Long-Term Care (LTC)
User Guide for TexMedConnect

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

v2020_0924

Contents

Terms and Abbreviations

API	Atypical Provider Identifier
ARD	Assessment Reference Date
CBA	Community Based Alternatives
CMS	Centers for Medicare & Medicaid Services
CS	Community Services
CSI	Claim Status Inquiry
DLN	Document Locator Number
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOPS	Explanation of Pending Status
ETN	EDI Transaction Number
FFS	Fee For Service
FSI	Form Status Inquiry
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization (Note: HMO has been changed to MCO)
ICF/IID	Intermediate Care Facility/Facilities for Individuals with an Intellectual Disability or Related Conditions
ICN	Internal Control Number
ID	Intellectual Disabilities
IDD	Intellectual and Developmental Disabilities
LTC	Long-Term Care
MCO	Managed Care Organization (Formerly HMO)
MCO ICN	Managed Care Organization Internal Control Number
MESAV	Medicaid Eligibility and Service Authorization Verification
MN	Medical Necessity
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
PDF	Portable Document Format
R&S	Remittance and Status
RUG	Resource Utilization Group
SAS	Service Authorization System
SC	Service Code
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**

Adjustments

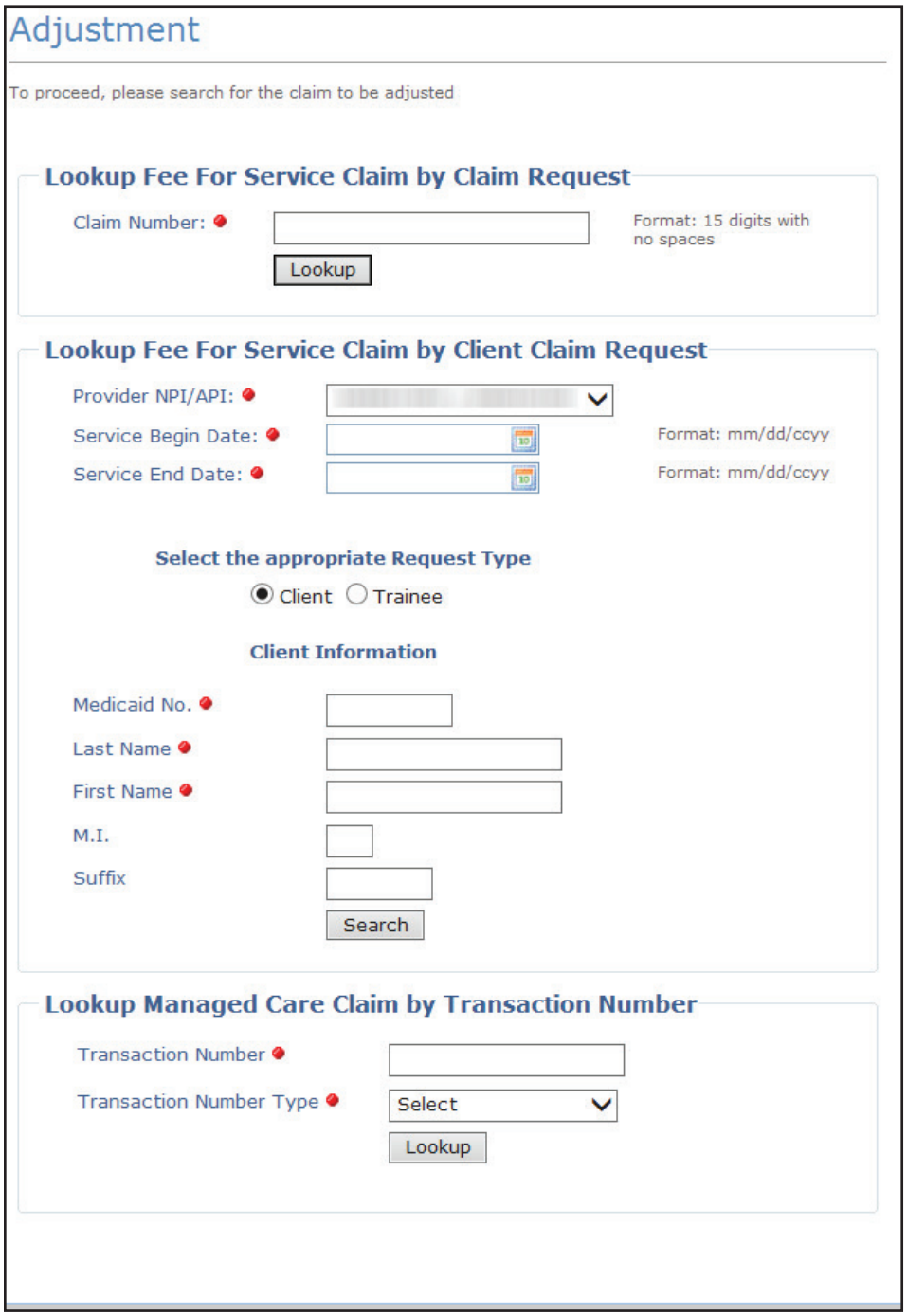
Creating an Adjustment for a Fee-For-Service Claim

An adjustment is a change made to a previously paid claim. Adjustments reimburse Health and Human Services (HHS) for overpayments and to reimburse providers if units were underbilled and must be paid correctly. Only claims that are set to status ***Paid*** can be adjusted using TexMedConnect. If you submit an Adjustment, you must return the amount that you were paid, not the amount that was billed.

NOTE: *Providers must contact MCOs directly to make adjustments to claims forwarded by TMHP.*

1) To make an adjustment on a fee-for-service claim, click the **Adjustments** link under the CSI section on the navigation panel.

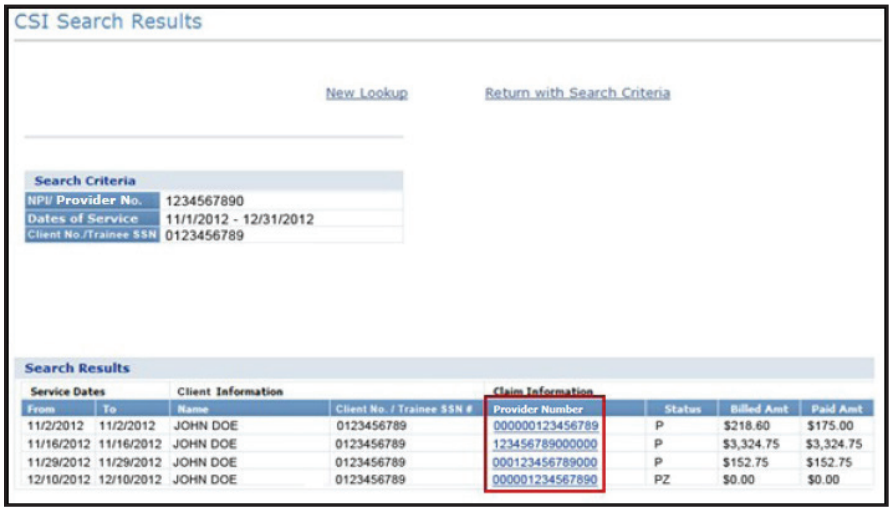
2) Option one, enter the claim number, and click the **Lookup** button.



3) Option two, if you do not know the claim number, you can search for the claim using the person's information. Enter the required information, and click the **Search** button.

- The date range must be no more than three months long.
- You must enter both a Service Begin Date and a Service End Date.
- The Service Begin Date cannot be more than 36 months before the current date.
- You must complete all of the fields that are indicated by a red dot.

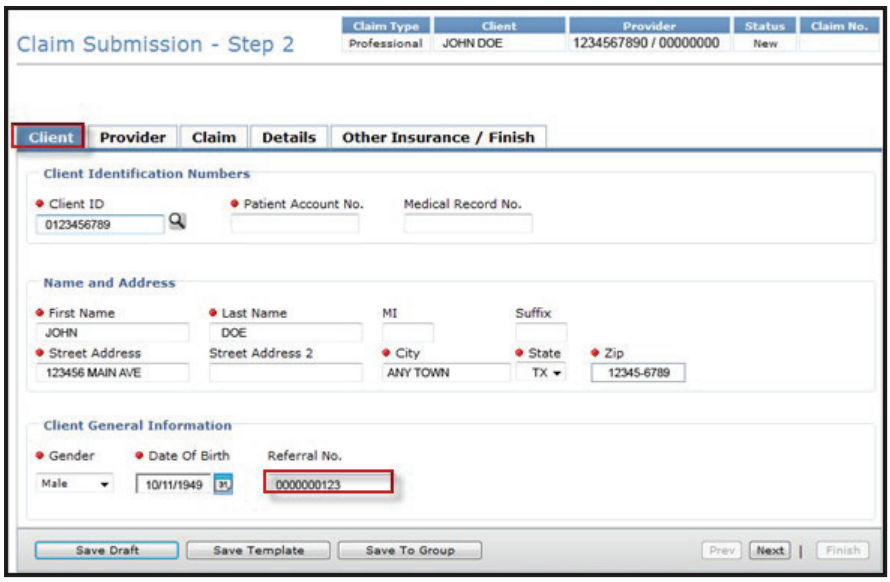
4) The search result is displayed. If more than one claim number with the same service dates and bill code is displayed as a result of your search, you can only adjust the claim with the most current processing (or status) date. Click the claim number to begin adjusting the claim. Providers can determine the most recent claim by comparing the Claim Status Dates, also known as the Effective Date. To determine which claim is the most recent, click on the hyperlink for each claim in the list for your date range and compare the effective dates of each claims. Whichever claim has the most recent Effective Date is the one that needs to be adjusted.



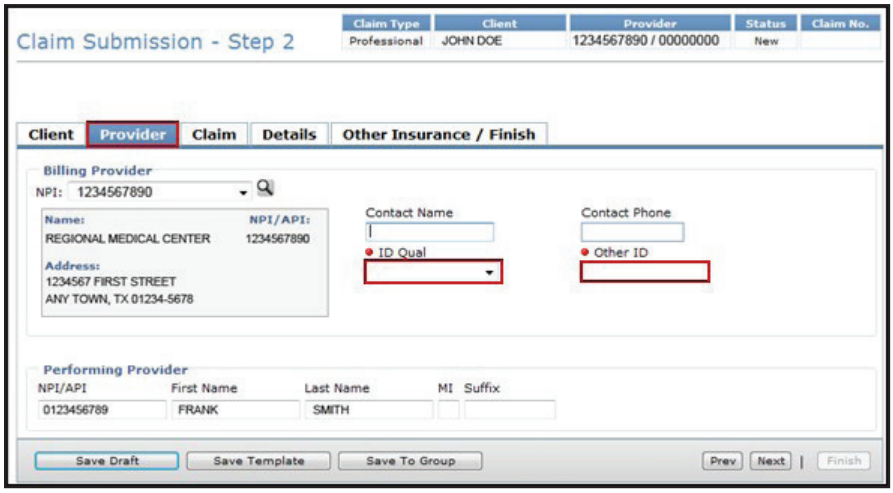
5) Select the appropriate Claim Type from the drop-down box, and click the **Adjust Claim** button.

6) Verify that all of the required fields that are indicated by a red dot are populated for each tab.

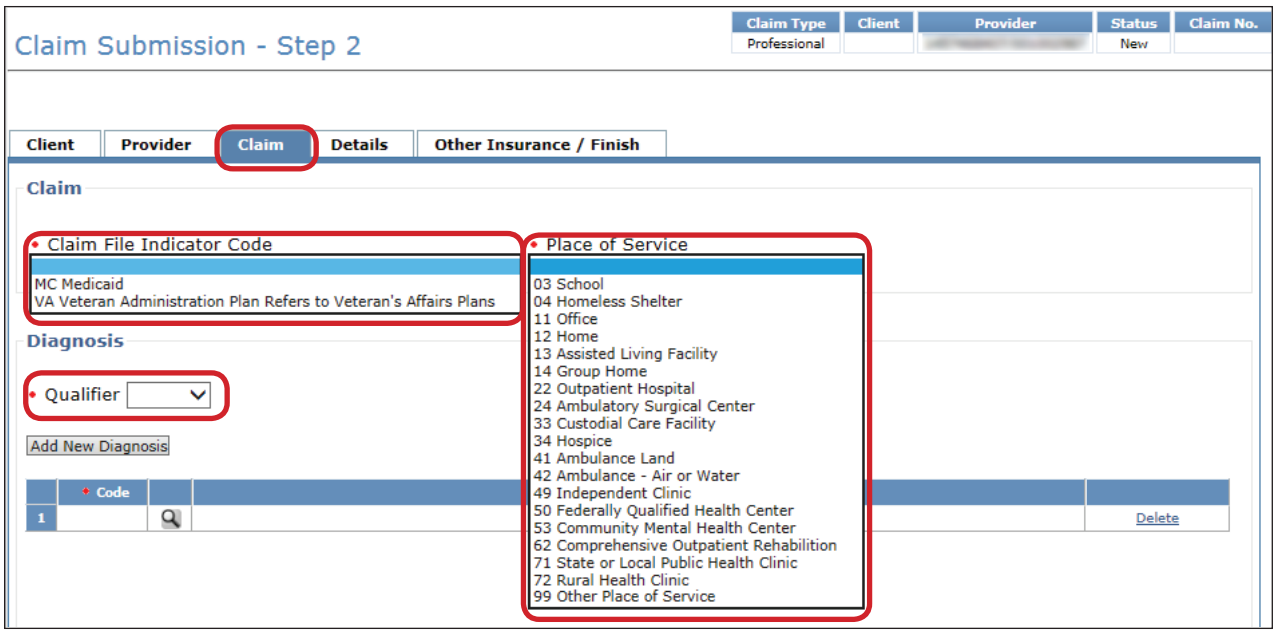
7) ***Client Tab***. Verify that the information is correct and that there is a referral number on the Professional claim.



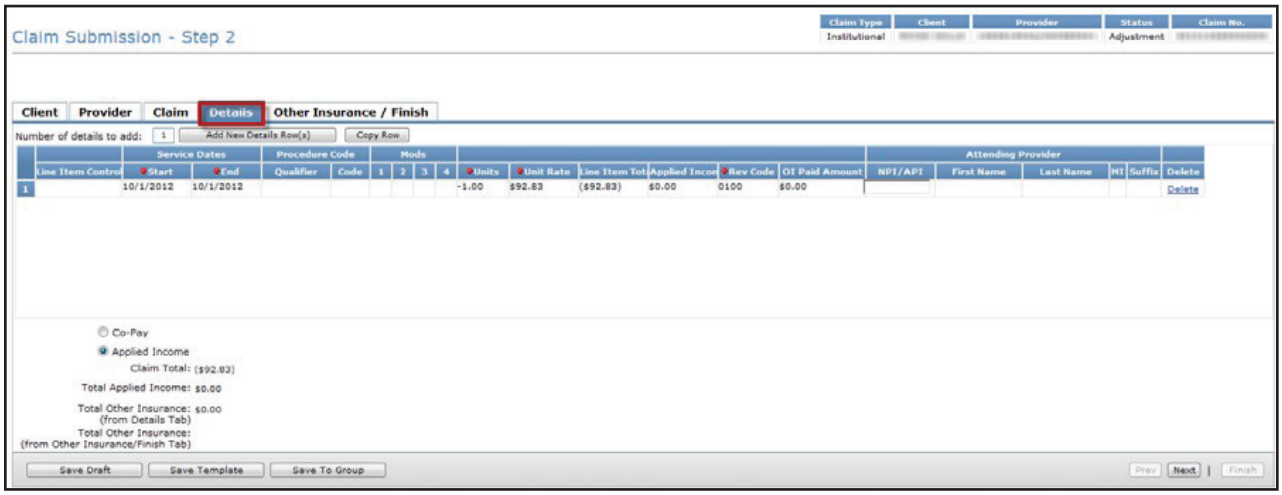
8) *Provider Tab*. Select the ID qualifier from the ID Qual drop-down box and enter the Other ID number in the Other ID field.



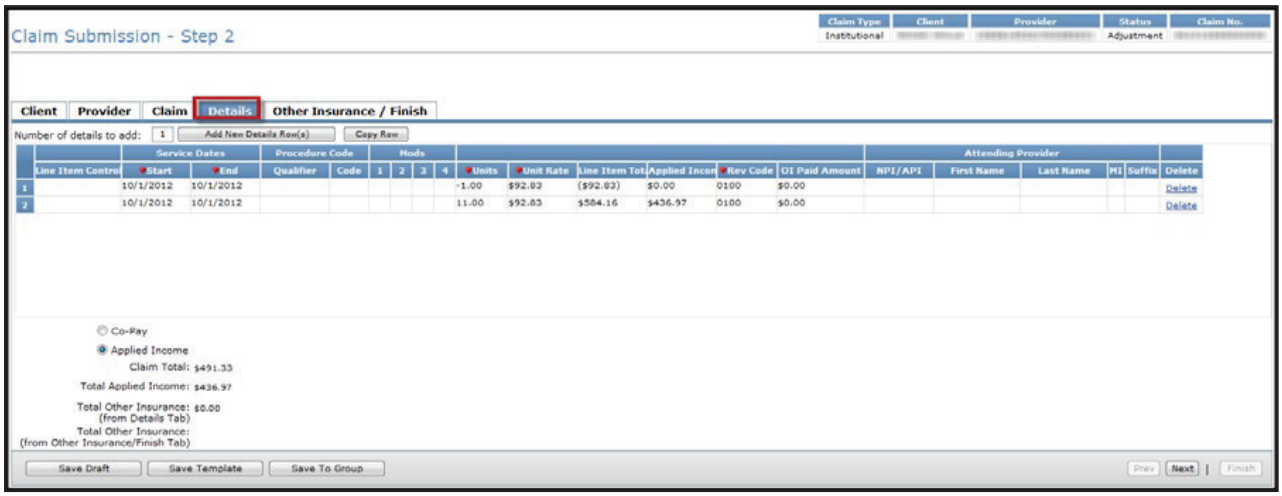
9) *Claim Tab.* Select a Claim File Indicator Code from the drop-down box. Select a Place of Service from the drop-down box. Both institutional and professional claims require a valid diagnosis code. Inputting an invalid diagnosis code may result in an error message (and a subsequent inability to submit a claim) in TexMedConnect. Use the Qualifier field to indicate whether the diagnosis code is an ICD-9 or ICD-10 code.



10) ***Details Tab***. On the details tab, the system will auto populate the negative row(s) with the data that was initially paid on the initial claim. The fields Unit, Unit Rate, and Line Item Total will be auto populated and read only. The fields OI and AI/Co-Pay on the negative row(s) will always be auto populated with 0. The user should not attempt to modify these fields on the negative row(s). If the initial claim to be adjusted had multiple details, all the claim detail rows will show up as negative line details. If the provider does not wish to adjust all the rows on the initial claim, they will need to delete the rows they do not wish to adjust by using the **Delete** button on the right side of the row. The line item total will be in parentheses. If the adjustment is to return the entire amount of the claim, there is no need to click the **Add New Details Row(s)** button.



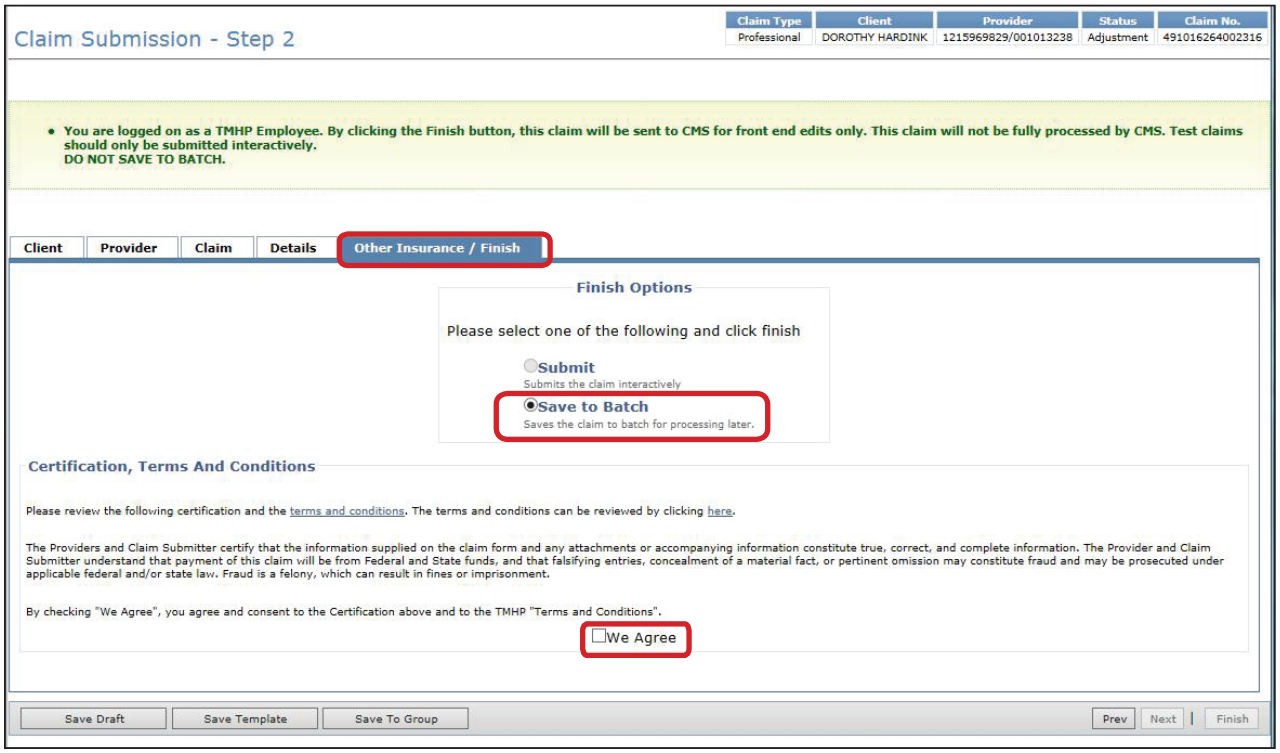
11) To bill positive units for the same adjusted claim, click the **Add New Details Row(s)** button. On the new row, you will add the dates of service and the accurate number of units that are to be paid. After the rate is entered, tab over to the Applied Income field. The Applied Income or Co-Pay will be calculated automatically. At the bottom left of the screen, the Claim Total and the Total Applied Income or Co-Pay that was deducted from the positive line will display. The provider should also fill in the OI field on the positive line (if applicable).



Saving and Submitting an Adjustment

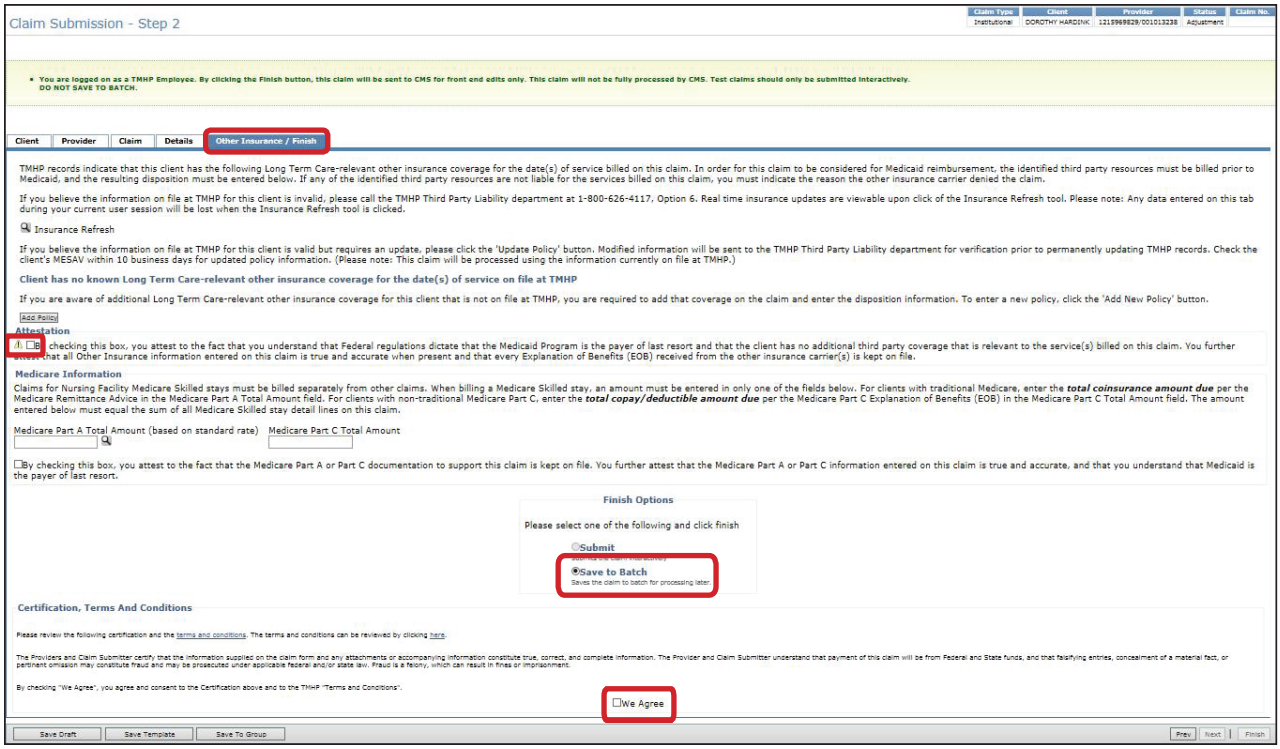
All adjustments must be submitted as batches.

1) To save a Professional or Dental claim adjustment as a batch, click the **Other Insurance / Finish** tab, click the **Save to Batch** radio button, check the **We Agree** box, and then click the **Finish** button in the lower right corner.



2) **For Institutional Claims**, check the box under Attestation, click the **Save to Batch** radio button, check the **We Agree** box, and then click the **Finish** button.

Note: *For claims in Service Group 1, 6, and 8, the OI Paid Amount entered in the Details tab will have to equal the OI Paid Amount in the Other Insurance/Finish Tab.*



Review your batch history to ensure that the adjustment was successfully processed. The submission of the pending batch is initially **Accepted** but can be **Rejected** once additional system edits are applied. Refer to the Submitting a Batch section of this User Guide for information about submitting batches.

Training and Support

TexMedConnect Training

The TexMedConnect for Long-Term Care Providers computer-based training (CBT) module is an online course that can be reviewed at your own pace. It is available in the Provider Education section of the TMHP learning management system at learn.tmhp.com.

Technical Support

You can contact the TMHP Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638, Option 4, Monday through Friday 7:00 a.m. to 7:00 p.m., for Long-Term Care technical issues. The TMHP EDI Help Desk provides technical assistance for TexMedConnect and the TMHP EDI Gateway. Contact your system administrator for assistance with modem, hardware, or Internet connectivity issues.

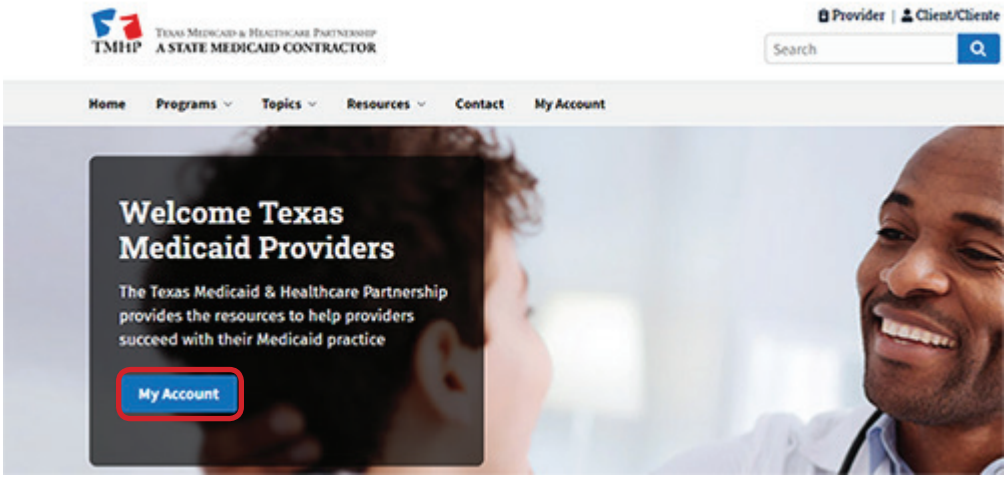
Claims Support

You can contact the TMHP LTC Helpdesk at 1-800-626-4117, Option 1, then Option 2, for questions about claims, Monday through Friday 7:00 a.m. to 7:00 p.m.

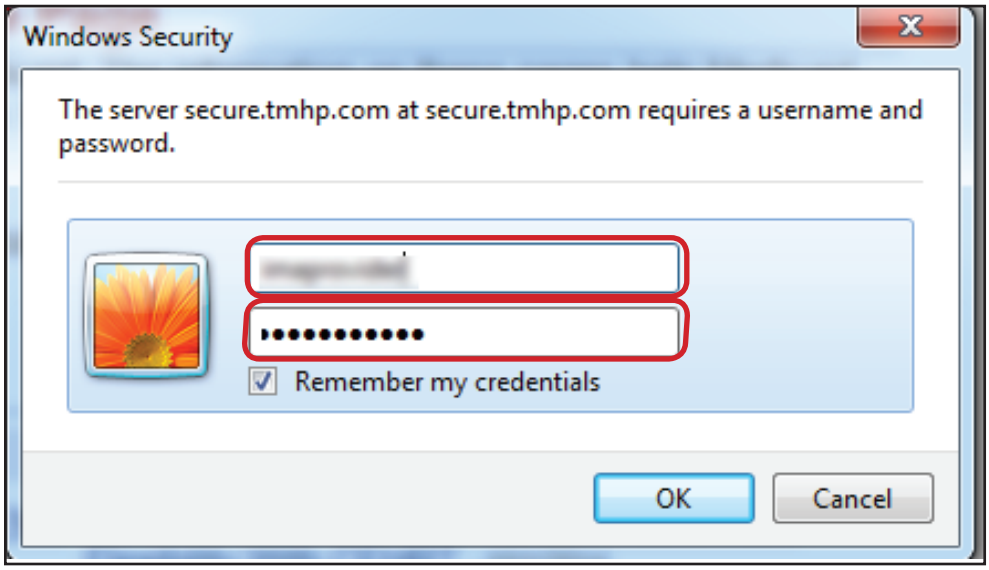
Getting Started

You can access TexMedConnect from the Long-Term Care Home page of the TMHP website. To use TexMedConnect you must already have an account on the TMHP website. If you do not have an account, you can set one up using the information provided in the *TMHP Website Security Provider Training Manual*.

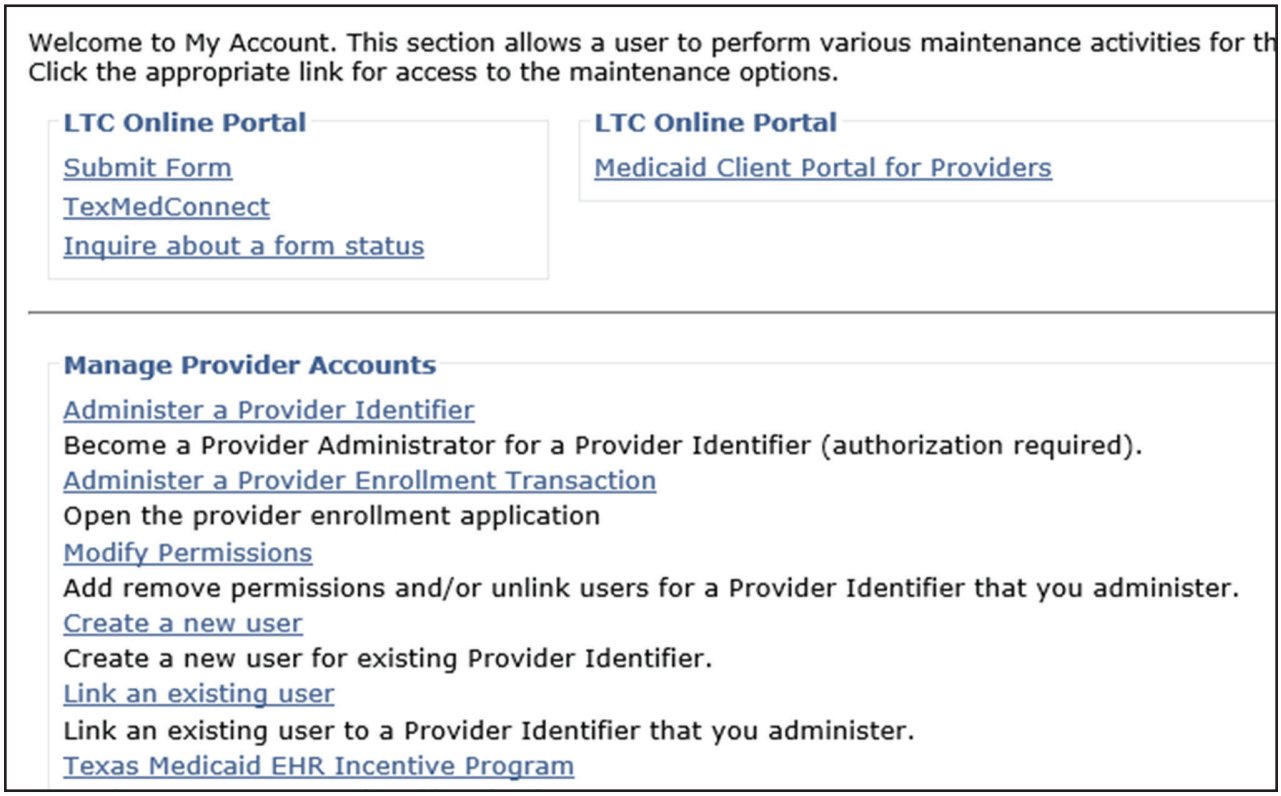
1) On www.tmhp.com click the **My Account** button.



