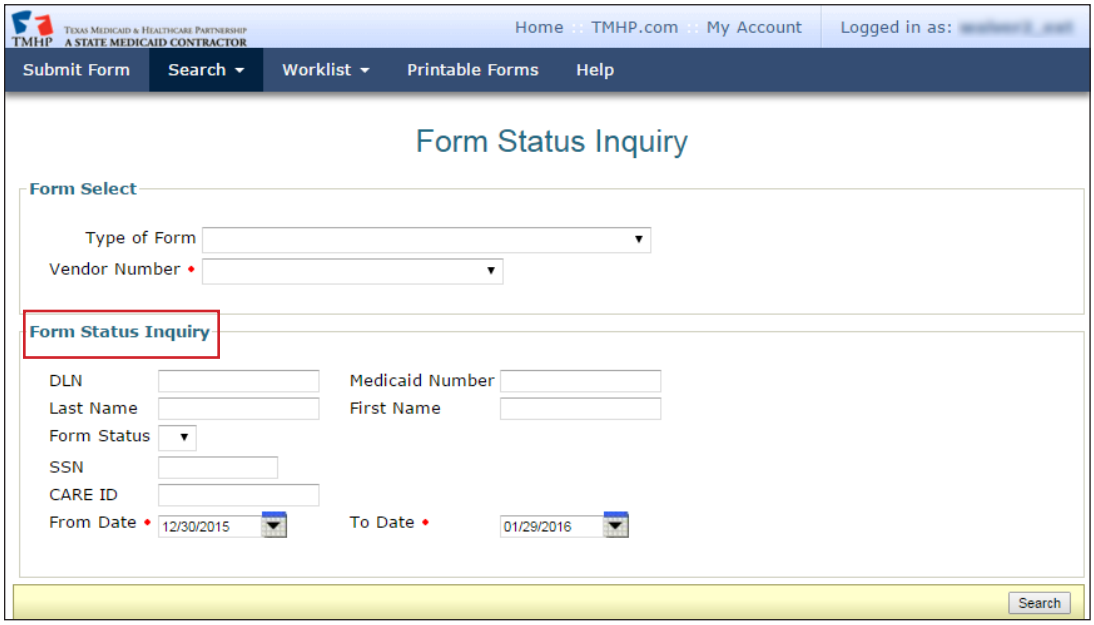


3) Click **Long-Term Care (LTC)** from the drop-down menu.



4) Click the **LTC Online Portal** button.

5) Enter your user name and password. Click the **OK** button. After login, Form Status Inquiry will display by default.

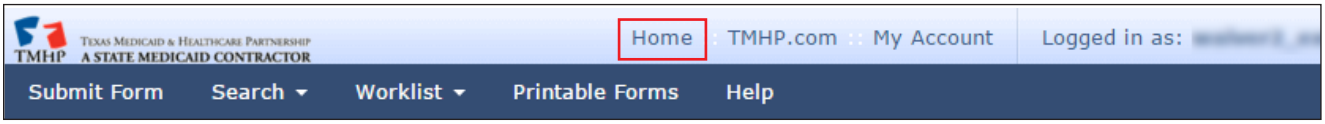


LTC Online Portal Basics

Blue Navigational Bar Links

All portal features based on your security level will be found in the blue navigational bar located at the top of the portal screen.

Options found in the blue navigational bar may include: **Home, Submit Form, Form Status Inquiry, Current Activity, Drafts, Printable Forms,** and **Help**.

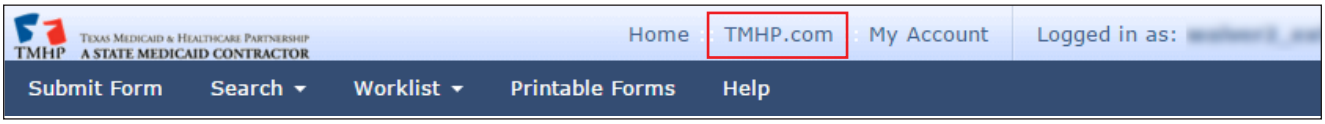


Home

When the blue navigational bar above is displayed, the **Home** link at the top will take you to the TMHP Long-Term Care program page.

TMHP.com

The **TMHP.com** link at the top of the blue navigational bar will take you to the www.tmhp.com home page.

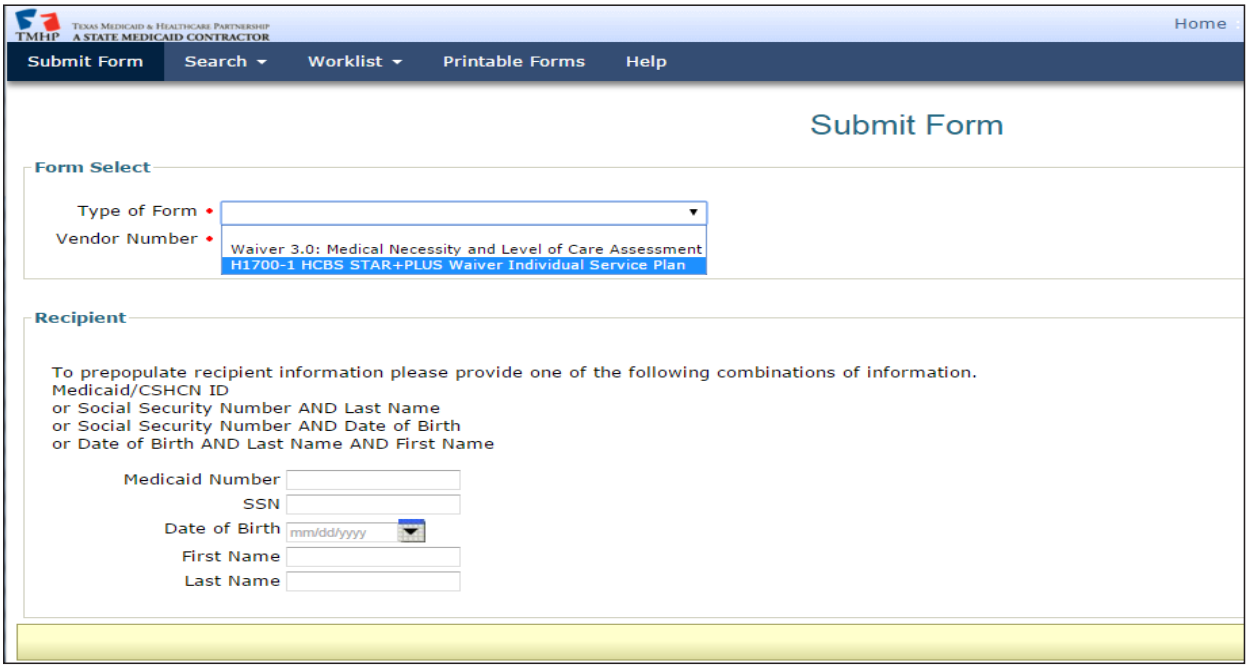


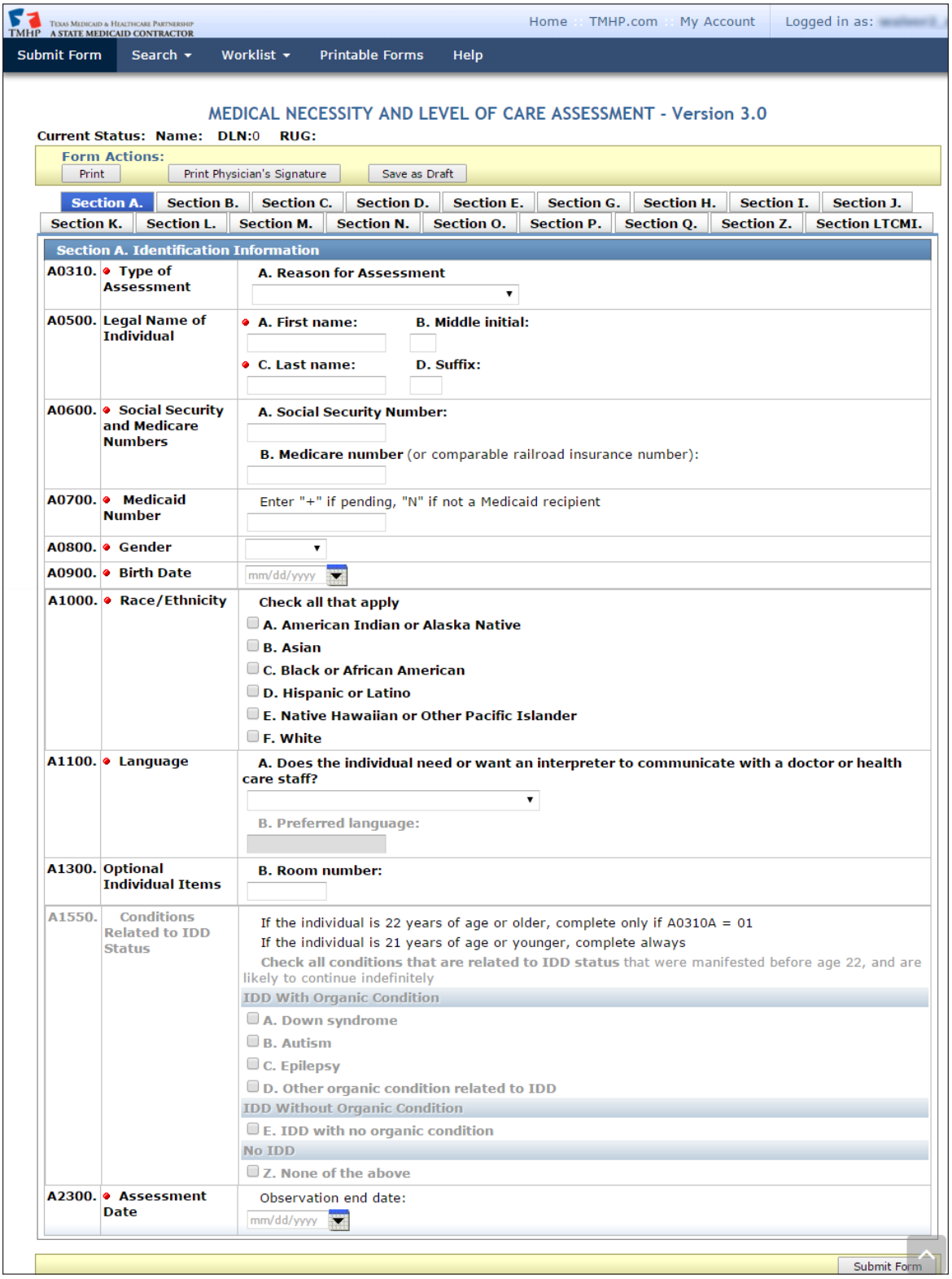
Using the TMHP home page providers may:

- Access the LTC Online Portal.
- Access TexMedConnect.
- Submit a prior authorization.
- Access provider manuals and guides.
- Access bulletins and banner messages.

Submit Form

The Submit Form feature allows providers to submit **Waiver 3.0: Medical Necessity and Level of Care Assessments** and **H1700-1 HCBS STAR+PLUS Waiver Individual Service Plan (ISP)** forms.





Note: *The steps to submit MN/LOC Assessments are covered in the Medical Necessity and Level of Care Assessment section.*

Note: *The steps to submit ISP forms are covered in the H1700/Individual Service Plan (ISP) Form section.*

Form Status Inquiry (FSI)

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

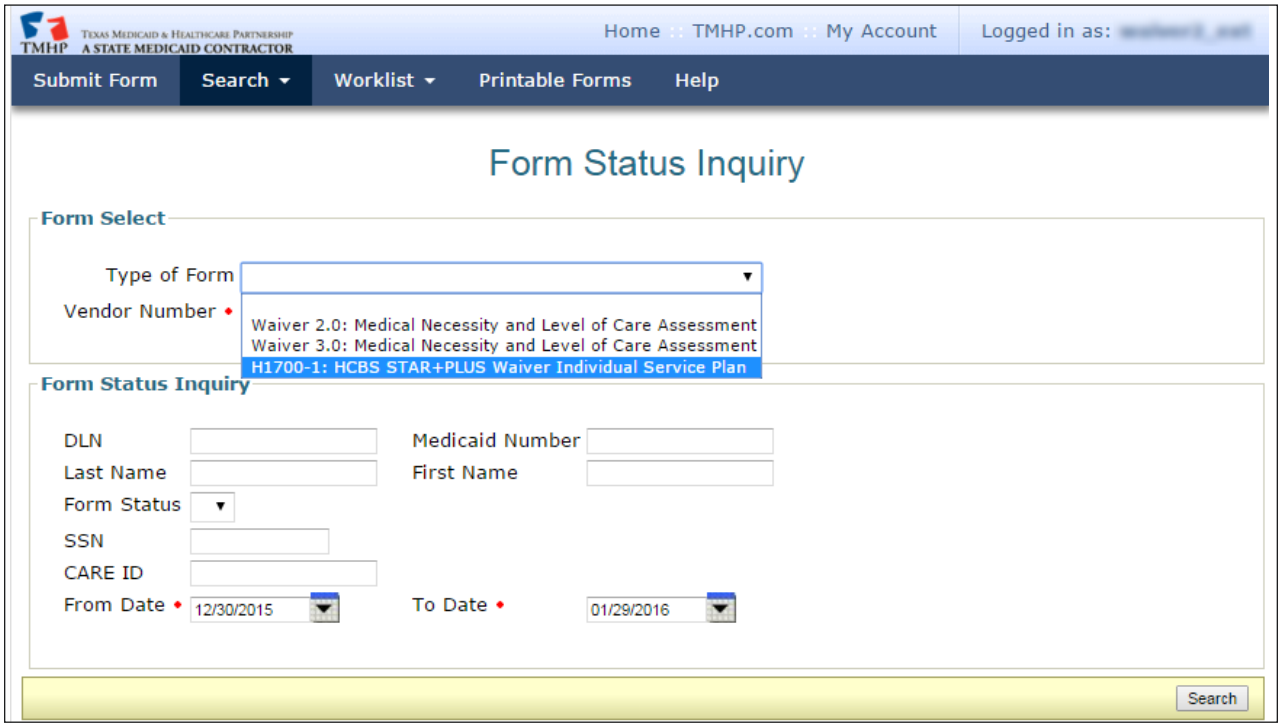
Providers may use FSI to search for either Type of Form: **Waiver 3.0: Medical Necessity and Level of Care Assessment** or **H1700-1 HCBS STAR+PLUS Waiver Individual Service Plan** forms.

FSI allows providers to retrieve assessments to:

- Access assessments to research and review statuses.
- Provide additional information to an assessment.
- Retrieve assessments to make corrections or perform inactivations.
- Resolve any assessments set to status Provider Action Required.

To locate and correct any forms set to status ***Provider Action Required***:

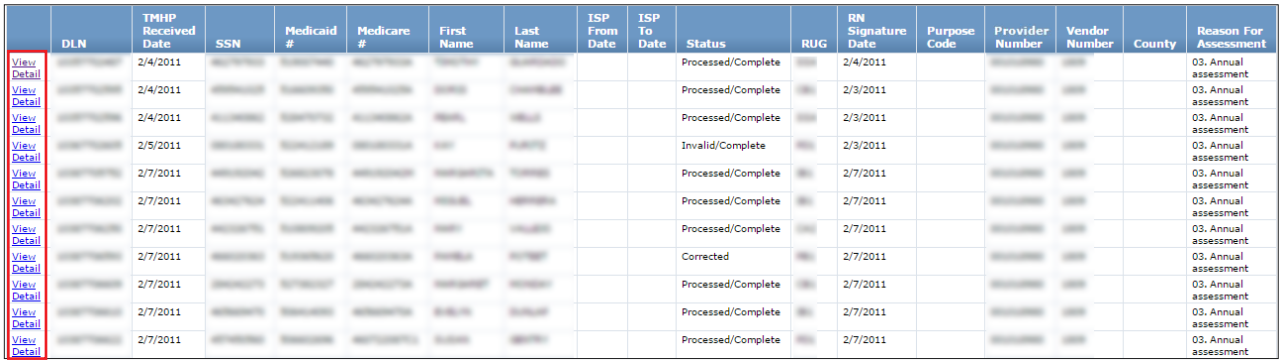
1) Click or hover over the **Search** link on the blue navigational bar.
2) Click on the **Form Status Inquiry** link from the drop-down box.



3) Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: Document Locator Number (DLN), Medicaid Number, Last Name, First Name, SSN, Form Status, From and To Dates, and Reason for Assessment. Dates are searched against the TMHP Received Date (date of successful submission).

4) Click the **Search** button, and the LTC Online Portal will return any matching submissions (records). **Note**: *FSI search results will only display the Type of Form selected.*

5) Click the **View Detail** link of the requested assessment to open and view the assessment.



	DLN	TMHP Received Date	SSN	Medicaid #	Medicare #	First Name	Last Name	ISP From Date	ISP To Date	Status	RUG	RN Signature Date	Purpose Code	Provider Number	Vendor Number	County	Reason For Assessment
View Detail		2/4/2011								Processed/Complete		2/4/2011					03. Annual assessment
View Detail		2/4/2011								Processed/Complete		2/3/2011					03. Annual assessment
View Detail		2/4/2011								Processed/Complete		2/3/2011					03. Annual assessment
View Detail		2/5/2011								Invalid/Complete		2/3/2011					03. Annual assessment
View Detail		2/7/2011								Processed/Complete		2/7/2011					03. Annual assessment
View Detail		2/7/2011								Processed/Complete		2/7/2011					03. Annual assessment
View Detail		2/7/2011								Processed/Complete		2/7/2011					03. Annual assessment
View Detail		2/7/2011								Corrected		2/7/2011					03. Annual assessment
View Detail		2/7/2011								Processed/Complete		2/7/2011					03. Annual assessment
View Detail		2/7/2011								Processed/Complete		2/7/2011					03. Annual assessment
View Detail		2/7/2011								Processed/Complete		2/7/2011					03. Annual assessment

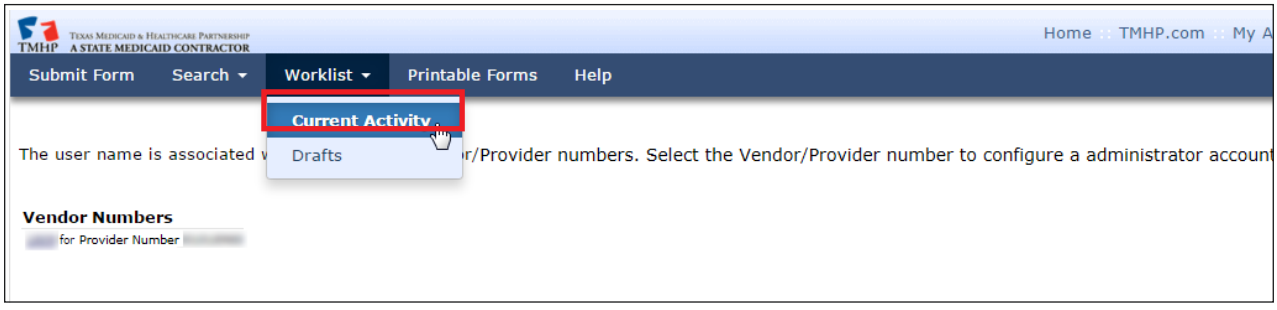
FSI can retrieve information from the previous seven years. The search is based on the TMHP Received Date. There is a 50-record line limit for search results; therefore, you may need to narrow your search to retrieve specific records. Descriptions of the column headings seen above are:

- **View Detail:** This is the hyperlink used to open the assessment.
- **DLN:** This is the unique document locator number (DLN) assigned to each successfully submitted assessment.
- **TMHP Received Date:** This is the actual date the assessment was successfully submitted on the LTC Online Portal.
- **SSN:** (2.0: AA5a, 3.0: A0600A). This is the Social Security Number (SSN) is used to identify the person associated with the assessment.
- **Medicaid #:** (2.0: AA7, 3.0: A0700). This information is used to identify the person associated with the assessment.
- **Medicare #:** (2.0: AA5b, 3.0: A0600B). This information is used to identify the person associated with the assessment.
- **First Name and Last Name:** (2.0: AA1a and AA1c, 3.0: A0500A and A0500C). This information is used to identify the person associated with the assessment.
- **ISP From/To Date:** These dates define for how long an ISP is valid.
- **Status:** This is the status of the assessment at the time of the search.
- **RUG:** This is the assigned Resource Utilization Group (RUG) value.
- **RN Signature Date:** This is the date the assessment was completed as identified in field R2b for 2.0 Assessments and field Z0500B for 3.0 Assessments.
- **Provider Number:** This the nine-digit number formerly known as the contract number.
- **Vendor Number:** This the four-digit site identification number.
- **County:** This is county on file for an ISP form.

Current Activity

The Current Activity feature allows providers to view assessment submissions or status changes that have occurred within the last 14 calendar days. After 14 days, providers must utilize the FSI query tool to locate an assessment.

1) Click or hover over the **Worklist** link on the blue navigational bar.
2) Click the **Current Activity** link in the drop-down box.
3) Click the appropriate vendor number (if applicable).