2) Enter your user name and password, and click the **OK** button. As an option, you can save your login information by putting a check in the Remember my credentials box.



3) The My Account page will open to display all of the website features to which you have access. Click the **TexMedConnect** link.



TexMedConnect Navigation Panel

All of the available TexMedConnect Long-Term Care functions are located under the Long-Term Care branch in the left navigation panel. You can select any feature to which you have access. A user's access permissions determine which options are available in the left navigation panel. The provider administrator will grant access rights to the account. The complete details of how to setup access rights can be found in the *TMHP Website Security Provider Training Manual*.

MESAVs

Providers can view Medicaid Eligibility and Service Authorization Verifications (MESAVs) electronically using TexMedConnect. To prevent claim denials, it is necessary to verify a person's eligibility for Medicaid services.

Providers can interactively verify the eligibility for specific dates of service for a single person. The date range is restricted to three calendar months. The service authorization section of a MESAV indicates the billable or allowable services for the person.

To verify eligibility for a group of people at one time, create a MESAV Group Template. Each MESAV Group Template can contain up to 250 people. You can create up to 100 Group Templates for each National Provider Identifier (NPI) number.

Note: *People in a nursing facility (NF) with managed care eligibility segments must have service authorizations verified by the appropriate managed care organization (MCO). NFs should contact MCOs directly to determine service authorizations. NFs can use the Managed Care eligibility section at the bottom of the MESAV to verify enrollment with an MCO.*

Submitting a MESAV Interactively

To verify a person's eligibility:

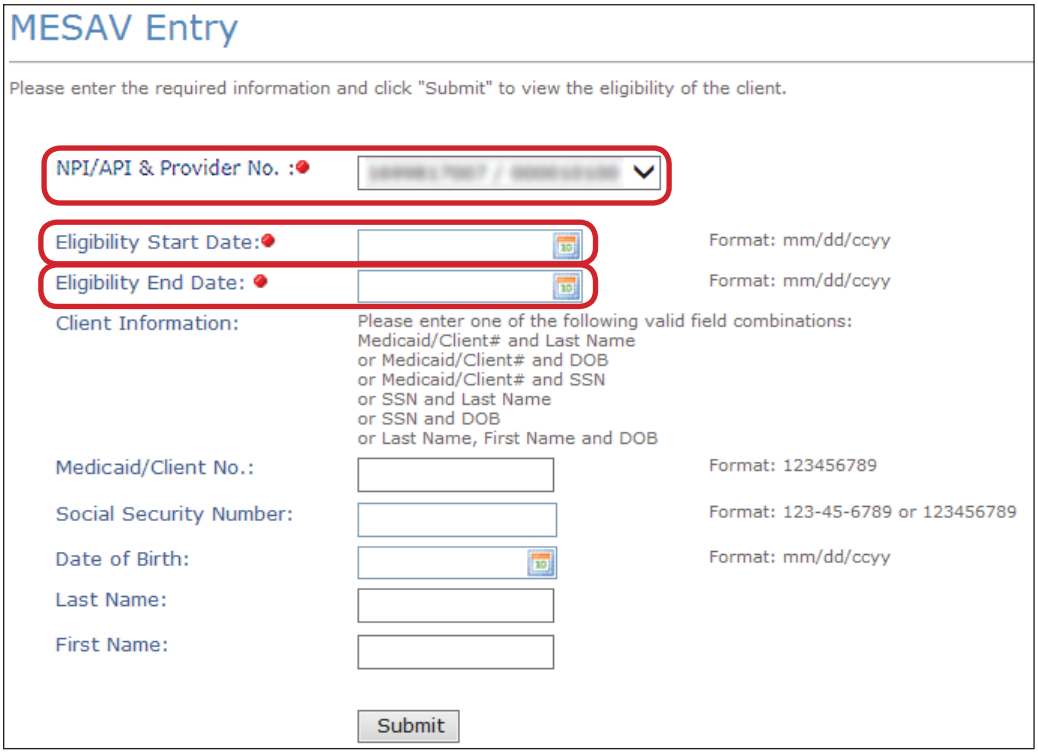
1) Click the **MESAV** link under the MESAV section on the navigation panel.

2) Complete the following required fields:

- Provider NPI/API* & Provider No.
  *National Provider Identifier (NPI)/Atypical Provider Identifier (API)
- Eligibility Start Date
- Eligibility End Date

Note: *The date range may not exceed three calendar months. Selecting a date range greater than three months will result in an error.*

- The Eligibility Start Date cannot be more than 36 months before the current date or be more than 3 consecutive months from the Eligibility End Date.
- The Eligibility End Date can include future dates of service, but cannot be more than 3 consecutive months from the Eligibility Start Date. For example, if the Eligibility Start Date of the MESAV is today, the Eligibility End Date can be up to 3 months in the future.

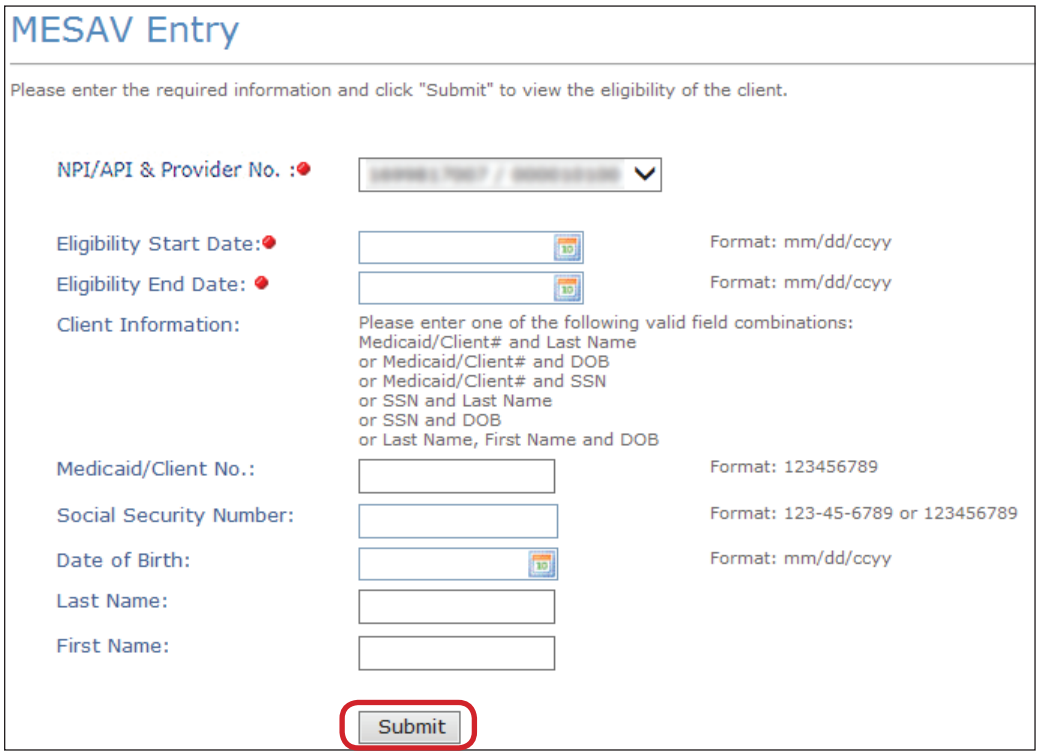


3) You must also enter additional information in any of the following field combinations:

- Medicaid/Client No. and Last Name
- Medicaid/Client No. and Date of Birth
- Medicaid/Client No. and Social Security Number
- Social Security Number and Last Name
- Social Security Number and Date of Birth (DOB)
- Last Name, First Name, and DOB

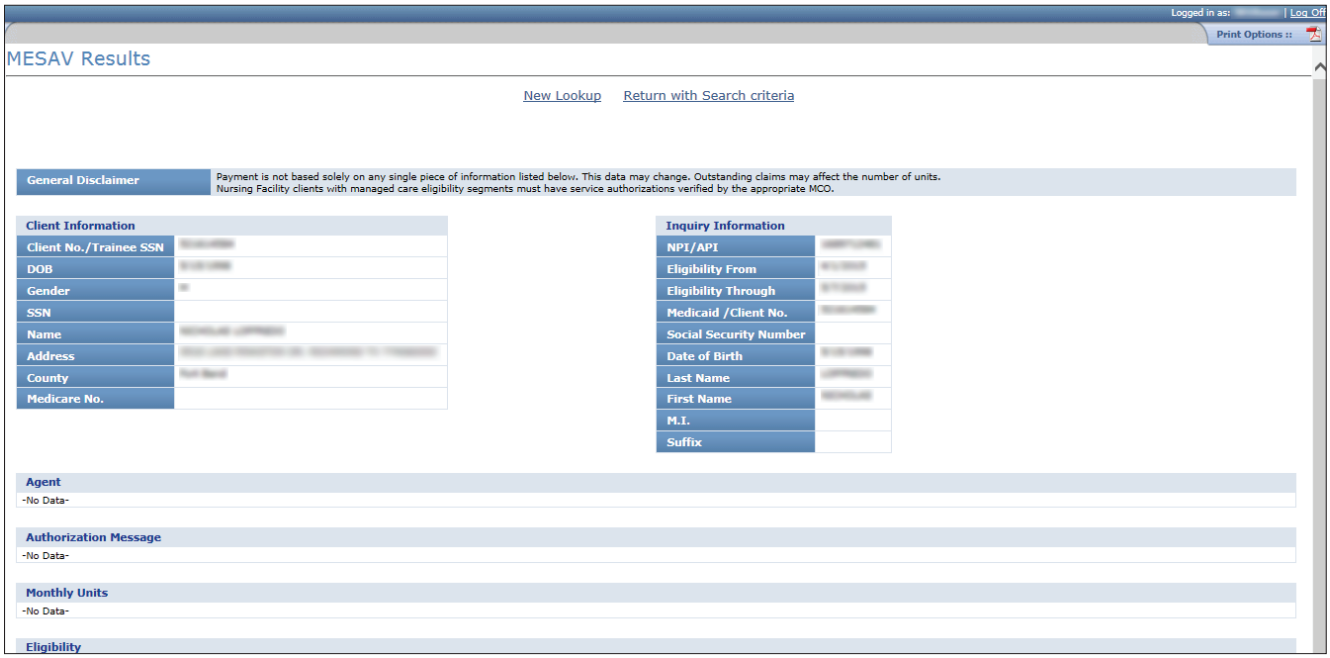
If you perform more than one interactive MESAV, the NPI or API and provider number on the MESAV Entry page will default to the last one that you used.

4) Click the **Submit** button.



5) The MESAV results screen will allow you to print the MESAV results in a Portable Document Format (PDF) file. To print the PDF click the **PDF** icon at the top right of the screen. If you want to print a paper copy of the results, click the **Print** button on your browser's toolbar.

Note: *PDF copies of MESAVs are only current at the time of printing and are not necessarily accurate afterwards. MESAV information can update daily. For the most up-to-date information, you should perform another MESAV electronically.*

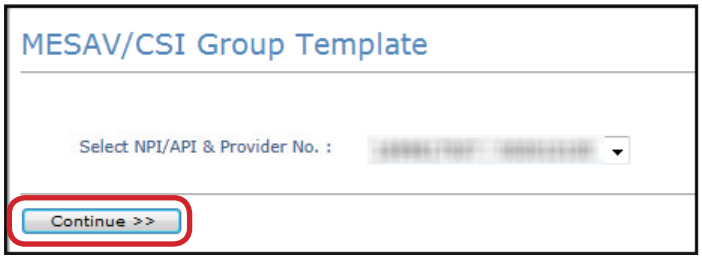


Creating a MESAV Group Template

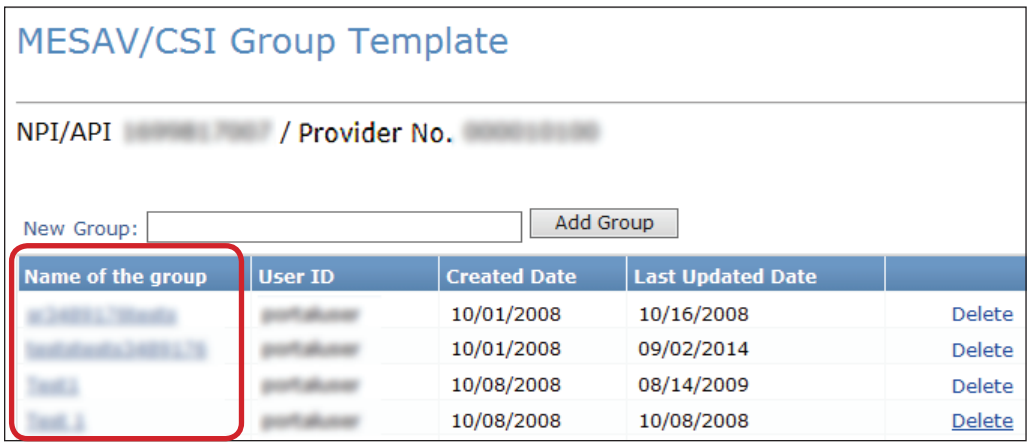
The Group Template feature allows you to create a list of people for whom you would like to verify eligibility. To create a MESAV group template and add a person:

1) Click the **Group Template** link under the MESAV section on the navigation panel.

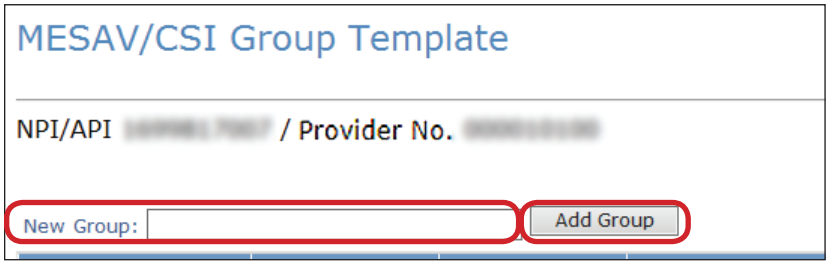
2) The MESAV/CSI Group Template screen will open. Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and then click the **Continue** button.



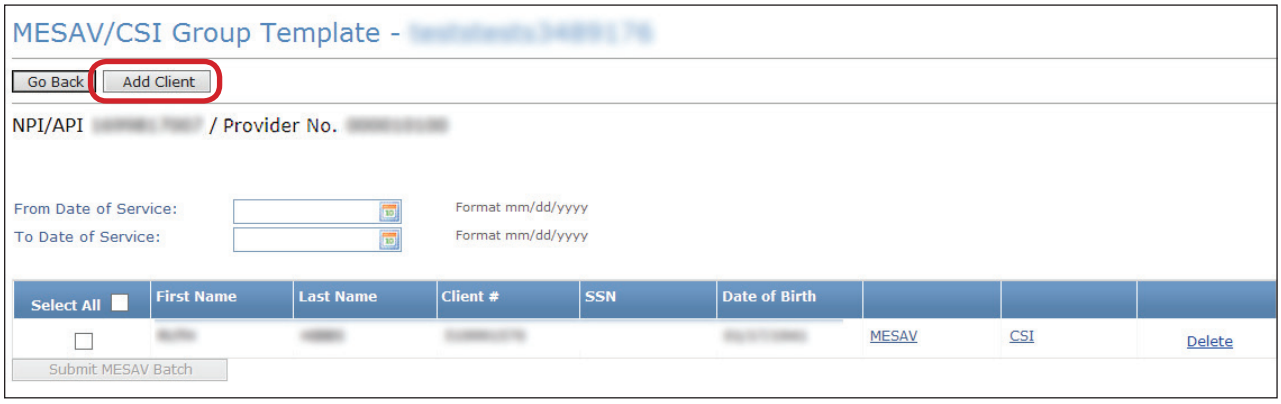
3) If you have already created a group and want to add a person to one of the existing Group Templates, click the link from the list that is displayed under the Name of the group column and skip to Step 5.



4) If you have not created a group or want to add a person to a new Group Template, enter the New Group name of your choice, and click the **Add Group** button.

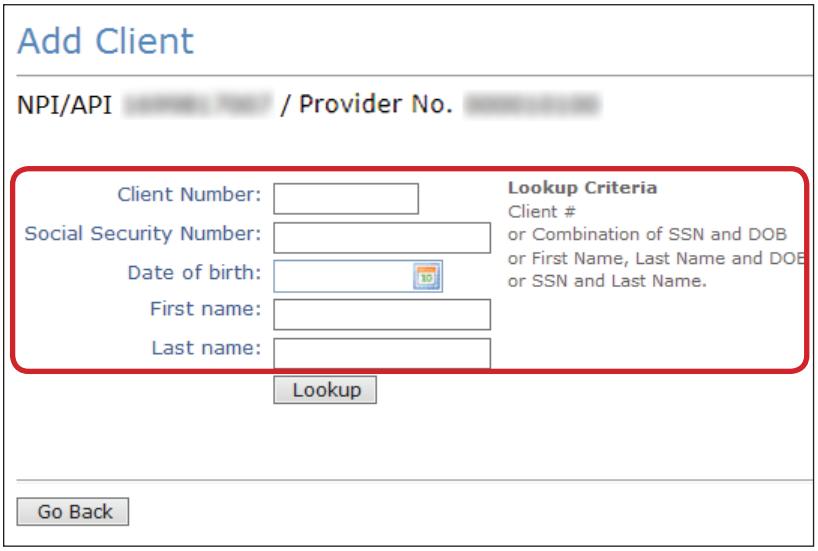


5) To add a person to the Group Template, click the **Add Client** button.

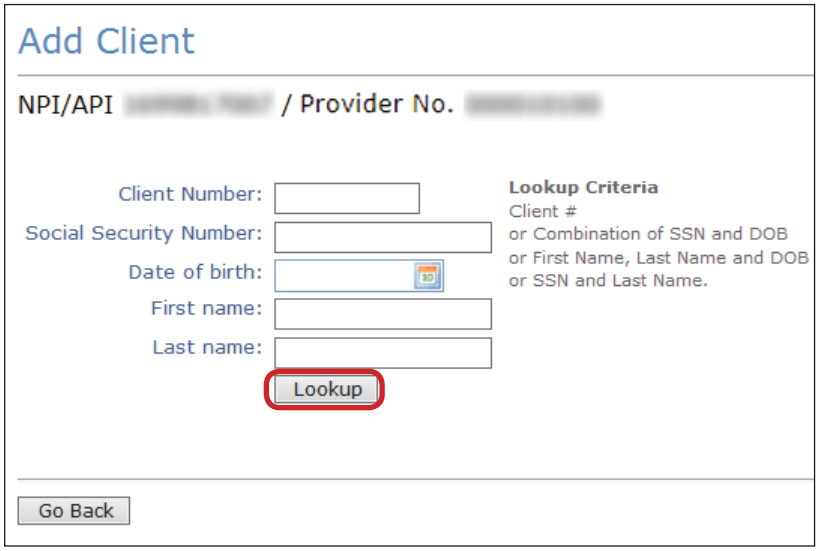


6) The Add Client page will open. Enter the person's information. If you do not have the person's Client Number, you must use one of the following combinations to find the person:

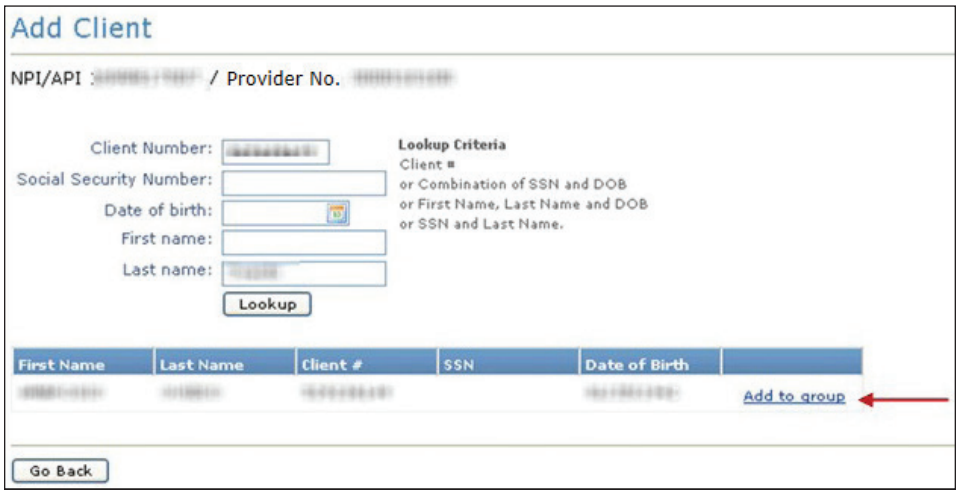
- Social Security Number and Last name
- Social Security Number and Date of birth
- Last name, First name, and Date of birth



7) Click the **Lookup** button.



8) To add the person, click the **Add to group** link.



9) The person will be added to the MESAV Group Template that you are working on.

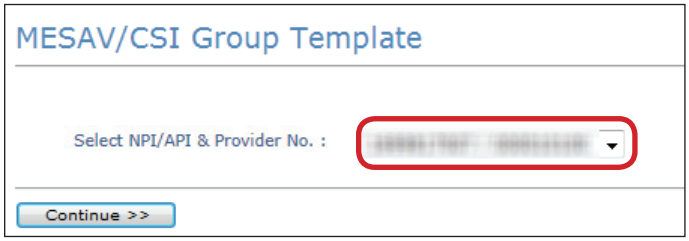
- You can create up to 100 groups for each NPI or API and provider number.
- Each group can contain up to 250 people.
- You can view, add, and delete people from the list.

Submitting a MESAV Group Template

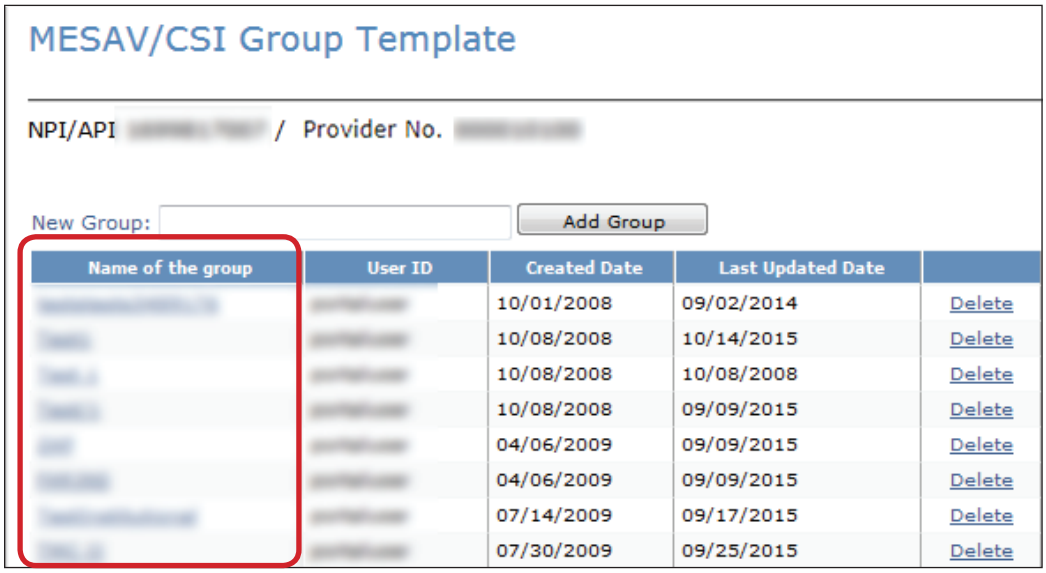
To verify eligibility using a group template:

1) Click the **Group Template** link under the MESAV section on the left navigation panel.

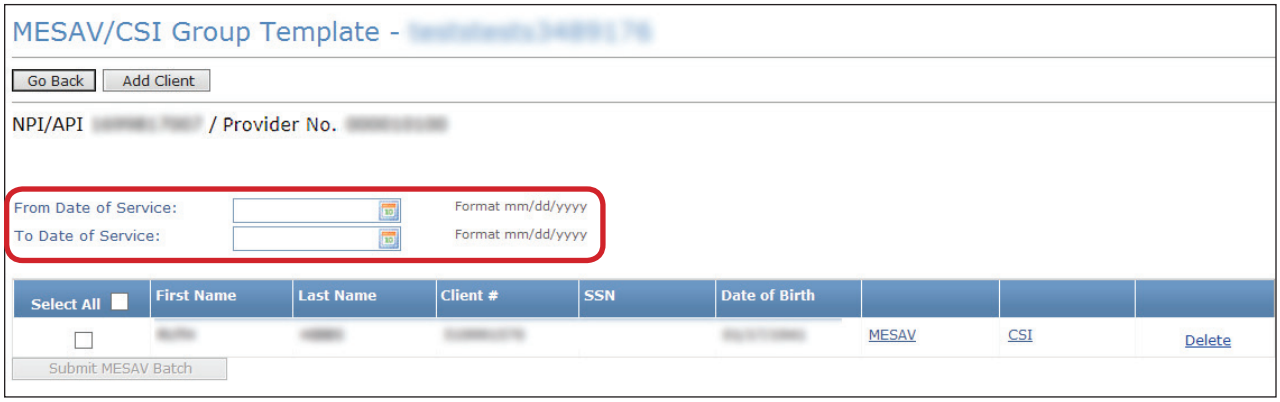
2) Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.



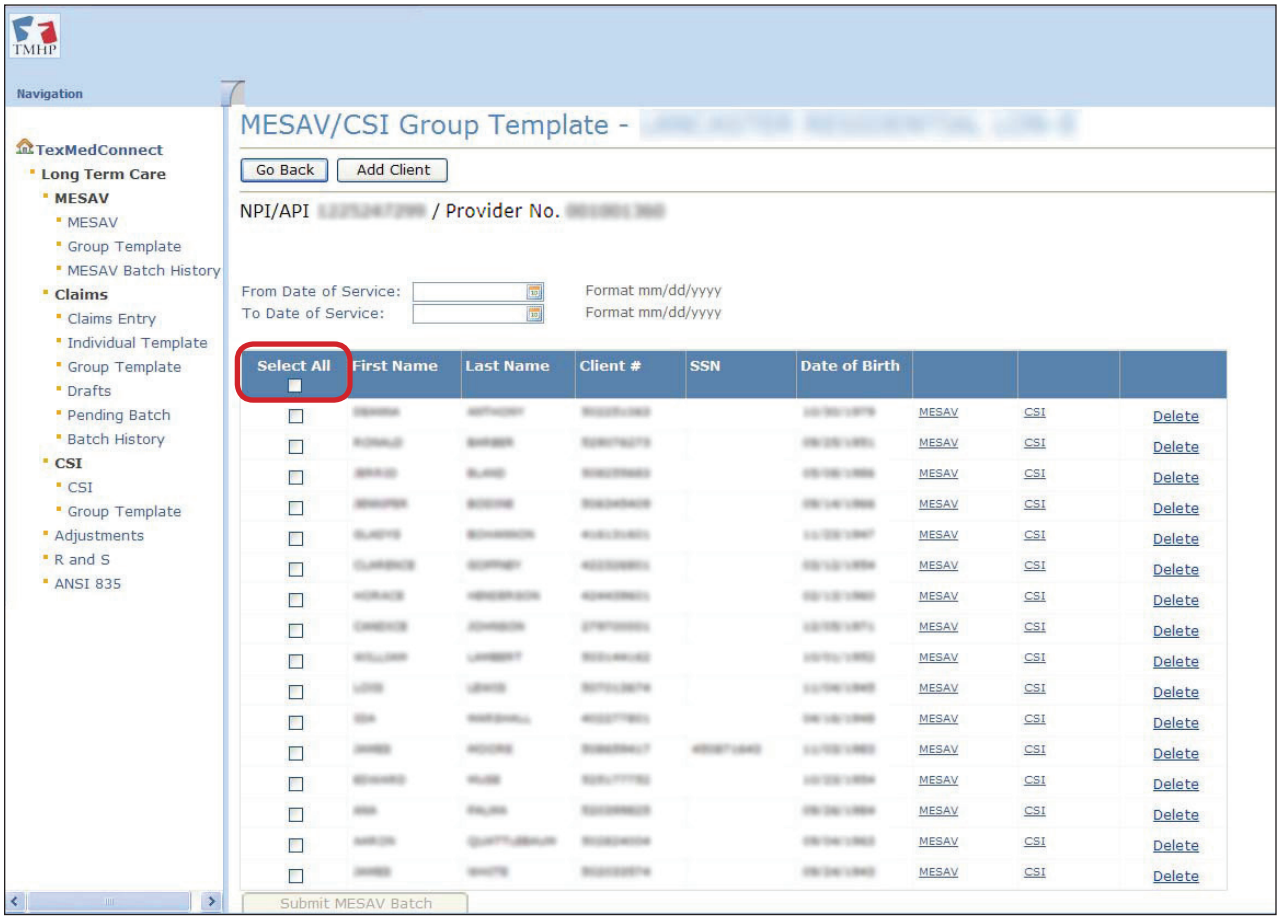
3) Select one of the templates listed under Name of the group to open the group list.



4) Enter a date range in the From Date of Service and To Date of Service fields. The date range can be up to three months long.



5) Check the individual boxes of the templates that you want to submit, or to submit all of the templates, check the **Select All** box.



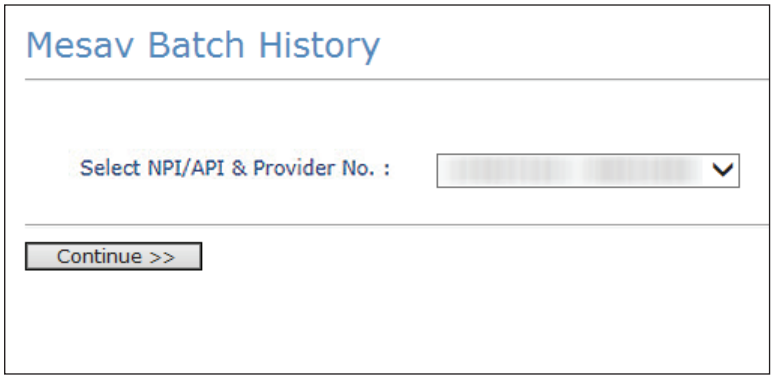
6) Click the **Submit MESAV Batch** button at the bottom left of the screen. The batch will process and be ready for viewing within 24 hours.