4) The results display a summary of all assessment submissions or status changes within the last 14 calendar days.
Note: *Unlike FSI search results, there is not a 50-record line limit for Current Activity search results.*

Current Activity

Waiver 3.0	Received	Medicaid	SSN	Medicare	Name	Status
[redacted]	3/2/2016 10:27:11 AM	[redacted]	[redacted]	[redacted]	[redacted]	Processed/Complete
[redacted]	3/4/2016 12:46:44 PM	[redacted]	[redacted]	[redacted]	[redacted]	Processed/Complete
[redacted]	3/9/2016 1:58:42 PM	[redacted]	[redacted]		[redacted]	Processed/Complete
[redacted]	3/4/2016 2:44:49 PM	[redacted]	[redacted]	[redacted]	[redacted]	Processed/Complete
[redacted]	2/12/2016 10:12:29 AM	[redacted]	[redacted]	[redacted]	[redacted]	Processed/Complete
[redacted]	3/11/2016 7:47:43 AM	[redacted]	[redacted]		[redacted]	Pending Review
[redacted]	3/11/2016 12:57:04 PM	[redacted]	[redacted]	[redacted]	[redacted]	Pending Review
[redacted]	3/15/2016 8:46:40 AM	[redacted]	[redacted]	[redacted]	[redacted]	Pending Review
[redacted]	3/12/2016 12:53:14 PM	[redacted]	[redacted]		[redacted]	Pending Review

H1700-1	Received	Medicaid	SSN	Name	ISP From Date	ISP To Date	Status	County	Current SAS Response Code
[redacted]	3/8/2016 4:12:45 PM	[redacted]	[redacted]	[redacted]	5/1/2016 12:00:00 AM	4/30/2017 12:00:00 AM	Processed/Complete	Hidalgo	SP-0000
[redacted]	3/5/2016 5:16:13 PM	[redacted]	[redacted]	[redacted]	4/1/2016 12:00:00 AM	3/31/2017 12:00:00 AM	Processed/Complete	Cameron	SP-0000
[redacted]	3/7/2016 4:53:28 PM	[redacted]	[redacted]	[redacted]	5/1/2016 12:00:00 AM	4/30/2017 12:00:00 AM	Processed/Complete	Hidalgo	SP-0000
[redacted]	3/11/2016 8:40:26 AM	[redacted]	[redacted]	[redacted]	5/1/2016 12:00:00 AM	4/30/2017 12:00:00 AM	Processed/Complete	Cameron	SP-0000
[redacted]	3/10/2016 5:09:19 PM	[redacted]	[redacted]	[redacted]	6/1/2016 12:00:00 AM	5/31/2017 12:00:00 AM	Processed/Complete	Webb	SP-0000
[redacted]	3/11/2016 2:20:52 PM	[redacted]	[redacted]	[redacted]	4/1/2016 12:00:00 AM	3/31/2017 12:00:00 AM	Pending Notification	Willacy	SP-0000
[redacted]	3/10/2016 9:51:34 AM	[redacted]	[redacted]	[redacted]	6/1/2016 12:00:00 AM	5/31/2017 12:00:00 AM	Processed/Complete	Maverick	SP-0000
[redacted]	3/9/2016 3:12:58 PM	[redacted]	[redacted]	[redacted]	6/1/2016 12:00:00 AM	5/31/2017 12:00:00 AM	Processed/Complete	Hidalgo	SP-0000

The following are descriptions of the column headings seen above:

- **Waiver 3.0:** This the unique DLN assigned to each successfully submitted assessment.
- **H1700-1:** This the unique DLN assigned to each submitted ISP form.
- **Received:** This is the actual date the assessment was successfully submitted to TMHP on the LTC Online Portal.
- **SSN (A0600A):** This information is used to identify the person associated with the assessment.
- **Medicaid #:** (A0700): This information is used to identify the person associated with the assessment.
- **Medicare #:** (A0600B): This information is used to identify the person associated with the assessment.
- **Name:** (A0500A and A0500C): This information is used to identify the person associated with the assessment.
- **Status:** This is the status of the assessment.
- **County:** This is the county on file for an ISP form.
- **Current Service Authorization System (SAS) Response Code:** This column lists the most recent SAS response code for each ISP form.

5) Click the **DLN** link to display the details of the requested assessment.

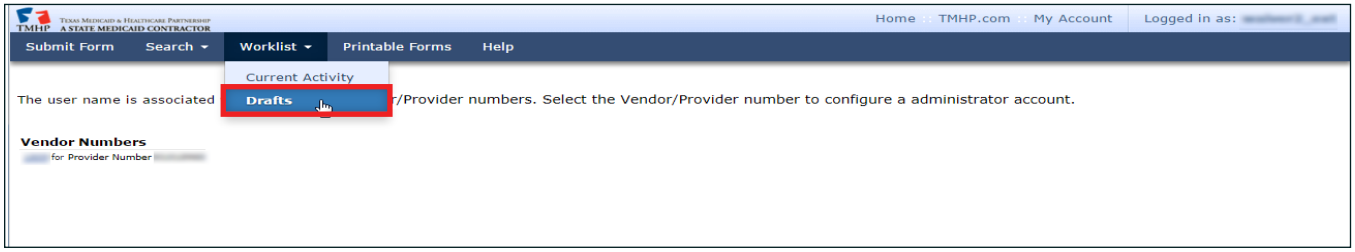
Providers are able to sort the Current Activity results in a variety of ways. By clicking on the heading of a column, the provider can choose to sort results by DLN, Received Date, SSN, Medicaid Number, Medicare Number, Name, or Status. When the provider clicks on a column heading the first time, it is sorted in ascending order. By clicking on the column heading a second time, the sort will change to descending order.

Drafts

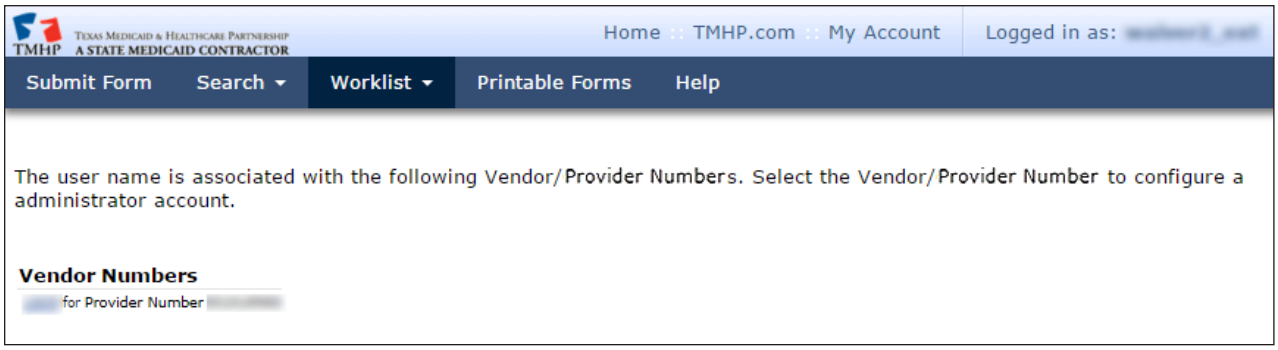
The Drafts feature allows access to all drafts saved under the vendor/provider number to which the user is linked.

To access a saved draft:

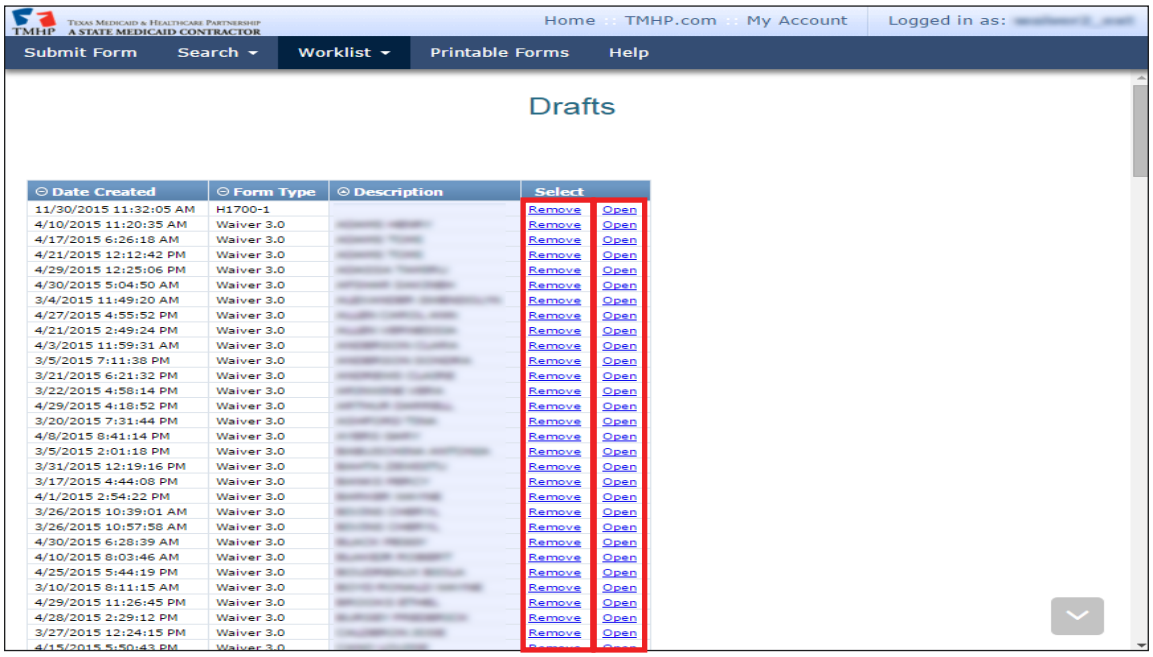
1) Click or hover over the **Worklist** link on the blue navigational bar.
2) Click the **Drafts** link in the drop-down box.



3) Click the appropriate vendor number hyperlink under Vendor Numbers. A list of drafts saved for the selected vendor/provider number will display.
4) Drafts can be sorted by date and time, form type, or by the person's last name by clicking on the appropriate column header(s).



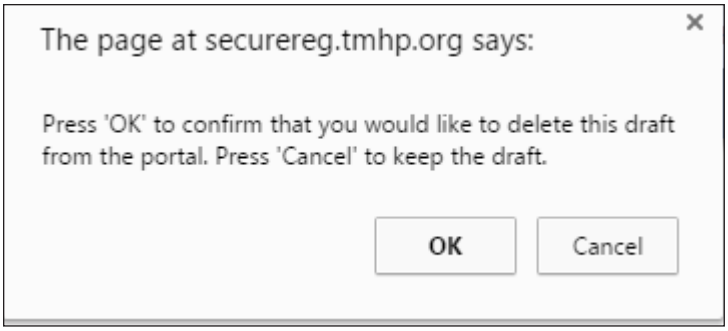
5) From here you have two choices:



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

or

b) Click the **Remove** link to permanently delete the draft. The following confirmation prompt message appears:



- Click the **OK** button to delete the draft.

  or

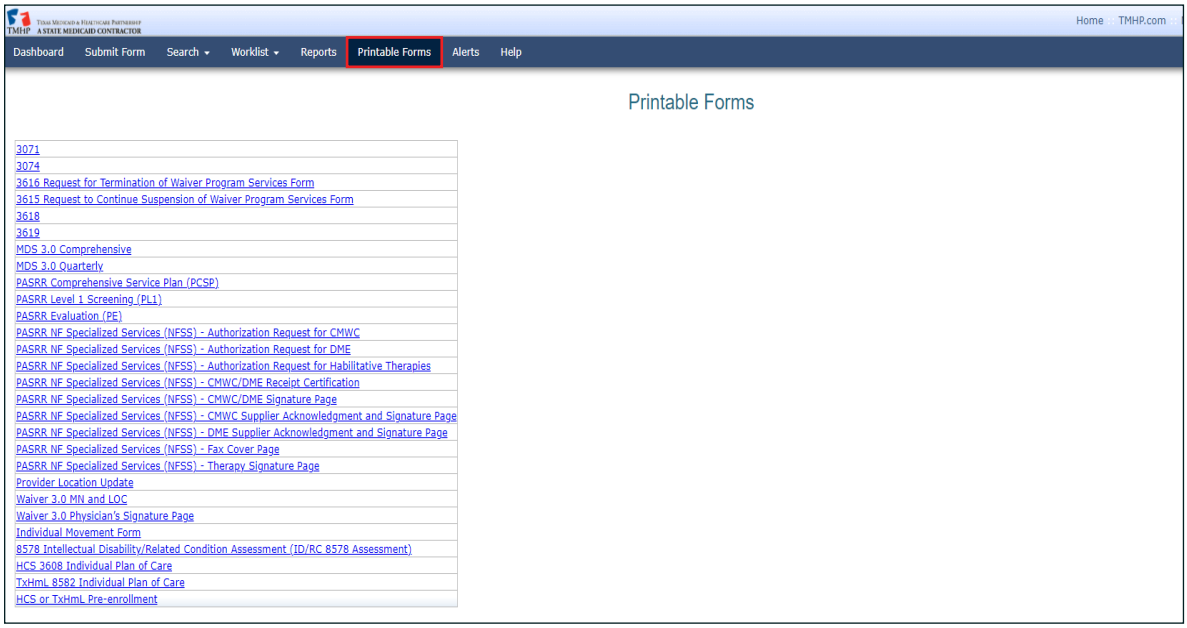
- Click the **Cancel** button to keep the draft.

Note: *Once a draft has been deleted, it cannot be retrieved. Saved drafts opened after the effective date of MN/LOC changes will require the assessor to complete any new required fields prior to submission.*

Printable Forms

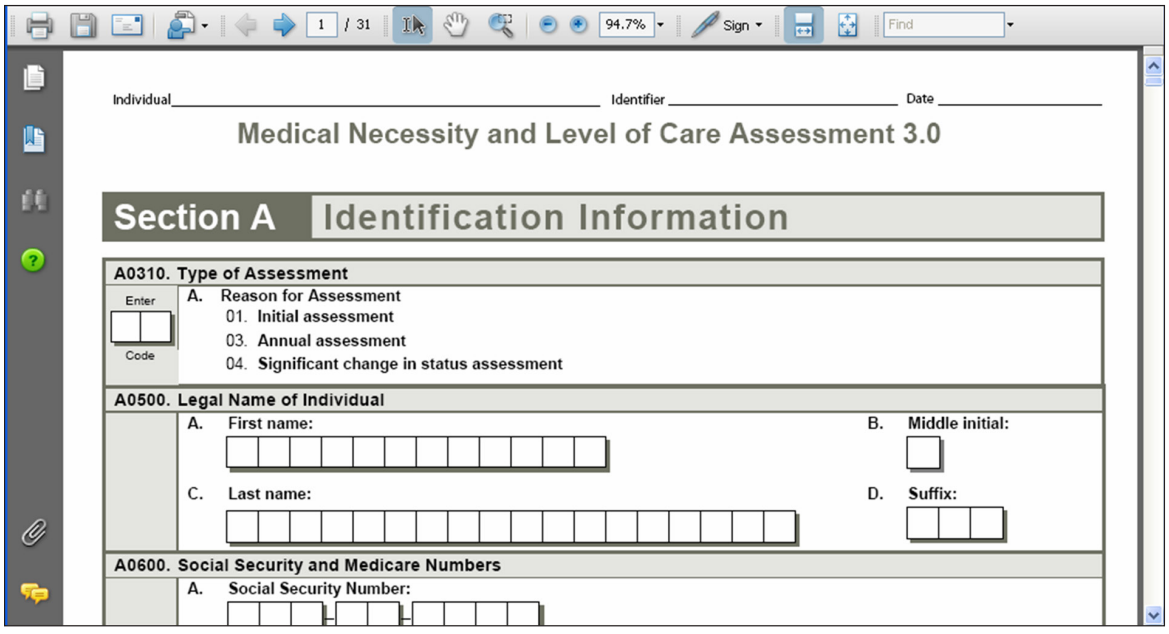
The Printable Forms feature allows the provider to view blank assessments and forms, print blank assessments or forms, print or interactively complete assessments by saving to the provider's desktop.

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



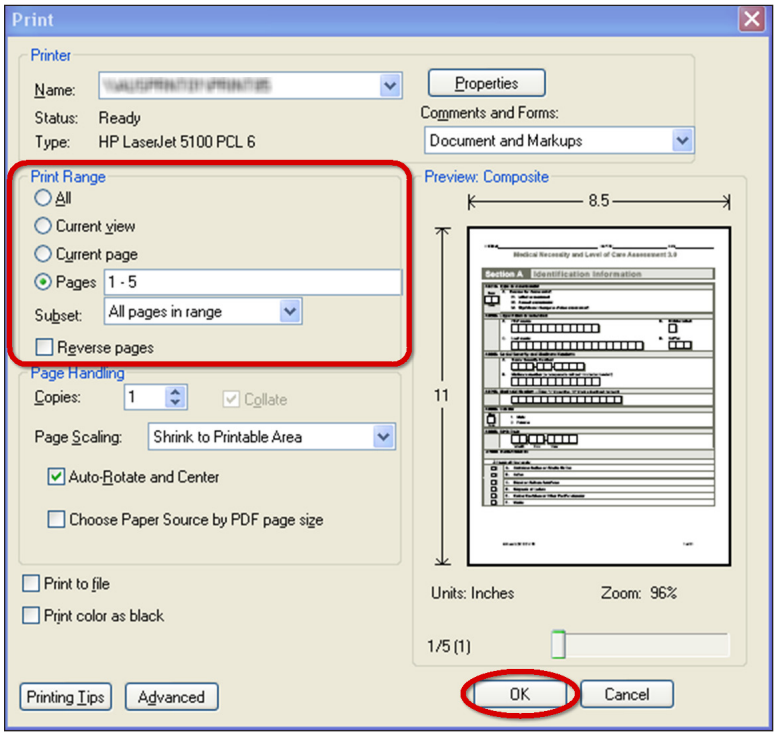
Choose an assessment or form by clicking the corresponding link. Adobe Reader® will open in a new window and will display the blank assessment in Portable Document Format (PDF).

Note: To type information into an assessment, click on the appropriate link. Once open, save the document to your desktop and begin entering information.



2) Click the **Print** Icon.

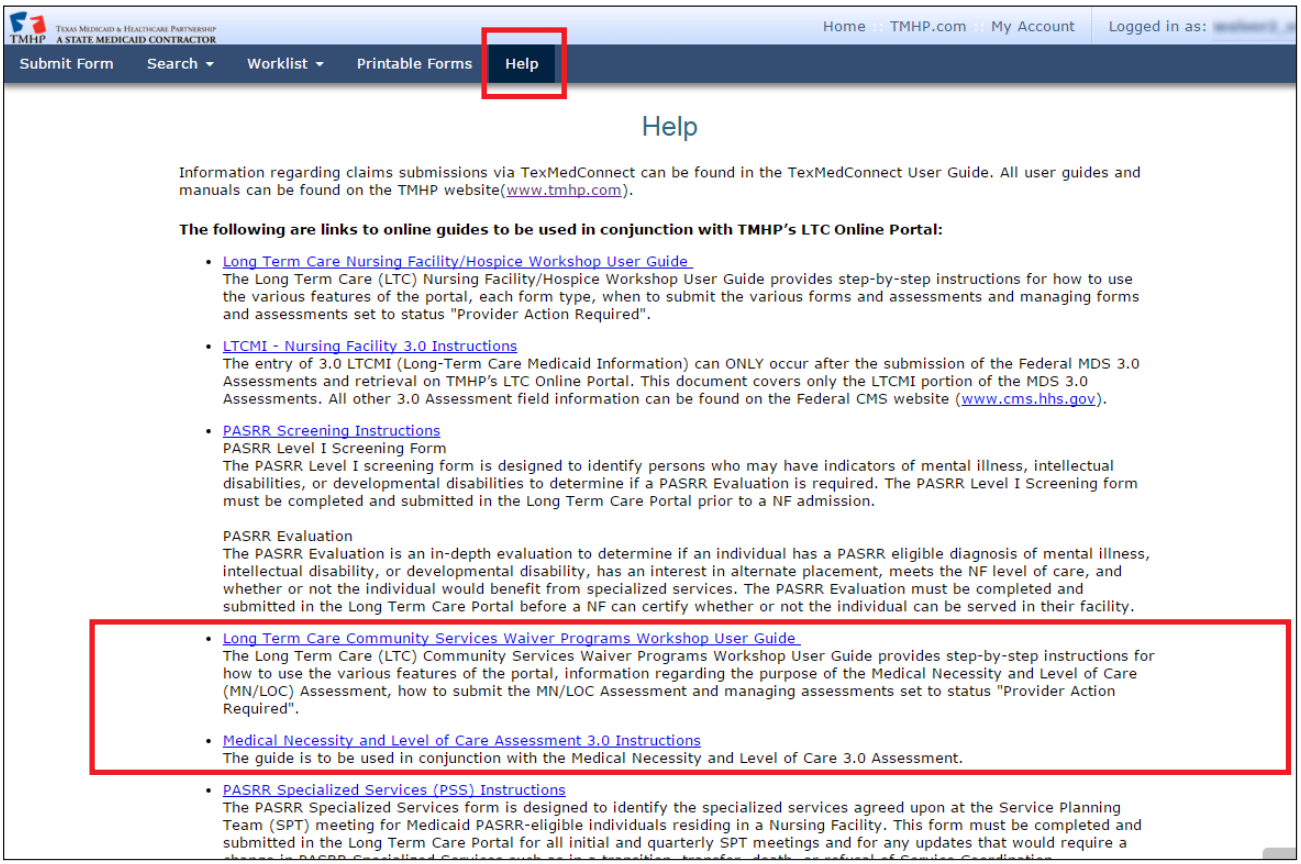
- To print the entire document:
  1. Printer: Choose the appropriate printer name from drop-down box.
  2. Print Range: Click the **All** radio button.
  3. Click the **OK** button.
- To print certain pages, instead of the entire document:
  1. Printer: Choose the appropriate printer name from drop-down box.
  2. Print Range: Click the **Pages** radio button.
  3. Enter the pages to print. (Example: 1-5 will print all pages 1 through 5; 1, 3, 7 will print only pages 1, 3, and 7.) This is useful for printing only the LTCMI, instead of the entire MN/LOC Assessment.
  4. Click the **OK** button.