Viewing a MESAV Batch History

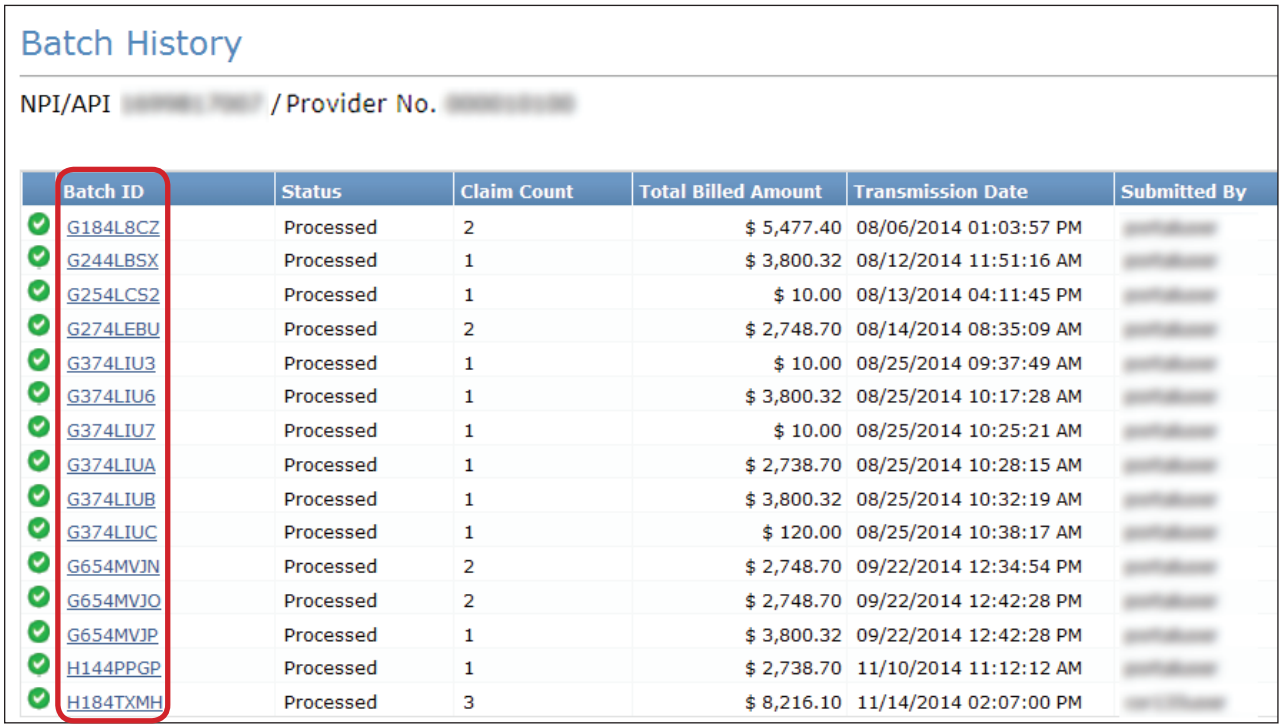
To view a MESAV Batch History:

1) Click the **MESAV Batch History** link under the MESAV section on the navigation panel.

2) Choose the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.



3) Click the Batch ID of the MESAV batch that you would like to view.

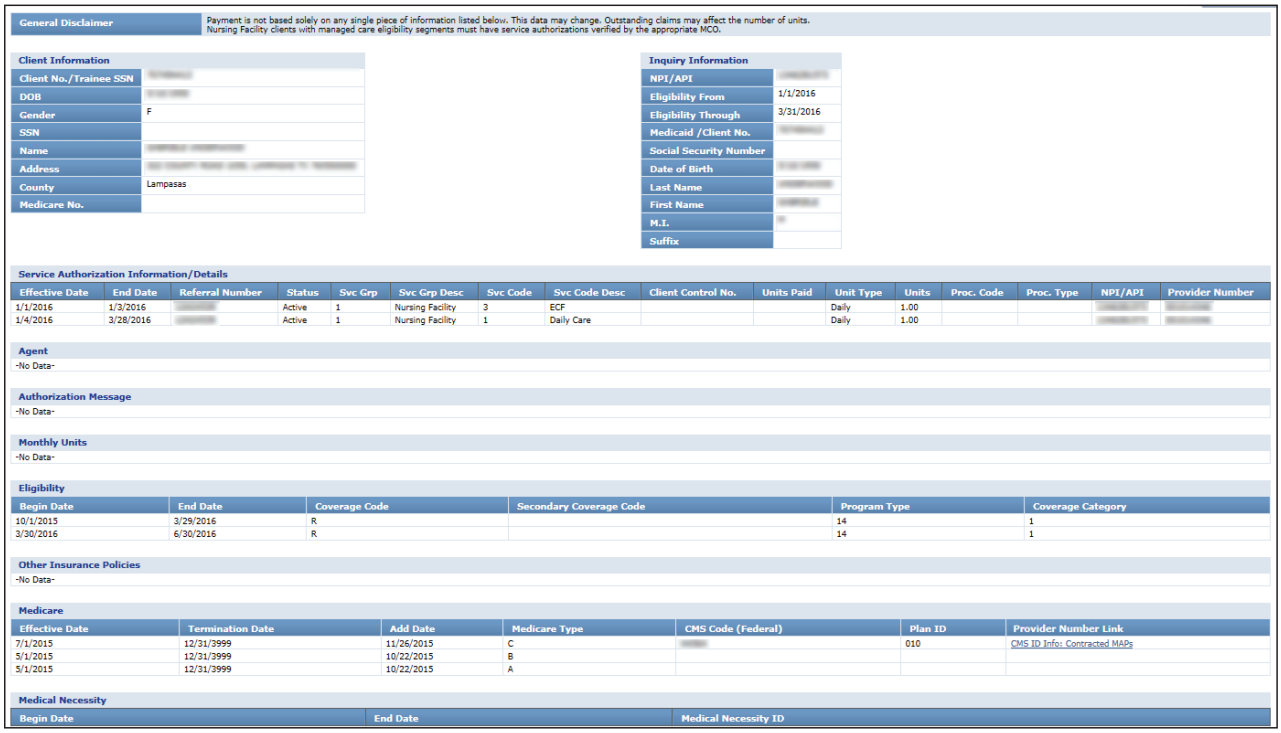


Batch History

NPI/API [redacted] / Provider No. [redacted]

	Batch ID	Status	Claim Count	Total Billed Amount	Transmission Date	Submitted By
✓	G184L8CZ	Processed	2	$ 5,477.40	08/06/2014 01:03:57 PM	[redacted]
✓	G244LBSX	Processed	1	$ 3,800.32	08/12/2014 11:51:16 AM	[redacted]
✓	G254LCS2	Processed	1	$ 10.00	08/13/2014 04:11:45 PM	[redacted]
✓	G274LEBU	Processed	2	$ 2,748.70	08/14/2014 08:35:09 AM	[redacted]
✓	G374LIU3	Processed	1	$ 10.00	08/25/2014 09:37:49 AM	[redacted]
✓	G374LIU6	Processed	1	$ 3,800.32	08/25/2014 10:17:28 AM	[redacted]
✓	G374LIU7	Processed	1	$ 10.00	08/25/2014 10:25:21 AM	[redacted]
✓	G374LIUA	Processed	1	$ 2,738.70	08/25/2014 10:28:15 AM	[redacted]
✓	G374LIUB	Processed	1	$ 3,800.32	08/25/2014 10:32:19 AM	[redacted]
✓	G374LIUC	Processed	1	$ 120.00	08/25/2014 10:38:17 AM	[redacted]
✓	G654MVJN	Processed	2	$ 2,748.70	09/22/2014 12:34:54 PM	[redacted]
✓	G654MVJO	Processed	2	$ 2,748.70	09/22/2014 12:42:28 PM	[redacted]
✓	G654MVJP	Processed	1	$ 3,800.32	09/22/2014 12:42:28 PM	[redacted]
✓	H144PPGP	Processed	1	$ 2,738.70	11/10/2014 11:12:12 AM	[redacted]
✓	H184TXMH	Processed	3	$ 8,216.10	11/14/2014 02:07:00 PM	[redacted]

4) The MESAV will open in a new window. Review the Status for each client number you selected.



General Disclaimer Payment is not based solely on any single piece of information listed below. This data may change. Outstanding claims may affect the number of units. Nursing Facility clients with managed care eligibility segments must have service authorizations verified by the appropriate MCO.

Client Information

Client No./Trainee SSN	[redacted]
DOB	[redacted]
Gender	F
SSN	
Name	[redacted]
Address	[redacted]
County	Lampasas
Medicare No.	

Inquiry Information

NPI/API	[redacted]
Eligibility From	1/1/2016
Eligibility Through	3/31/2016
Medicaid /Client No.	[redacted]
Social Security Number	
Date of Birth	[redacted]
Last Name	[redacted]
First Name	[redacted]
M.I.	[redacted]
Suffix	

Service Authorization Information/Details

Effective Date	End Date	Referral Number	Status	Svc Grp	Svc Grp Desc	Svc Code	Svc Code Desc	Client Control No.	Units Paid	Unit Type	Units	Proc. Code	Proc. Type	NPI/API	Provider Number
1/1/2016	1/3/2016	[redacted]	Active	1	Nursing Facility	3	ECF			Daily	1.00			[redacted]	[redacted]
1/4/2016	3/28/2016	[redacted]	Active	1	Nursing Facility	1	Daily Care			Daily	1.00			[redacted]	[redacted]

Agent
-No Data-

Authorization Message
-No Data-

Monthly Units
-No Data-

Eligibility

Begin Date	End Date	Coverage Code	Secondary Coverage Code	Program Type	Coverage Category
10/1/2015	3/29/2016	R		14	1
3/30/2016	6/30/2016	R		14	1

Other Insurance Policies
-No Data-

Medicare

Effective Date	Termination Date	Add Date	Medicare Type	CMS Code (Federal)	Plan ID	Provider Number Link
7/1/2015	12/31/3999	11/26/2015	C	[redacted]	010	CMS ID Info: Contracted MAPs
5/1/2015	12/31/3999	10/22/2015	B			
5/1/2015	12/31/3999	10/22/2015	A			

Medical Necessity

Begin Date	End Date	Medical Necessity ID

MESAV - Other Insurance (OI) Applicable to Service Groups (SGs) 1, 6, 8

For Nursing Facility (SG 1), non-state Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (SG 6), and Hospice (SG 8) providers, there is an LTC TexMedConnect MESAV screen titled "Other Insurance Policies." Providers in service groups 1, 6, and 8 can view the policies that a person in their care has for the service dates entered on the MESAV. The OI section contains all active lines of coverage that have been reported to TMHP.

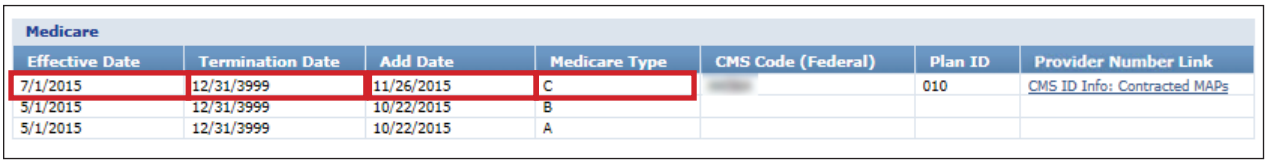
- Each listing contains detailed information about the insurance company, subscriber information, and the lines of coverage (types of coverage, effective date, termination date fields, and whether or not the coverage is LTC relevant).

The OI information should be used to assist providers in filing claims with insurance companies and obtaining the disposition of those claims as paid or denied. Not having the insurance company claim disposition information available for the claims to be submitted for people with Medicaid could cause a denial for lack of OI information.

If, as a result of filing the insurance claim, it is discovered that the insurance information on the MESAV is incorrect for the person, the TMHP Third-Party Liability (TPL) Resource Line will be available to handle updates to the insurance information. Call the LTC Help Desk at 1-800- 626-4117 and choose Option 6: LTC Other Insurance for answers to incoming LTC Other Insurance Referral Inquiries.

MESAV Medicare Eligibility

The Medicare section includes the policy's Effective Date, Termination Date, Add Date, Medicare Type, CMS Code (federal), Plan ID, and Provider Number Link. The MESAV Medicare section will display underneath the Other Insurance Policies section of the MESAV.



Medicare

Effective Date	Termination Date	Add Date	Medicare Type	CMS Code (Federal)	Plan ID	Provider Number Link
7/1/2015	12/31/3999	11/26/2015	C	[redacted]	010	CMS ID Info: Contracted MAPs
5/1/2015	12/31/3999	10/22/2015	B			
5/1/2015	12/31/3999	10/22/2015	A			

Filing a Claim

Claims filed on TexMedConnect by nursing facilities for people who have transitioned to managed care will be forwarded to a managed care organization (MCO). If there are any issues or questions regarding a claim that has been forwarded to an MCO, providers must contact the MCO directly. TMHP cannot answer questions regarding claims rejected by an MCO. Claims submitted by nursing facility providers whose people are not transitioning to managed care will not be forwarded.

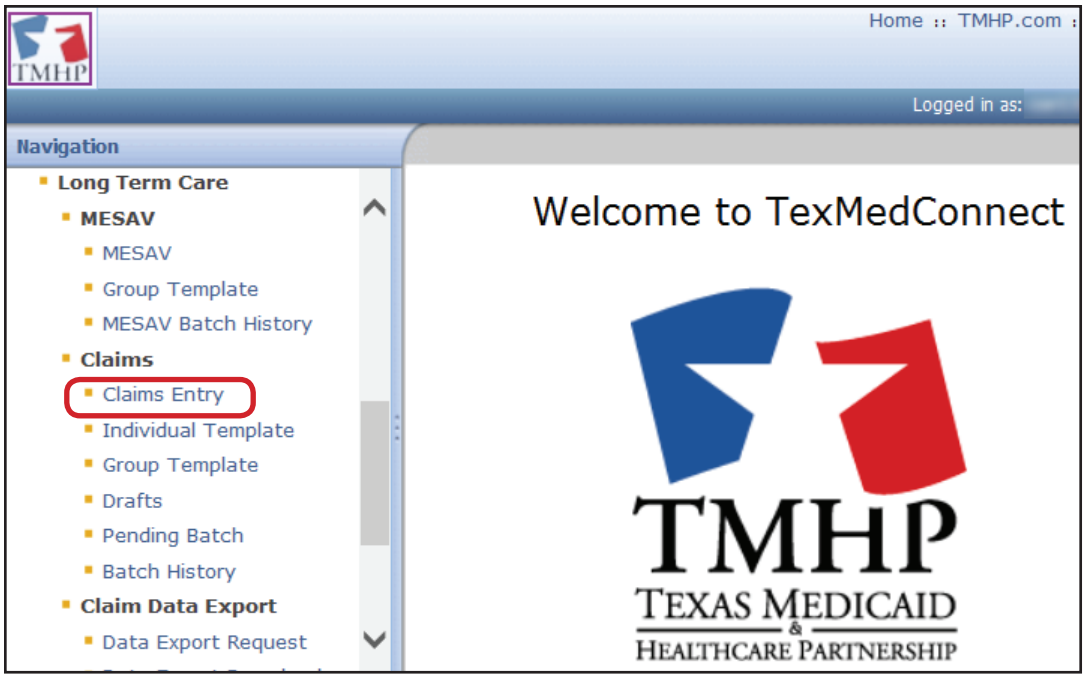
Users may submit the following claim types:

- Professional: Services rendered by an individual provider.
- Dental: Services rendered by a dental provider and billed by the Long-Term Care provider.
- Institutional: Services rendered in a facility.
- Nurse Aide Training (NAT): Classes, testing, and materials for Nurse Aide Training.

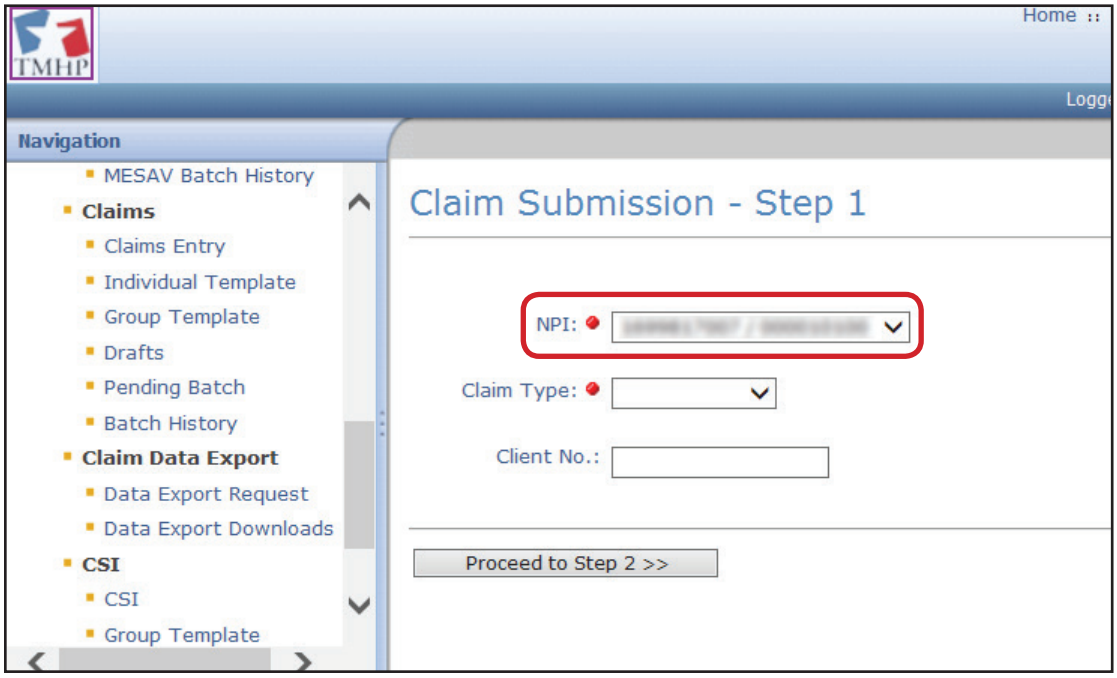
Entering a Claim on TexMedConnect

The following steps are used to begin the process of submitting all claim types (Professional, Dental, Institutional, and NAT).

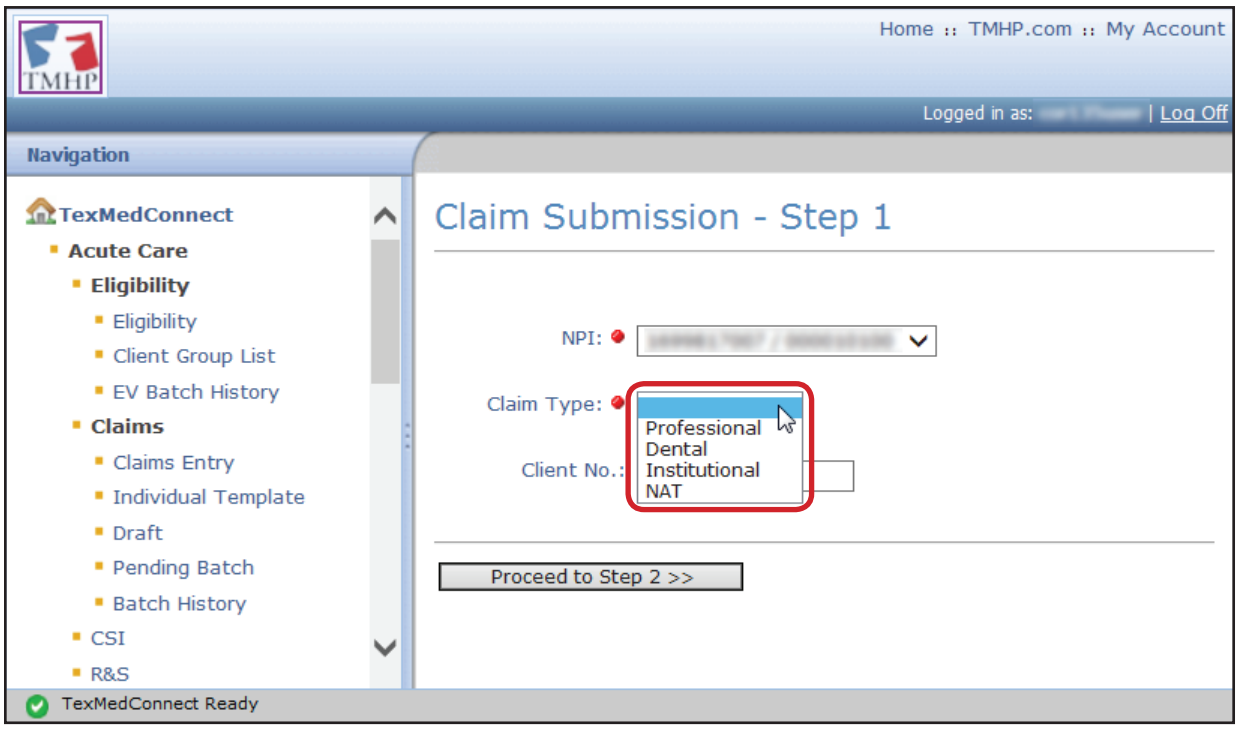
1) Click the **Claims Entry** link under the Claims section on the navigation panel.



2) A list of NPIs/ APIs, provider numbers, and related data will be displayed according to the user's login information. Select the appropriate NPI/API and provider number from the NPI drop-down box.



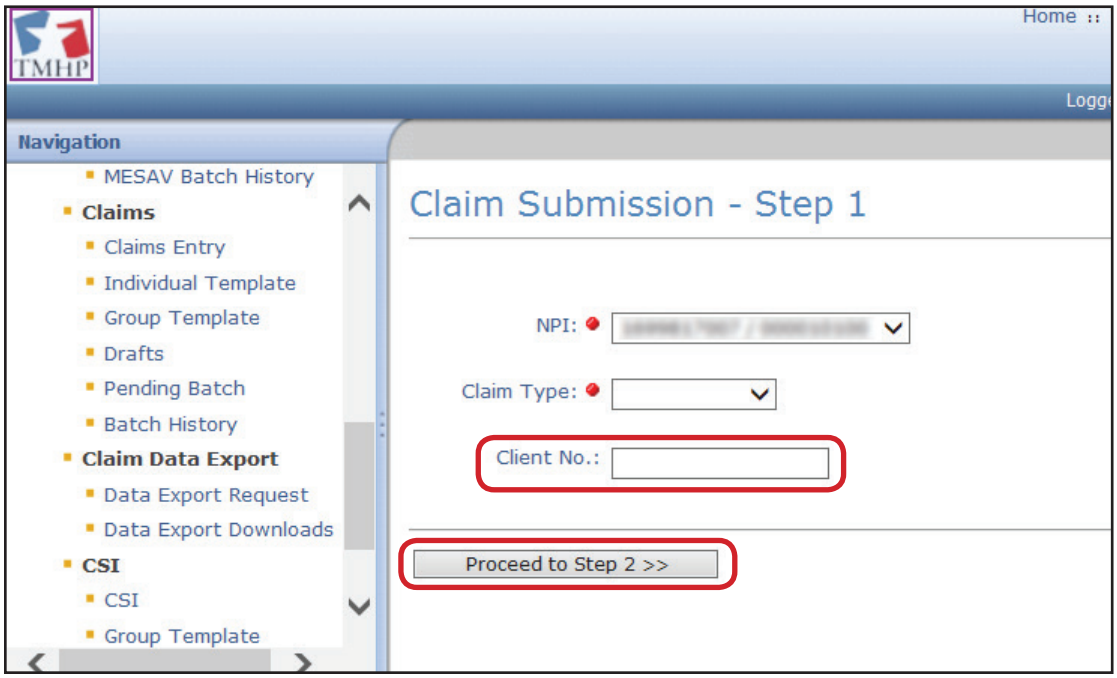
3) Choose the appropriate claim type from the drop-down box.



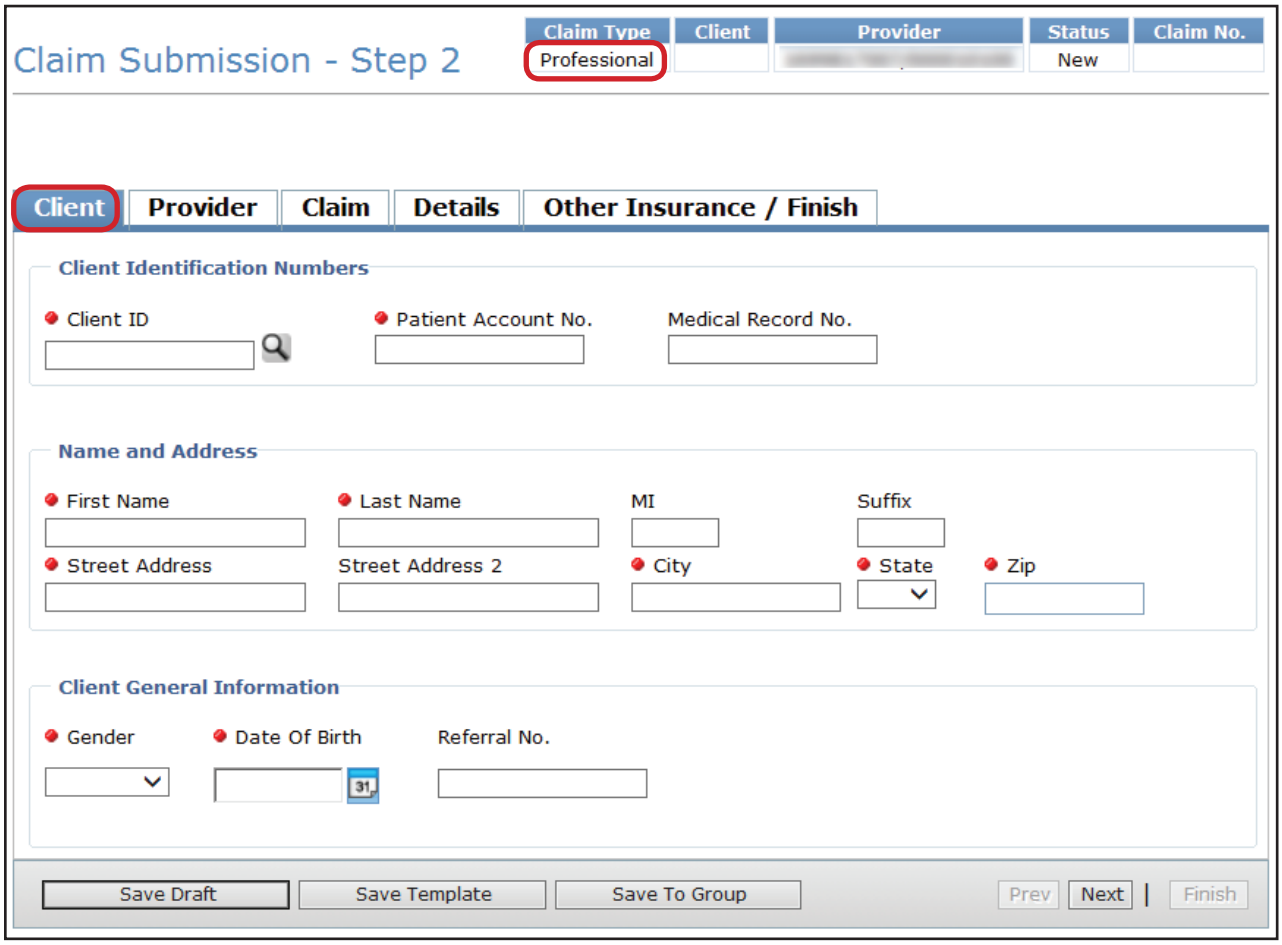
4) As an option, you may enter a client number at this time.

Note: *Although a client number is not required, providing one saves time. The system will use the client number to auto- populate many of the required fields. If a client number is not entered, you must manually enter information into the required fields under the Client tab.*

5) Click the **Proceed to Step 2** button.



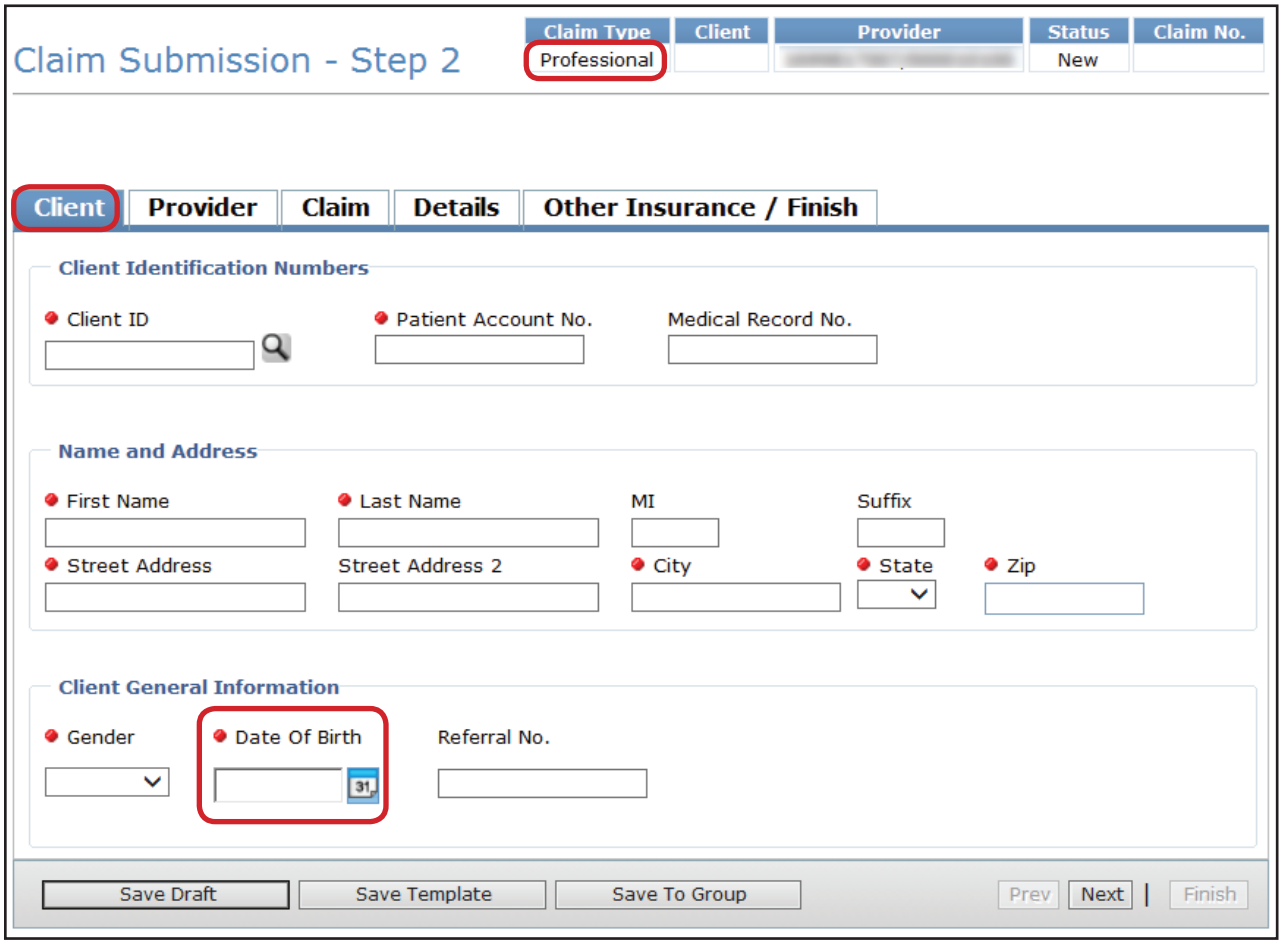
6) The Claim Submission screen will display for the claim type that you selected. It will default to the Client tab. The type of claim you are working on is indicated in the Claim Type box in the upper right of the screen. You must complete all required fields (indicated by a red dot) on each tab. If you entered the client number on the Claims Entry - Step 1 screen, many of these fields will be auto-populated. If necessary, most fields can be edited. After the claim has been submitted successfully, an Internal Control Number (ICN) will be displayed in the Claim No. field. The ICN is also known as a claim number.



Entering a Professional Claim

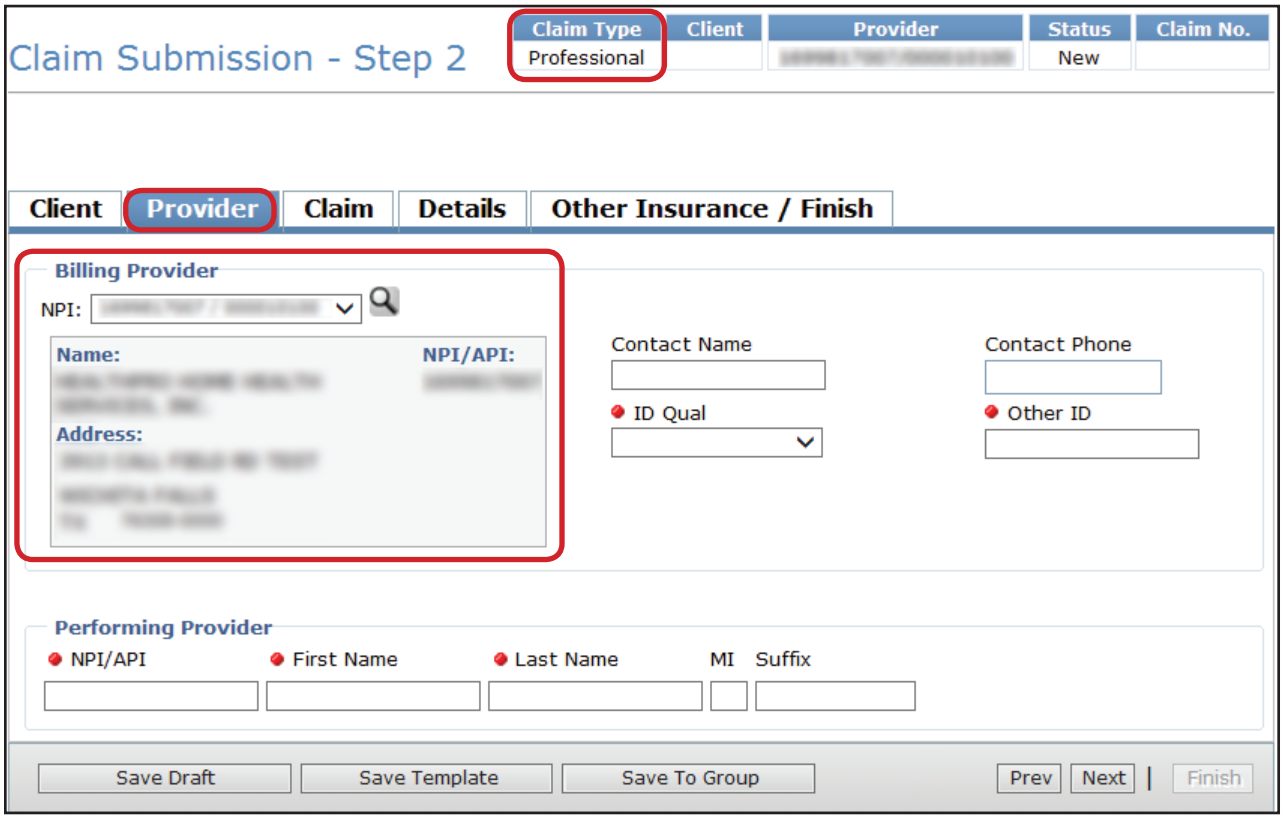
To enter a professional claim:

1) Begin on the Client tab. You must complete all required fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field.



Note: *If there is more than one contract associated with an NPI number, you must include a referral number on the claim or the claim will be denied. As noted earlier, you can access the referral number by searching a person's eligibility with the MESAV function.*

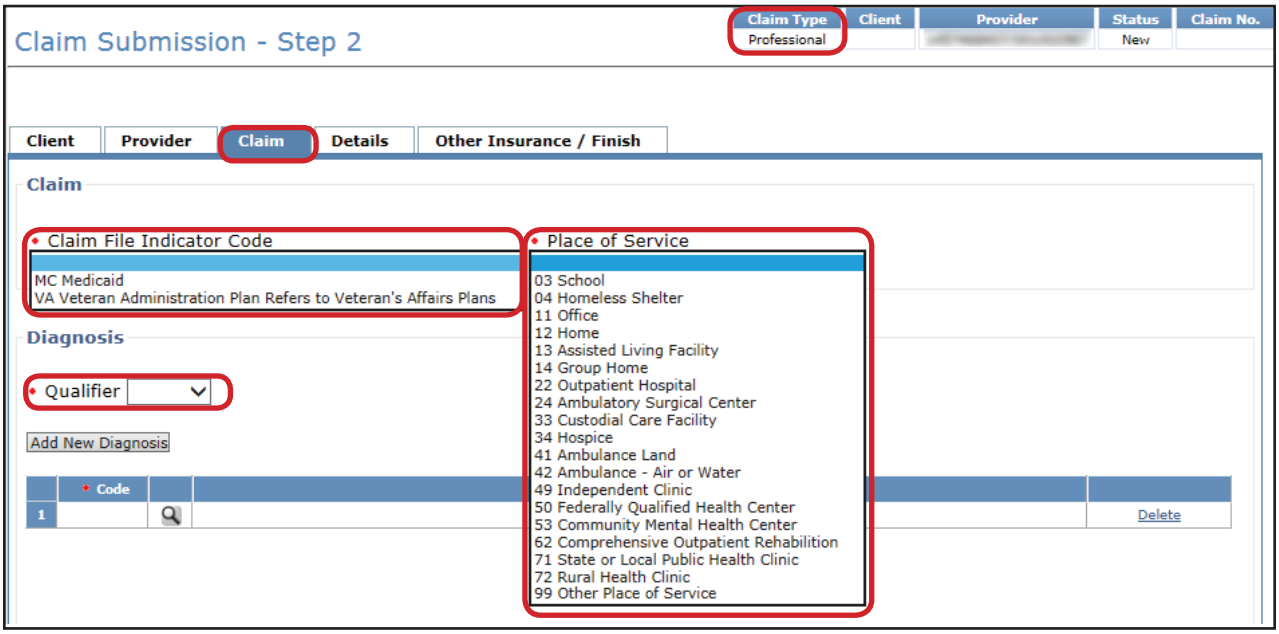
2) Click the **Provider** tab. You must complete all required fields that are indicated by a red dot. TexMedConnect auto-populates the billing provider information using the NPI that was selected on the Claims Entry screen.



3) Click the **Claim** tab. You must complete all of the required fields that are indicated by a red dot.

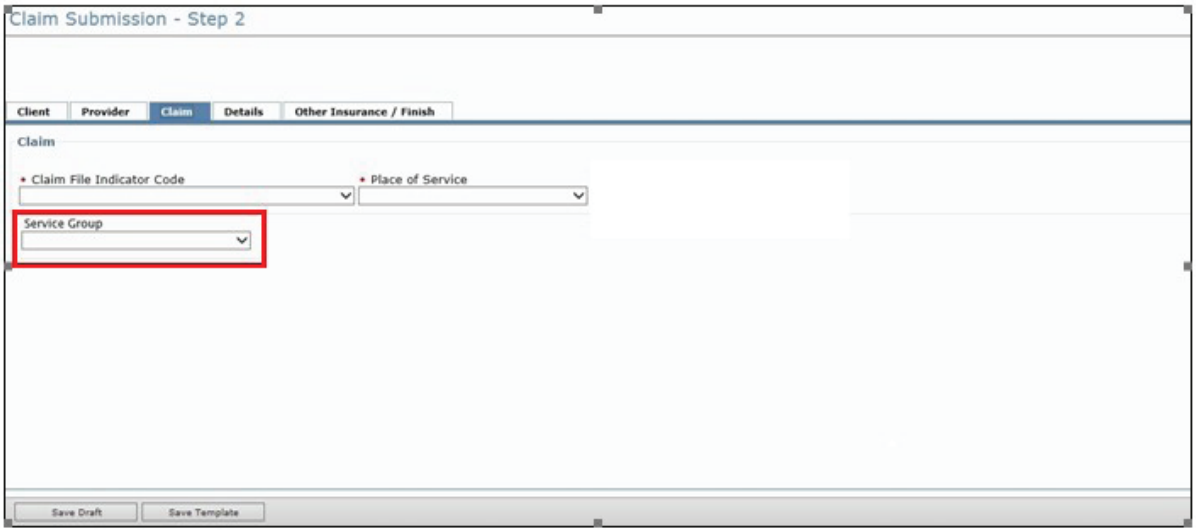
- A valid Principal Diagnosis code is required for professional claims. Inputting an invalid diagnosis code may result in an error message (and a subsequent inability to submit a claim) in TexMedConnect.
- To add more diagnosis codes, click the **Add New Diagnosis** button.
- To view the diagnosis description, click the magnifying glass icon.

- The Qualifier field is used to indicate an ***International Classification of Diseases***, Ninth Revision (ICD-9) or ***International Classification of Diseases***, Tenth Revision (ICD-10) diagnosis code. Select from the drop-down box based on the diagnosis code entered.



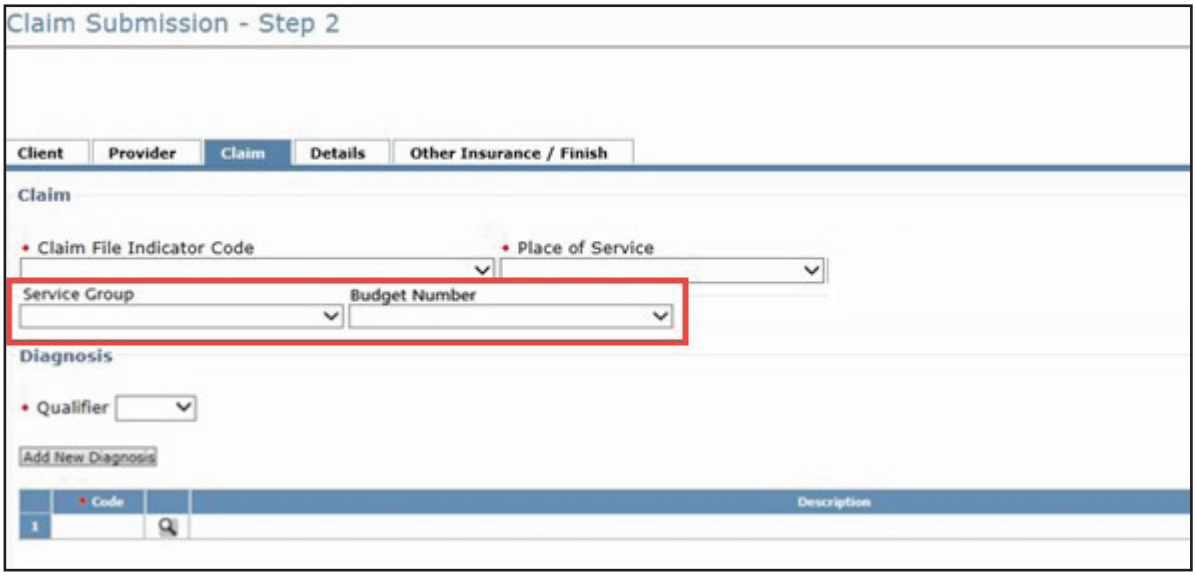
Note: *The HHSC-LTC Bill Code crosswalk requires that modifiers start in position 1 and any subsequent modifier will be in sequential position order and not be the same (duplicate). Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate Service Group, Residence Service Group, and Budget Number. Instead, Billing providers will indicate Service Group, Residence Service Group, and Budget Number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.*

The Service Group drop down is to be used on LTC Professional, Institutional, and Dental claims by Billing Providers with multiple service groups linked to the same LTC Provider Contract number. It will not appear for other providers.



- The Budget Number drop down will only appear for providers billing LTC Professional claims for Title XX services. Providers will need to select the correct budget number from the drop down.

Note: *The provider can be linked to multiple Service Groups and SG 7 or SG 20 needs to be selected in the Service Group field for Budget Number field to display. If the provider is only linked to SG 7 or SG 20, the Service Group field is not displayed.*



Note: *Billing Providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC LTC Bill Code Crosswalk. It is important to remember that modifier placements changed as of February 1, 2019, so providers should consult the Crosswalk to update their previously saved claims and templates to reflect the new modifier positions.*

4) Click the **Details** tab. You must complete all of the fields that are indicated by a red dot.
   - To add a blank row, click the **Add New Detail row(s)** button.
   - To duplicate an existing row, highlight the row and click the **Copy Row** button.
   - To delete a row, scroll over and click the **Delete** link at the end of the row.

5) Click the **Other Insurance/Finish tab**.

   Note: *Other insurance information is not required on a Professional Claim, only an Institutional Claim.*

   a) Click either the **Submit** radio button or the **Save to Batch** radio button;

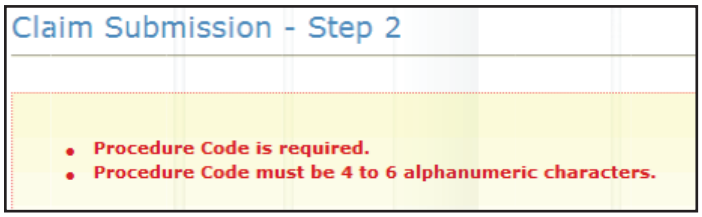
b) Check the **We Agree** box;

c) Click the **Finish** button.

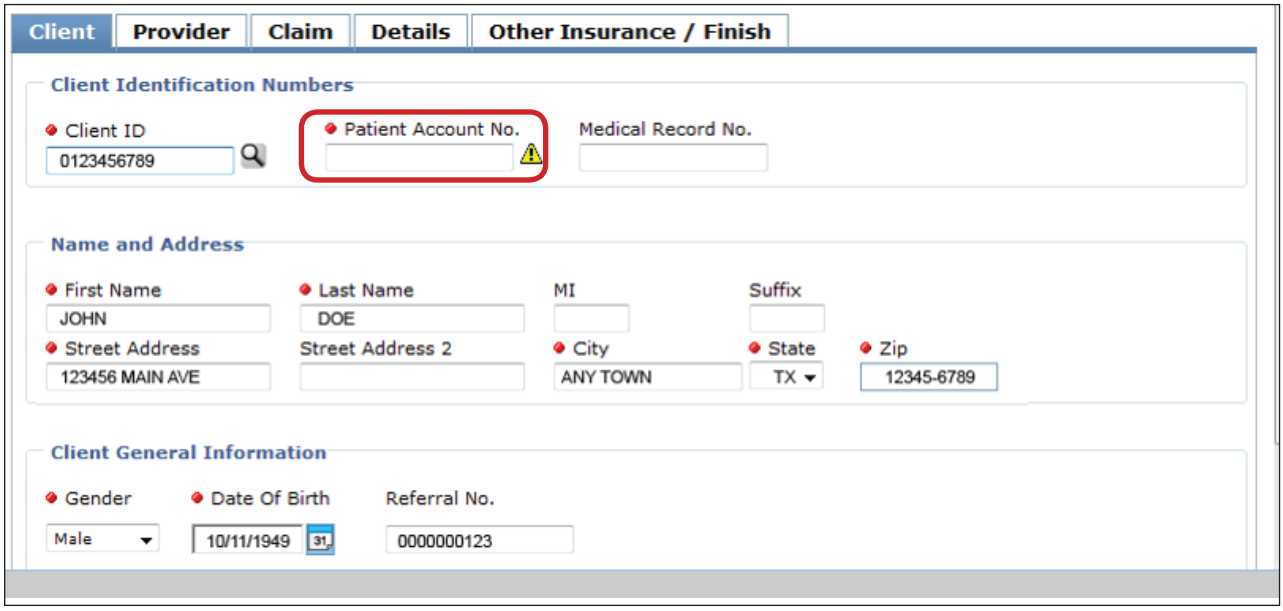
d) If the claim is submitted successfully, an Internal Control Number (ICN) will be displayed at the top of the page. This is also known as a claim number.

- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- To submit the claim as part of a batch, refer to the Submitting a Batch section of this User Guide.

6) If there is any missing or invalid information, an error message will be displayed. Click the tab that is indicated in the error message. Error fields are indicated with red exclamation marks. Once you have made all of the necessary corrections, click the **Finish** button in the lower right corner of the screen.



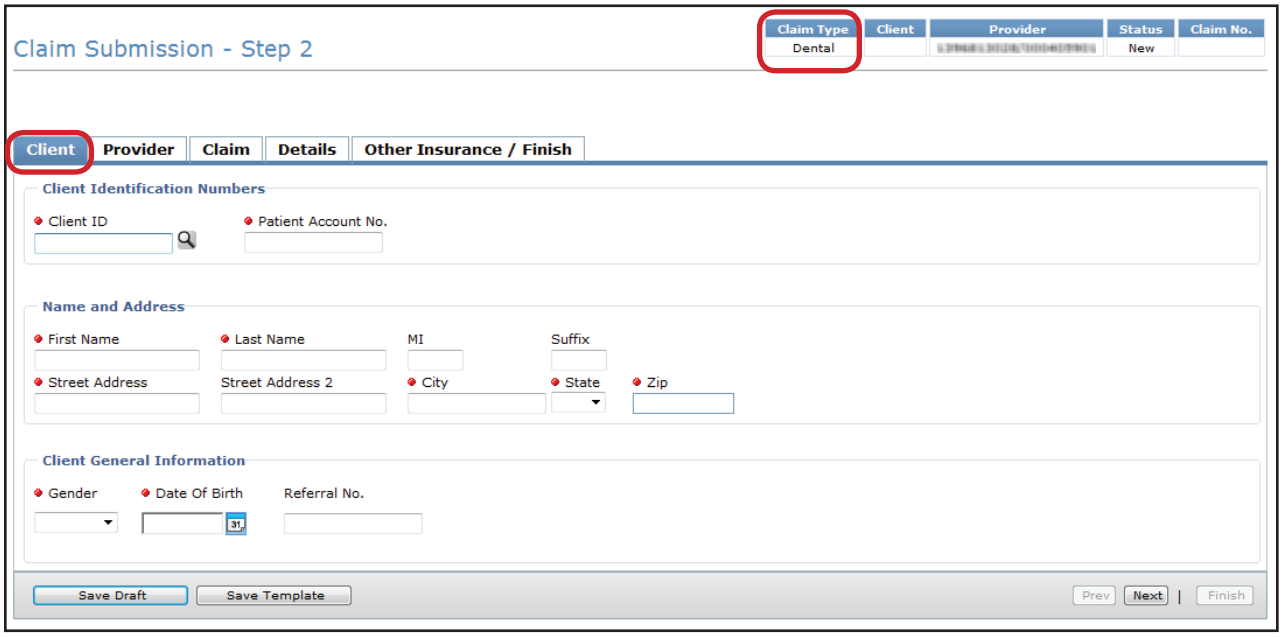
7) In each of the tabs, any field with an error is marked with a yield sign. You must correct these errors before you can resubmit the claim. You can navigate through the claim by clicking each tab or by clicking the **Prev** and **Next** buttons at the bottom of the Claim Submission – Step 2 screen.



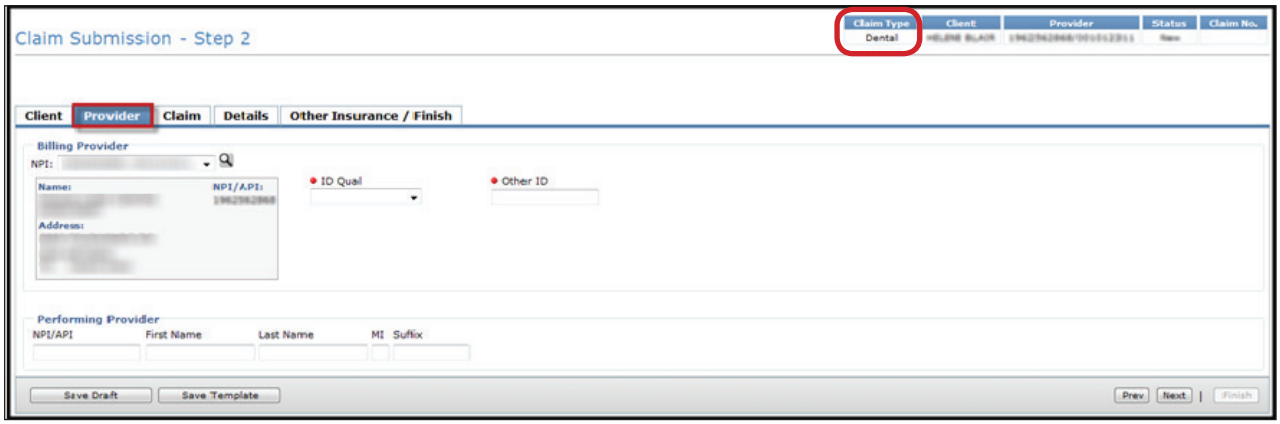
Entering a Dental Claim

To enter a Dental claim:

1) Click the **Client** tab. You must complete all of the required fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field.



2) Click the **Provider** tab. You must complete all of the fields that are indicated by a red dot. TexMedConnect auto-populates the billing provider information using the NPI that was selected on the Claims Entry screen. You can enter the NPI/API and contact name in the Performing Provider section, but it is not required.



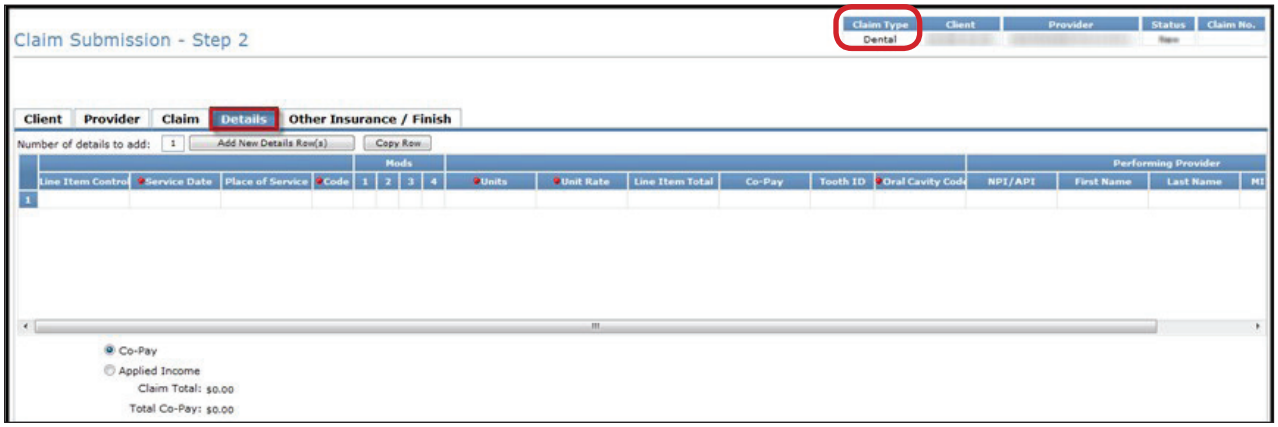
3) Click the **Claim** tab. Enter the General Claim information. You must choose a claim File Indicator Code and Place of Service.

Note: *The HHSC-LTC Bill Code Crosswalk requires that modifiers start in position 1 and any subsequent modifier will be in sequential position order and not be the same (duplicate). Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate Service Group, Residence Service Group, and Budget Number. Instead, Billing providers will indicate Service Group, Residence Service Group, and Budget Number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.*

- The Service Group drop down is to be used by Billing providers with multiple service groups linked to the same LTC Provider contract number.

Note: *Billing Providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC LTC Bill Code Crosswalk. It is important to remember that modifier placements has changed as of February 1, 2019, so providers should consult the Crosswalk after that date and update their previously saved claims and templates to reflect the new modifier positions.*

4) Click the **Details** tab. You must complete all of the fields that are indicated by a red dot. Entering a future date is not allowed in the Service Date field.



- To add more rows, click the **Add New Detail Row(s)** button.
- To copy the information from the previous detail, click the **Copy Row** button.
- To delete a row, scroll over and click the **Delete** link at the end of the row.

5) Click the **Other Insurance/Finish** button.

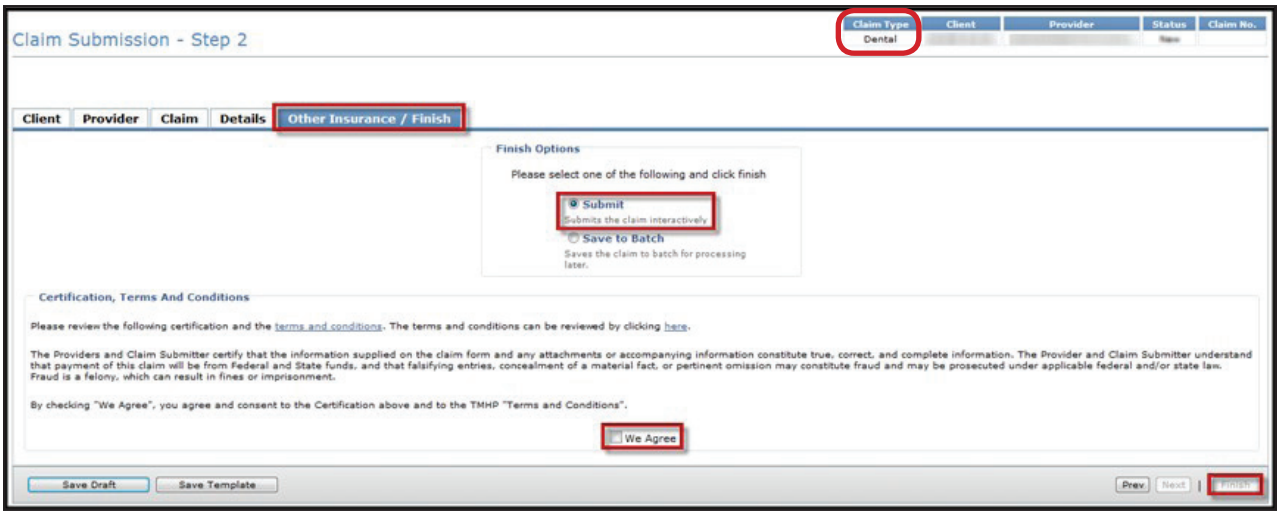
Note: *Other insurance information is not required on a Dental Claim, only an Institutional Claim.*

a) Click the **Submit** or **Save to Batch** radio button.

b) Check the **We Agree** box in the Certification, Terms, and Conditions section.

c) Click the **Finish** button in the lower, right corner of the screen.

d) If the claim is submitted successfully, an Internal Control Number (ICN) will be displayed at the top of the page. This is also known as a claim number.



- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- To submit the claim as part of a batch, refer to the Submitting a Batch section of this User Guide.

Entering an Institutional Claim

TMHP will forward certain Institutional Claims to managed care organizations (MCOs). These claims can be set to the following statuses:

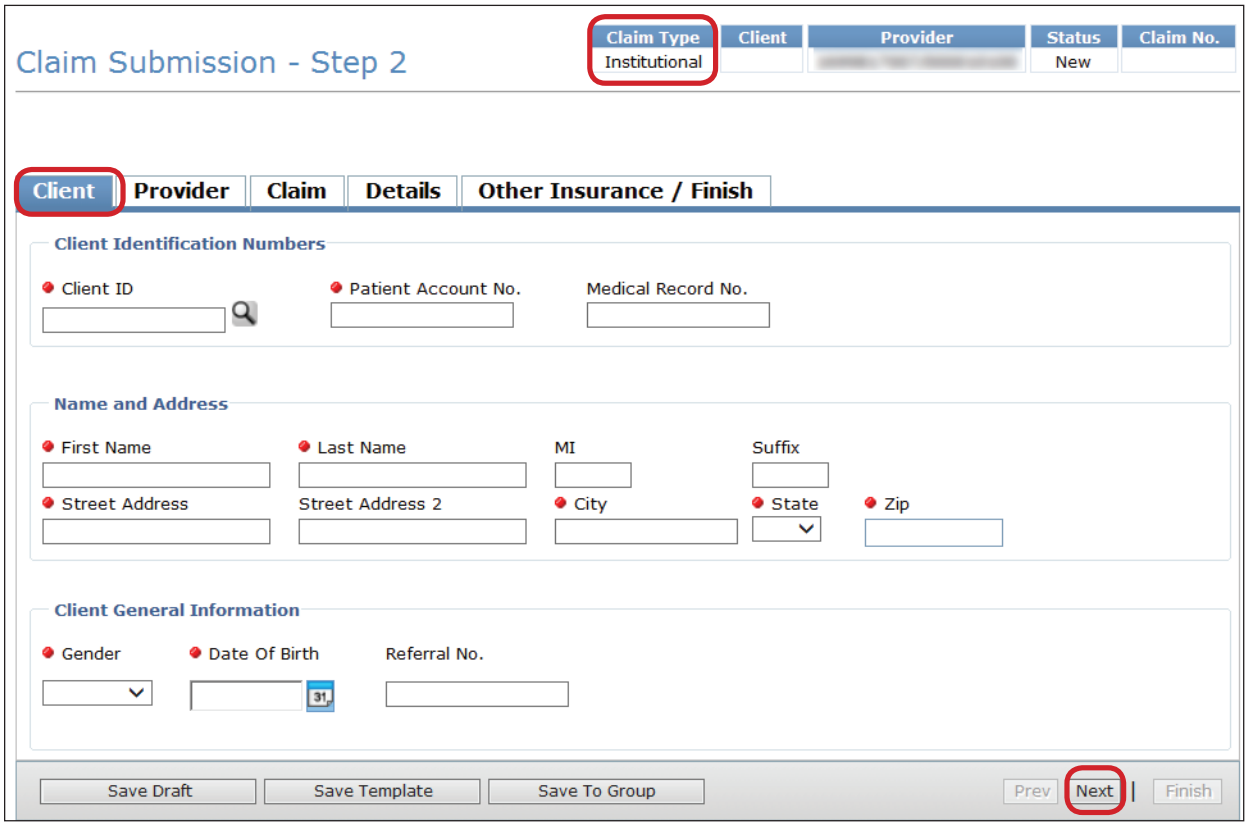
- ***Forwarded:*** means that the claim has been Forwarded to (but not yet Accepted or Rejected by) an MCO.
- ***Rejected:*** means that the claim has been rejected by TMHP or the MCO to which it was forwarded.
- ***Accepted:*** means that the claim has been Accepted by TMHP or an MCO. When a claim is accepted by an MCO it is assigned a 28 character, alphanumeric EDI transaction number, or ETN.

Claims handled by TMHP (not an MCO) can also be set to the following statuses:

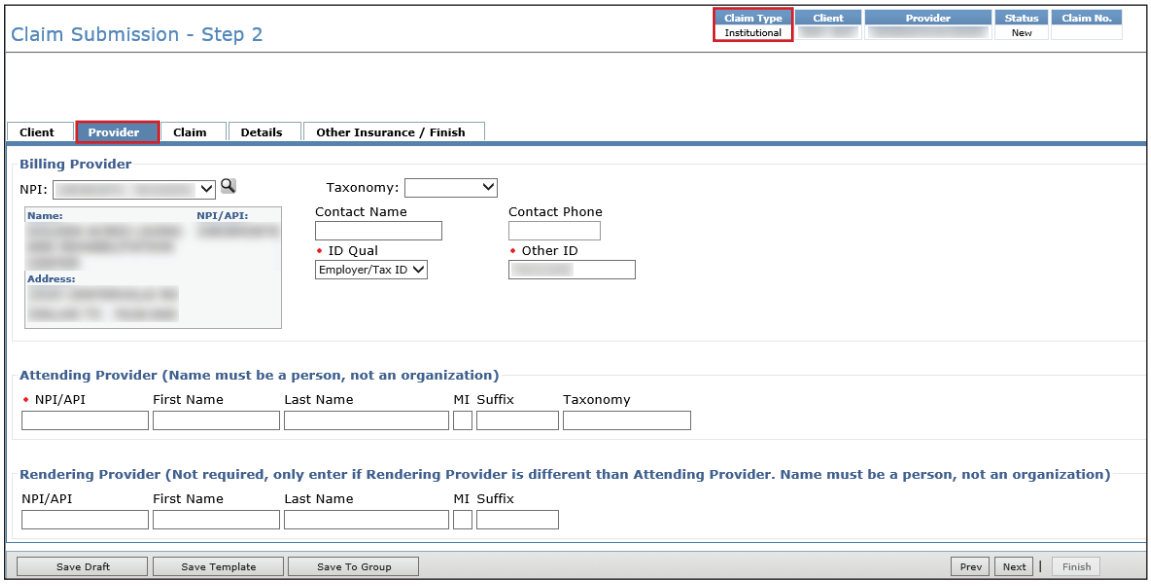
- ***I: In Process***
- ***D: Denied***
- ***A: Approved for Payment***
- ***FT: Forced Transfer***
- ***S: Suspended***
- ***T: Transferred***
- ***P: Paid***
- ***PF: Paid Forced Transfer***
- ***PT: Paid Transfer***
- ***PZ: Zero Net Balance to the Provider***

To enter an Institutional claim:

1) Click the **Client** tab. You must complete all of the fields that are indicated by a red dot. Entering a future date is not allowed in the Date of Birth field. After you have completed all of the required fields, click the **Next** button or click on the Provider tab.



2) Click the **Provider** tab. You must complete all of the fields that are indicated by a red dot.



3) The Taxonomy drop-down box is auto-populated with three values. Taxonomy codes further define the type, classification, or specialization of the health-care provider. If a provider attempts to submit a claim to TMHP without a valid taxonomy code, regardless of the date of service, the claim will be rejected and the provider will receive an error message.