Help

The Help feature at the far right on the blue navigational bar will display a Help page consisting of links to online guides that will assist with questions you may have about the LTC Online Portal. The **Medical Necessity and Level of Care Assessment 3.0 Instructions** link provides section-by-section instructions to guide registered nurses (RNs) in completing the MN/LOC Assessment.

Note: *Providers can access an electronic version of the LTC User Guide by clicking the Long-Term Care Community Services Waiver Programs User Guide link within the Help page.*



Yellow Form Actions Bar

Options found in the yellow Form Actions bar may include: **Print, Print Physician's Signature, Use as template, Correct this form, Add Note,** or **Inactivate Form**. Options will vary depending on your security level as well as the document status. The yellow Form Actions bar is available when a single document is being viewed in detail.

Print

The Print feature allows the provider to print completed MN/LOC Assessments. Click the **Print** button to print completed assessments.

Note: *To only print specific sections of the assessment, click the* **Pages** *radio button and enter the page range for the desired pages only. When printing the MN/LOC 3.0 Assessment, the person's name will appear on the top left corner of each page. The name will be auto populated based on the information entered in field A0500.*

Print Physician's Signature on Certification Statement

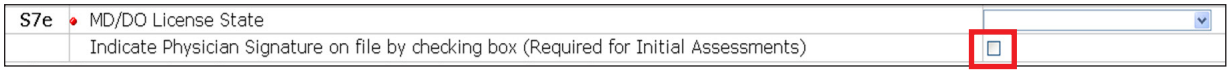
The Print Physician's Signature feature allows a provider to generate and print a Physician's Signature page at any time. Initial Assessments require a physician's signature on the certification statement. The certification statement is found on the Physician's Signature page. A physician's signature is optional on Annual Assessments and Significant Change in Status Assessments (SCSA).

To print the Physician's Signature page (required for an Initial Assessment):

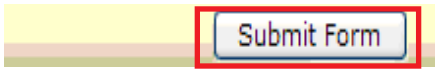
1) Complete all designated fields of the assessment on the LTC Online Portal.
2) Before submitting the assessment, click the **Print Physician's Signature** button located in the yellow Form Actions bar. The diagnoses listed on the printed Physician's Signature page are pulled from the information entered in Section I and the Primary Diagnosis listed in field S3a of the Section LTCMI of the MN/LOC Assessment.

3) Click the **Save as Draft** button to save the assessment until the physician's signature is obtained.

4) Once the physician's signature is obtained, retrieve the assessment from Drafts.
5) Check the box labeled **Physician's Signature on File** found in the LTCMI section under S7e to indicate that the physician's signature is on file.

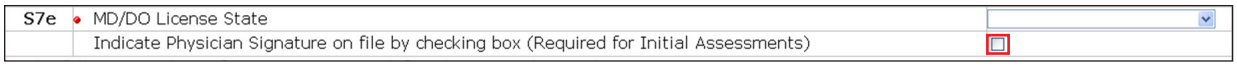


6) Click the **Submit Form** button to submit the Assessment.



Physician's Signature page for Annual Assessments and Significant Change in Status Assessments (optional):

1) Once the physician's signature is obtained on the Initial Assessment, check the **Physician's Signature box** on the Annual Assessments and Significant Change in Status Assessments.



2) Click the **Submit Form** button to submit the assessment.

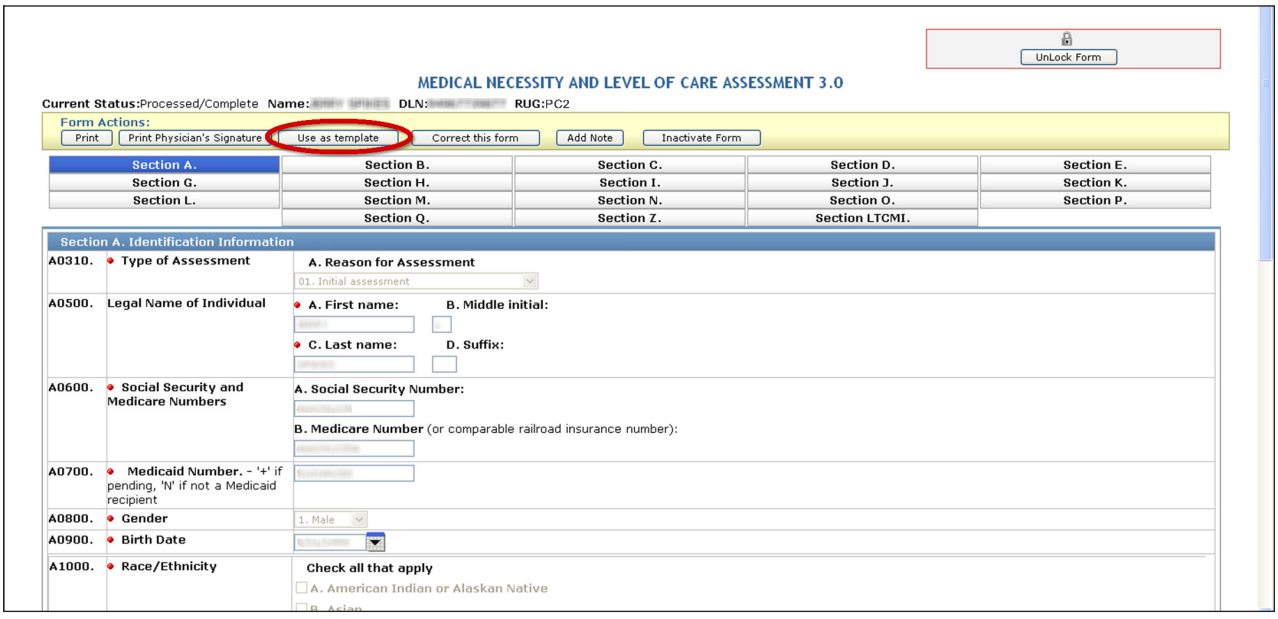
Use as template

The Use as template feature allows a provider to complete a new assessment by using the information in a previously submitted assessment as a template. Various fields will auto populate; be sure to check entire document for accuracy and update with current information. For example, be sure to update Section I Active Diagnoses to include any new diagnoses active in the last seven days, update Section J1550 to include or remove any Problem Conditions, and in Section J0100 Pain Management, if J0100B is marked "yes", ensure a PRN pain medication is listed in S9 Medications.

Be careful not to confuse this feature with a similarly-named feature in TexMedConnect.

Once you have found and are displaying the assessment using FSI or Current Activity:

Click the **Use as template** button; the data in this assessment will be used to create a new assessment.



Note: *Modify assessment data to reflect the person's current status. Also, adjust the Reason for Assessment if necessary (e.g., if you chose to use an Initial Assessment as a template for the Annual Assessment, don't forget to change the Reason for Assessment from Initial to Annual).*

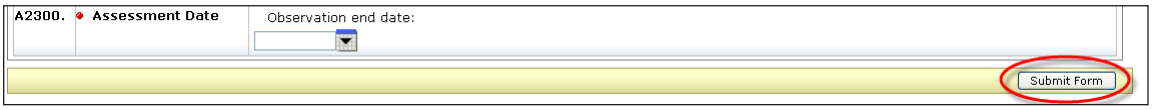
Enter data into remaining required fields that are not auto populated.

Note: *Fields not auto populated in the 3.0 Assessment are: Assessment Date (A2300), Date Assessment was Completed (Z0500B), and Medication Certification Checkbox (S9).*

1) Click the **Print** button located in the yellow Form Actions bar to print the assessment in progress, if you want a hard copy for your records.

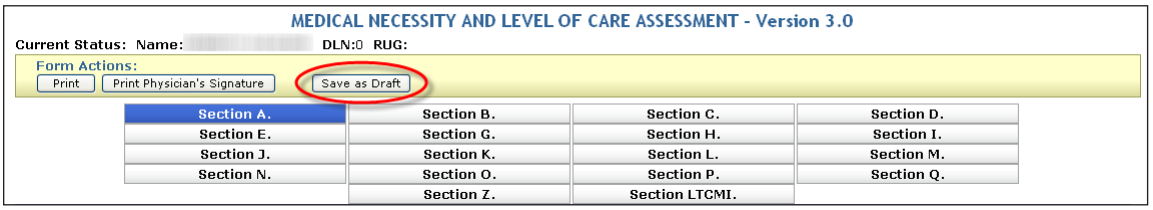
   From here you have two choices:

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



   or

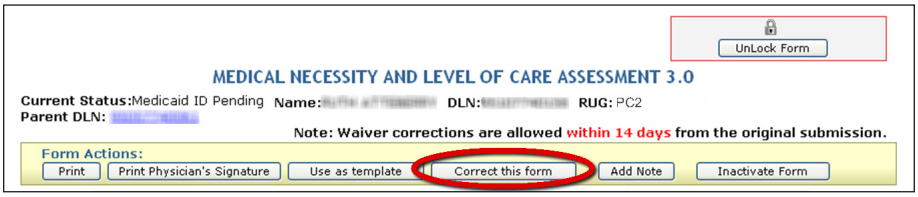
   b) Click the **Save as Draft** button located in the yellow Form Actions bar to save an assessment as a draft until you are ready to submit.



Correct this form

The Correct this form feature allows providers to perform corrections to the MN/LOC Assessment within 14 calendar days of the original submission (i.e., TMHP received date). However, corrections are not allowed if an assessment is set to status: ***Form Inactivated***, ***Invalid/Complete***, ***SAS Request Pending***, or ***Corrected***.

Note: *A parent assessment is the original assessment that is being corrected and will be set to status* **Corrected**. *The child assessment is the new assessment that will be processed through the LTC Online Portal.*



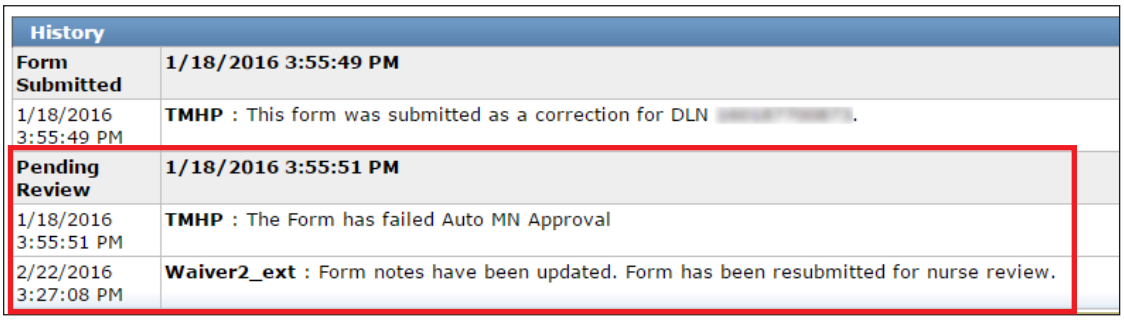
Note: *The steps to correct an assessment are covered in the Corrections section.*

Add Note

The Add Note feature located in the yellow Form Actions bar is always available unless the assessment is locked by another user. It 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 (i.e., not added to Comments in the LTCMI section of the assessment).

If the status is set to ***Pending Denial (need more information)*** and a note is added, the assessment will be set to status ***Pending Review***. The additional information entered will then be reviewed by a TMHP nurse.

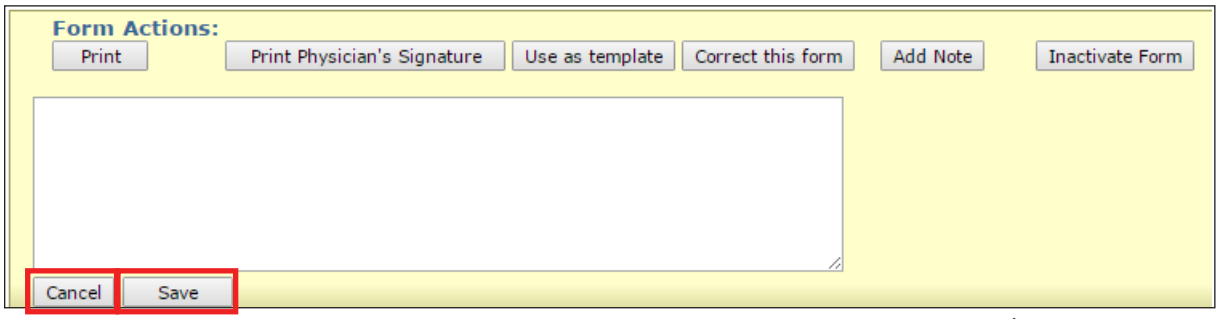


History	
Form Submitted	**1/18/2016 3:55:49 PM**
1/18/2016 3:55:49 PM	**TMHP** : This form was submitted as a correction for DLN [redacted].
Pending Review	**1/18/2016 3:55:51 PM**
1/18/2016 3:55:51 PM	**TMHP** : The Form has failed Auto MN Approval
2/22/2016 3:27:08 PM	**Waiver2_ext** : Form notes have been updated. Form has been resubmitted for nurse review.

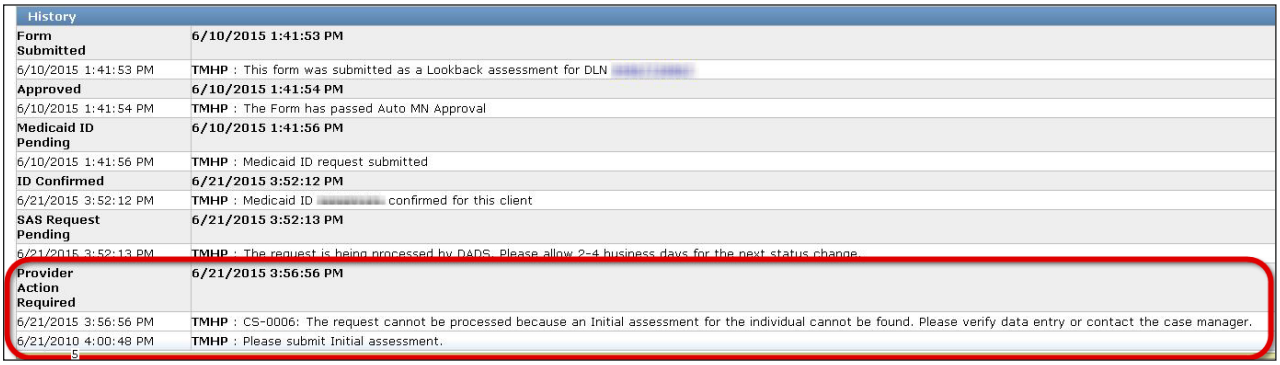
To add a note to a submitted assessment:

1) Locate the assessment using FSI or Current Activity.
   Click the **Add Note** button to open a text box.

2) Enter additional information (up to 500 characters). Click the **Save** button to save your note or the **Cancel** button to erase your note. Both buttons are under the text box.



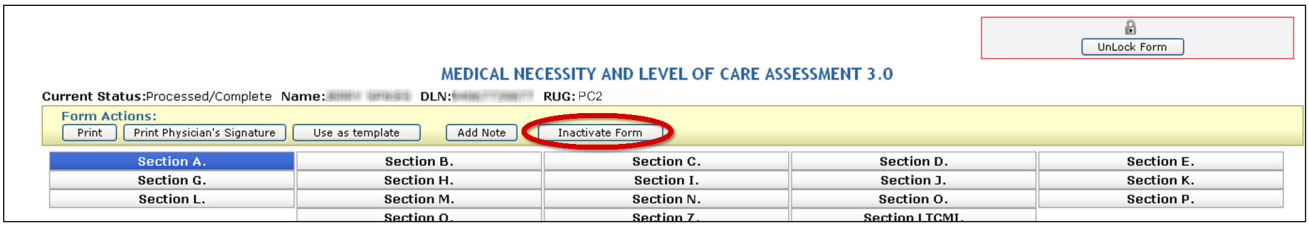
Note: *If you're unsure why an assessment is set to status* **Pending Denial (need more information)**, *call the TMHP Help Desk* ***800-626-4117, Option 2****, to speak with a nurse. If Add Note is chosen for any assessment set to status* **Pending Denial (need more information)**, *the assessment will be reviewed again for MN. If the nurse is unable to approve the assessment with the additional information provided, the assessment will be sent to the TMHP Medical Director for review and determination of MN. Notes added in any status other than* **Pending Denial (need more information)** *are added to the History trail of the assessment but are not reviewed by TMHP.*



Note: *HHSC staff can add notes to an MN/LOC Assessment to assist a provider in resolving their assessment-related issue(s) for those assessments set to status* **Provider Action Required** or **Submitted to manual workflow**. *Providers should look for these notes in the History trail of the MN/LOC Assessment.*

Inactivate Form

The Inactivate Form feature allows providers to inactivate an MN/LOC Assessment. Once inactivated, the assessment will not be available for further processing. Inactivations are not allowed if an assessment is set to status ***Corrected***, ***Form Inactivated***, or ***SAS Request Pending***. Inactivated assessments may be used as templates by the Use as template feature.



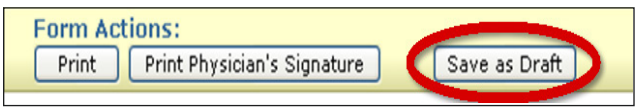
Note: *The steps to inactivate an assessment will be covered in the Inactivations section.*

Save as Draft

The Save as Draft feature allows users to save unfinished assessments on the LTC Online Portal. Once saved, these drafts will be accessible by all users under the provider number to which the draft is linked. The user may access the draft by clicking the **Worklist** link located on the blue navigational bar.

Note: *The* ***Save as Draft*** *button will only display in the yellow Form Actions bar until the assessment being entered has been successfully submitted on the portal. Drafts will display for 60 days only.*

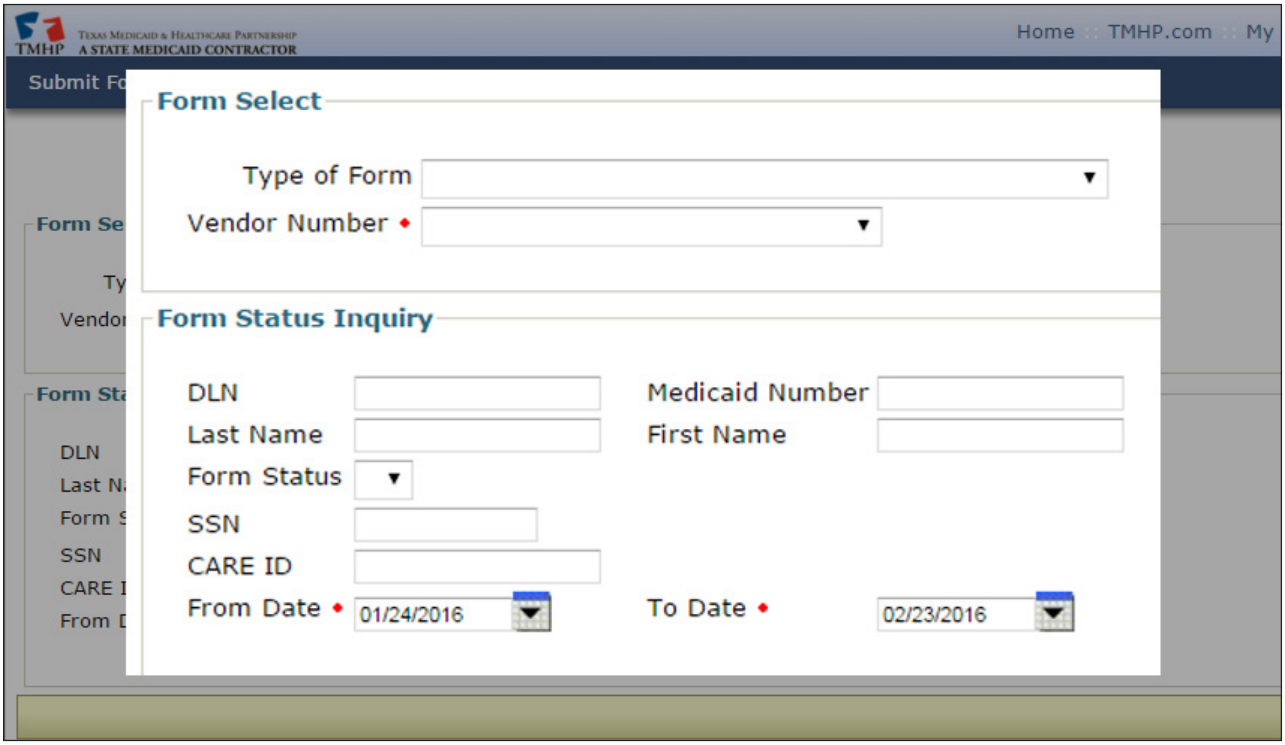
Note: *When a newer version of the MN/LOC Assessment is available, and the user opens a currently saved draft, the new fields will be available and must be completed.*



Other Basic Information

Required Fields

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



History

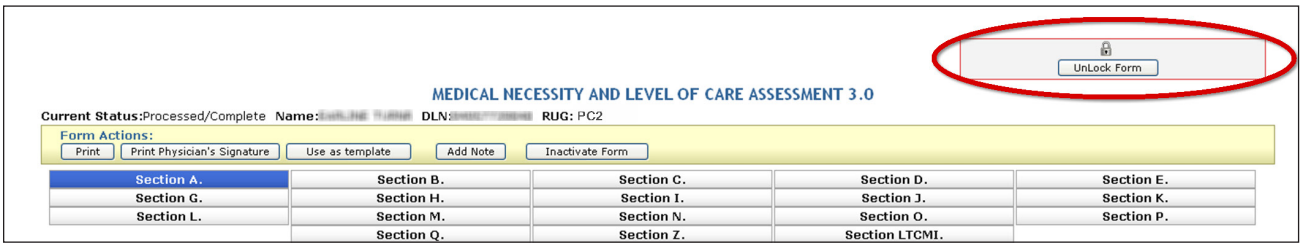
An assessment's History can be found by scrolling to the bottom of the screen on an open assessment. This History trail shows the different statuses the assessment has held. The most recent status will appear at the bottom.