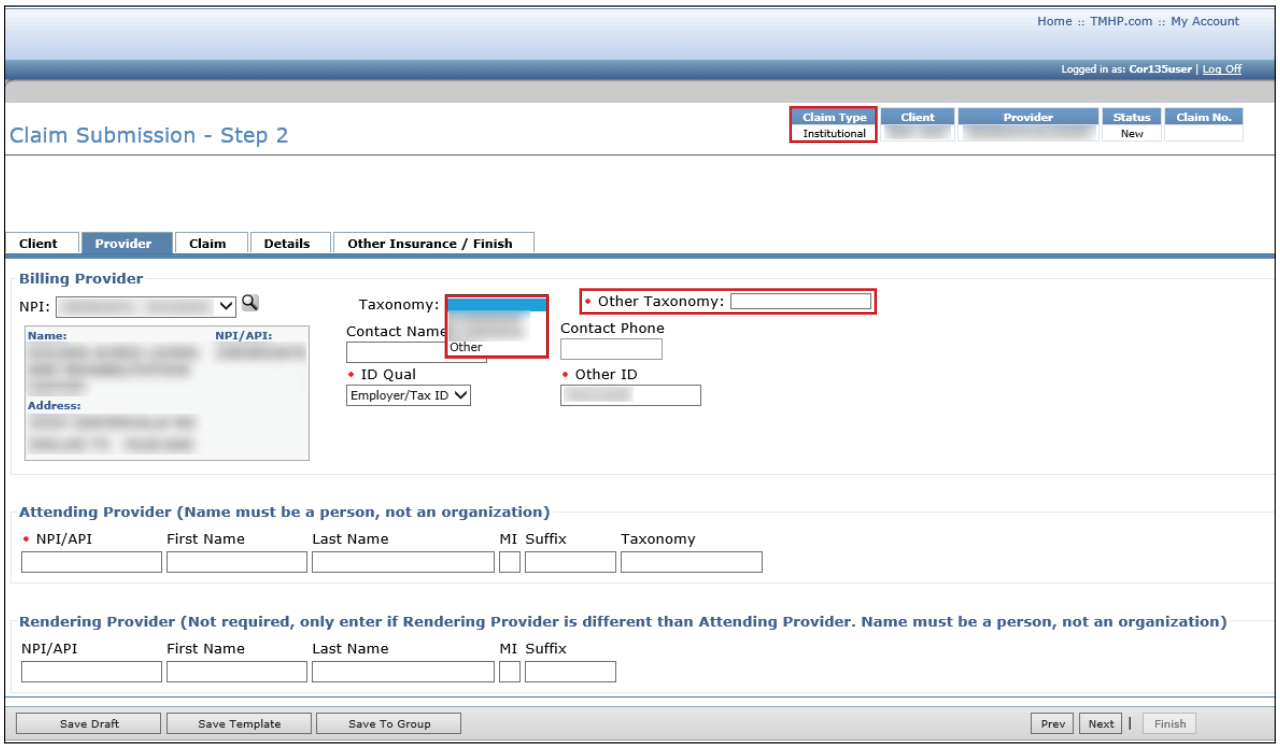
According to the Centers for Medicare & Medicaid Services, all health-care providers must select a taxonomy code(s) when applying for an NPI. The values in the Taxonomy drop-down box are:

- 314000000X (for Skilled NFs)
- 313M00000X (for Other NFs)
- Other

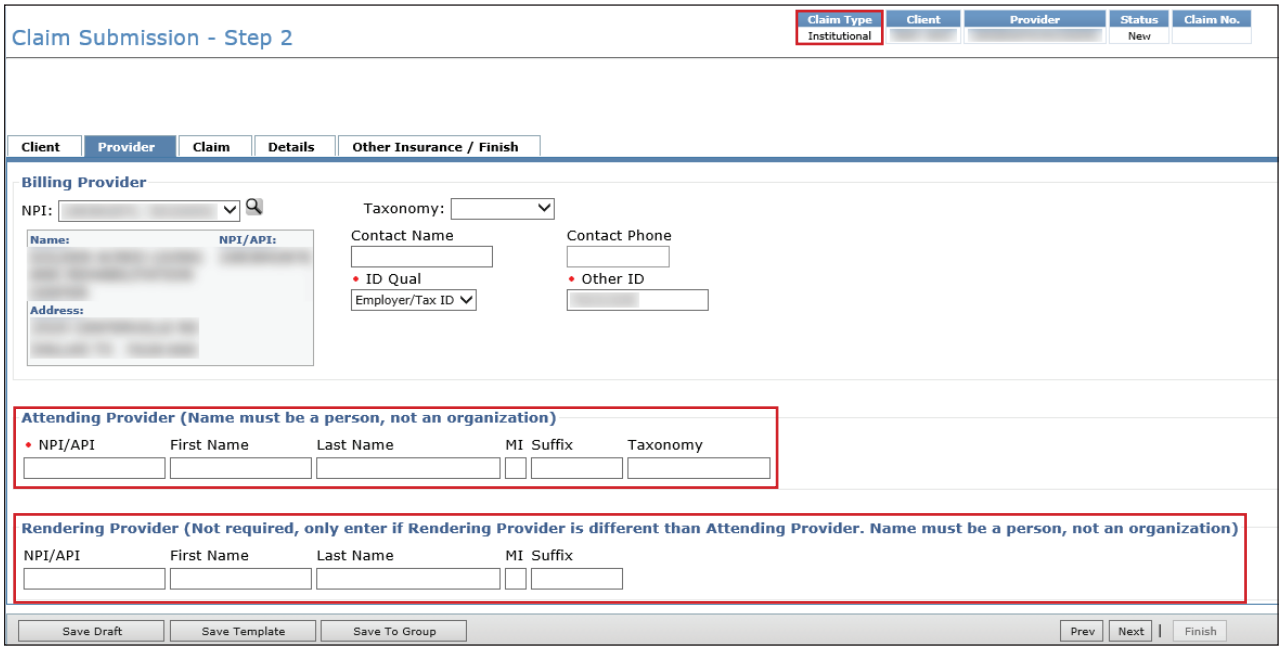
Choose the provider taxonomy code that was used by your facility when it initially applied for a National Provider Identifier (NPI).

If neither of the two auto populated codes apply, choose **Other**. If you choose **Other**, a text box called Other Taxonomy will display and is required.

NOTE: *If an API was chosen, the Taxonomy field will not display.*

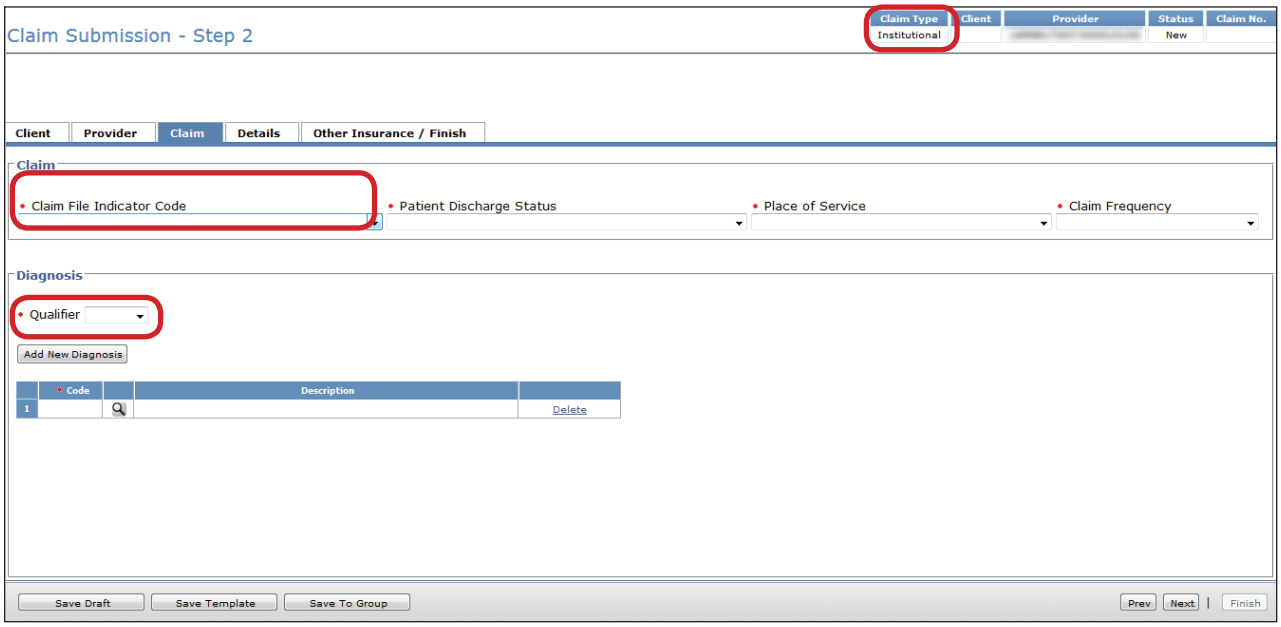


4) The Attending Provider is required to enter their NPI/API and name. If the Rendering Provider is different from the Attending Provider, that person's information should be added.



Note: *For the claim to be successfully processed, the NPI/API for the Attending Provider, Billing Provider, and Rendering Provider (if entered) must be different. Additionally, the NPI/API for both the Attending Provider and Rendering Provider must be for a person, not a facility.*

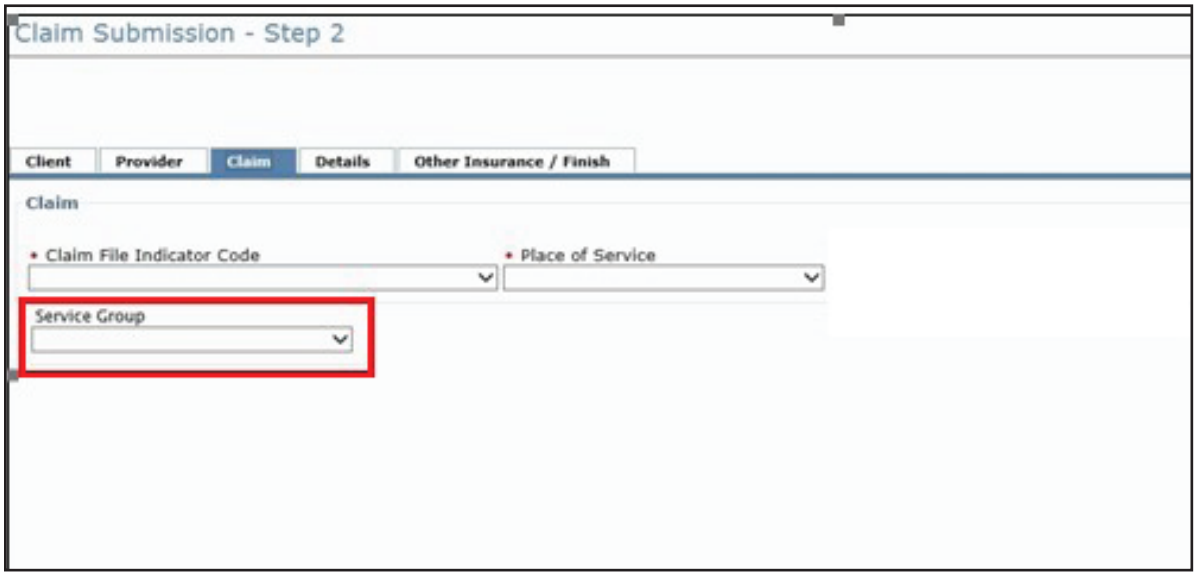
5) Click the **Claim** tab. You must complete all of the fields that are indicated by a red dot. Choose the appropriate indicator from the Claim File Indicator Code drop-down box.



Note: *The HHSC-LTC Bill Code Crosswalk requires that modifiers start in position 1 and any subsequent modifier will be in sequential position order and not be the same (duplicate). Claims with duplicate modifiers or skipped modifier positions will be rejected. Modifiers in positions 1 and 2 will no longer be used to indicate Service Group, Residence Service Group, and Budget Number. Instead, Billing providers*

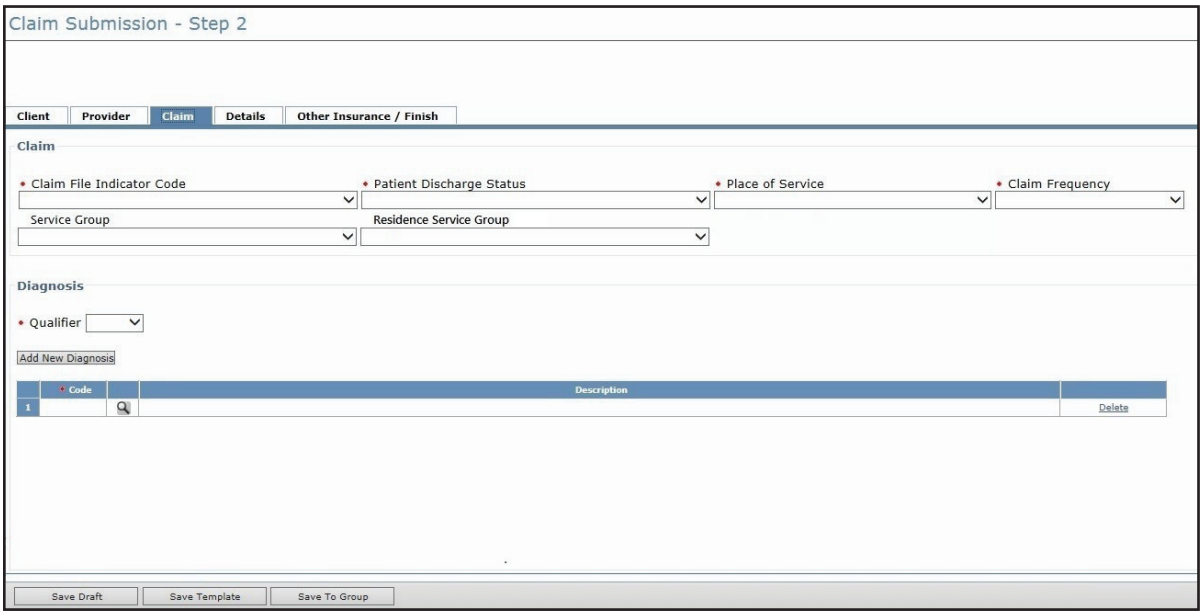
will indicate Service Group, Residence Service Group, and Budget Number (when applicable) in the appropriate drop-down fields located in the Claim tab in TexMedConnect.

- The Service Group drop down is to be used by Billing providers with multiple service groups linked to the same LTC Provider contract number.



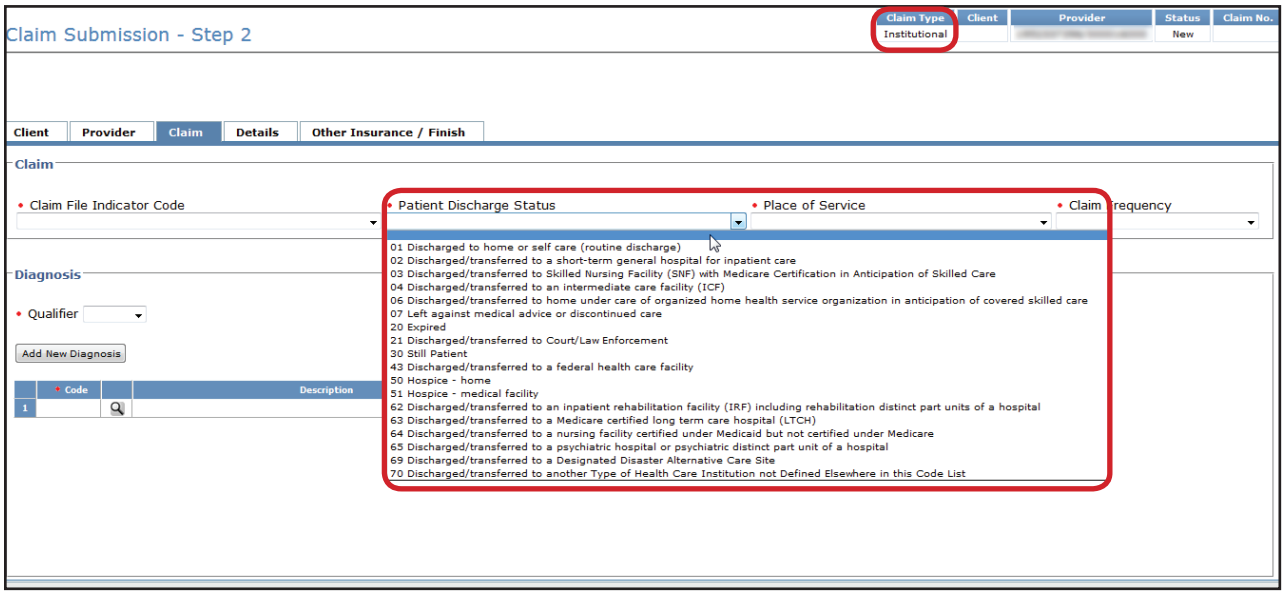
- The Residence Service Group drop down will be utilized by SG 8 (Hospice) Billing Providers to indicate the person's residence at the time of service for LTC Institutional claims. It will be a conditional field, but will result in claim rejections if not filled out when required (when people are in an ICF/IID facility and the correct service group is either left blank or not selected).

Note: *The provider can be linked to multiple Service Groups and SG 8 needs to be selected in the the Service Group field for Residence Service Group field to display. If the provider is only linked to SG 8, the Service Group field is not displayed.*

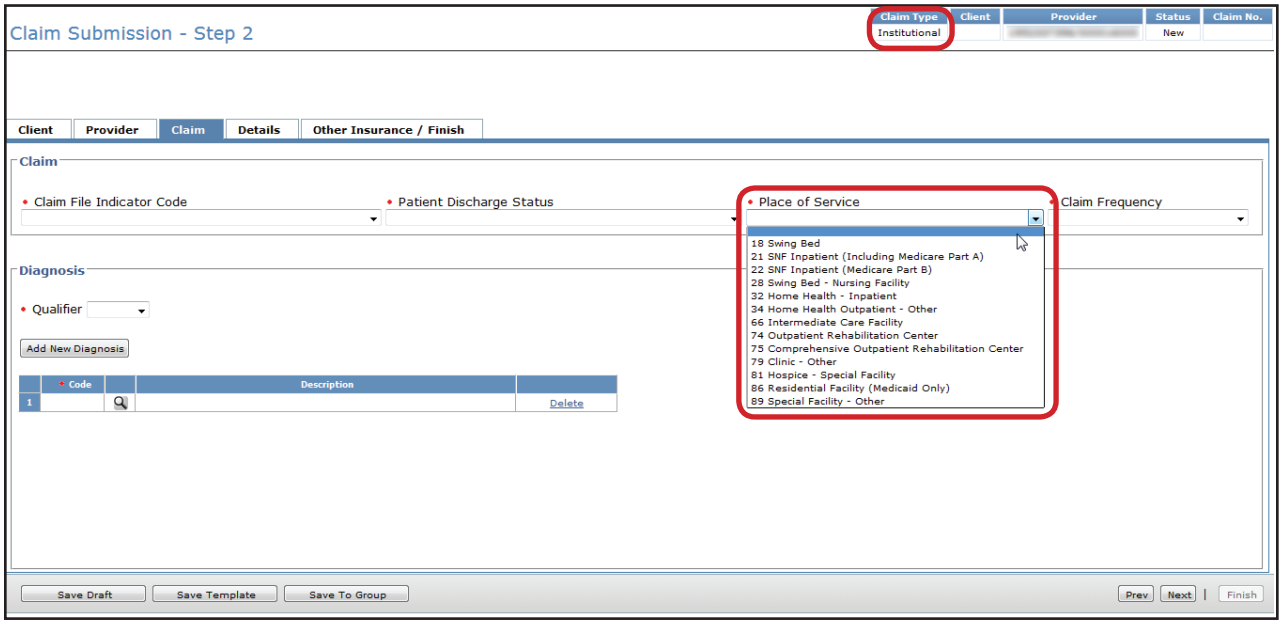


Note: *Billing Providers will continue to use modifiers in position 1, 2, 3, and 4 as they appear on the HHSC LTC Bill Code Crosswalk. It is important to remember that modifier placements changed as of February 1, 2019, so providers should consult the Crosswalk to update their previously saved claims and templates to reflect the new modifier positions.*

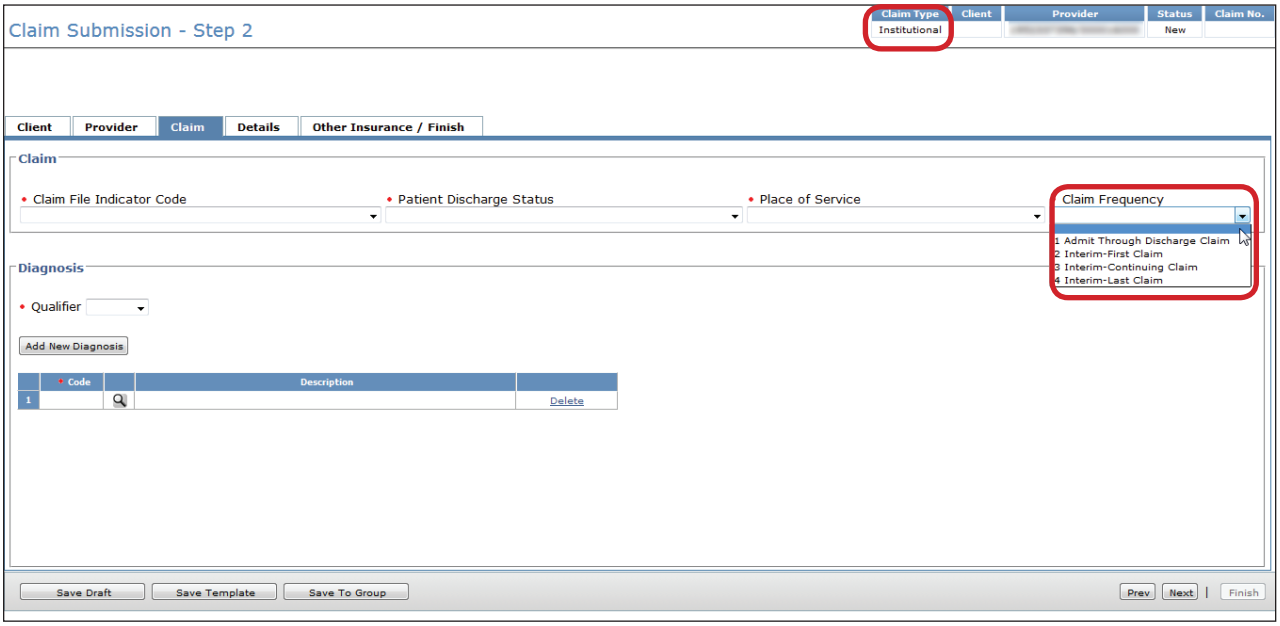
6) Choose the appropriate status from the Patient Discharge Status drop-down box.



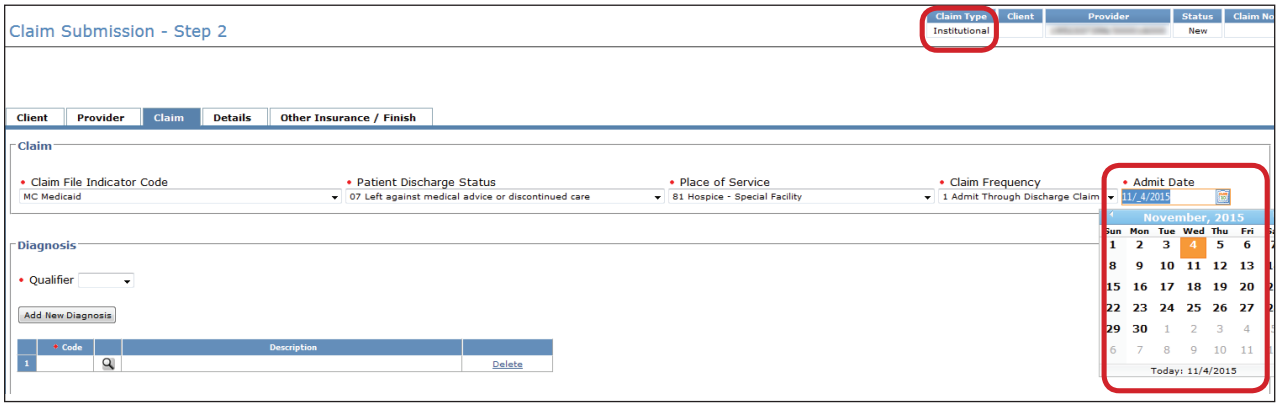
7) Choose the appropriate facility type from the Place of Service drop-down box.



8) Choose the appropriate claim frequency from the Claim Frequency drop-down box.
   - Choose **1 Admit Through Discharge Claim** when the claim will cover the entire duration of the stay.
   - Choose **2 Interim-First Claim** if this is the first claim billed for the person.
   - Choose **3 Interim-Continuing Claim** for all dates of service between the first and last claims.
   - Choose **4 Interim-Last Claim** if this is the last claim billed for the person.

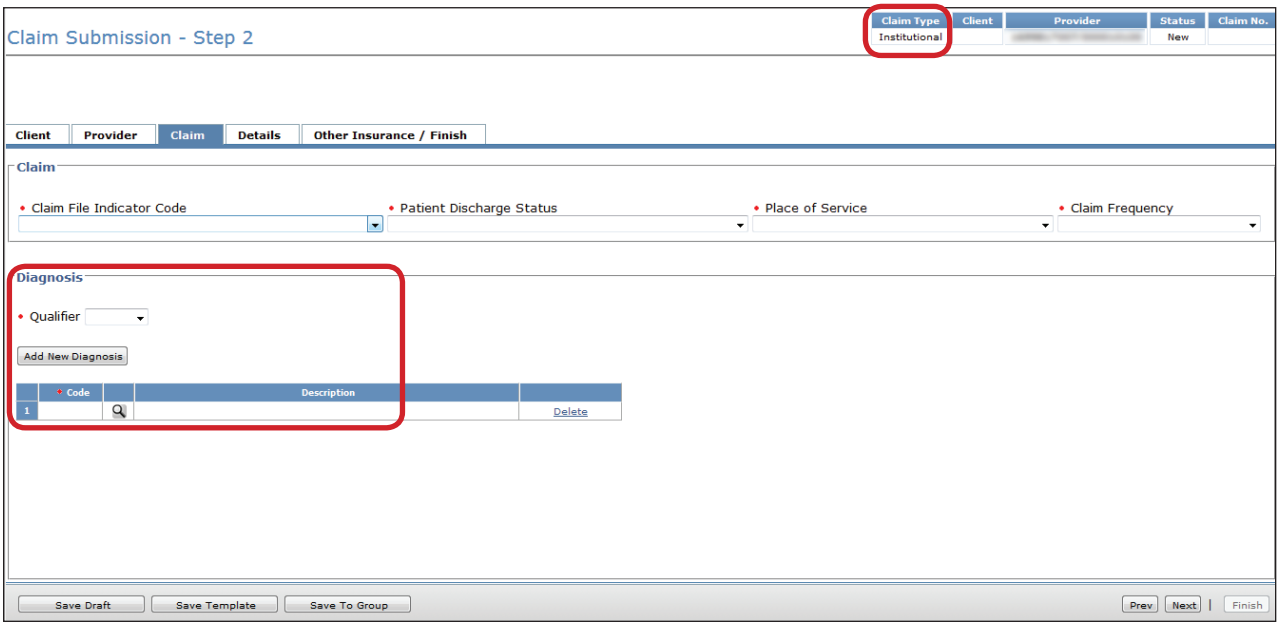


9) Depending on the value in the Claim Frequency field you selected, the Admit Date field may be required. The admit date is the date that the person is admitted to the facility.

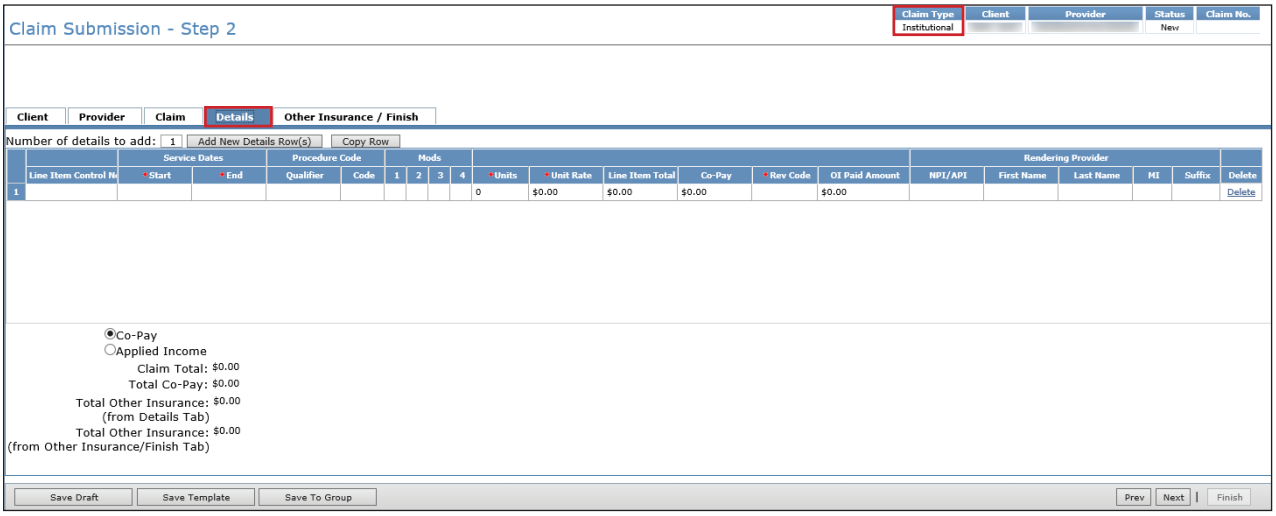


10) The Principal Diagnosis code is required for institutional claims. Inputting an improper diagnosis code may result in a claim rejection by an MCO. The Admitting Diagnosis is conditional for certain values in the Claim Frequency field.

- To add more diagnosis codes, click the **Add New Diagnosis** button. You may list up to three diagnosis codes. The third Diagnosis field is intended for use with External Cause of Injury codes for ICD-9 or External Cause of Morbidity codes for ICD-10.
- To view the diagnosis description, click the magnifying glass icon.
- The Qualifier field is used to indicate an ICD-9 or ICD-10 diagnosis code. Select from the drop-down box based on the diagnosis code(s) entered.



11) Click the **Details** tab. You must complete all of the fields that are indicated by a red dot. If the person is in Service Group 1, 6, or 8, enter the total amount paid by the person's other insurance in the OI Paid Amount field.

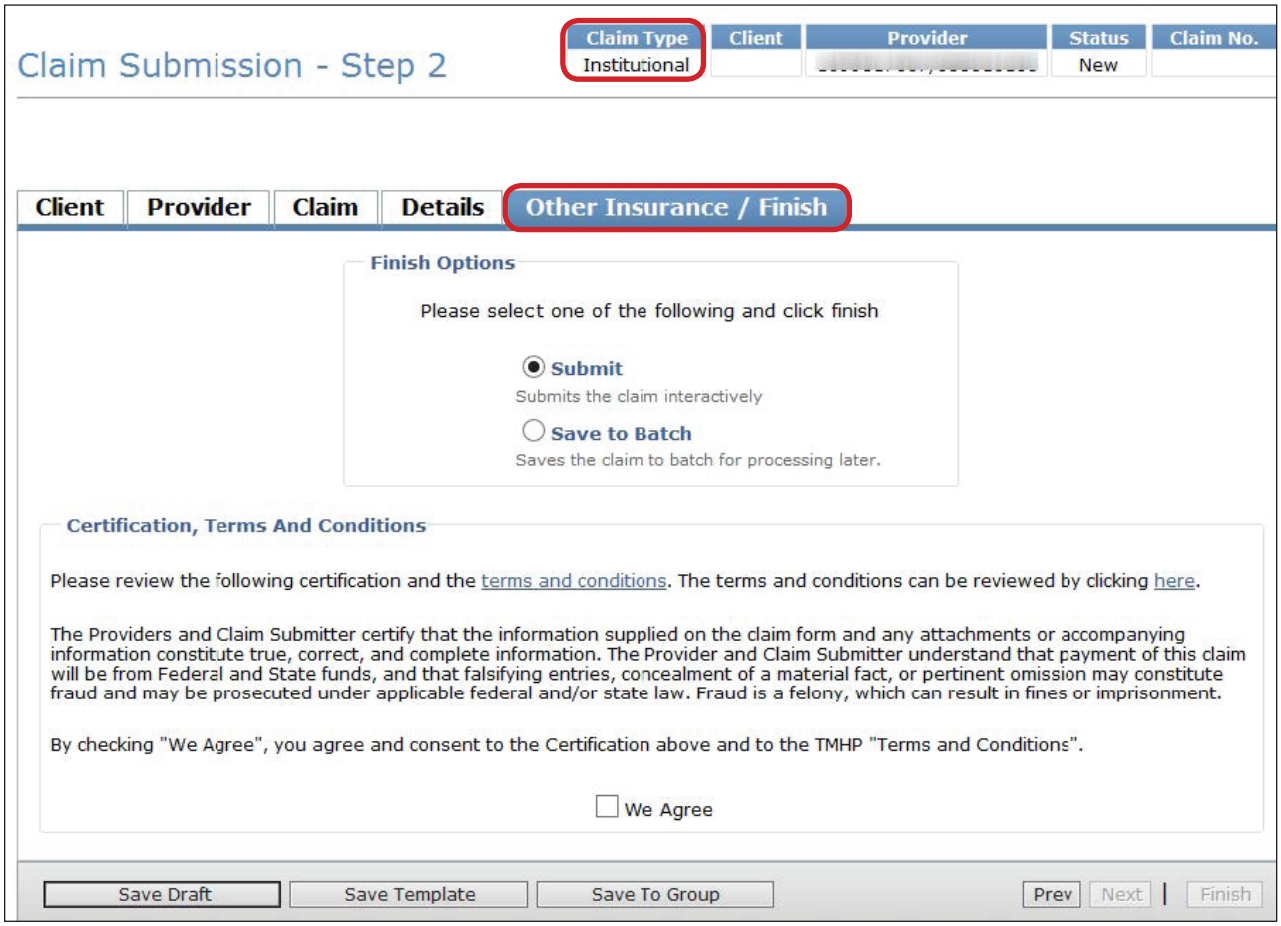


- To add more rows, click the **Add New Detail Row(s)** button.
- To copy the information from the previous detail, click the **Copy Row** button.
- To delete a row, scroll over and click the **Delete** link at the end of the row.