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

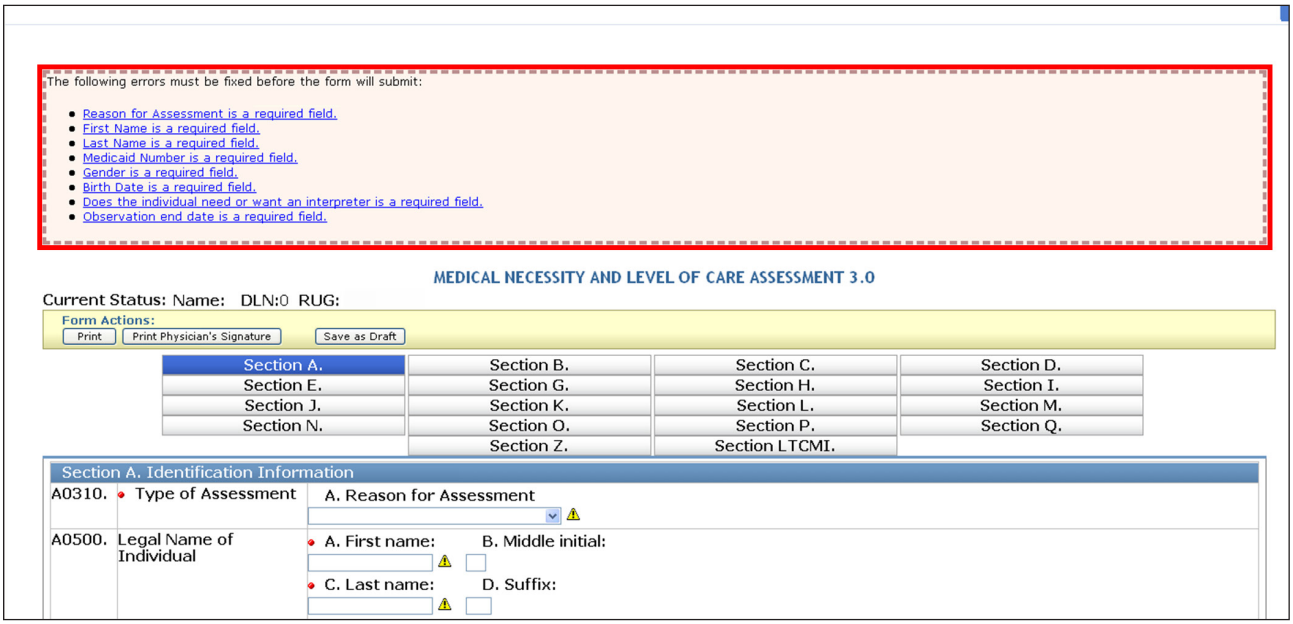
Upon opening, the assessment becomes automatically locked by the viewer and will remain locked for 20 minutes of no activity or until the viewer clicks the **UnLock Form** button. The **UnLock Form** button will unlock the assessment so that a different user can make changes. If an assessment is locked,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

To unlock an assessment, click the **UnLock Form** button located at the top right corner of the screen.



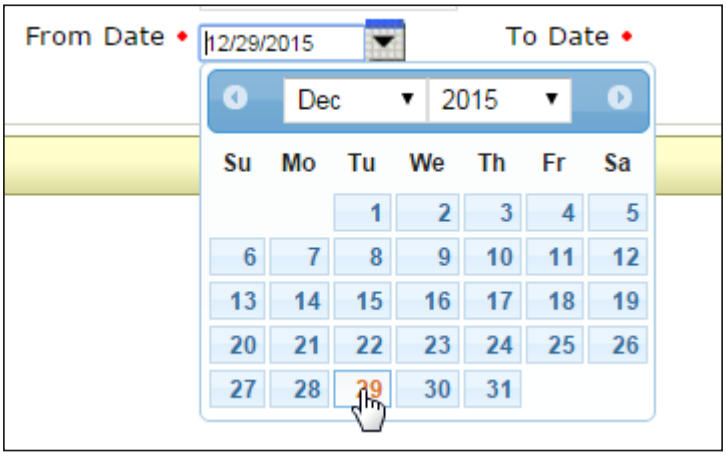
Error Messages

If required information is missing or the submitted information is invalid, an error message(s) will display, and you will not be able to continue to the next step until the error is resolved. You may need to scroll to the top of the screen to find the error message(s) since the error message(s) will be displayed at the top. If you click an error message hyperlink, you will automatically be taken to the field containing the error.



Entering Dates

To enter dates, you have the option to click on the calendar icon next to any of the date fields to activate the dynamic calendar. Choose the date desired or you may manually enter the date using the mm/dd/yyyy format.

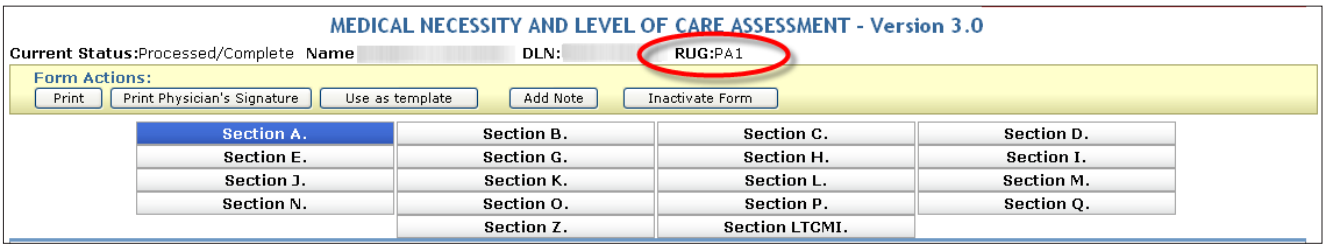


Timeout

The LTC Online Portal will timeout after 20 minutes of no activity. To prevent this timeout from occurring, complete and submit the assessment within 20 minutes or click on a different tab (e.g., Section A) to reset the timer, then return to the previous tab.

RUG Value

Resource Utilization Group (RUG) is used to classify relative direct care resource requirements for people who live in a nursing facility (NF), and to establish the cost limit for community services consumers in the STAR+PLUS Home and Community Based Services (HCBS) program.
Once a successfully submitted assessment is open, the RUG value can be found next to the DLN, as seen in the screenshot below.



Medical Necessity and Level of Care 3.0 Assessment

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

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

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

Note: *A SCSA does not apply for Program for All-Inclusive Care for the Elderly (PACE). For MCOs STAR+PLUS, the SCSA is completed but not submitted on the LTC Online Portal unless eligibility for the STAR+PLUS HCBS program 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 person.

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

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

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

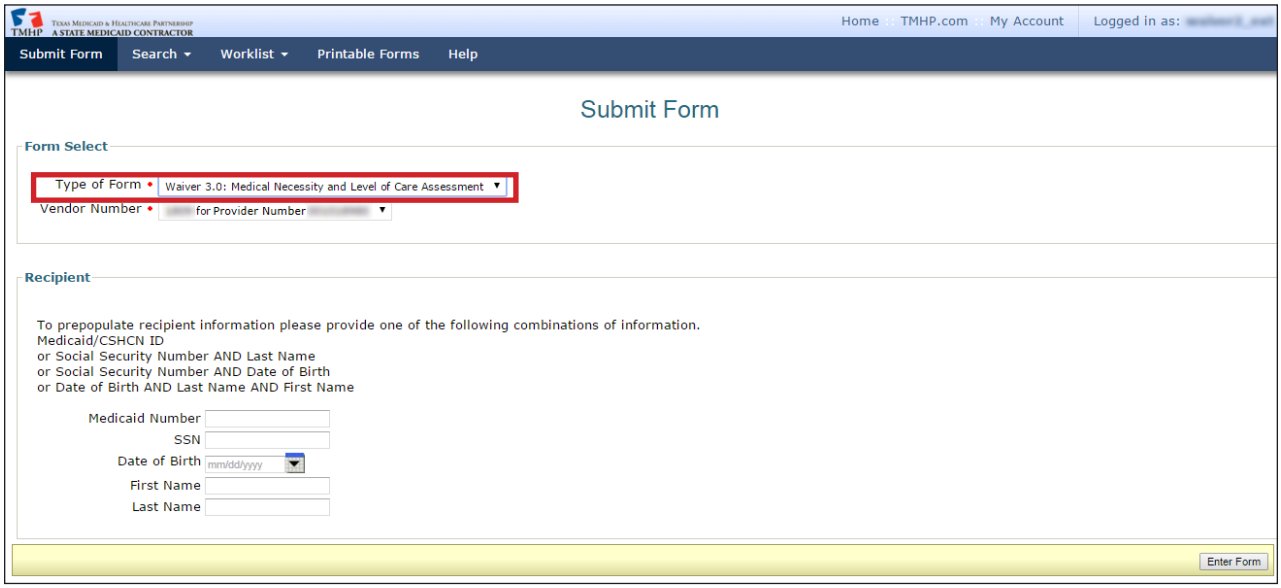
In the above circumstance, the following error message will display:

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 person's records. If the member receives CFC services, the MCO submits it on the LTC Online Portal.*

How to Submit a Medical Necessity and Level of Care Assessment

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



4) To auto populate a person's information in the MN/LOC Assessment, enter one of the following combinations of information:
    - Medicaid Number
      or
    - Social Security number (SSN) *and* Last Name
      or
    - SSN *and* Date of Birth
      or
    - Date of Birth *and* Last Name *and* First Name
      Note: *All demographic information (except gender) is auto populated when one of the aforementioned data items is entered. Refer to the demographic information located in Section A and the Section LTCMI of the MN/LOC Assessment.*
5) Click the **Enter Form** button.
6) Click the tabs (Section A, Section B, etc.) and enter the assessment information.

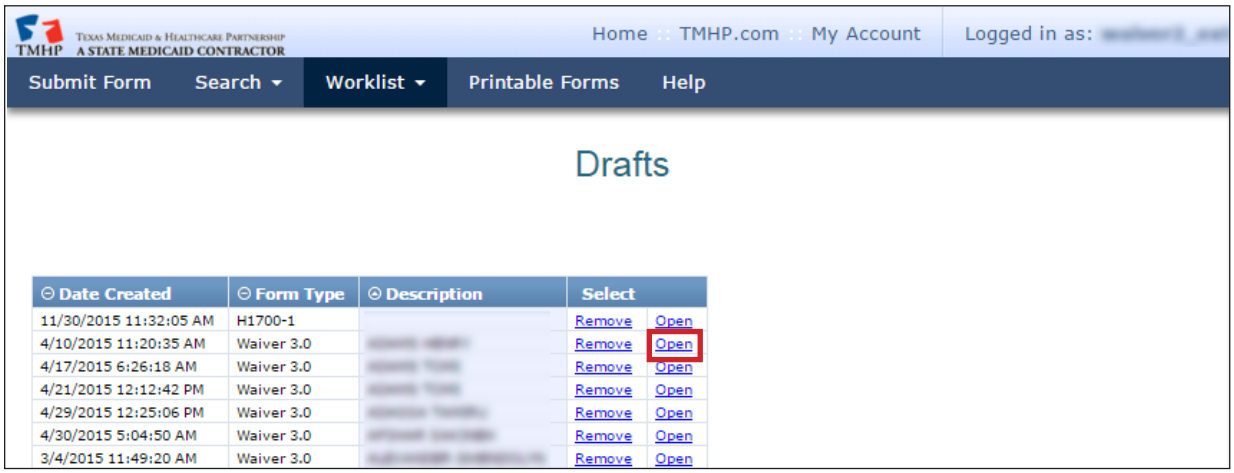
For Initial Assessments only, the following is required:

1) Click the **Print Physician's Signature** button and print the signature page and obtain the MD/DO signature.

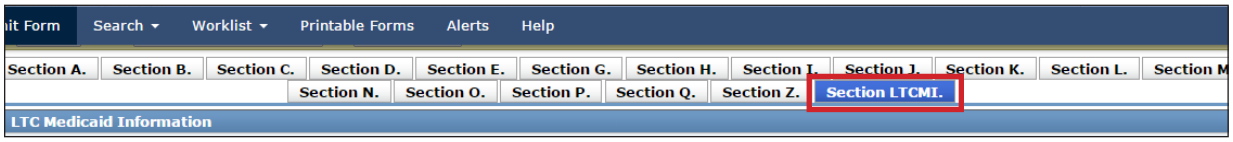
2) Click the **Save as Draft** button to save the MN/LOC Assessment to be recalled later.

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

4) Click the **Open** link.

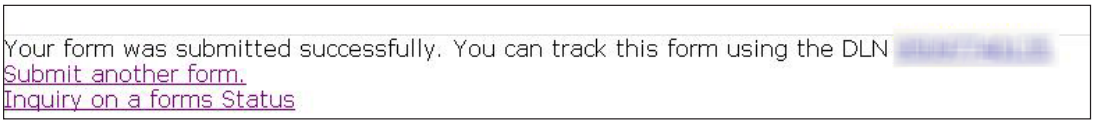


5) Click the **Section LTCMI** tab. Check the box indicating the physician's signature is on file.

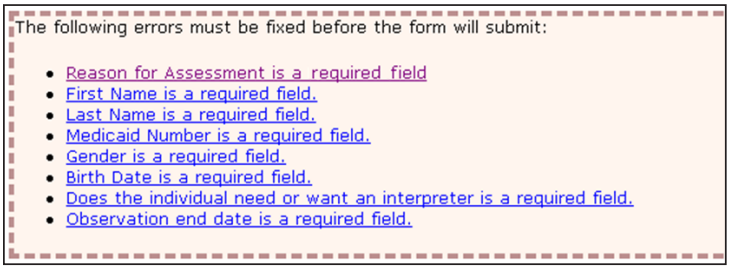


6) Click the **Submit Form** button.

   a) If the assessment is submitted successfully, a DLN will be assigned and the following message will be displayed:

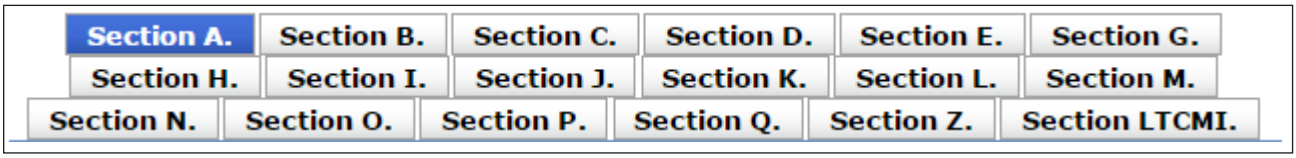


   b) If an assessment is not successfully submitted, an error message will appear at the top of the screen. The provider must resolve the error(s) to ensure the assessment will be submitted successfully. The error message will prompt the provider as to how to resolve the error or save to draft for research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



MN/LOC 3.0 Assessment Sections

The following are the MN/LOC 3.0 Assessment sections:



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

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

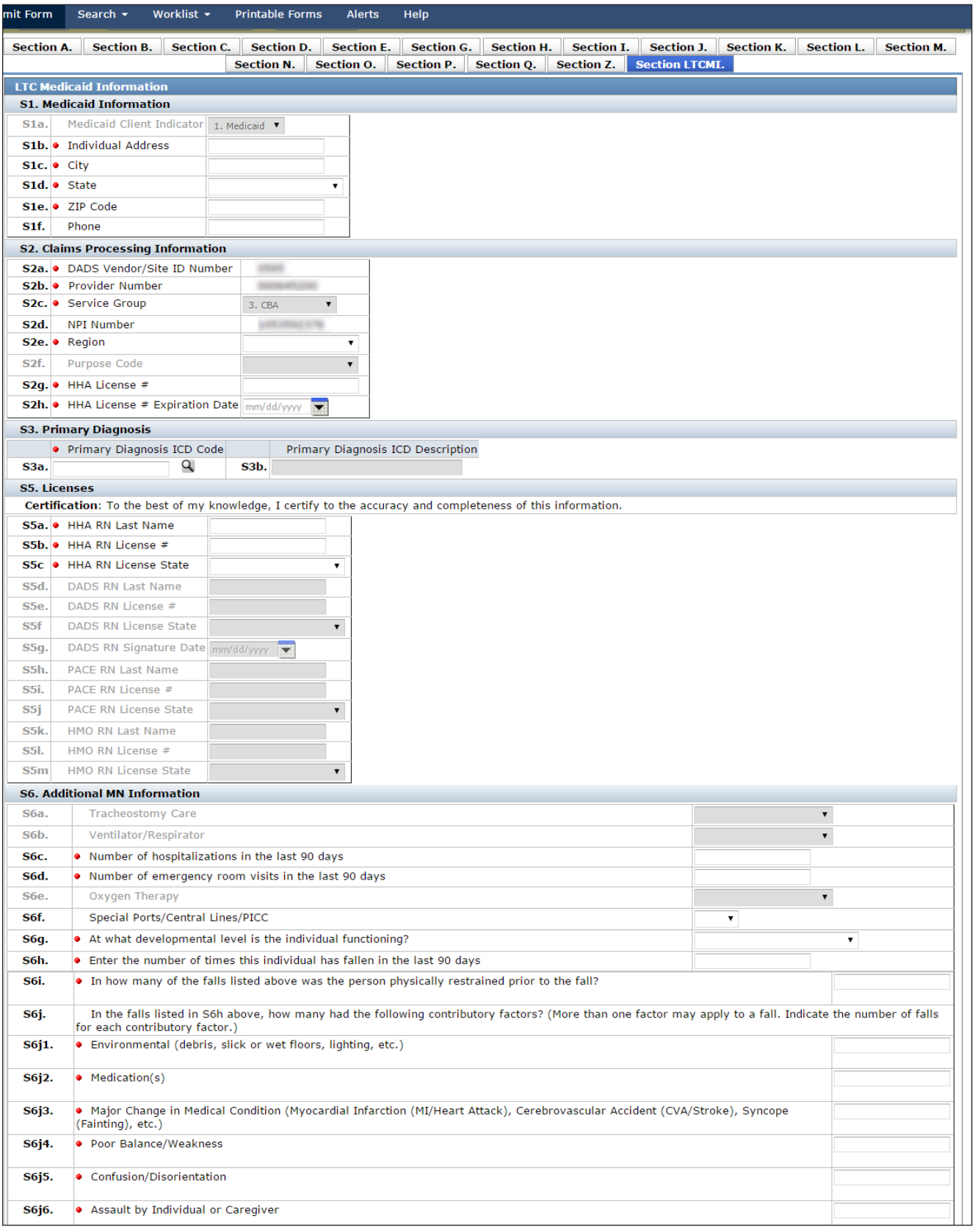
- Go to www.tmhp.com/programs/ltc/forms and click the **Medical Necessity and Level of Care 3.0 Instructions** link found under the Community Waivers Programs heading.
- Click the **Help** link in the blue navigational bar and click the **Medical Necessity and Level of Care 3.0 Instructions** link.

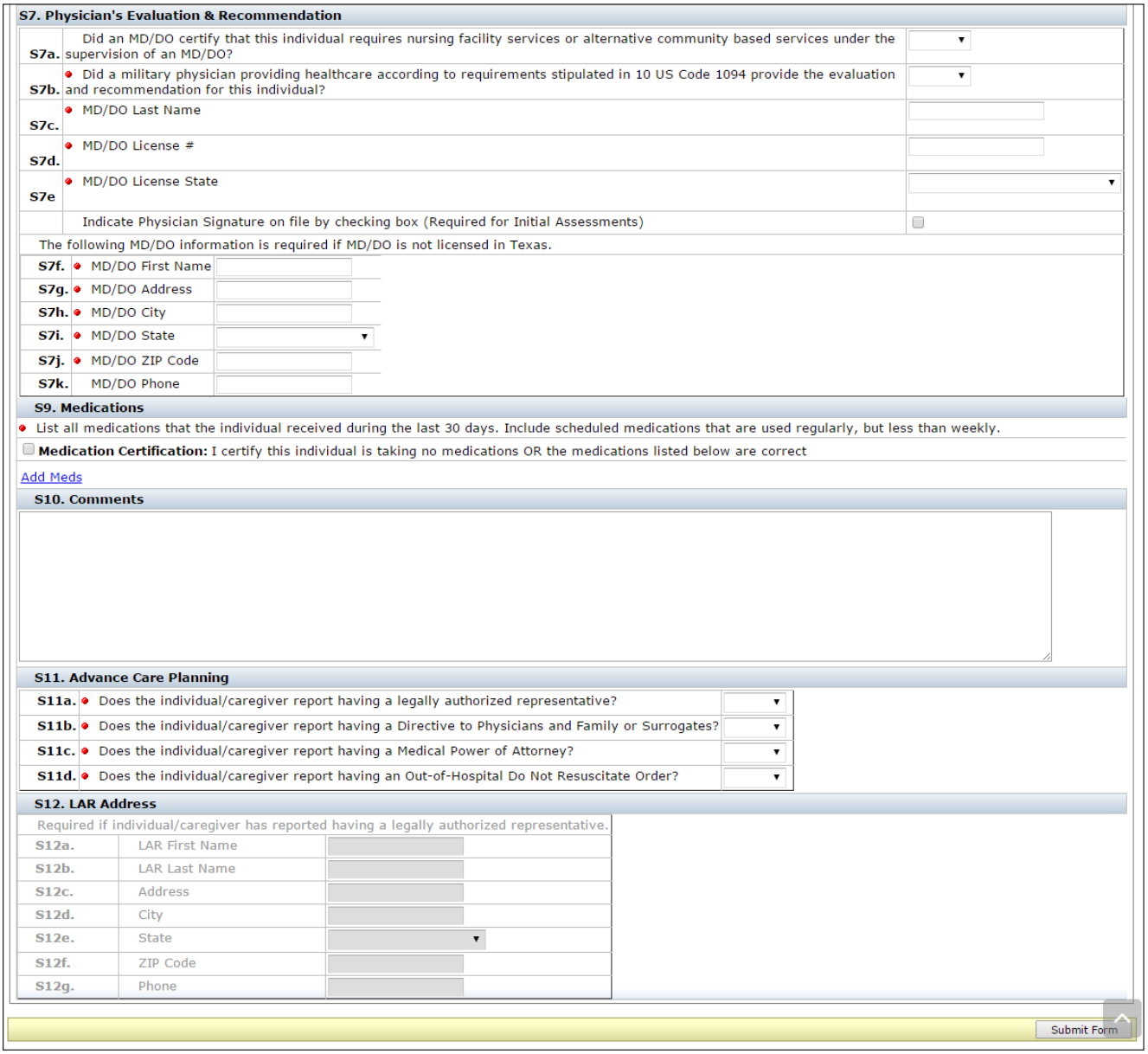
Blank MN/LOC Assessments can be found at the following locations:

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

Long Term Care Medicaid Information (LTCMI)

This is what the LTCMI section looks like.