- When billing for managed care claims with consecutive service dates without a change in the level of service Resource Utilization Group (RUG) or gap in service dates, providers must enter these claim transactions as one line item on the Details tab. Entering multiple rows for consecutive service dates can result in an initial claim denial by the MCO during processing.

Note: *The Rendering Provider information in the Detail tab should only be added if it is different from the Rendering Provider listed in the Provider tab. The Rendering Provider in the Detail tab should also be different from the Attending Provider and Billing Provider listed in the Provider tab.*

12) Click the **Other Insurance / Finish** tab.



When submitting an Institutional Claim, there are four scenarios for the Other Insurance / Finish section. They are:

- **Scenario 1. Other Insurance/Finish tab** – The options that are available on the Other Insurance / Finish tab are the same as a Professional claim, unless the person is in Service Group 1, 6, or 8.

Note: *If your claim will be forwarded to an MCO, it is recommended to submit the other insurance information directly to the MCO. Otherwise, the claim may be held for manual review by the MCO.*

Note: *For people with Medicare in Service Group 1, Service Code 3 Extended Care Facility, enter either the Medicare Part A or Part C amount in the Medicare Information section. The Medicare attestation box must also be checked when billing for SG 1, Service Code 3.*

a) Click the **Submit** radio button.

b) Check the **We Agree** box in the Certification, Terms And Conditions section.

c) Click the **Finish** button in the lower right corner of the screen.

- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- To submit the claim as part of a batch, refer to the Submitting a Batch section of this User Guide.
- **Scenario 2. Other Insurance / Finish tab (no known OI coverage) -** For Providers in SG 1, 6, or 8:

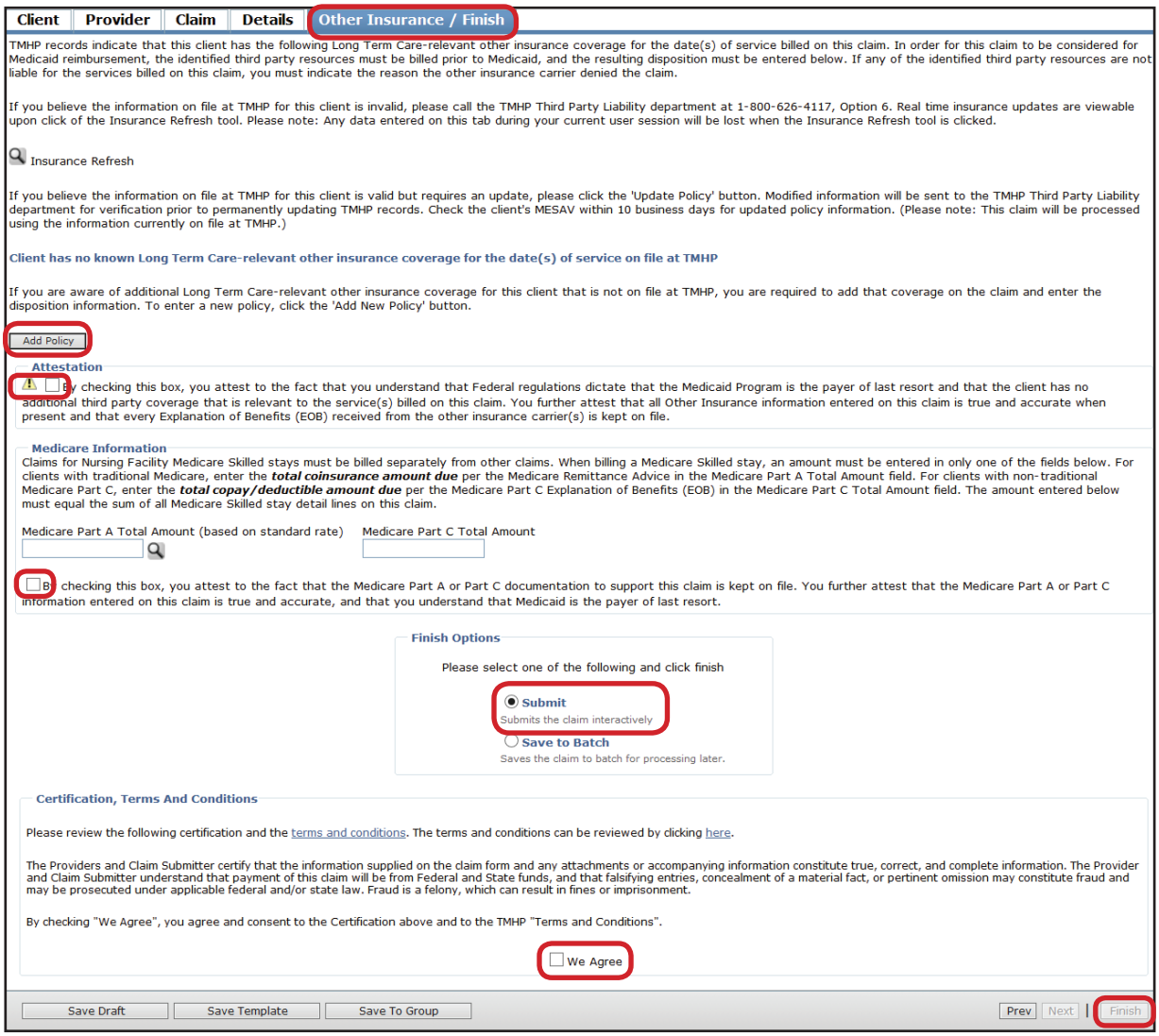
If you are aware of additional OI coverage for the person that is Long-Term Care relevant, you are required to add that coverage on the claim by using the **Add Policy** button.

a) Check the box under Attestation

b) Click the **Submit** radio button.

c) Check the **We Agree** box in the Certification, Terms And Conditions section.

d) Click the **Finish** button in the lower right corner of the screen.



- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- To submit the claim as part of a batch, refer to the Submitting a Batch section of this User Guide.
- **Scenario 3. Other Insurance / Finish Tab add OI policy** – The Other Insurance Policy will be validated by TMHP Third-Party Liability department before being added to the OI database. However, any Other Insurance Paid Amount will be taken into consideration on the submission of the claim.

  a) Enter the required fields as indicated by the red dots.

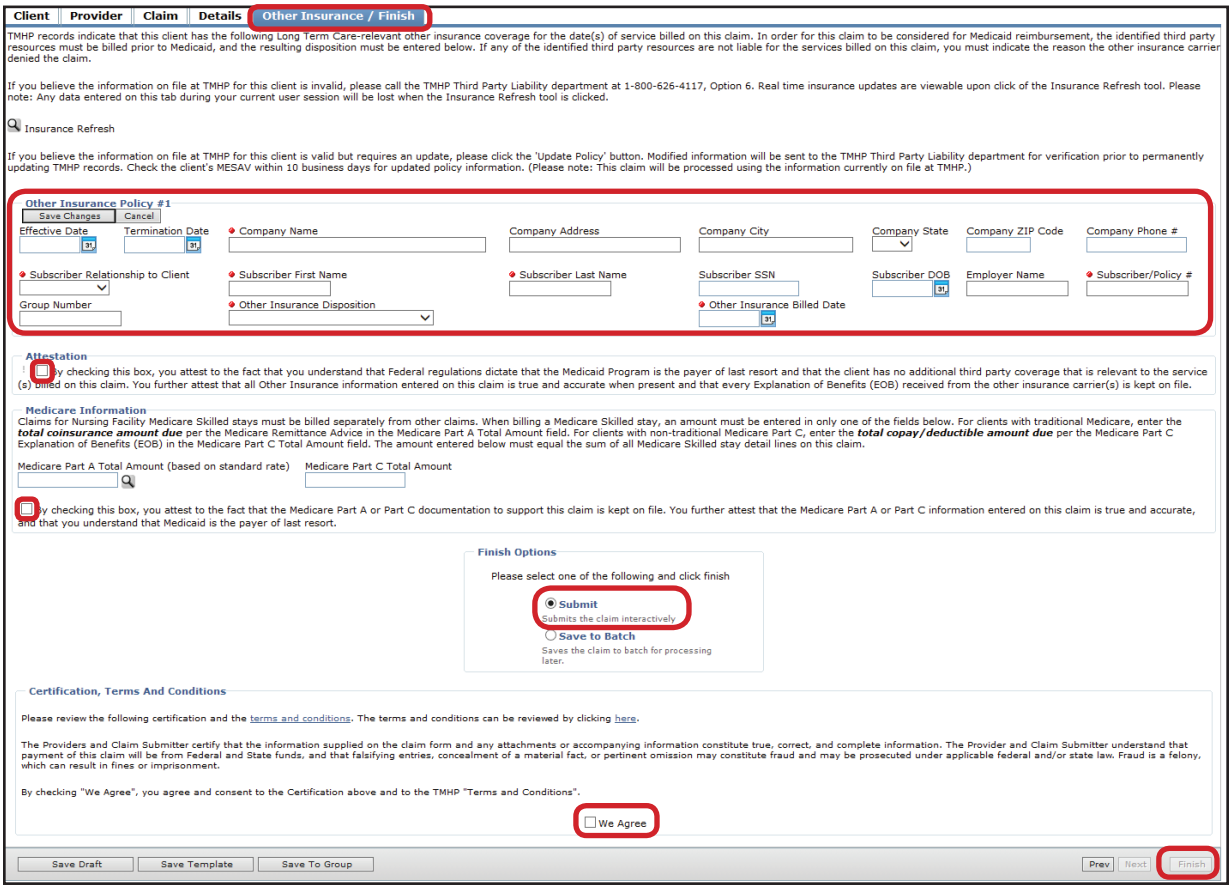
  b) Check the box under Attestation.

  c) Click the **Submit** radio button.

  d) Check the **We Agree** box in the Certification, Terms And Conditions section.

  e) Click the **Finish** button in the lower right corner of the screen.

Note: *To avoid processing errors, enter either Employer Name or Group Number but not both, when applicable.*



- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- To submit the claim as part of a batch, refer to the Submitting a Batch section of this User Guide.
- **Scenario 4. Other Insurance/Finish Tab (with known OI coverage)** - For people in SGs 1, 6, or 8, TexMedConnect will display any known Long-Term Care-relevant OI coverage currently on file with TMHP.

  a) Verify the OI information is valid and correct.

  b) Fill in all required Other Insurance Policy information as indicated by a red dot.

  c) Choose the appropriate option in the Other Insurance Disposition drop-down box. If no response has been received, and it has been more than 110 calendar days since the billing date, choose **No response (initial bill for services)** or **No response (subsequent bill for services)**.

  d) If you chose **Paid** in the Other Insurance Disposition drop-down box, choose an option in the Other Insurance Disposition Reason drop-down box as shown below, and if applicable, enter the Other Insurance Paid Amount.

Note: *The amount entered in this field must match the total amount entered on the Details tab in the OI Paid Amount field.*

e) If you chose **Denied** in the Other Insurance Disposition drop-down box, choose an option in the Other Insurance Disposition Reason drop-down box.

f) Enter the appropriate date in the Other Insurance Billed Date field. If you choose either of the No response options in the Other Insurance Disposition drop-down box, the Other Insurance Billed Date must be at least 110 calendar days prior to the submission date.

g) If you need to update the other insurance policy, click the **Update Policy** button to display the Other Insurance Policy fields. Once information is updated, click the **Save Changes** button.

h) If you need to add another insurance policy, click the **Add Policy** button to display the Other Insurance Policy field.

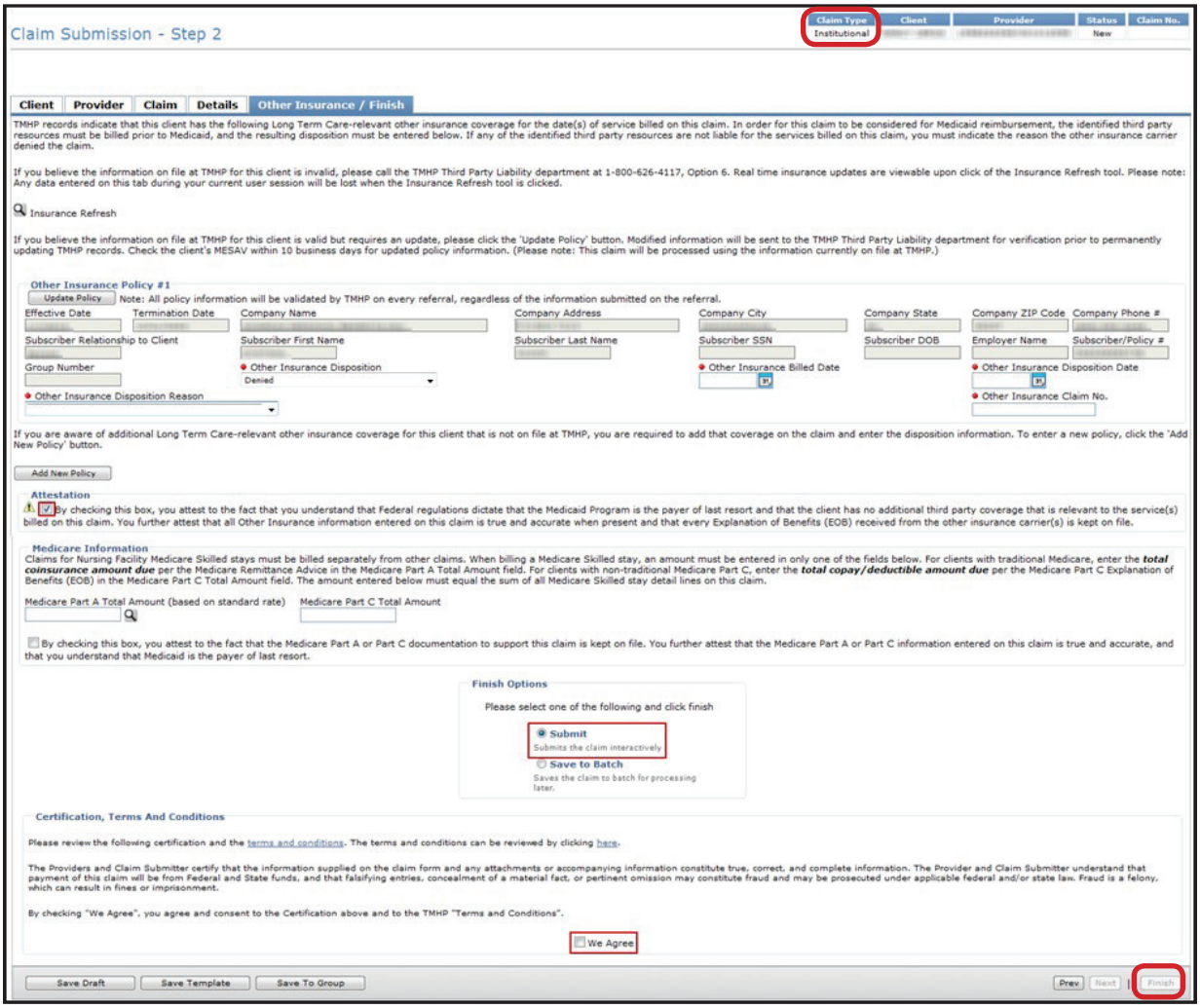
i) Check the box under Attestation.

j) Click either the **Submit** radio button or the **Save to Batch** radio button.

k) Check the **We Agree** box in the Certification, Terms and Conditions section.

l) Click the **Finish** button.

Note: *The Other Insurance Policy will be validated by the TMHP Third-Party Liability department before being added to the Other Insurance database.*



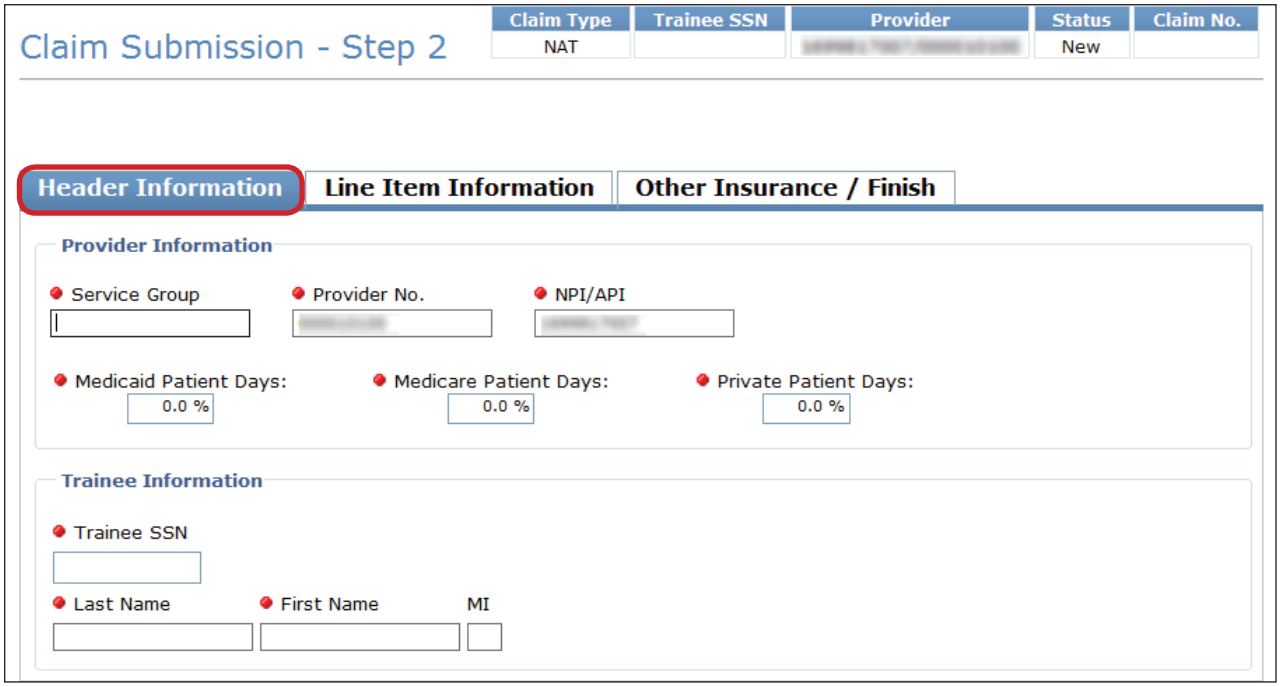
- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- To submit the claim as part of a batch, refer to the Submitting a Batch section of this User Guide.

Nurse Aide Training (NAT)

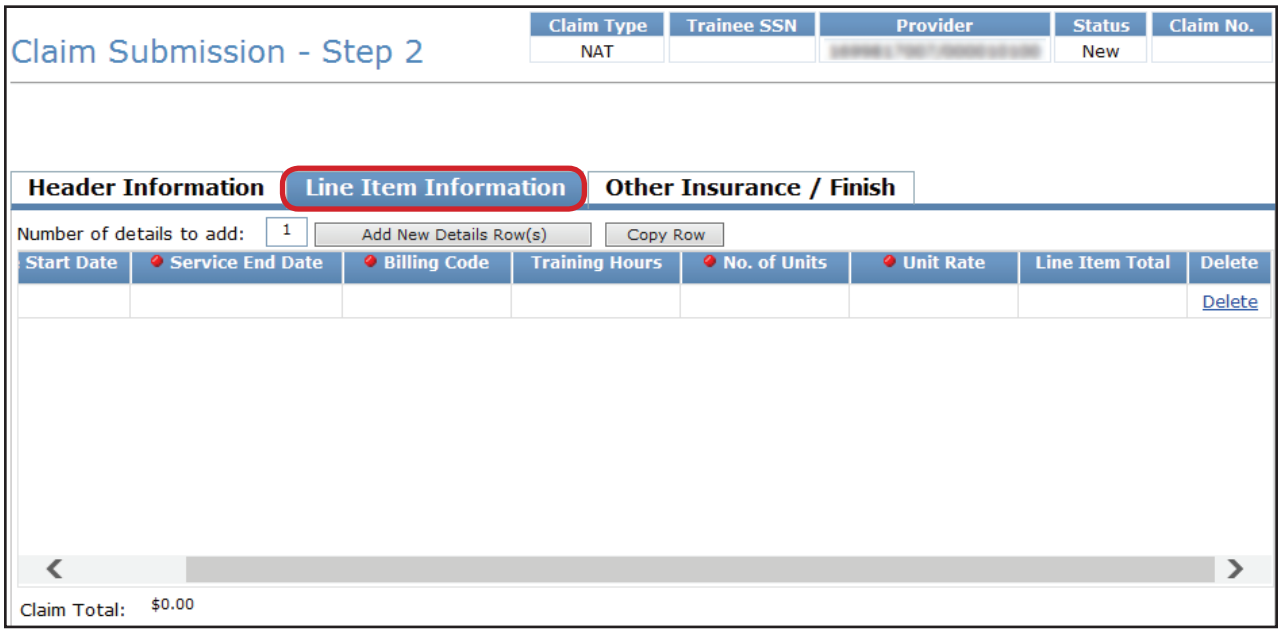
To enter a NAT claim:

1) Click the **Header Information** tab. Complete all of the required fields as indicated by a red dot. The Provider No. field and the NPI/API field will be auto-populated based on the information entered in Step 1.

Note: *The percentages entered for Medicaid Patient Days, Medicare Patient Days, and Private Patient Days must total 100 percent.*



2) Click the **Line Item Information** tab. Complete all of the required fields as indicated by a red dot. No future date is allowed in the Service Start Date or Service End Date fields.



- If you want to add more rows, click the **Add New Detail Row(s)** button.
- If you want to copy the information from the previous detail, click the **Copy Row** button.

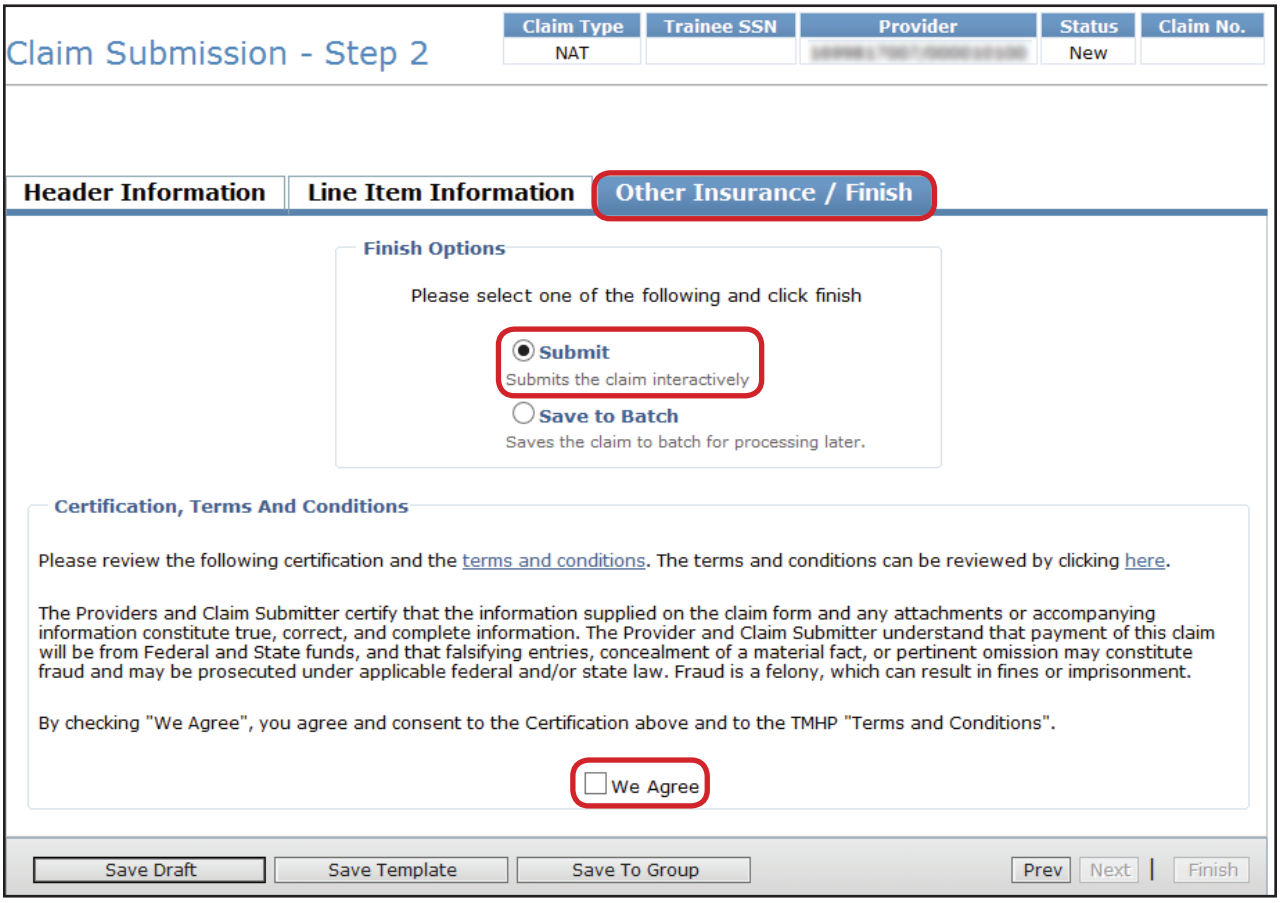
3) Click the **Other Insurance/Finish** button.

Note: *Other insurance information is not required on a Nurse Aide Training Claim, only an Institutional Claim.*

a) Click the **Submit** or **Save to Batch** radio button.

b) Check the **We Agree** box in the Certification, Terms and Conditions section. Click the **Finish** button in the lower right corner of the screen.

c) If the claim is submitted successfully, an Internal Control Number (ICN) will be displayed in the Claim No. field at the top of the page. The ICN is also known as a claim number.

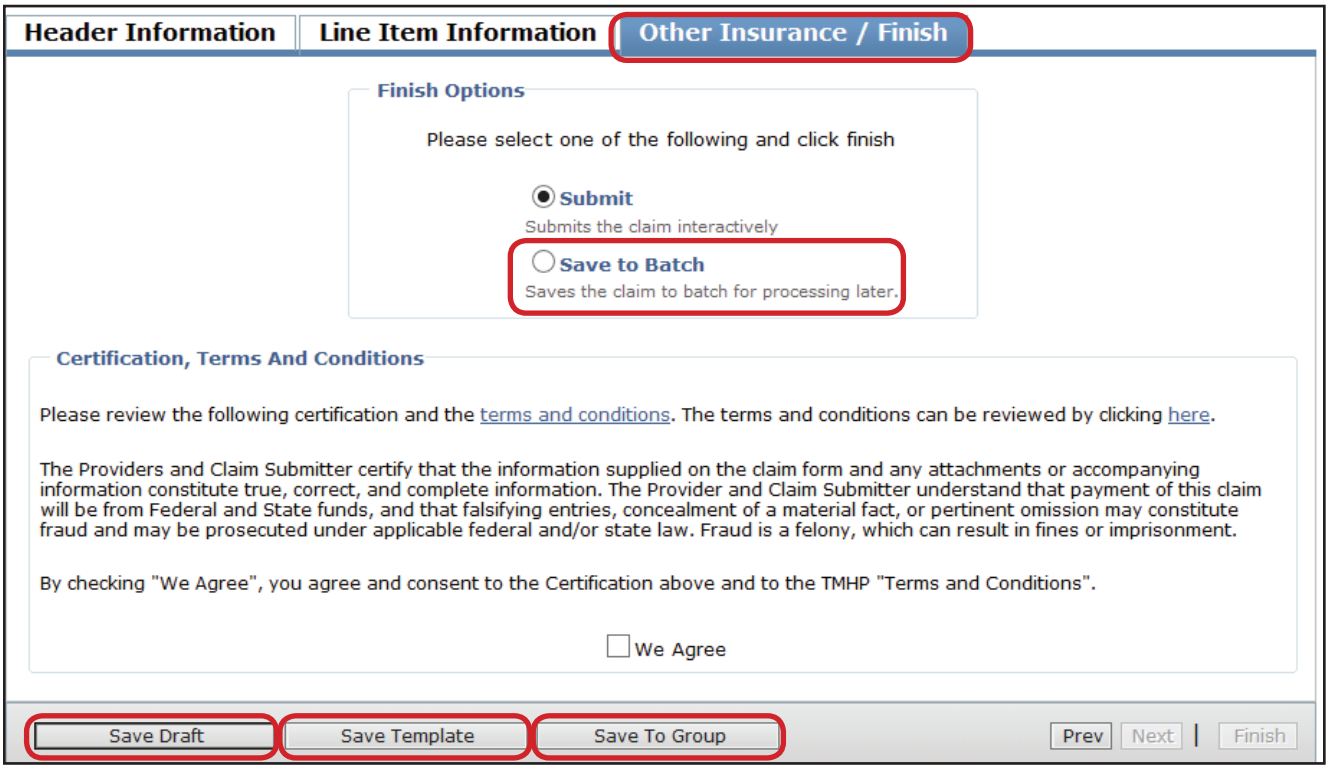


- To save the claim as a draft, click the **Save Draft** button.
- To save the claim as an individual template, click the **Save Template** button.
- To save the claim as part of a group, click the **Save To Group** button.
- To submit the claim as part of a batch, refer to the Submitting a Batch section of this User Guide.

Saving a Claim

There are four options available for saving a claim:

1) **Save Draft** - The claim will be added to the draft list for completion later.
2) **Save Template** - The claim will be added to the template list for faster claims creation in the future.
3) **Save To Group** - The claim will be added to a group template, which includes templates for many people.
4) **Save To Batch** - The claim will be added to a batch of claims that can be submitted as a group.

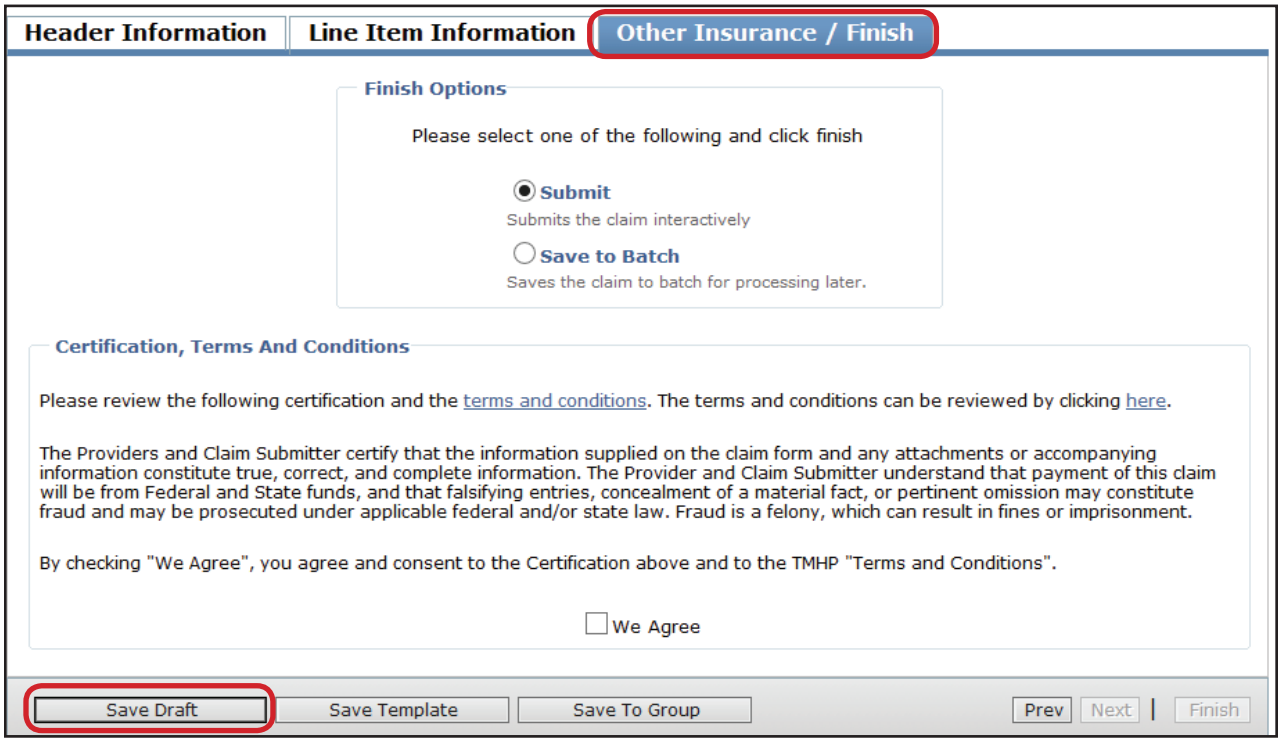


Draft Claims

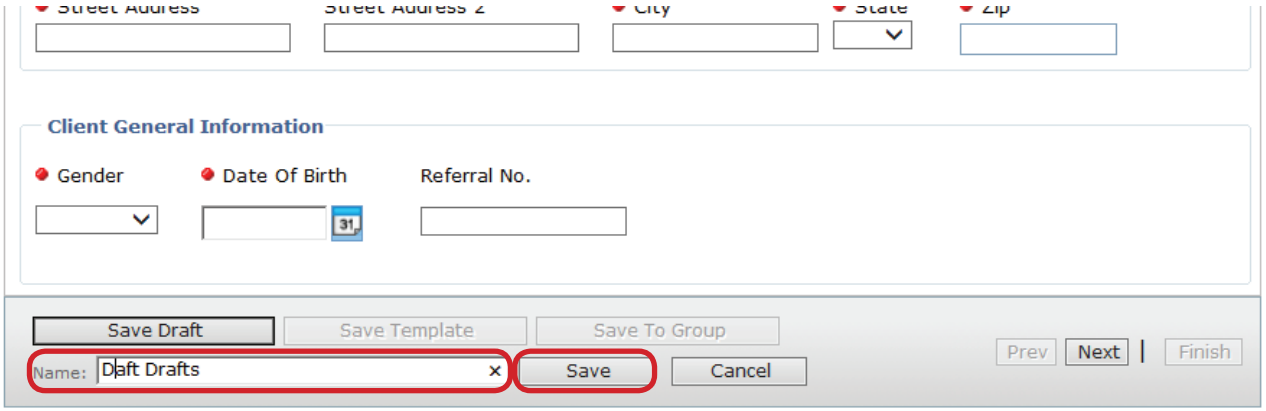
Saving Draft Claims

To save a claim as a draft:

1) Click the **Save Draft** button at the bottom of the screen.



2) Enter a name for the draft, and click the **Save** button. The claim will be added to the draft list. A maximum of 500 claims can be saved as drafts. Saved drafts are available for 45 days after the last time they were accessed. After 45 days have elapsed, saved drafts are automatically deleted.



Viewing Draft Claims

To view a list of all your draft claims:

1) Click the **Drafts** link under the Claims section on the navigation panel.

2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.

3) If there are multiple drafts, you can click a column heading to sort the list by that column category. Click a Draft Name to view the saved claim.

- Once a claim from the draft list has been submitted, that draft claim is removed from the draft list.
- After 45 days, drafts will automatically be deleted from the draft list.
- A maximum of 50 drafts can be created for each NPI or API and provider number.

Individual Templates

Saving as an Individual Template

To save an individual claim as a template, complete a claim and then:

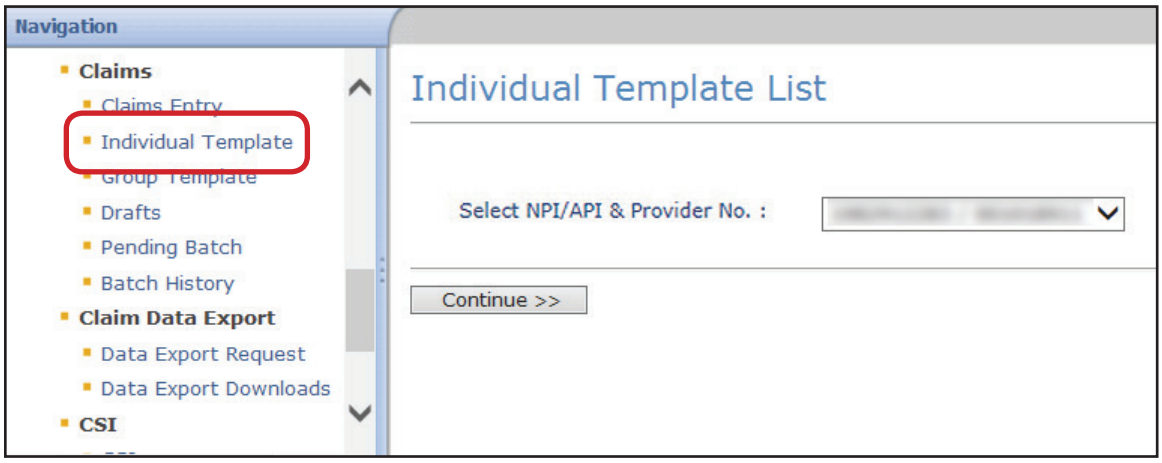
1) Click the **Save Template** button.

2) Enter a template name, and click the **Save** button. The claim will be added to the Individual Template list.
3) Templates do not disappear when they are used and can be used an unlimited number of times. However, they will be automatically removed if they have not been used for 365 days.
4) A maximum of 1,000 individual claim templates can be created for each NPI or API and provider number.

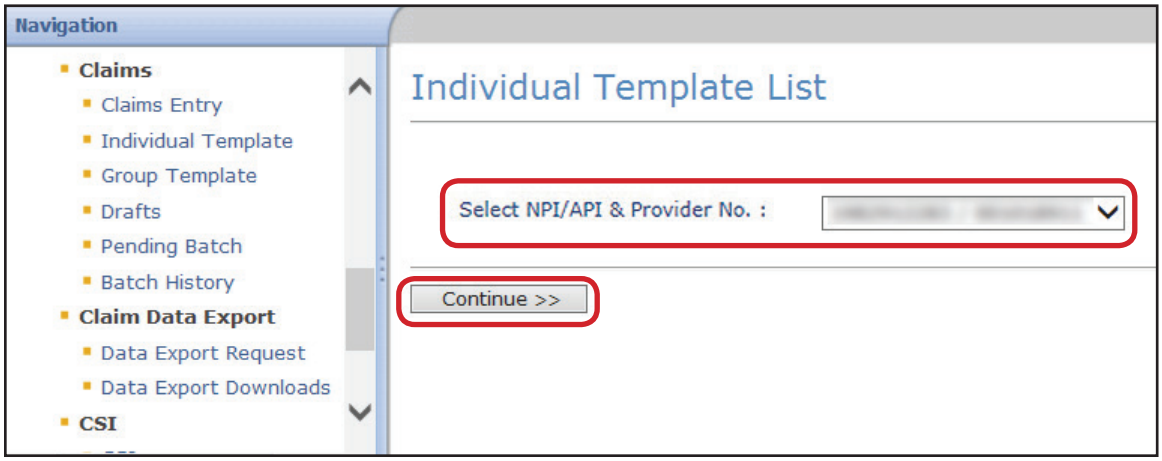
Viewing Individual Templates

To view individual templates:

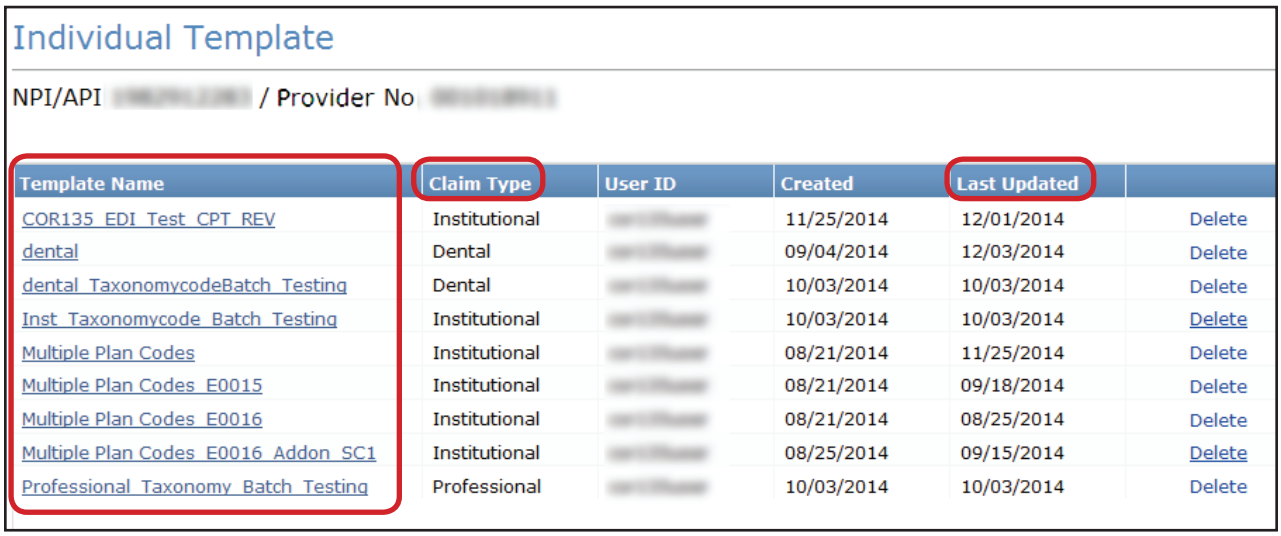
1) Click the **Individual Template** link under the Claims section on the navigation panel. Templates are displayed by NPI.



2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.



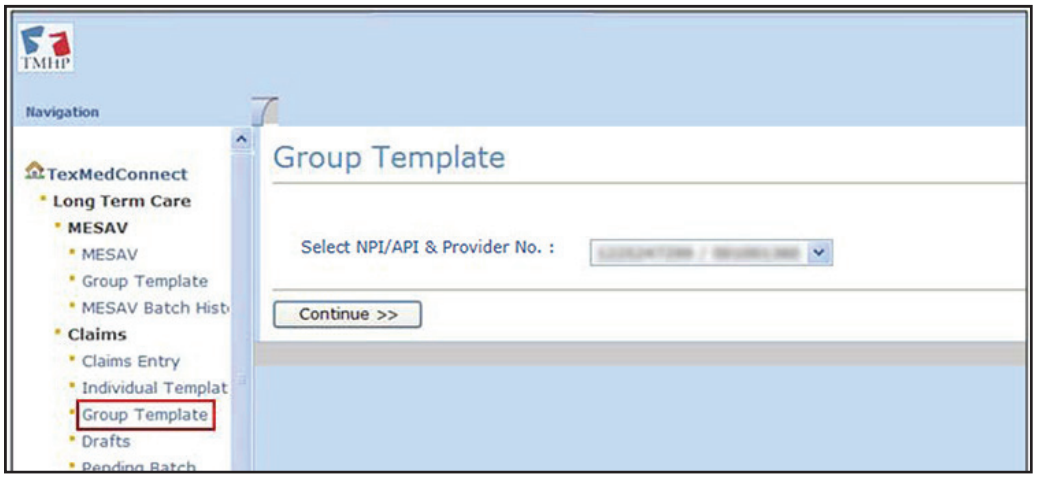
3) If there are multiple drafts, you can click a column heading to sort the list by that column category. Click on the template name to open it.



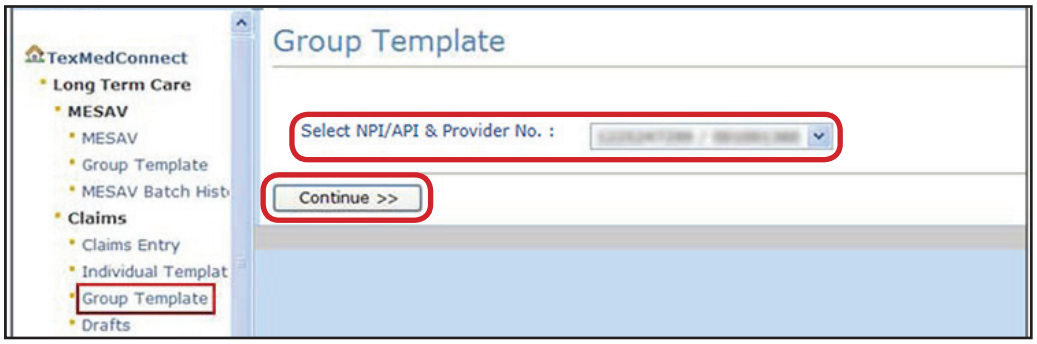
Group Templates

Viewing Existing Group Templates

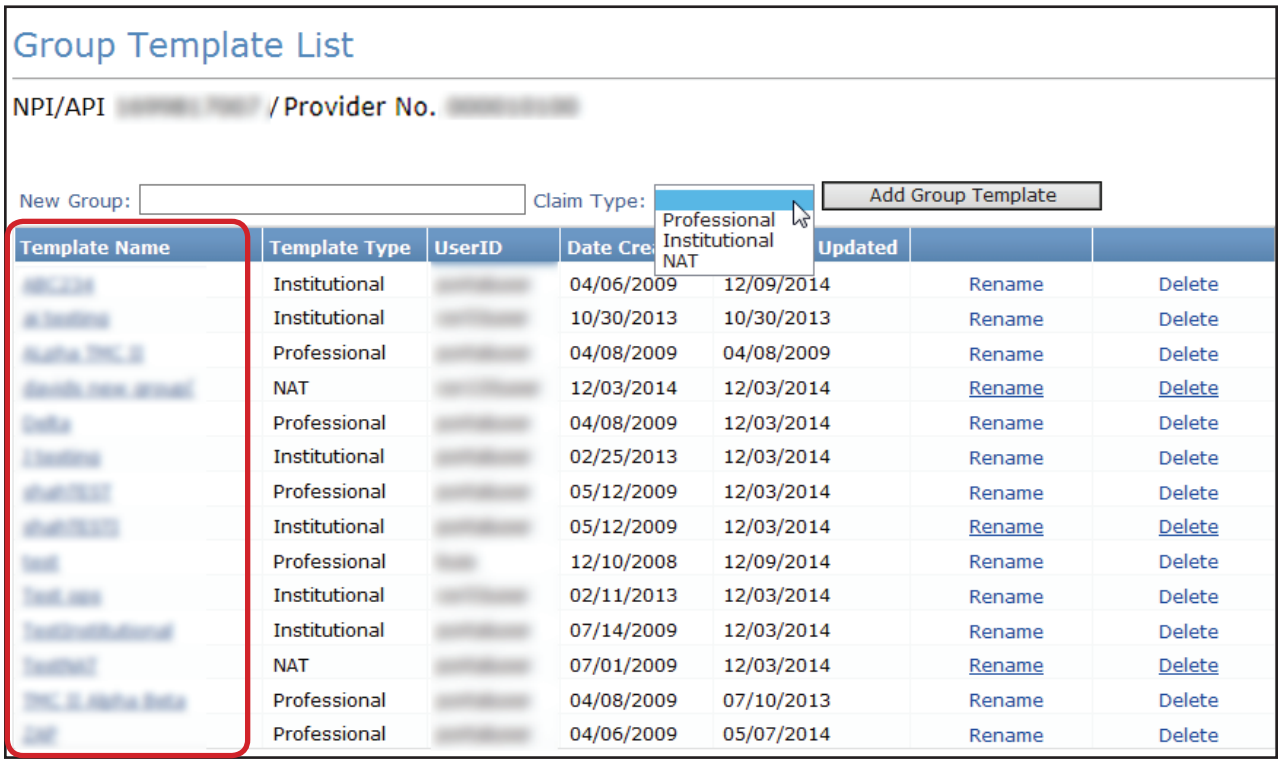
1) Click the **Group Template** link under the Claims section on the navigation panel.



2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.



3) Under the **Template Name** column, click the template name on which you want to work.

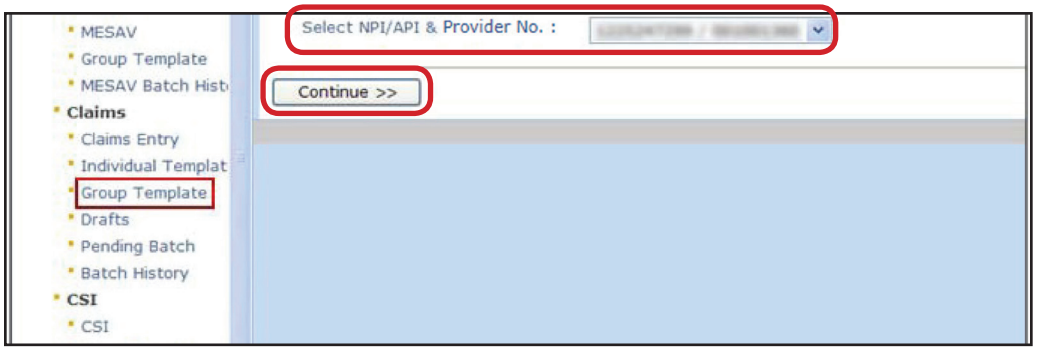


Creating New Group Templates

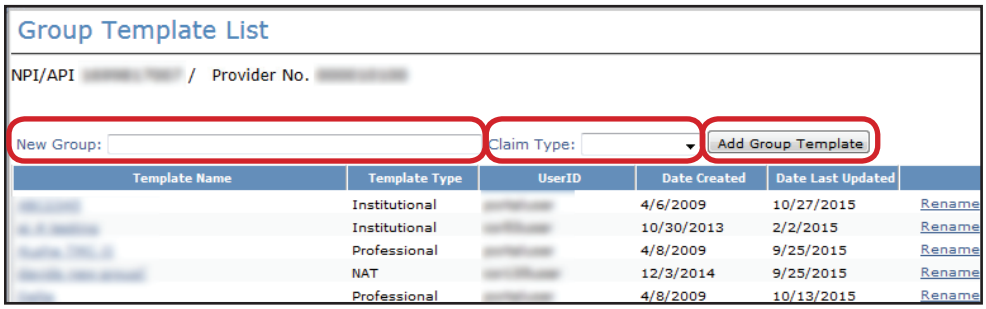
To create a new Group Template:

1) Click the **Group Template** link under the CSI on the navigation panel.

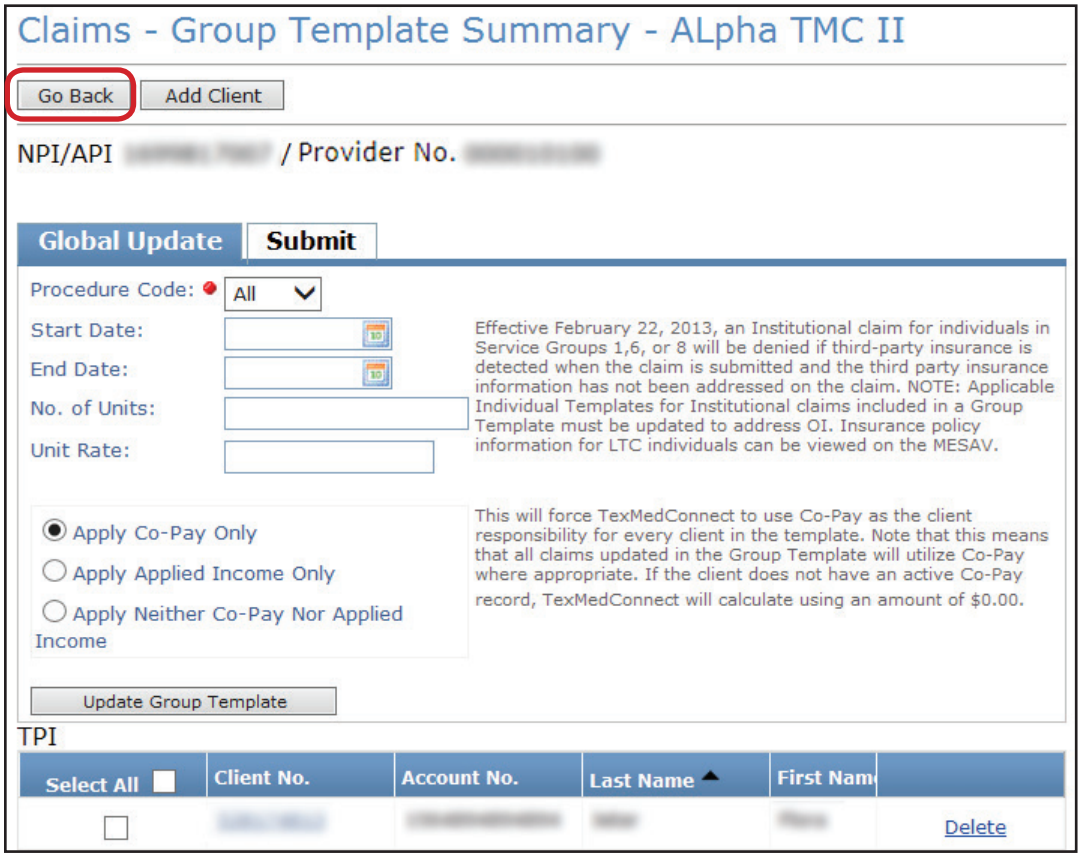
2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.



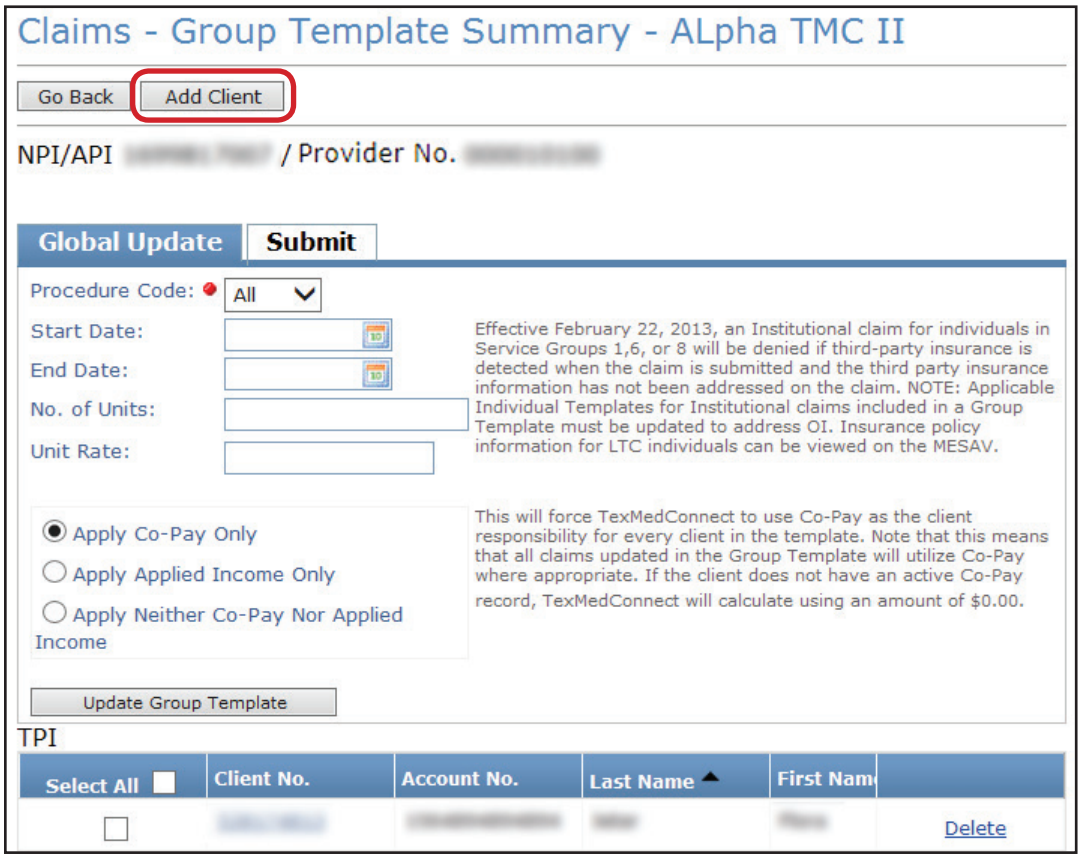
3) Enter the name of a group in the **New Group** field, choose the Claim Type from the drop-down box, and then click the **Add Group Template** button.



4) After you have created the Group Template, the Group Template Summary page will display. To add a person, go to step 5. To return to the Group Template List page, click the **Go Back** button.



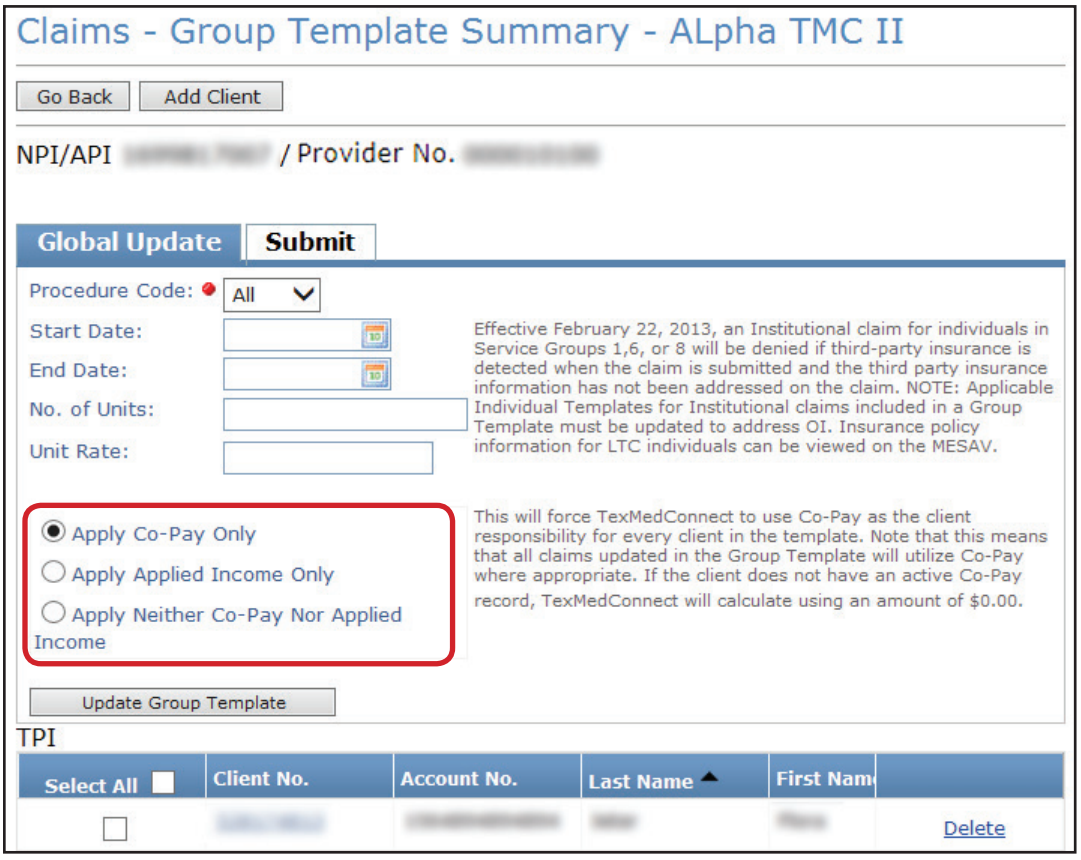
5) To add a person to the group, click the **Add Client** button.



6) You can define the start date and end date, the number of units, and the unit rate for all of the claims in the template. You must click one of the three radio buttons:

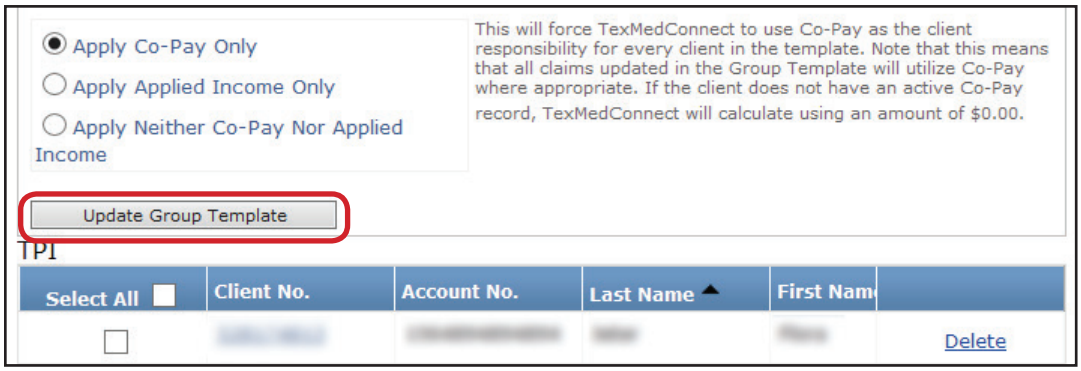
- **Apply Co-Pay Only;** or
- **Apply Applied Income Only;** or
- **Apply Neither Co-Pay Nor Applied Income.**
- If you choose **Apply Co-Pay Only,** TexMedConnect will use Co-Pay as the individual responsibility for every person in the template. This means that all of the claims that are updated in the template will use Co-Pay where it is appropriate to do so. If the person does not have an active Co-Pay record, TexMedConnect will make calculations using an amount of $0.00.
- If you choose **Apply Applied Income Only,** TexMedConnect will use Applied Income as the individual responsibility for every person in the template. This means that all claims updated in the Group Template will utilize Applied Income where appropriate. If the person does not have an active Applied Income record, TexMedConnect will calculate using an amount of $0.00.

- If you choose **Apply Neither Co-Pay Nor Applied Income,** TexMedConnect will use no individual responsibility for every person in the template. This means that the individual responsibility field will be set to zero whether or not the person has an active individual responsibility record. The total payment calculated by TexMedConnect will be higher than the actual payment if any of the claims should have had individual responsibility deducted.



7) When you have entered all the required information, click the **Update Group Template** button to apply that information to all of the claims in the group.

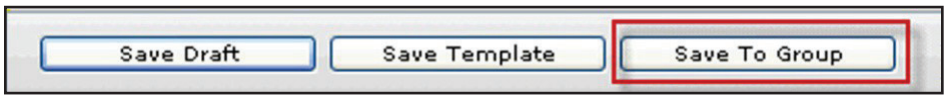
A template will remain in the system as a template after each use. However, if a template has not been used for 365 days it will be deleted from the system. A maximum of 100 group templates can be created for each NPI or API and provider number. Each group template can store up to 250 claims.



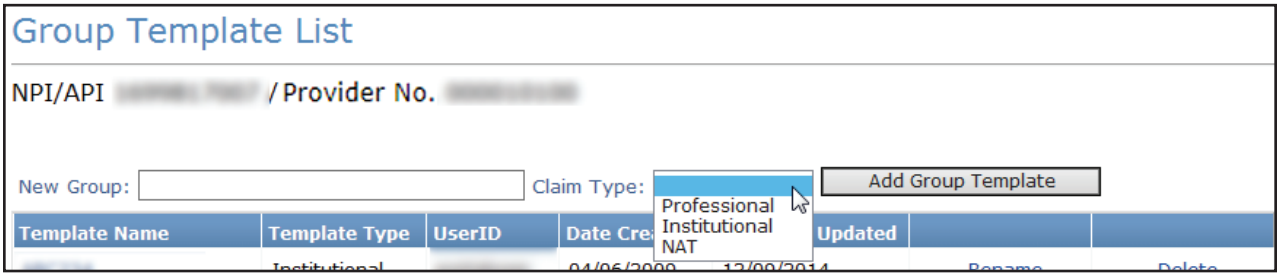
Saving as a Group Template

To create a group template, enter the information for a claim, but before you submit the claim:

1) Click the **Save To Group** button.



2) Enter a group template name, and click the **Save** button.
   - If you enter the name of an existing template, the claim will be added to that existing group template.
   - If you enter the name of a new group template, a new template will be added to the Group Template list. To modify the settings for the new template see the Group Templates section of this User Guide.