- **S1. Medicaid Information**
  - S1a. Medicaid Client Indicator
    - This field will be auto populated.
  - S1b. Individual Address
    - Required
      - Enter the street address where the person is presently living.
      - The person's Address is used for mailing MN letters.
  - S1c. City
    - Required
      - Enter the city where the person is presently living.

- S1d. State
  - Required
    - Choose the state where the person is presently living from the drop-down box.
    - The person's Address is used for mailing MN letters.
- S1e. ZIP Code
  - Required
    - Enter the ZIP Code where the person is presently living.
    - The person's Address is used for mailing MN letters.
- S1f. Phone
  - Optional
    - Enter the person's contact telephone number, if known.
- **S2. Claims Processing Information**
  - S2a. HHSC Vendor/Site ID Number
    - This field will be auto populated based on the user's logon security credentials and cannot be changed.
  - S2b. Provider Number
    - This field will be auto populated and cannot be changed.
  - S2c. Service Group
    - Required
    - Choose from the drop-down box:
      - 3. CBA
      - 11. PACE
      - 17. CWP
      - 19. STAR+PLUS
      - 23. CFC
  - S2d. NPI Number
    - Required
      - This field will be auto populated and cannot be changed.
      - This is where API would be included if using an API number. API is "D", two zeros, then provider number.
  - S2e. Region
    - Required
    - Choose from the drop-down box:

        - 01 (Lubbock)
        - 02 (Abilene)
        - 03 (Arlington)
        - 04 (Tyler)
        - 05 (Beaumont)
        - 06 (Houston)
        - 07 (Austin)
        - 08 (San Antonio)
        - 09 (Midland / Odessa)
        - 10 (El Paso)
        - 11 (Edinburg)
    - S2g. Home Health Agency (HHA) License #
        - Required
        - If you work for a Home Health Agency:
            - Enter the Home Health Agency License number. HHA License # must be up to seven numeric digits.
        - If you do not work for a Home Health Agency:
            - Enter all zeros.
    - S2h. HHA License # Expiration Date
        - Required
            - Enter the license expiration date of the Home Health Agency License number. If you entered all zeros in field S2g, this field will deactivate.
            - HHA License # Expiration Date must be in mm/dd/yyyy format.
- **S3. Primary Diagnosis**
    - S3a. Primary Diagnosis International Classification of Diseases (ICD) Code
        - Required
            - Enter a valid ICD code for the person's primary diagnosis. Use your best clinical judgment.
    - S3b. Primary Diagnosis ICD description
        - Optional
            - This field will be auto populated after S3a was inputted.
            - Click the **magnifying glass** and the description will be auto populated based on the primary diagnosis ICD code.

- **S4. For HHSC use only**
    - When a successfully submitted LTCMI is printed, field S4b will show the calculated RUG value. **Note:** *The RUG value also appears at the top of each page on all successfully submitted MN/LOC Assessments.*
- **S5. Licenses**

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

- S5a. HHA RN Last Name
    - Conditional
        - This is a required field for Service Group (SG) 23 CFC.
        - Enter the last name of the RN completing the assessment.
- S5b. HHA RN License #
    - Conditional
        - This is a required field for SG 23 CFC.
        - Enter the license number of the RN.
        - Licenses issued in Texas will be validated against the Texas Board of Nursing (BON). Compact licenses will be validated with the issuing state's nursing board.
        - This number is validated to ensure RUG training requirements have been met.
- S5c. HHA RN License State
    - Conditional
        - This is a required field for SG 23 CFC.
        - Choose the state in which the RN is licensed from the drop-down box.
- S5h. PACE RN Last Name
    - Conditional
        - This is a required field for SG 11 PACE.
        - Enter the last name of the RN completing the assessment.
- S5i. PACE RN License #
    - Conditional
        - This is a required field for SG 11 PACE.
        - Enter the license number of the RN.
        - Licenses issued in Texas will be validated against the Texas BON. Compact licenses will be validated with the issuing state's nursing board.
        - This number is validated to ensure RUG training requirements have been met.

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

- **S6. Additional MN Information**
  - S6a. Tracheostomy Care
    - Conditional
      - This field is only required and available for data entry if O0100E, Tracheostomy care, is checked *and* the person is 21 years of age or younger.
    - Choose from the drop-down box:
      - Less than once a week
      - 1 to 6 times a week
      - Once a day
      - Twice a day
      - 3 – 11 times a day
      - Every 2 hours
      - Hourly / continuous
  - S6b. Ventilator/Respirator

    - Conditional
        - This field is only required and available for data entry if O0100F, ventilator or respirator, is checked. It does not enable for BiPap or CPAP.
        - Choose from the drop-down box:
        - Less than once a week
        - 1 to 6 times a week
        - Once a day
        - Twice a day
        - 3 – 11 times a day
        - 6 – 23 hours
        - 24-hour continuous
- S6c. Number of hospitalizations in the last 90 days
    - Required
        - Record the number of times the person was admitted to hospital with an overnight stay in the last 90 days (or since last assessment if less than 90 days).
        - Enter 0 (zero) if no hospital admissions.
        - Valid range includes 0 – 90.
- S6d. Number of emergency room visits in the last 90 days
    - Required
        - Record the number of times the person visited the emergency room (ER) without an overnight stay in the last 90 days (or since last assessment if less than 90 days).
        - Enter 0 (zero) if no ER visits.
        - Valid range includes 0 – 90.
- S6e. Oxygen Therapy
    - Conditional
        - This field is only required and available for data entry if O0100C, Oxygen therapy, is checked.
    - Choose from the drop-down box:
        - Less than once a week
        - 1 to 6 times a week
        - Once a day
        - Twice a day
        - 3 – 11 times a day

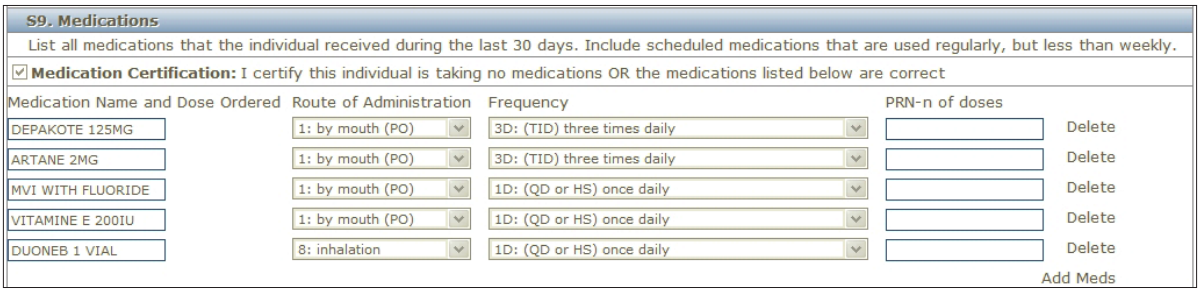
    - 6 – 23 hours
    - 7 – 24-hour continuous
- S6f. Special Ports/Central Lines/PICC
    - Optional
        - Use this field to indicate if the person has any type of implantable access system or central venous catheter (CVC). This includes epidural, intrathecal, or venous access or Peripherally Inserted 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 people who are 20 years of age and younger based on birth date minus date of submission (TMHP Received date). Not available for data entry if the person 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 person has fallen in the last 90 days. Enter 0 (zero) if no falls.
        - Each fall should be counted separately. So, if the person 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 person has fallen.
    - Valid range includes 0 with a maximum being the number entered in S6h.
    - Enter 0 if no falls when the person 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 person 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 person 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 person 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 person 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 person 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 person 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 person 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 person 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 to 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 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 is required information if the MD/DO is *not* licensed in Texas.
    - Enter the address and telephone number of the facility in which the physician providing the evaluation and recommendation practices in S7g-S7k. ***This information will be used to mail MN determination letters.***
- S7f. MD/DO First Name
  - Conditional
    - This field is required if the MD/DO is not licensed in Texas.
    - Enter the first name of the person'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 person'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 person'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 person'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 person'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 person'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 person has no medications *or* that the person 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)



- **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 person'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 person wants to be treated if ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die, they are not able to talk or to let others know how they feel.
  - Advance care planning is a five-step process that should be discussed with the person.
  1. Thinking about what you would want to happen if you could not talk or communicate with anyone.
  2. Finding out about what kind of choices you will need to make if you become very ill at home, in a nursing home, or in a hospital.
  3. Talking with your family and doctor about how you want to be treated.
  4. Filling out papers that spell out what you want if you are in an accident or become sick.
  5. Telling people what you have decided.
- S11a. Does the individual/caregiver report having a legally authorized representative?
  - Required
    - Legally Authorized Representative is a person authorized by law to act on behalf of a person, 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 person'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 person is not currently admitted to a hospital. It lets the person tell health-care workers, including Emergency Medical Services (EMS) workers, *not* to do some things if the person stops breathing or their heart stops. If a person does not have one of these forms filled out, EMS workers will *always* give the person Cardiopulmonary Resuscitation (CPR) or advanced life support, even if the advance care planning forms say not to. A person should complete this form as well as the Directive to Physicians and Family or Surrogates and the Medical Power of Attorney form if they do *not* want CPR.
        - Choose from the drop-down box:
            - 0. No
            - 1. Yes
- **S12. Legally Authorized Representative (LAR) Address**
  Note: *In the future, this information may be used to send MN determination letters to the LAR when 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 Legally Authorized Representative.
    - 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 Legally Authorized Representative.
    - 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 Legally Authorized Representative.
- 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 Legally Authorized Representative.
        - 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 Legally Authorized Representative.
- 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 Legally Authorized Representative.
- S12g. Phone
    - Optional
        - Enter the contact telephone number for the Legally Authorized Representative, if known.

H1700/Individual Service Plan (ISP) Form

What is the ISP Form?

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

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

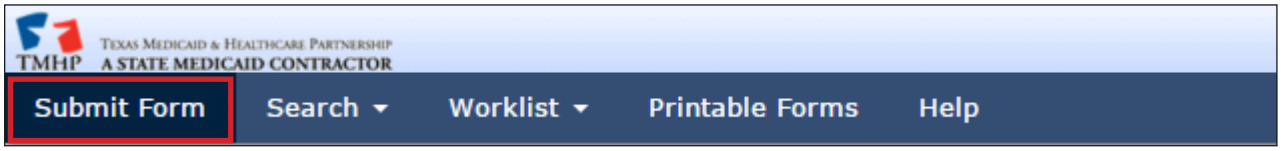
Features of Submitting ISP Forms on the LTC Online Portal

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

TMHP provides LTC Online Portal technical support by telephone at **800-626-4117**, **Option 1**, for Customer Service then **Option 5**, from 7:00 a.m. – 7:00 p.m., Central Time, Monday through Friday – excluding holidays.

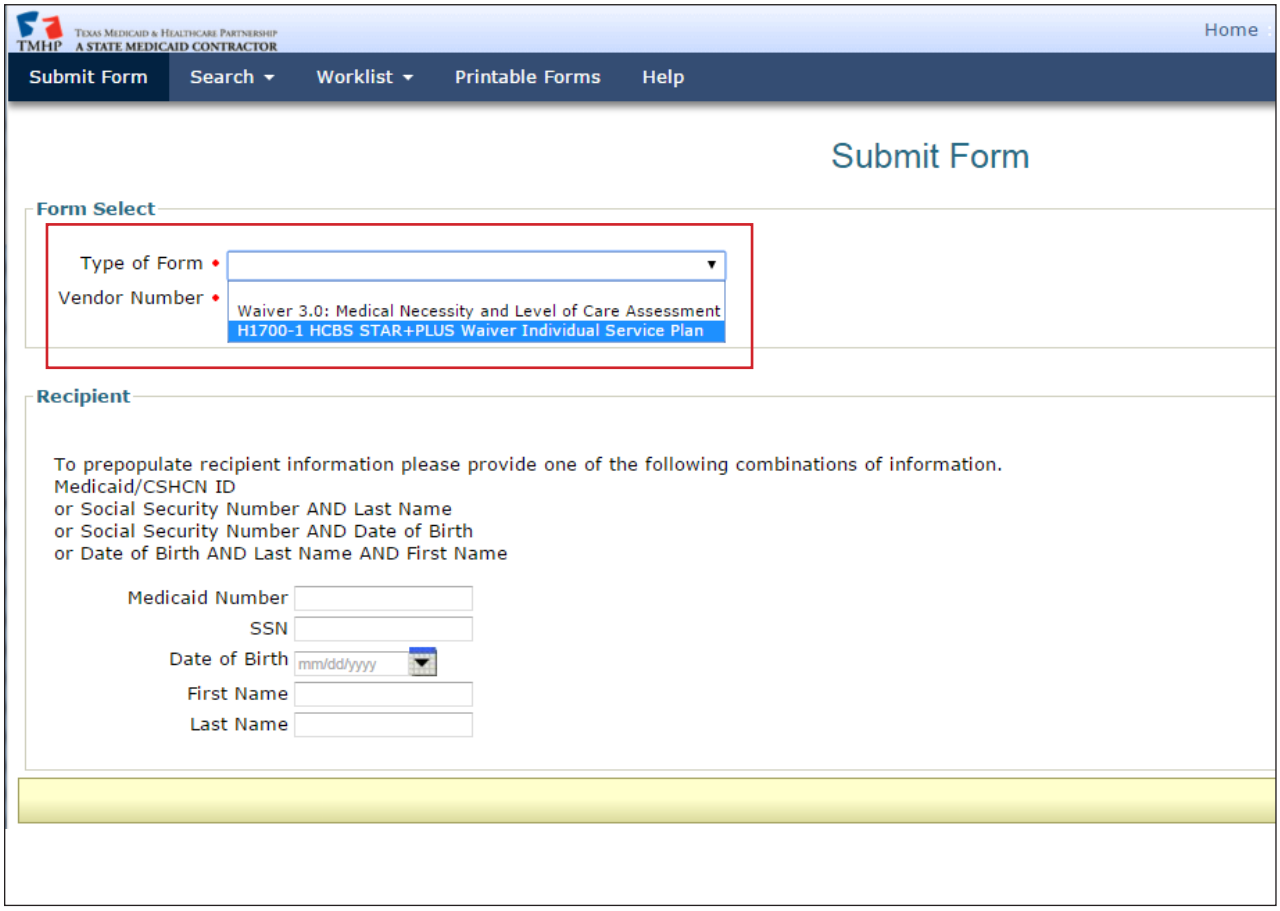
Submitting an ISP

1) When the blue navigational bar is displayed, click the **Submit Form** link.



2) You may need to reenter your security credentials.

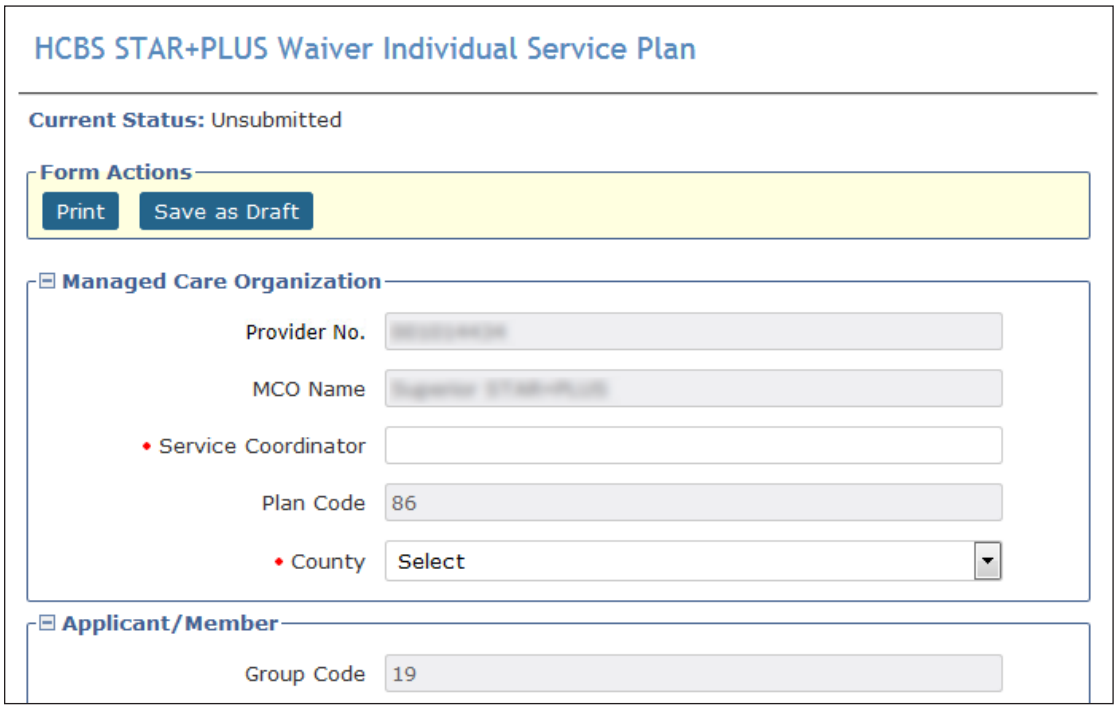
3) From the Type of Form drop-down menu, select **H1700-1 HCBS STAR+PLUS Waiver Individual Service Plan**.



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 most recent MN/LOC Assessment in a finalized status. Auto populated fields are not editable.

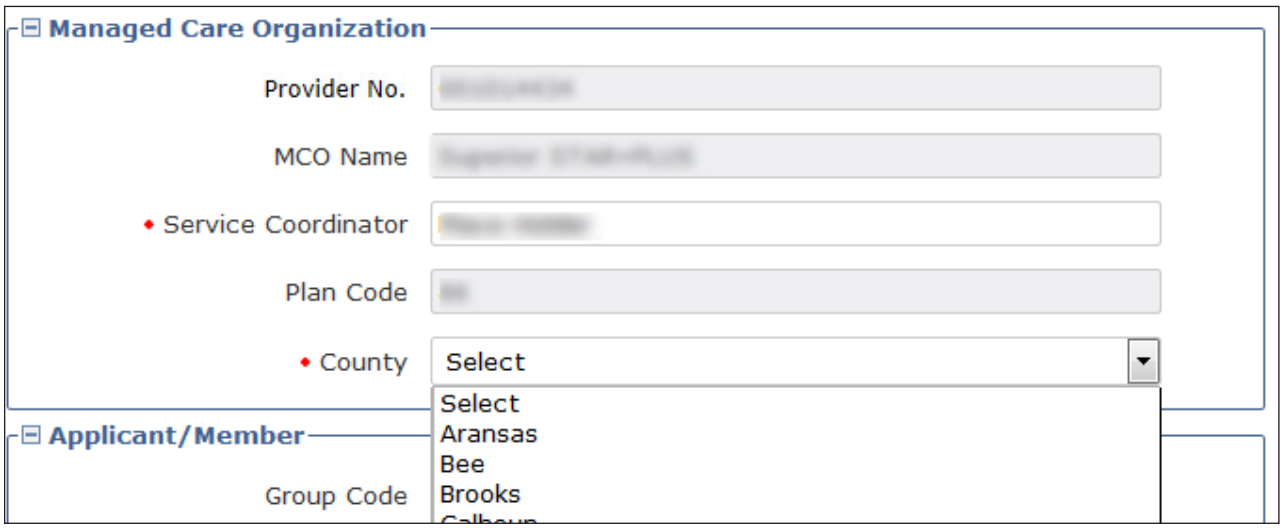
Required fields are indicated by a red dot.

The form sections of the ISP are:

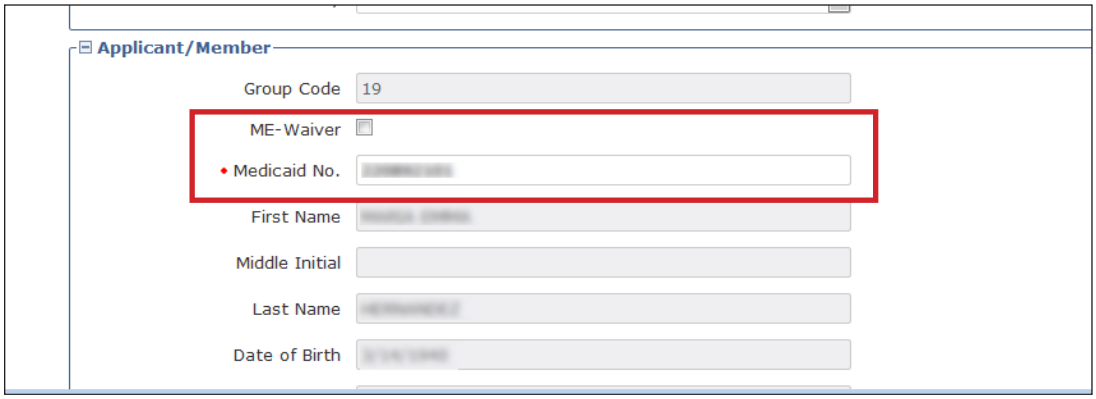
- MCO Information
- Applicant/Member Information
- Individual Service Plan Event
- Individual Service Plan Services

Completing the H1700 / ISP Form Fields

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

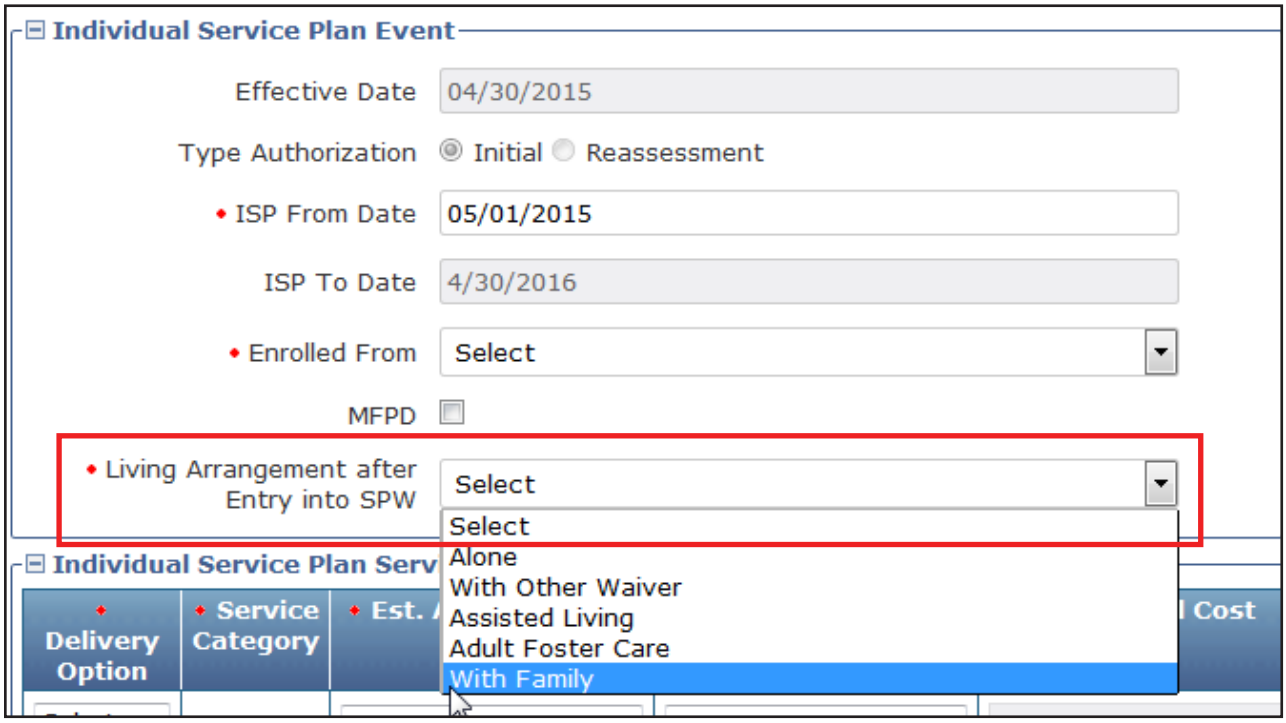


3) In the Applicant/Member section of the form, verify that the Medicaid number is correct. It is a required field.
   Note: *Applicant/Member section of the ISP form will be auto populated using information from their recent MN/LOC Assessment in a finalized status.*
4) Check the ME-Waiver box, if applicable,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



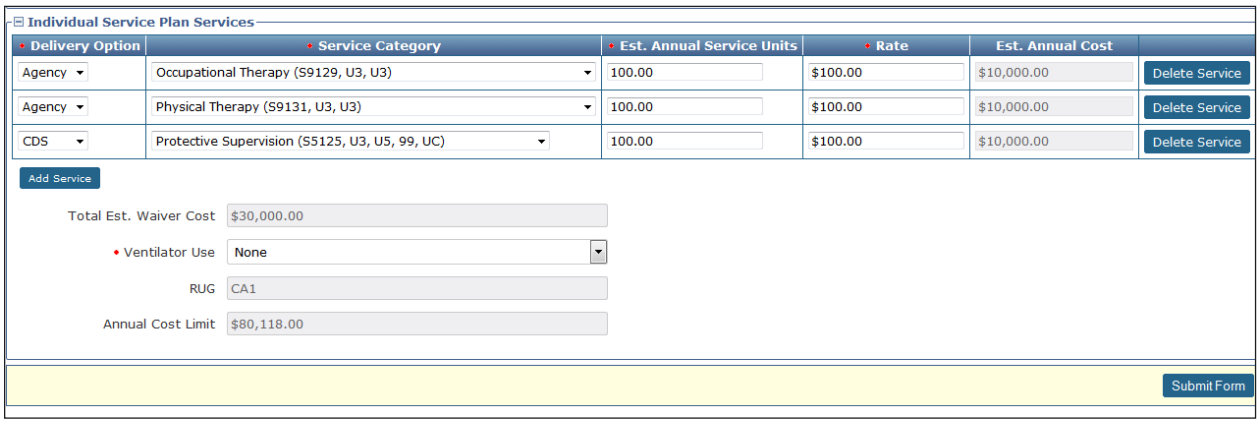
Note: *The Type Authorization indicates whether the current ISP will be submitted as an Initial ISP or a Reassessment. This field automatically determines this based on the dates entered below and whether or not the person has an existing ISP on file. If the ISP has been out of date for 120 days, it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

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

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



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

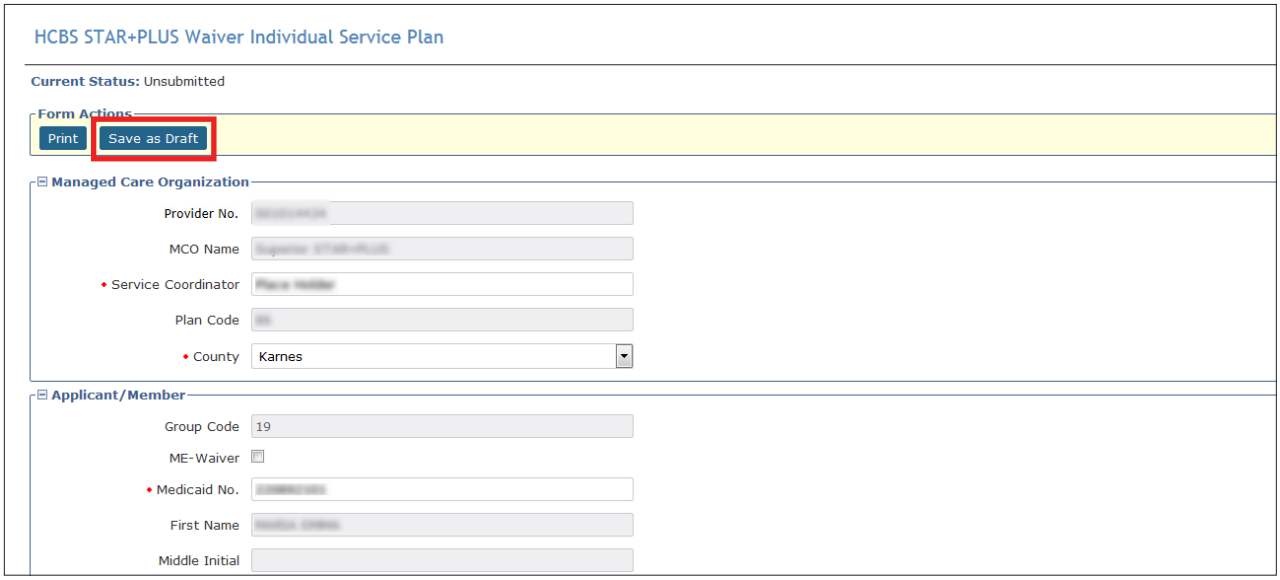
16) Click the **Submit Form** button at the bottom right of the screen.
Note: *If the ISP is flagged for review by HHSC staff, it can be tracked using the FSI or Power Search tools on the blue navigational bar. Additionally, submitted ISPs may be found for 14 calendar days by clicking the* **Current Activity** *link on the blue navigational bar.*

Submitting Individual ISP forms by Multiple Users

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

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

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



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

4) Other users linked to that contract may now access the ISP form by clicking the **Drafts** link on the blue navigational bar.

5) Once the form is completed, it can be submitted by following the steps described above.

Medical Necessity and the MN Determination Process

Definition of Medical Necessity

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

"Medical Necessity is 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

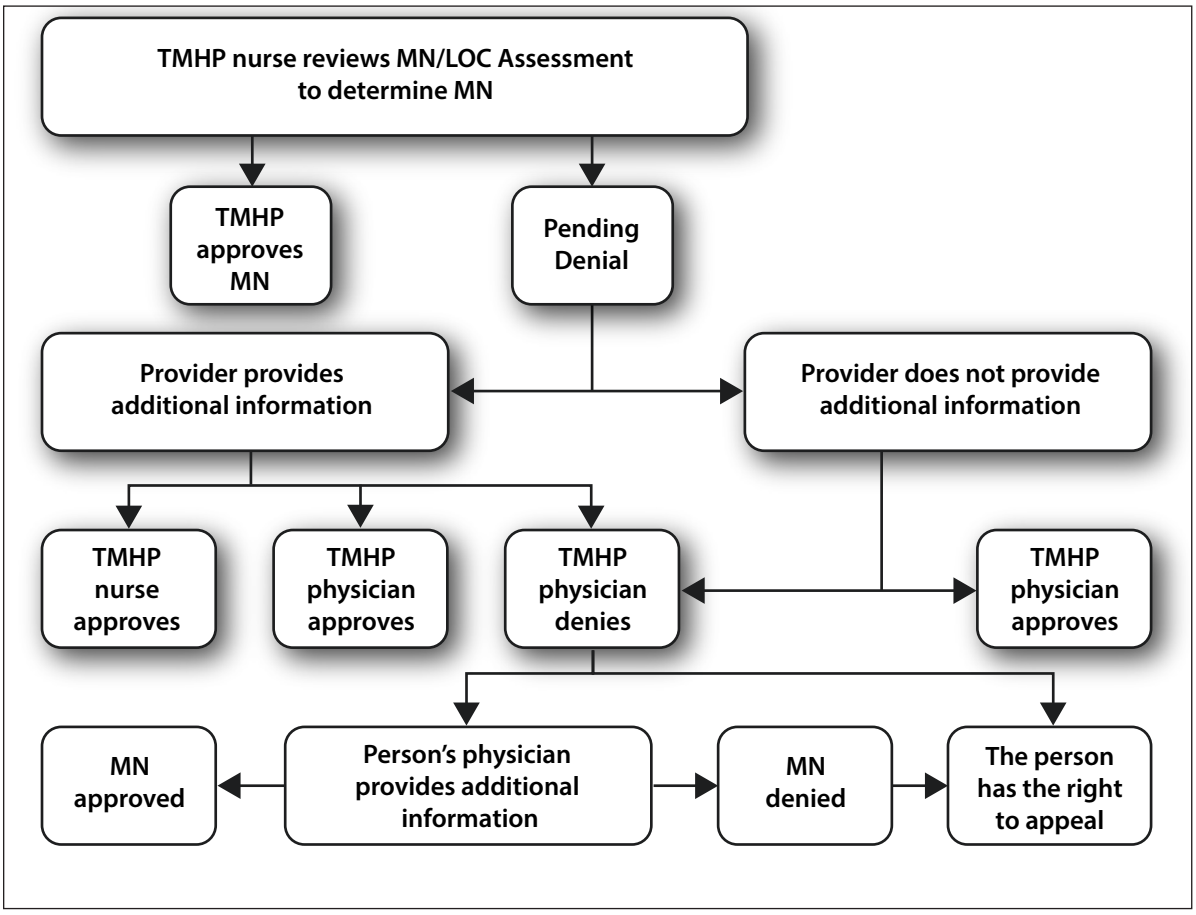
26 TAC §554.2401 states:

"Medical Necessity is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. This section contains the general qualifications for a Medical Necessity determination. To verify that Medical Necessity exists, a person must meet the conditions described in paragraphs (1) and (2) of this section."

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

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

Medical Necessity Determination Process



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

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

6) If the TMHP physician determines that MN has been met, the assessment is approved.
7) If the MN is denied by the TMHP physician, notification of denied MN is sent to the person and the physician of record, as specified in Section LTCMI of the MN/LOC Assessment, by mail. The provider will have access to the status of the assessment by FSI or Current Activity on the LTC Online Portal.
8) The attending physician may respond within 10 business days of the date of the denial letter by faxing or calling TMHP with additional medical information (26 TAC 554 §19.2407(a)). Alternatively, a licensed nurse familiar with the person may provide additional information by calling and speaking with a TMHP nurse.
9) If the TMHP physician or nurse determines that MN has been met, the assessment is approved.
10) If the TMHP physician determines that MN has not been met, the assessment remains in a ***Denied*** status.
11) If the provider does not provide additional information clarifying nursing/medical needs within the 21 calendar days of ***Pending Denial (need more information)*** status, the assessment is sent to the TMHP physician for review, and steps 7 – 11 will apply.
12) The person may initiate the appeal process when notified by a HHSC case manager using the Form 2065-C, that MN has been denied by the TMHP physician. If a hearing is requested, additional information may be submitted at any time by the provider or by the person's physician either by a telephone call to the TMHP nurses or by fax.

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

Request for Fair Hearing

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

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

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

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

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

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

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

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

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

Note: *The fair hearings and appeals process for STAR+PLUS managed care members and the MCOs to follow is included in section 4212, Fair Hairings and Appeals Procedures, of the* STAR+PLUS Handbook (*https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook*)

Assessment Statuses

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

- ***Appealed:*** The assessment was previously denied and the person or their representative has requested a fair hearing.
- ***Approved:*** MN has been determined and approved. 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:*** This assessment has been corrected by the submitting provider. There will be a new DLN located in the History trail indicating the replacement DLN for the corrected assessment. No further actions are allowed on assessments with a status of ***Corrected*.**
- ***Denied:*** The assessment has been reviewed by the TMHP doctor who has determined that the information did not support MN.
- ***Escalated Needs Review:*** The assessment has been escalated for review.
- ***Form Inactivated:*** This assessment has been inactivated 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 person's name, SSN, and Medicaid ID. A new assessment with the correct information will need to be submitted.
- ***Invalid/Complete:*** Per HHSC, this 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 attempted nightly for six months and failed or the request was canceled. 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. Validation attempts occur nightly until deemed valid, invalid, or until six months has expired, whichever comes first. 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 original submission to correct the erroneous 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 assessment was denied MN, and the provider has supplied additional information for review. The assessment is pending TMHP doctor review for MN determination.
- ***Overturned Doctor Review Expired:*** The assessment was denied MN, and no additional information has been submitted for review within the 14 business days following the MN denial.
- ***Pending Denial (need more information):*** This status occurs when the information is reviewed by a TMHP Nurse and does not support MN. The provider has up to 21 calendar days to give additional information for further consideration either by telephone or by using the Add Note feature on the LTC Online Portal. The TMHP nurse did not find the assessment to be qualified for MN. The provider has 21 calendar days to submit additional information for consideration.
- ***Pending MD/DO License Verification:*** The MD/DO License number is pending manual verification by TMHP for licenses that are issued from states other than Texas. TMHP will validate the MD/DO License number entered in field S7d of the LTCMI, and set assessment status to either ***Out of State MD/DO License Valid*** or ***Out of State MD/DO License Invalid***. If the status is set to ***Out of State MD/DO License Valid***, the assessment will continue to process through the workflow.
- ***Pending More Info:*** This status appears when the form is in the CS Workflow, and HHSC is waiting for more information from the provider. Information required may be found within the assessment History trail.
- ***Pending Review:*** The assessment is waiting for TMHP RN to manually review it for MN.
- ***Pending RN License Verification:*** The RN License number is pending manual verification by TMHP from the Texas BON or the licensing state from which the compact license was issued.
- ***Processed/Complete:*** The assessment has been processed and complete. Check Medicaid Eligibility and Service Authorization Verification (MESAV).
- ***Provider Action Required:*** The assessment must be reviewed by the provider due to the assessment being rejected by Service Authorization System (SAS). Refer to the assessment History trail for the specific error message. The error message must be resolved before further processing of assessment will occur.
- ***SAS Request Pending:*** The assessment has passed all TMHP validations and will be sent from TMHP to HHSC-LTC for SAS processing. Allow 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 on the part of the provider.

Provider Workflow Process

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

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

Assessments reach this status if:

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

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

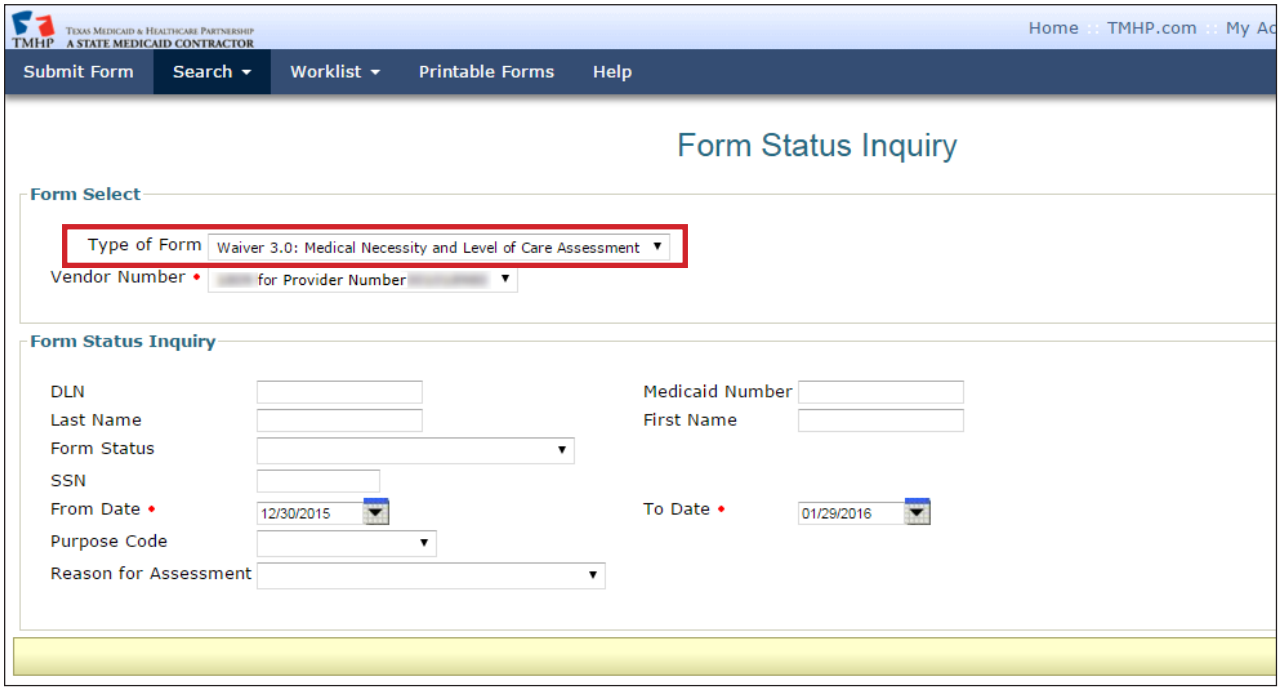
If a system error occurs, the error will be displayed in the History trail of the assessment. The assessment is set to status ***Provider Action Required***.

Finding Assessments with Provider Action Required Status

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

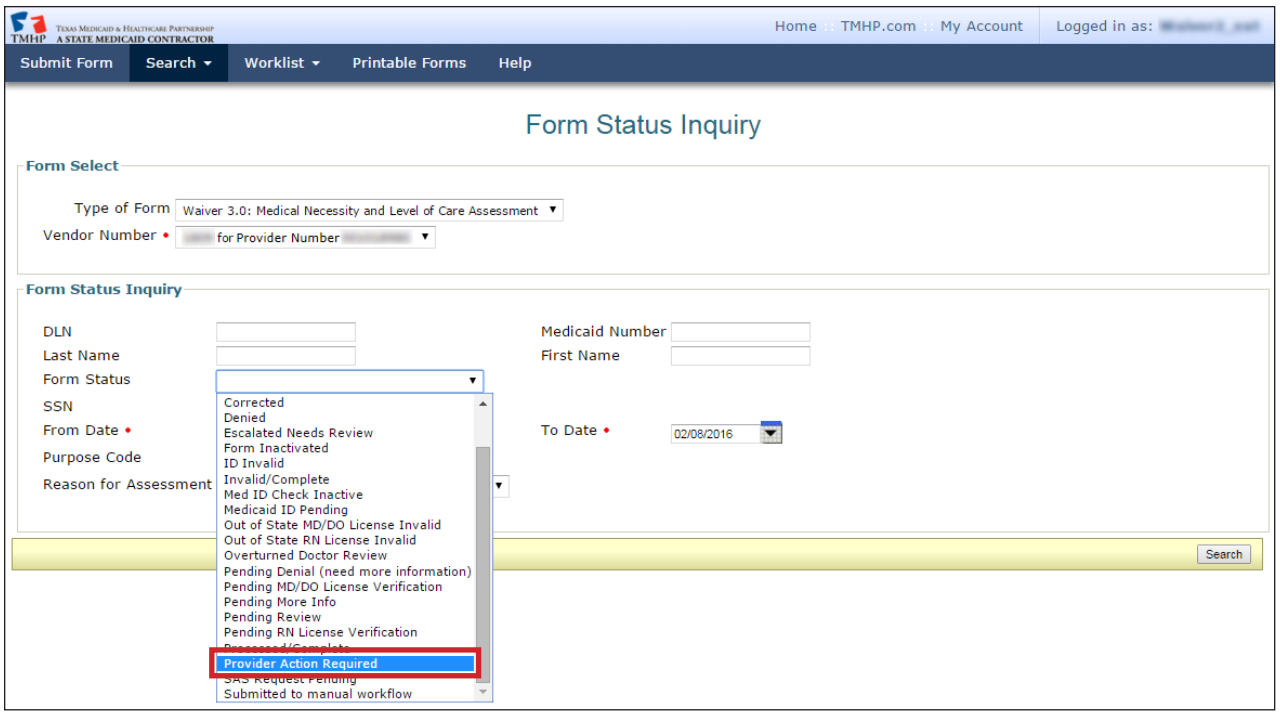
1) Click or hover over the **Search** link in the blue navigational bar.
2) Click **Form Status Inquiry** in the drop-down menu.

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



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

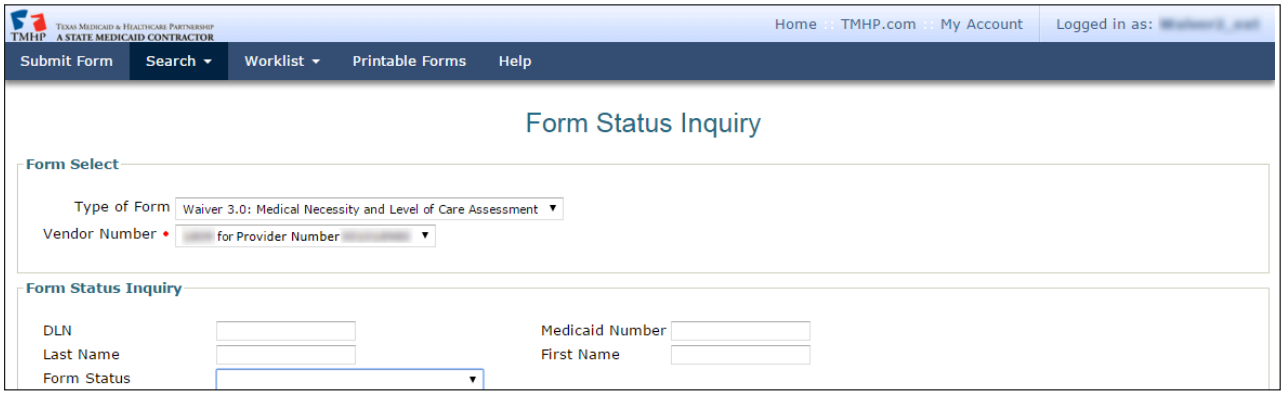
5) Form Status: Choose ***Provider Action Required*** from the drop-down box.



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

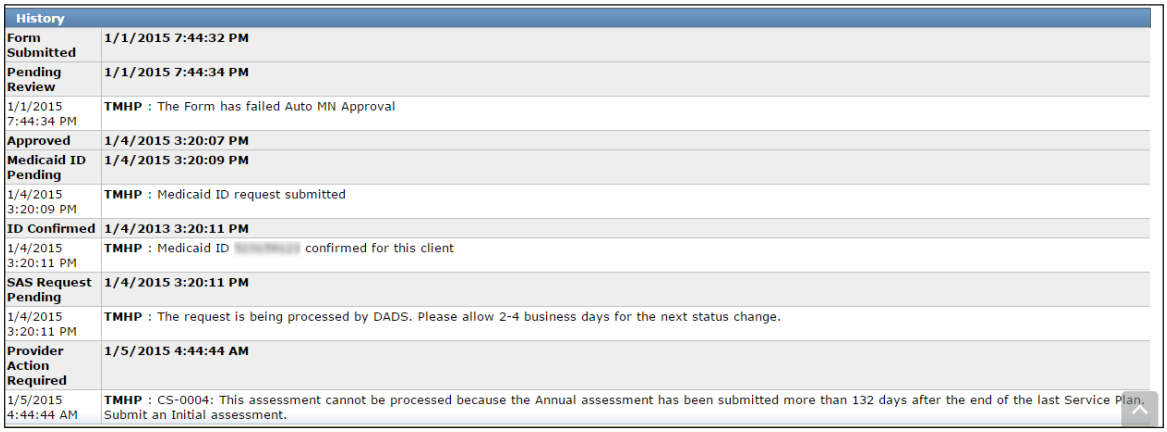
7) All Waiver 3.0 Medical Necessity and Level of Care Assessments that are set to status ***Provider Action Required*** will display.

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



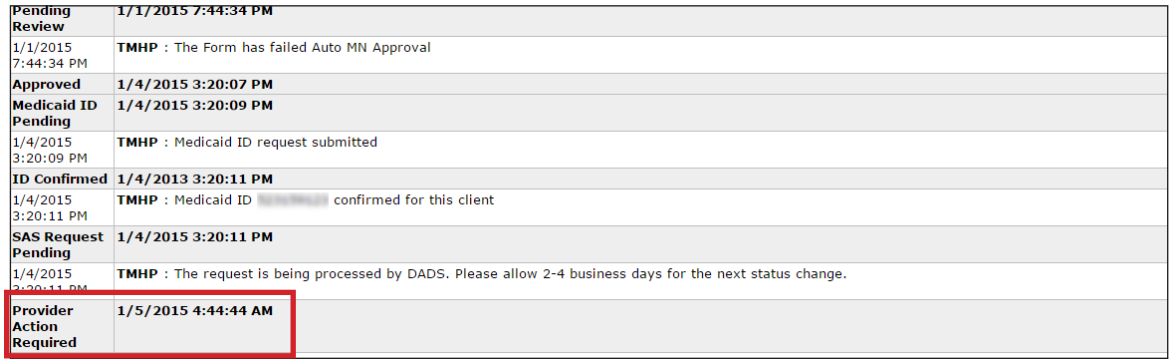
8) Click the **View Detail** link to open the assessment.

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



History	
Form Submitted	**1/1/2015 7:44:32 PM**
Pending Review	**1/1/2015 7:44:34 PM**
1/1/2015 7:44:34 PM	**TMHP** : The Form has failed Auto MN Approval
Approved	**1/4/2015 3:20:07 PM**
Medicaid ID Pending	**1/4/2015 3:20:09 PM**
1/4/2015 3:20:09 PM	**TMHP** : Medicaid ID request submitted
ID Confirmed	**1/4/2013 3:20:11 PM**
1/4/2015 3:20:11 PM	**TMHP** : Medicaid ID [redacted] confirmed for this client
SAS Request Pending	**1/4/2015 3:20:11 PM**
1/4/2015 3:20:11 PM	**TMHP** : The request is being processed by DADS. Please allow 2-4 business days for the next status change.
Provider Action Required	**1/5/2015 4:44:44 AM**
1/5/2015 4:44:44 AM	**TMHP** : CS-0004: This assessment cannot be processed because the Annual assessment has been submitted more than 132 days after the end of the last Service Plan. Submit an Initial assessment.

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



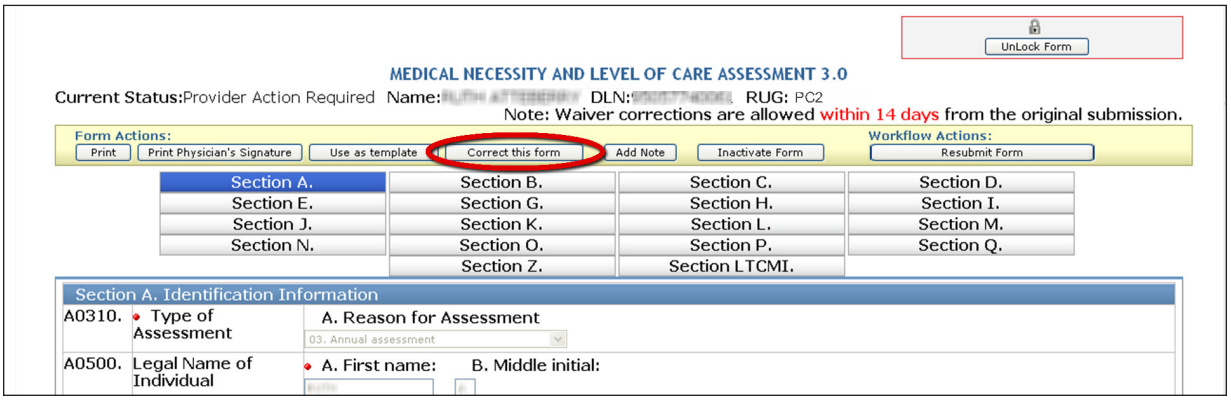
Pending Review	**1/1/2015 7:44:34 PM**
1/1/2015 7:44:34 PM	**TMHP** : The Form has failed Auto MN Approval
Approved	**1/4/2015 3:20:07 PM**
Medicaid ID Pending	**1/4/2015 3:20:09 PM**
1/4/2015 3:20:09 PM	**TMHP** : Medicaid ID request submitted
ID Confirmed	**1/4/2013 3:20:11 PM**
1/4/2015 3:20:11 PM	**TMHP** : Medicaid ID [redacted] confirmed for this client
SAS Request Pending	**1/4/2015 3:20:11 PM**
1/4/2015	**TMHP** : The request is being processed by DADS. Please allow 2-4 business days for the next status change.
Provider Action Required	**1/5/2015 4:44:44 AM**

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

12) Perform the necessary research to resolve the error. For more information on the error messages, see the Provider Workflow Rejection Messages section of this User Guide.

13) Depending on the provider research, a provider has one of three options to move the assessment out of the provider workflow. These are Correct this form, Inactivate form, or Resubmit form.

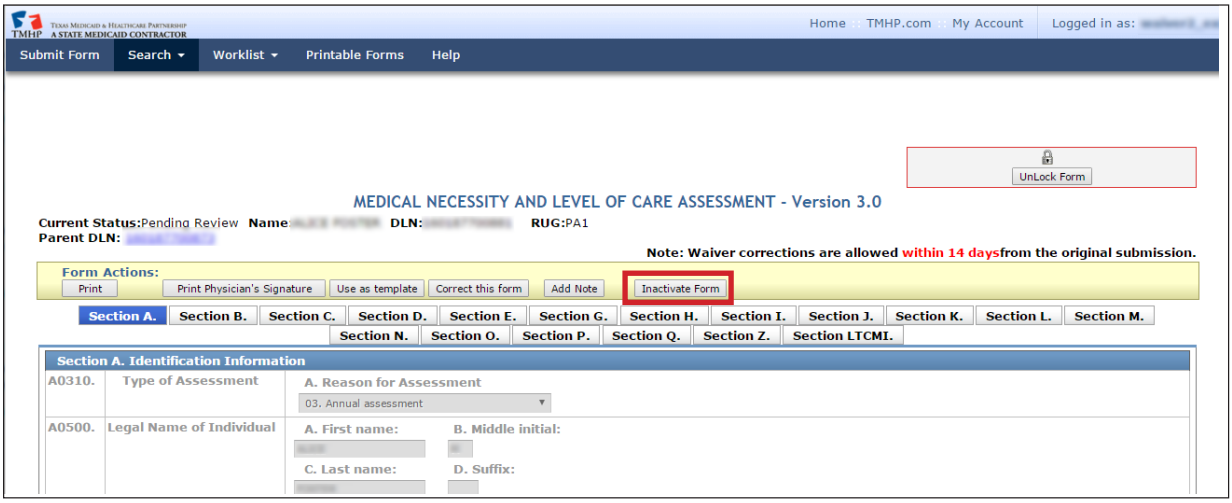
- Correct this form. The **Correct this form** button allows providers to submit a correction within 14 calendar days of the original submission date. The original assessment with a status of ***Provider Action Required*** will be set to status ***Corrected*** and will have a parent relationship DLN to the new/child assessment. The new assessment replaces the original assessment.



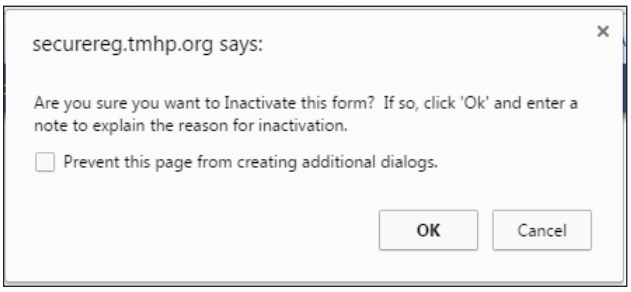
Most fields can be corrected. Only the following fields cannot be corrected:

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

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



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

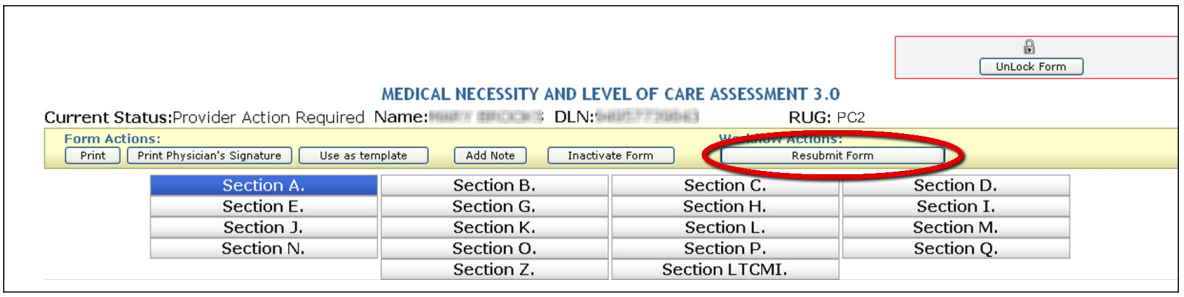


From here you have two choices:

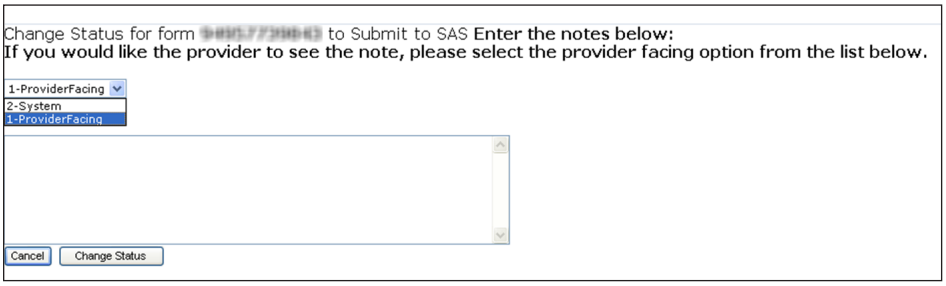
a) Click the **OK** button to Inactivate, and the assessment will set to status ***Form Inactivated***.
or

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



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



The provider can choose one of the following options:

- **1-ProviderFacing**: This option allows comments entered to be seen by both state staff and the provider.
- **2-System**: This option allows comments entered by the provider to be seen only by internal state staff. The comments will not be seen by the provider.

- In either case, the comments will be seen in the History trail of the assessment and are for informational purposes only. These comments will *not* be used in the system processing of the assessments. The provider may choose to enter comments. Entering comments is optional.

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

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

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

15) Repeat all of the steps for finding Wavier 3.0: Medical Necessity and Level of Care Assessments set to status ***Provider Action Required*** until there are no results found.

Provider Workflow Rejection Messages

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

The table contains four columns:

1) **Message Number.** This is the specific error message that will be displayed in the portal.
2) **System Message.** This provides further clarification of the portal error message including 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.

Message Number	System Message (Displayed in History)	Associated with Reason for Assessment	Suggested Action
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.
CS-0005	CS-0005: This assessment cannot be processed because a previous Service Plan cannot be found. Submit an Initial assessment.	Annual	The request cannot be processed because a previous Service Plan cannot be found. Submit an Initial Assessment.
CS-0006	CS-0006: The request cannot be processed because an Initial Assessment for the individual cannot be found.	Significant Change in Status Assessment	Verify data entry or contact your regional PSU Representative.
CS-0011	CS-0011: This assessment cannot be processed because there is not an open Service Plan for the individual. Verify data entry or contact the case manager.	Significant Change in Status Assessment	Inactivate Form.
CS-0012	CS-0012: This assessment cannot be processed because the SCSA assessment is being submitted more than 30 days after the Service Plan end date.	Significant Change in Status Assessment	Inactivate Form.
CS-0020	CS-0020: This assessment cannot be processed because the annual assessment is being submitted more than 90 days prior to the Level of Service end date.	Annual	Inactivate this assessment by clicking the **Inactivate Form** button and submit an Annual Assessment within 90 days of the Level of Service end date.

Message Number	System Message (Displayed in History)	Associated with Reason for Assessment	Suggested Action
CS-0021	CS-0021: This assessment cannot be processed because the annual assessment has been submitted more than 132 days after the end of the last Level of Service record.	Annual	Inactivate this assessment by clicking the **Inactivate Form** button and submit an Initial Assessment Waiver 3.0: 0310a=01.
CS-0023	CS-0023: This assessment cannot be processed because the individual is enrolled in PACE and has Permanent Medical Necessity. Annual assessments for this individual are not needed. This assessment should be Inactivated.	Annual	Inactivate Form.
GN-9007	This form must be manually processed by DADS.		Contact Provider Claims Services for assistance.
GN-9010	This form must be manually processed by DADS.		Contact Provider Claims Services for assistance.

Message Number	System Message (Displayed in History)	Associated with Reason for Assessment	Suggested Action
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://hhs.texas.gov/about-hhs/find-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 are correctable (see list of fields unable to be corrected in the Provider Workflow section).

Examples of incorrect data include:

- The person is listed as a male, but is actually a female.
- The person's diagnosis indicates diabetes, but the person actually has hypoglycemia.
- If corrections to the MN/LOC Assessment are needed, providers must access the assessment utilizing FSI or Current Activity.

When to Correct Assessments

MN/LOC Assessments can only be corrected during the 14 calendar day time period following the original submission date. The fields below are non-correctable.

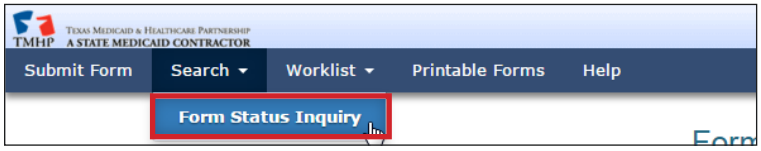
Waiver 3.0: MN/LOC Assessment	
A0500c	Individual Name (does not allow changes to last name)
A0600a	Social Security Number
A0600b	Medicare (or comparable railroad insurance number)
A0700	Medicaid Number
A0310a	Type of Assessment/Tracking
Z0500b	Date Assessment Completed
S5a-S5m	Licenses section
S2a	DADS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

Who May Submit the Correction?

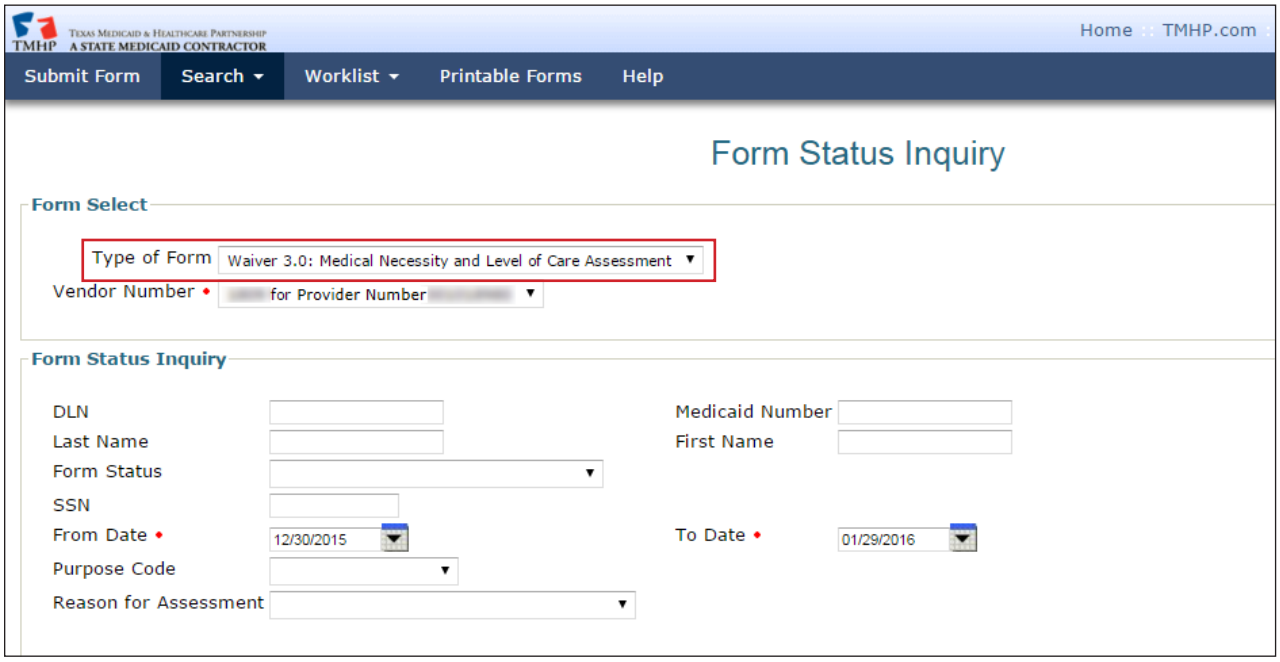
A correction does not have to be submitted by the original submitter, but it has to be from the same vendor/provider number. Regardless of the current status of an MN/LOC Assessment, corrections will not be allowed to assessments that have at any time been set to status ***Form Inactivated***, ***Invalid/Complete***,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

How to Submit a Correction

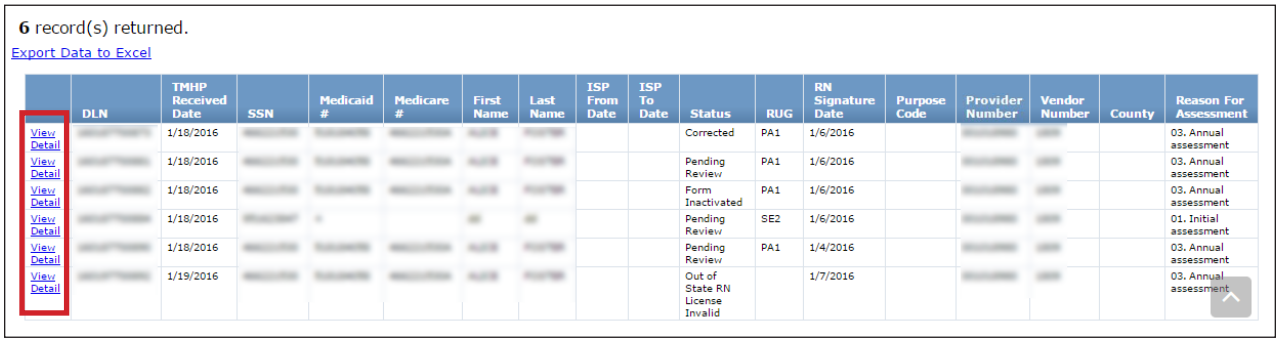
1) Click or hover over the **Search** link on the blue navigational bar.
2) Click the **Form Status Inquiry** link from the drop-down box.



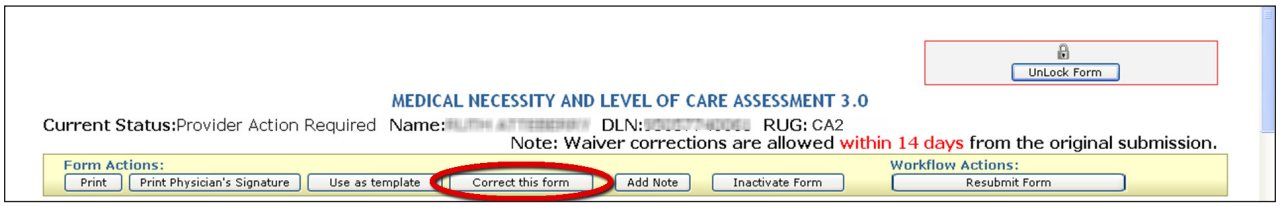
3) Type of Form: Choose **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the drop-down box.



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, From Date, and To Date.
5) Click the **Search** button.
6) Click the **View Detail** link of the requested assessment.



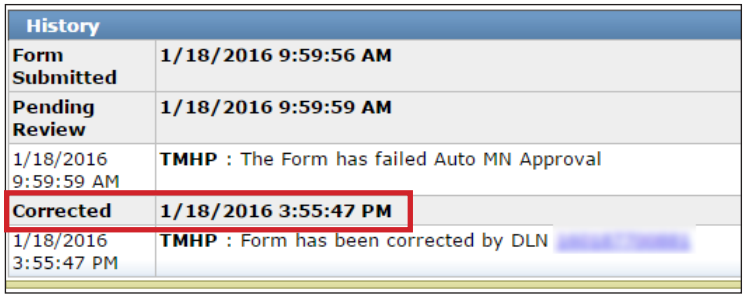
7) Click the **Correct this form** button.



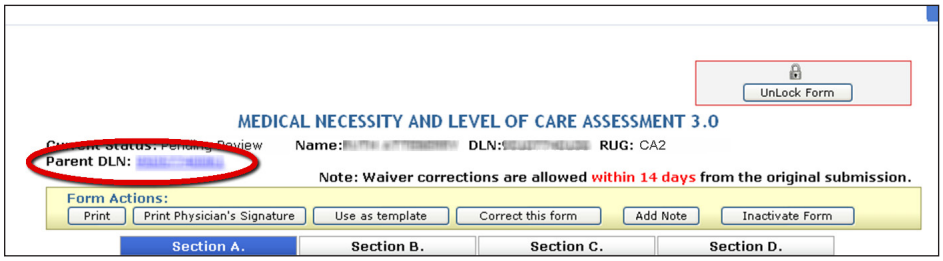
8) Complete only the fields needing correction.

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



Inactivations

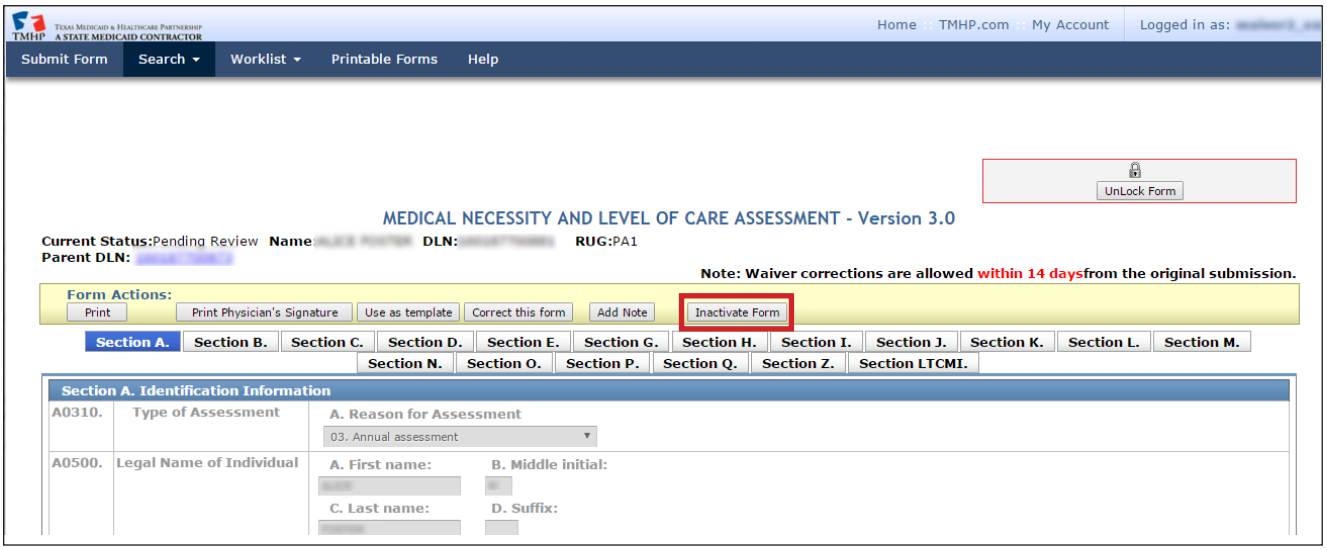
Assessments may need to be inactivated when fields cannot be corrected as needed (e.g., Medicaid #, Individual Name). MN/LOC Assessments can be inactivated through the LTC Online Portal by first retrieving the assessment using FSI or Current Activity. Once the assessment is inactivated, it will be set 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 #, Individual Name).

Who May Inactivate?

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



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

How to Inactivate an Assessment

1) Login to the LTC Online Portal.
2) Click or hover over the **Search** or **Worklist** links on the blue navigational bar.
3) Click the **Form Status Inquiry** or **Current Activity** link, respectively.
4) Click the **View Detail** link.
5) Click the **Inactivate Form** button.
6) Click the **Ok** button when the pop-up window asks “Are you sure you want to Inactivate this form?” If so, click **Ok** and enter a note to explain the reason for inactivation.
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 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. The State of Texas 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, SE1)
2) Rehabilitation All Levels (RAD, RAC, RAB, RAA)
3) Special Care (SSC, SSB, SSA)
4) Clinically Complex with/without Depression (CC2, CC1, CB2, CB1, CA2, CA1)
5) Cognitive Impairment with/without Nursing Rehab (IB2, IB1, IA2, IA1)
6) Behavior Problem with/without Nursing Rehab (BB2, BB1, BA2, BA1)
7) Physical Function with/without Nursing Rehab (PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, 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 utilizing the Texas State University online training. 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:
http://www.txstate.edu/continuinged/CE-Online/RUG-Training.html

Reminders

- LTC Online Portal has 24/7 availability to submit and track assessments.
- Utilize FSI and Current Activity. These features will keep you informed of the status of your 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**, **Option 2**. Refer to the Add Note section of this User Guide for instructions on how to do this.
- All RN and MD/DO licenses are validated against the appropriate licensing state board. Updates are received monthly, with MD licenses being updated within the first 10 days of the month and RN licenses being updated in the latter portion of the month (generally between the 20th and 25th). Be advised that delayed licensure renewal may result in a delay in form processing.
- Use the TMHP website at www.tmhp.com/programs/ltc for recent updates and new information.
- This User Guide can be found under the **Help** link located on the blue navigational bar within the LTC Online Portal.

Reporting Medicaid Waste, Abuse, and Fraud

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 Waste, Abuse, and Fraud

Reports may be made through the following website: https://oig.hhsc.state.tx.us. 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 waste, abuse, and fraud to report to the Office of the Inspector General (OIG).

If you are not sure if an action is waste, abuse, or fraud of Texas Medicaid, report it to OIG and let the investigators decide. If you are uncomfortable about submitting a report online, there is a telephone number for Client Fraud and Abuse reporting: **800-436-6184**.

HIPAA Guidelines and Provider Responsibilities

Providers must comply with HIPAA. It is your responsibility to comply with HIPAA, to seek legal representation when needed, and to consult the appropriate manuals or speak to your TMHP Provider Representative when you have questions.

Resource Information

TMHP Call Center/Help Desk

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

- General Inquiries: Press 1
- Medical Necessity: Press 2
- Technical Support: Press 3

Fax.....512-514-4223

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

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

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

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

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

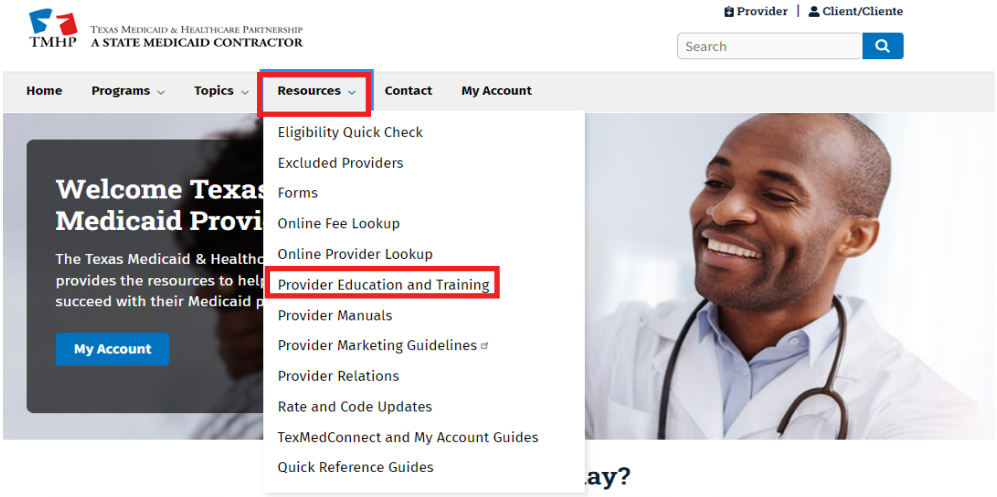
PACE Program Contacts.....512-438-2013

Additional Online Training

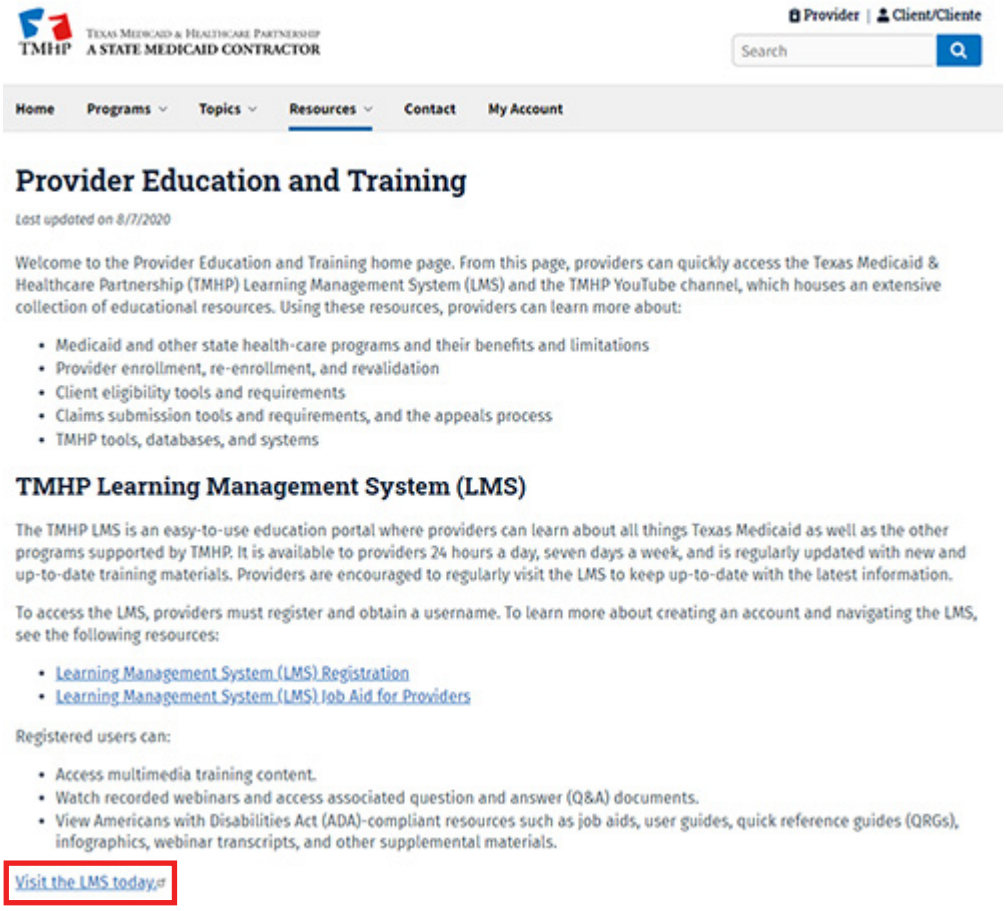
Webinar replays of the LTC Community Services Waiver Programs material are available on the TMHP Learning Management System (LMS).

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

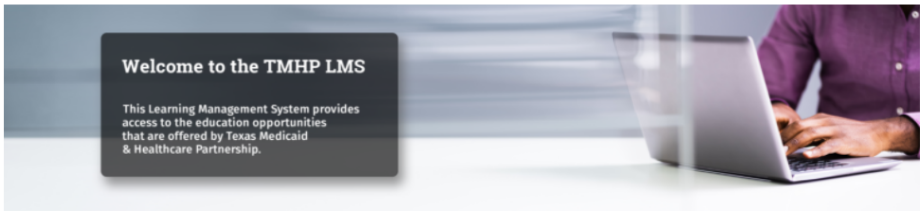
1) Go to www.tmhp.com, click **Resources**, then **Provider Education and Training**.



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.



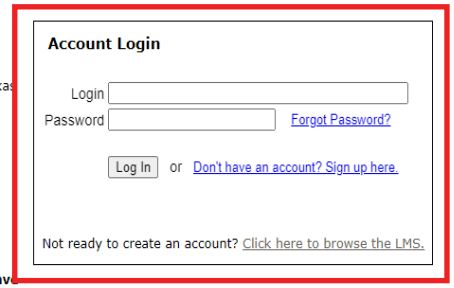
Welcome to the TMHP LMS

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

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

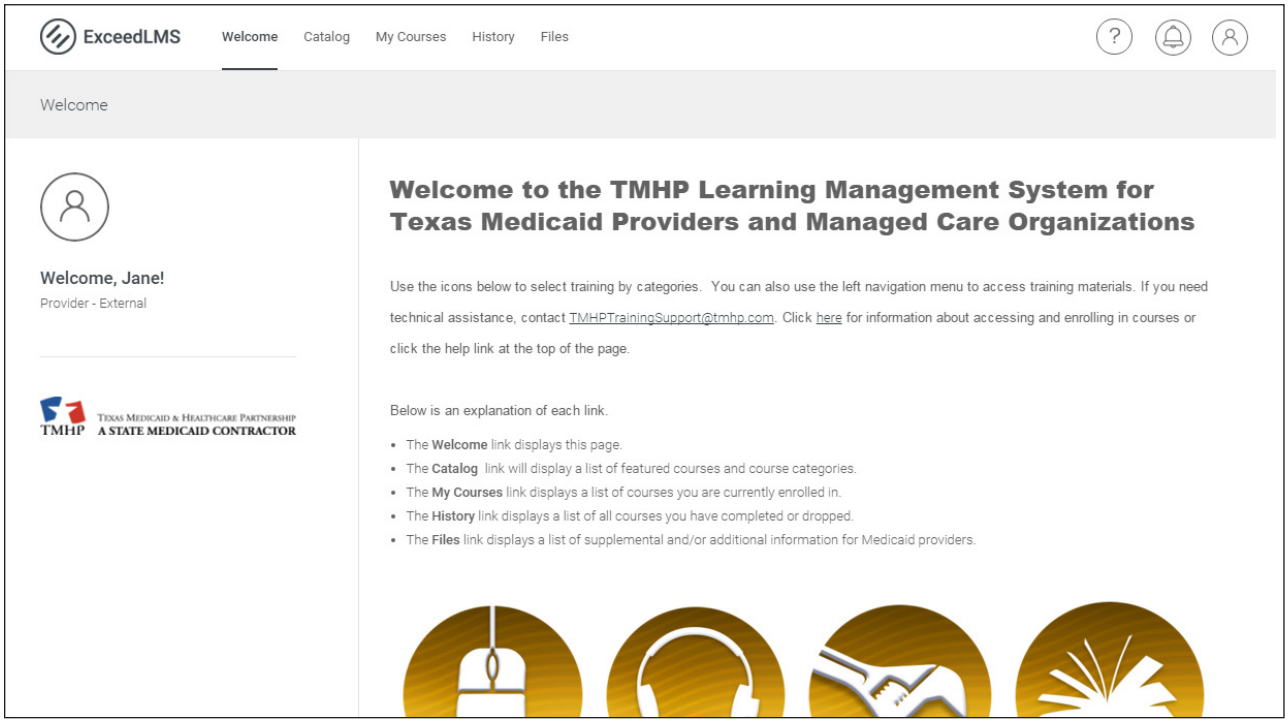
If this is your first visit, click **Don't have an account? Sign up here.** to create a user account. If you need help, click here or email TMHP Training Support.

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

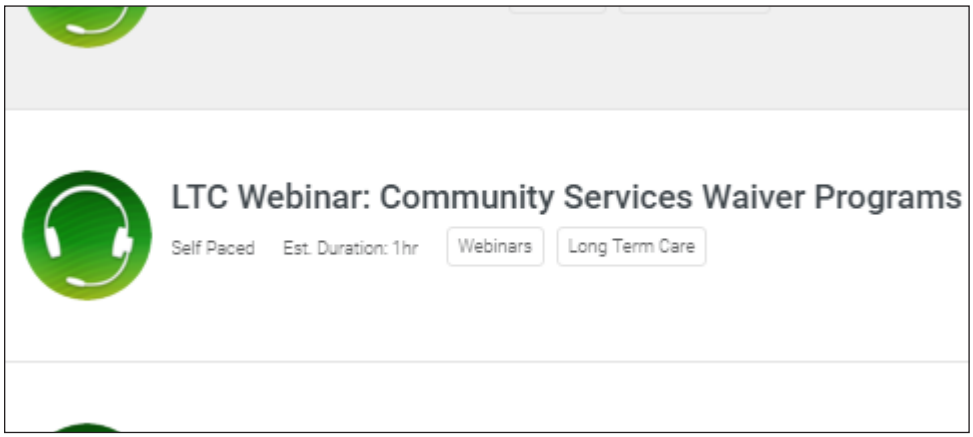


TMHP

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



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



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

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

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

Informational Websites

Website	Link
Centers for Medicare & Medicaid Services	www.cms.hhs.gov
Community Services Policies and Programs	https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers
Consumer Rights and Services (includes information about how to make a complaint)	https://hhs.texas.gov/about-hhs/your-rights/complaint-incident-intake
Health and Human Services Commission	https://hhs.texas.gov/
HHSC Regions	https://hhs.texas.gov/about-hhs/find-us
Long-Term Care Provider Bulletins	www.tmhp.com/programs/ltc/long-term-care-ltc-provider-bulletins
Medicaid Fraud	https://oig.hhsc.state.tx.us/
Medicaid Nursing Facility Program	https://apps.hhs.texas.gov/providers/NF/index.cfm

Website	Link
Medical Necessity and Level of Care 3.0 Assessment and Instructions	www.tmhp.com/programs/ltc/forms
RUG Training	www.txstate.edu/continuinged/CE-Online/RUG-Training.html
Texas Administrative Code	www.sos.state.tx.us/tac/
Texas Department of Aging Services	https://hhs.texas.gov/services/aging
Texas Department of Disability Services	https://hhs.texas.gov/services/disability
Texas Department of State Health Services	http://www.dshs.texas.gov/
Texas Medicaid & Healthcare Partnership	www.tmhp.com
TMHP Long-Term Care Division	www.tmhp.com/programs/ltc
Vendor Drug Program	http://txvendordrug.com/

Acronyms

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

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

Glossary

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

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

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

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

Individual - A person enrolled in a program.

LTSS - Long-Term Services and Support services are 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.

MCO - 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 specific payment per person. 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 Providers - A 1915(c) Medicaid waiver program approved for the managed care delivery system that is designed to allow people who qualify for nursing facility care to receive long-term services and supports to be able to live in the community.