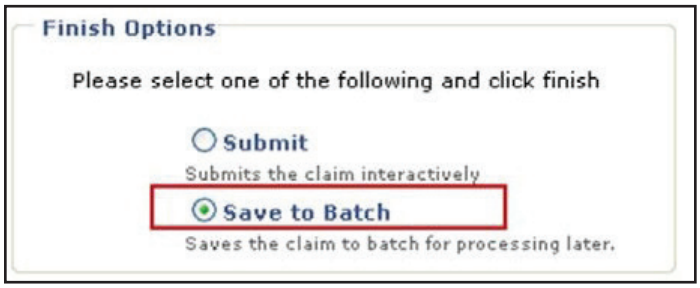


Batch Claims

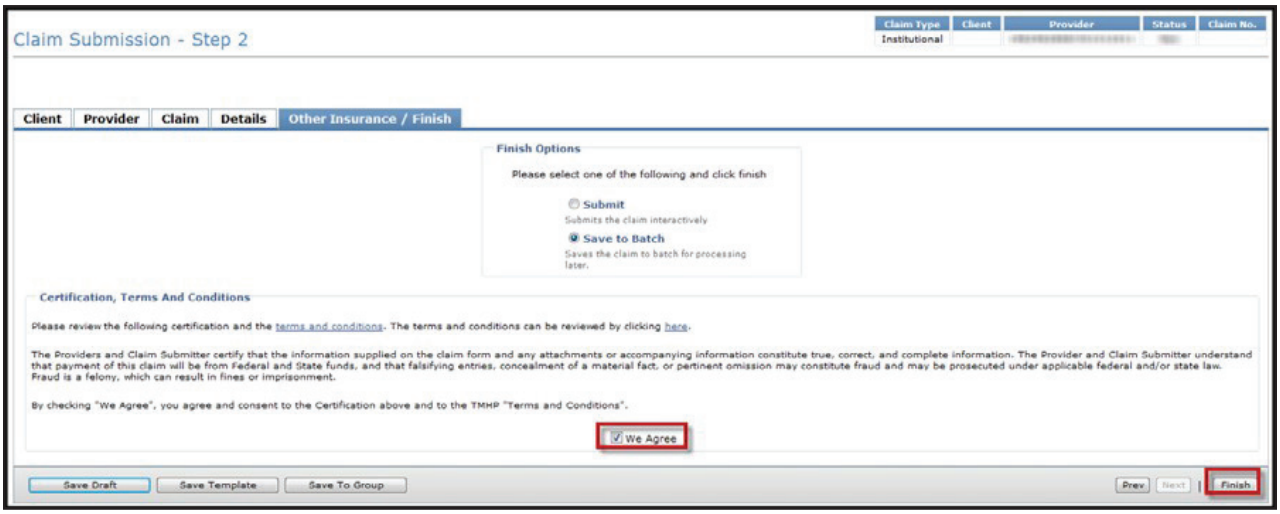
Saving To a Batch

To save a claim as part of a batch:

1) After completing a claim, click the **Save to Batch** radio button.



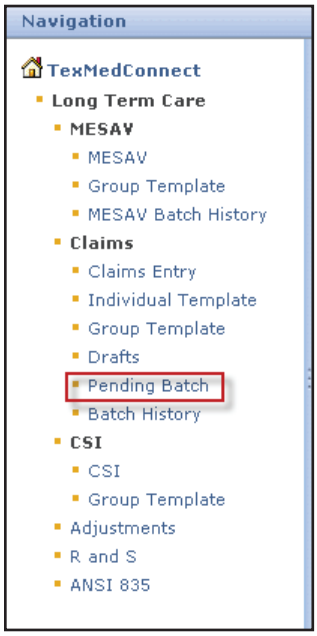
2) Check the **We Agree** box, and then click the **Finish** button. The claim will be saved as part of a batch and you will be returned to the claims entry screen so that you can continue to enter more claims.
   - You can save up to 250 claims to a batch.
   - Pending batches that are not submitted after 45 days are deleted from the system.
   - You can view or edit claims in a pending batch before you submit them.



Submitting a Batch

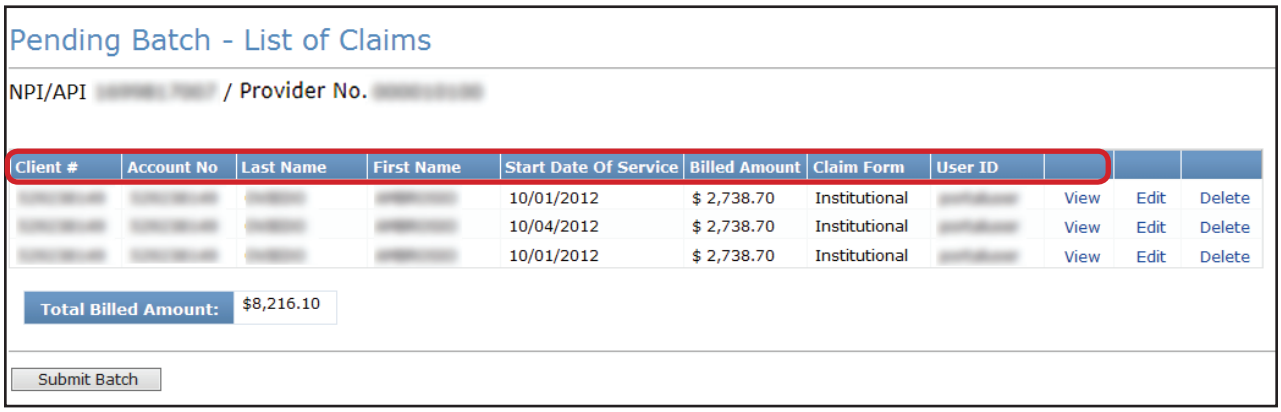
To submit a batch:

1) Click the **Pending Batch** link under the Claims section on the navigation panel.



2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.

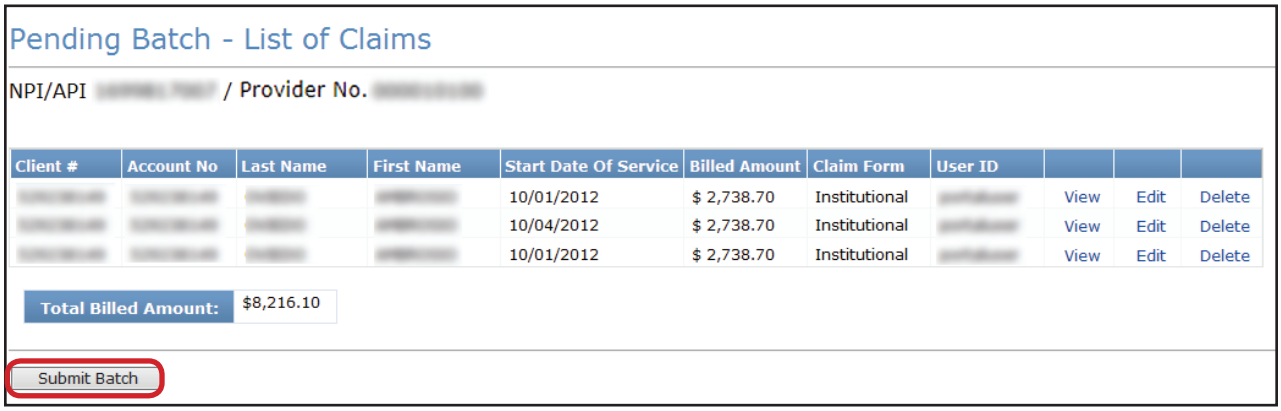
3) The Pending Batch page will display for the selected NPI or API and provider number. The pending batch list shows the claims that are ready to be submitted. Clicking a column heading will sort the list by the data in that column.



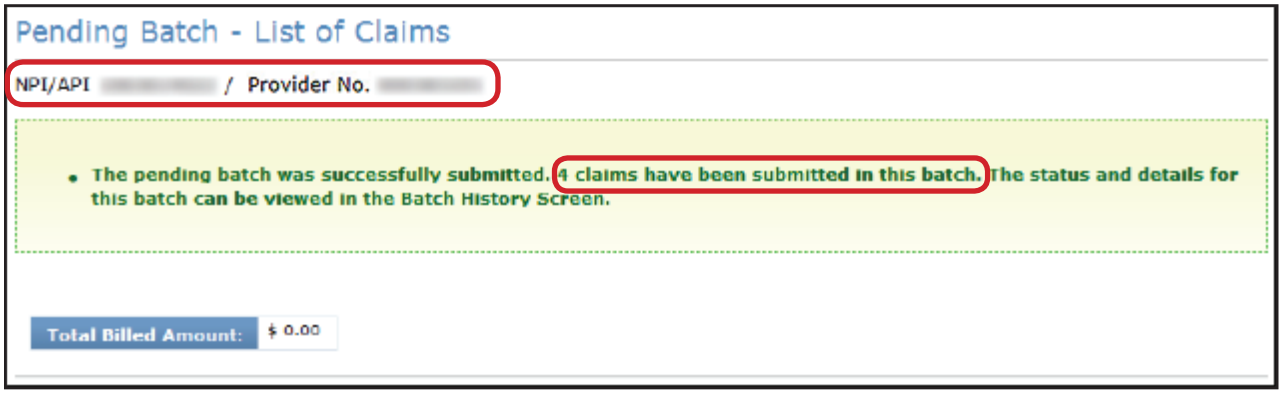
4) If there are more claims than can fit on one screen, click the **Continue** button to go to the next page.

5) If you want to return to a previous page, use your Internet browser's **Back** button.

6) On the last screen of the pending batch list, click the **Submit Batch** button. All of the claims in that batch will be submitted, even those created by other users.



7) When the Batch is submitted, a confirmation message will inform the user whether the submission was successful and the number of claims submitted in the batch.

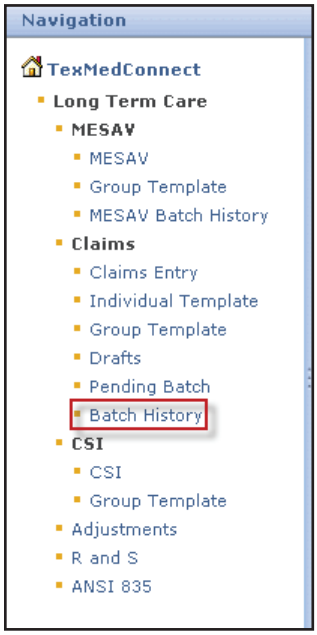


View Batch History

You can view the batch history of previously submitted claim batches. Batches that are more than 120 days old are automatically deleted.

To view a batch history:

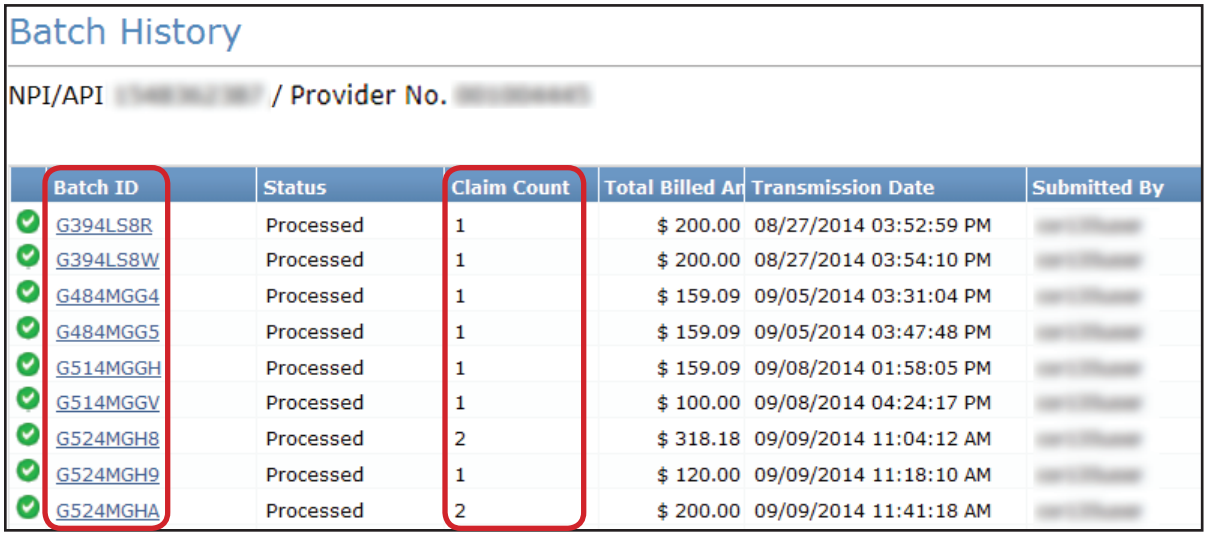
1) Click the **Batch History** link under the Claims section on the navigation panel.



2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.

3) Click on a Batch ID to view the list of claims included in that batch. The Batch History will display all available batches.

Note: *The Claim Count column indicates the total number of processed claims, not necessarily the total number of paid claims.*



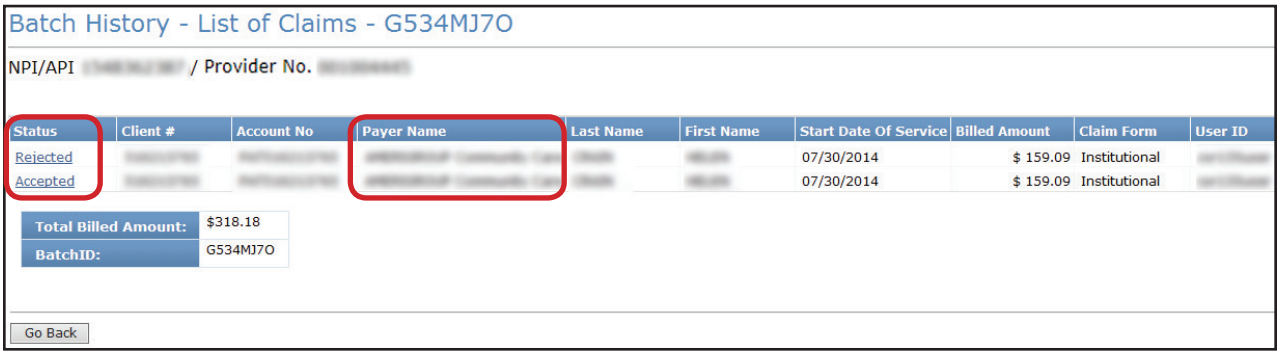
4) You will see a list of the Claims for the Batch you clicked. The Claims listed can be a mix of claims to different MCOs and to TMHP. Claims can be set to the following three statuses:

- ***Forwarded***: means that the claim has been Forwarded (but not yet Accepted or Rejected) by an MCO.
- ***Rejected***: means that the claim has been rejected by TMHP or the MCO to which it was forwarded.
- ***Accepted***: means that the claim has been Accepted by TMHP or an MCO.

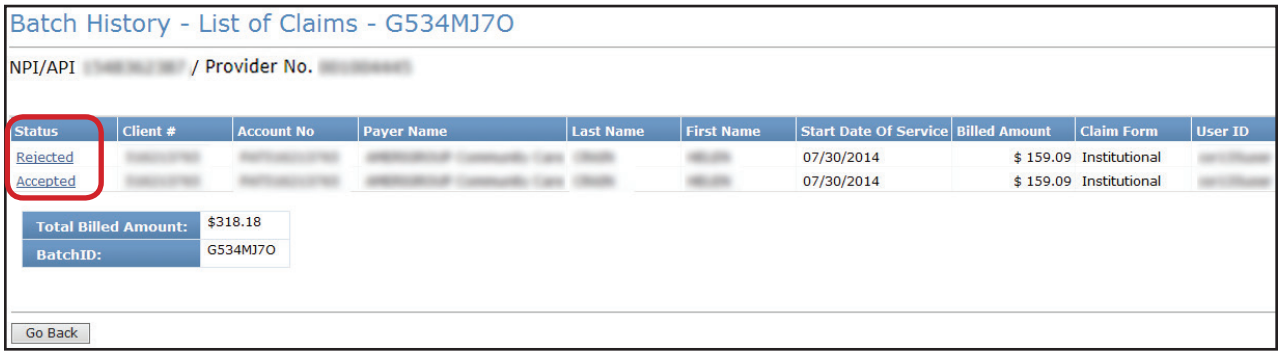
Claims handled by TMHP can also be set to the following statuses:

- ***I: In Process***
- ***D: Denied***
- ***A: Approved for Payment***
- ***FT: Forced Transfer***
- ***S: Suspended***
- ***T: Transferred***
- ***P: Paid***
- ***PF: Paid Forced Transfer***
- ***PT: Paid Transfer***
- ***PZ: Zero Net Balance to the Provider***

In addition to the status of the Claims and other information, there is a **Payer Name** column. The **Payer Name** column will display the name of the MCO that the claim was Forwarded to, Rejected, or Accepted by. The **Payer Name** column will display TMHP when the claim is accepted by TMHP. If the column is blank, that indicates that TMHP has Rejected the claim.



5) Click the Status of a claim to view the details of that claim.



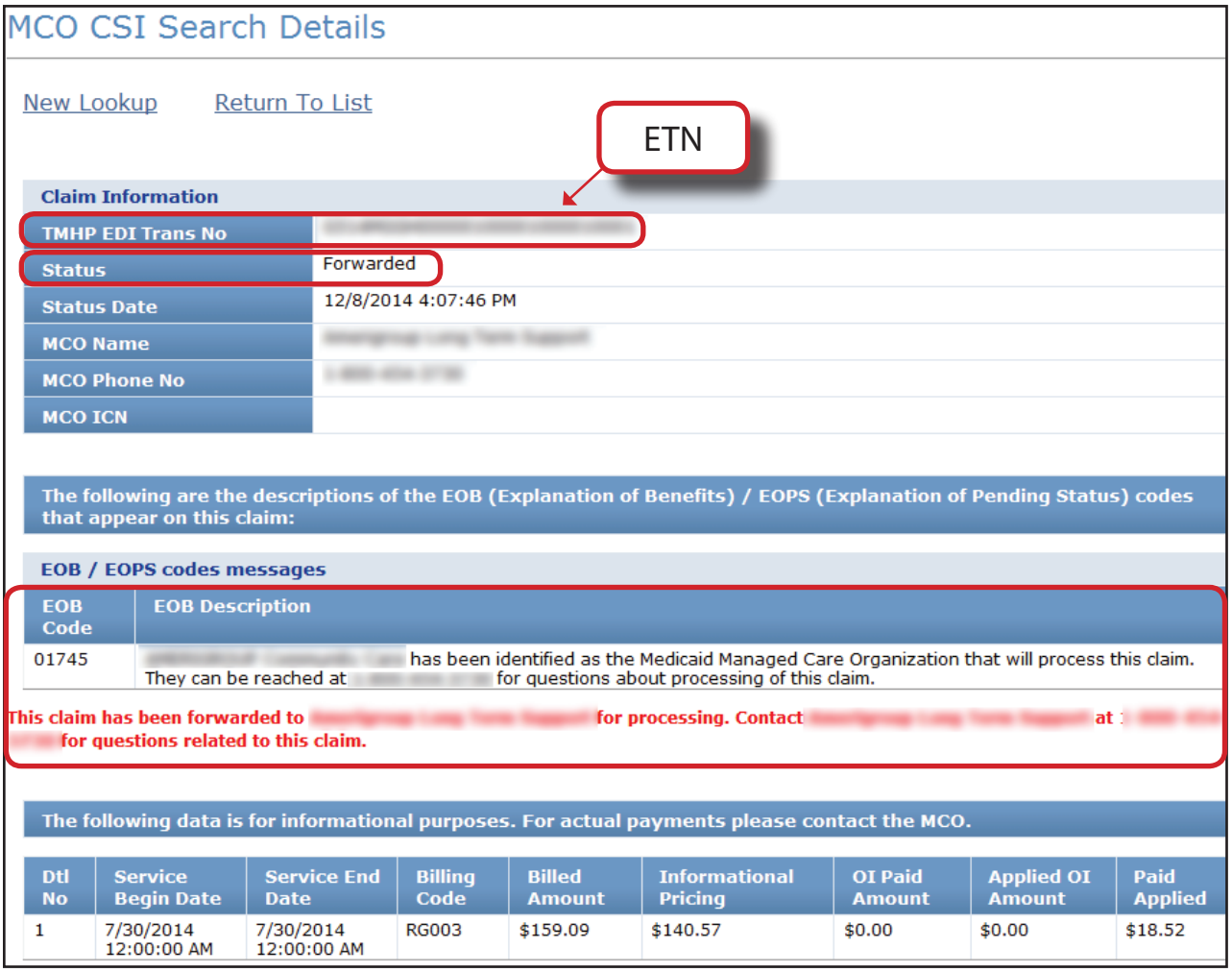
a) If the status of the claim that you clicked was ***Forwarded***:

- The Forwarded claim will have a 28-character, alphanumeric EDI Transaction Number (ETN). This is not the same as the internal control number (ICN) associated with fee-for-service (FFS) claims.
- The first eight characters of the EDI Transaction Number ETN are the same as the Batch ID.
- The claim will remain in the ***Forwarded*** status until the MCO responds with either an Accept or Reject.

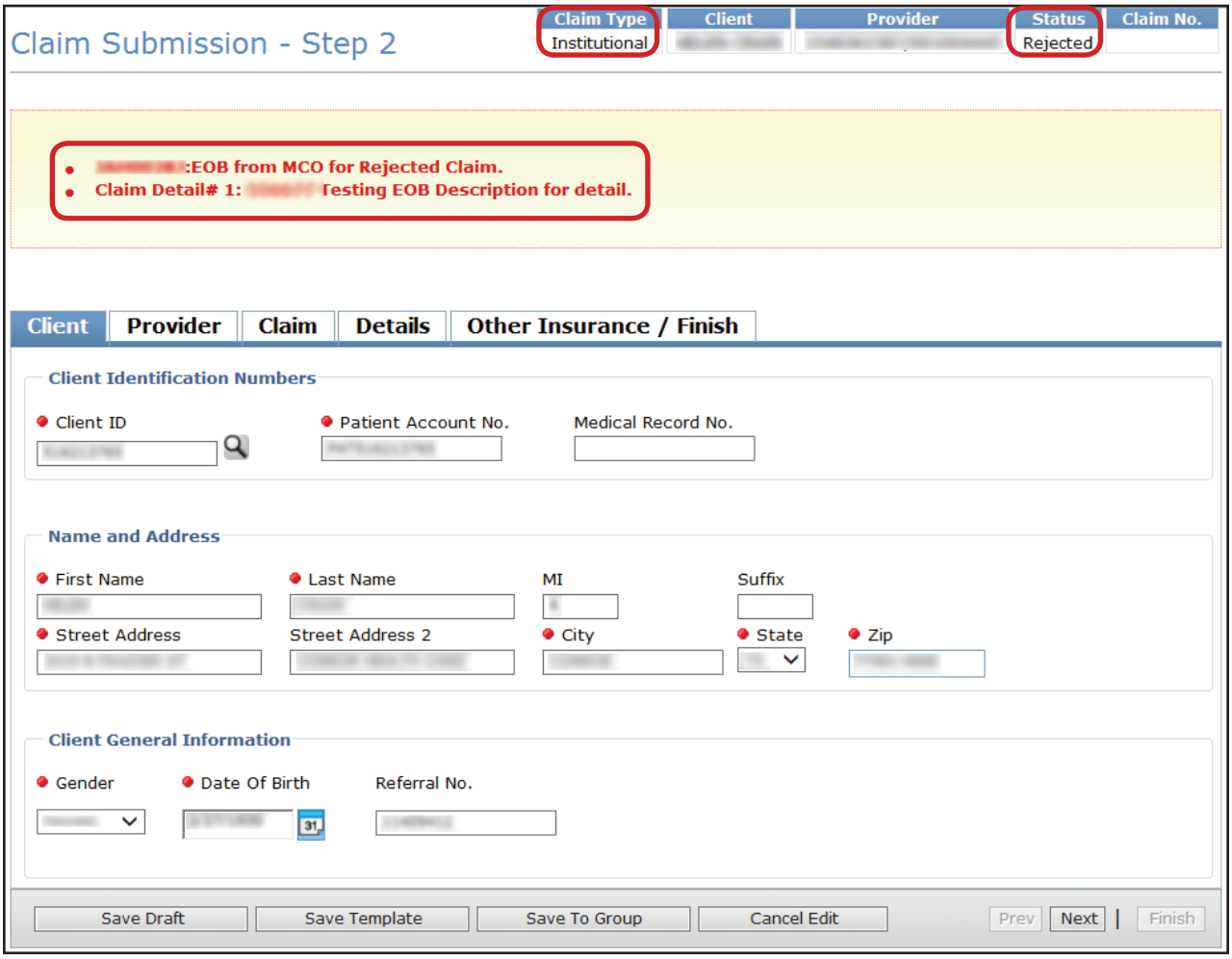
As you can see in the image below, the name and contact information of the MCO is identified in multiple places on the screen. Once a claim has been Forwarded to the MCO, providers must work directly with the MCO regarding any issues with the claim.

When TMHP Forwards a claim to an MCO, TMHP will assign an Explanation of Benefits (EOB) Code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB Code.

The last section on the screen, the Detail Service Line, will list information such as the Billing Code and in the Informational Pricing column (how TMHP would have priced the claim if processed as FFS for Service Group 1, Service Codes 1 and 3).



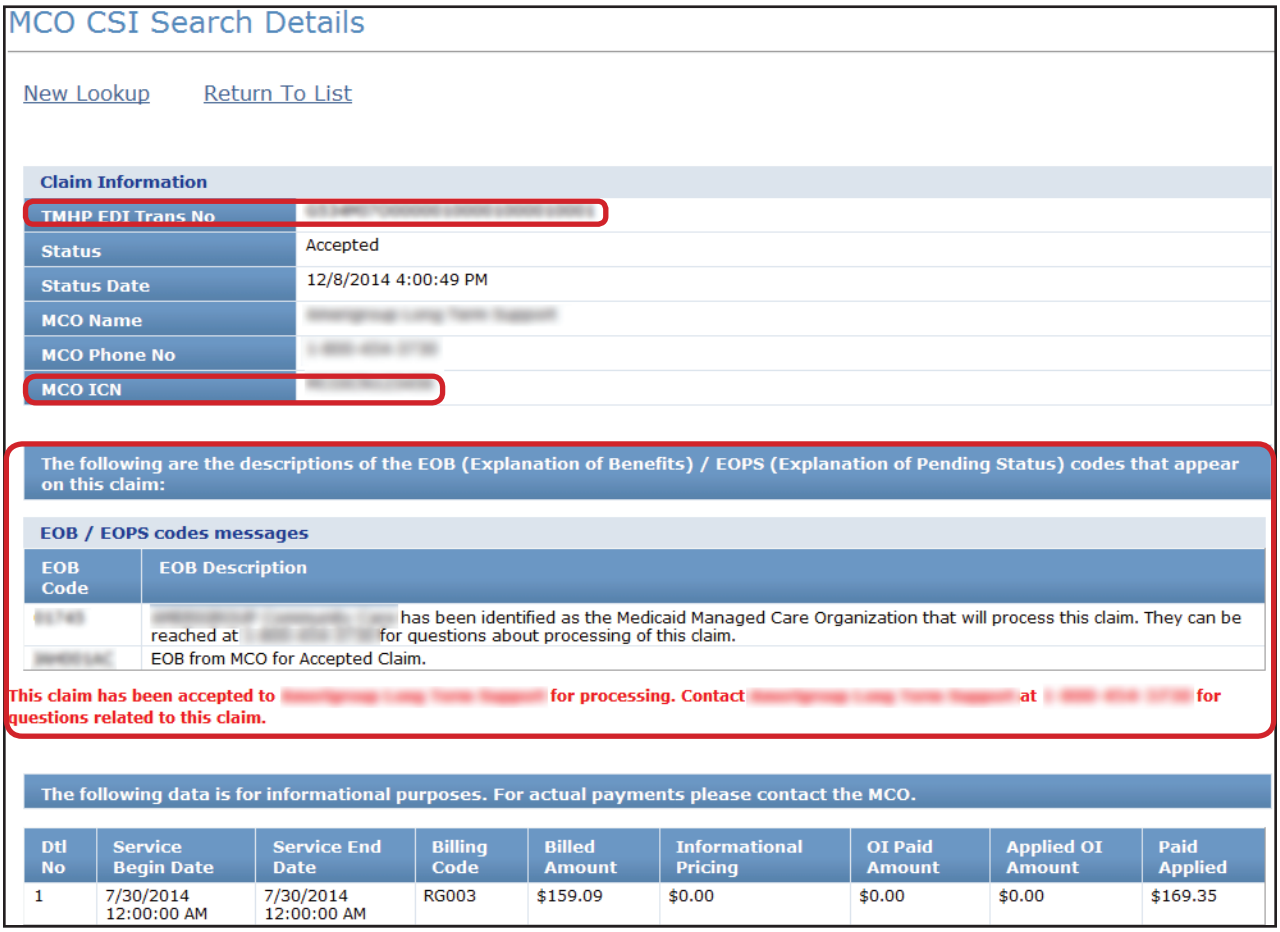
b) If the status of the claim that you clicked was ***Rejected***, you will see a yellow message box at the top of the screen listing the Rejected EOBs. The MCO may choose to list EOBs with a description. If a description is not present then only the EOB number will be displayed.



c) If the status of the claim that you clicked was ***Accepted*** and the Payer is an MCO, the MCO CSI Search Details page will display.

Once a Forwarded Claim has been Accepted by an MCO, the MCO ICN field will populate. The MCO ICN is a unique identifier that the MCO assigns to a Forwarded Claim.

The Header EOBs and descriptions returned by the MCO for the Accepted Claim will be displayed in the **EOB/EOPS codes messages** column. If the MCO does not return the description of the EOB it will appear as blank. The provider will need to use the MCOs EOB crosswalk to interpret the EOBs.



MCO CSI Search Details

New Lookup Return To List

Claim Information

TMHP EDI Trans No	
Status	Accepted
Status Date	12/8/2014 4:00:49 PM
MCO Name	
MCO Phone No	
MCO ICN	

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

EOB / EOPS codes messages

EOB Code	EOB Description
	has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at for questions about processing of this claim.
	EOB from MCO for Accepted Claim.

This claim has been accepted to for processing. Contact at for questions related to this claim.

The following data is for informational purposes. For actual payments please contact the MCO.

Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	$159.09	$0.00	$0.00	$0.00	$169.35

d) If the status of the claim that you clicked was ***Accepted*** and the Payer is TMHP, the CSI Search Details page will display:

CSI Details

New Lookup

Claim Information

Claim No.	
Dates of Service	8/1/2014 - 8/1/2014
Status	D
Effective Date	9/10/2014
Service Group	1
Warrant Number	

Client Information

Client/Medicaid No./Trainee SSN	
Name	
Gender	F
Date of Birth	8/24/1984
Patient Account No.	
Medical Record No.	
Referral No.	

Financial Information

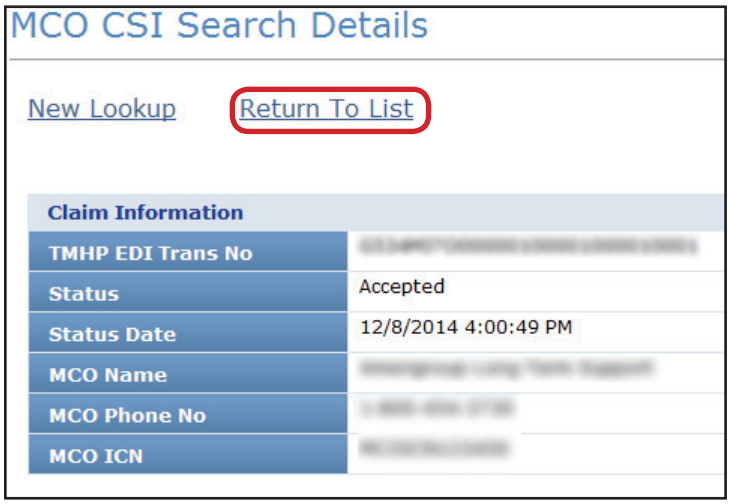
Total Billed Amount	$100.00
Total Paid Amount	$0.00
Total Applied Other Insurance Amount	$0.00
Budget Number	

Provider Information

Provider NPI/API	
Provider Name	
Medicare Patient Days %	0
Private Patient Days %	0
Medicaid Patient Days %	0

Dtl No	Detail Status	Service Begin	Service End Date	Billing Code	Billed Amount	Paid Amount	OI Paid Amount	Applied OI Amount	Billed Units	Paid Units	Estimated Paid Unit Rate	Nat'l EOB1	Nat'l EOB2	Modifier 1
1	D	8/1/2014	8/1/2014	RG008	$100.00	$0.00	$0.00	$0.00	1.00	0.00	$0.00			

6) Click the **Return To List** link to return to Batch History. The results are saved for 60 days.



Claims Data Export

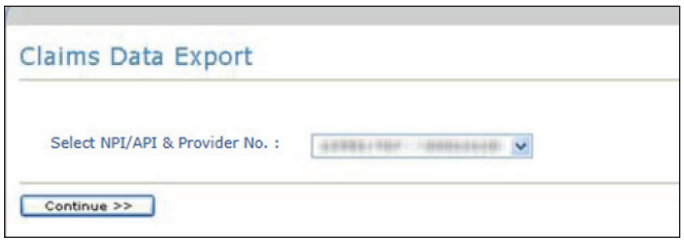
If you want to request an extract of claims data for a particular date range, you can use the Claims Data Export feature. The maximum date range between From Dates of Service and To Dates of Service for each search is three months.

Note: *Claims Data Export is only available to users with administrative rights on their account.*

To request the claims data to be exported:

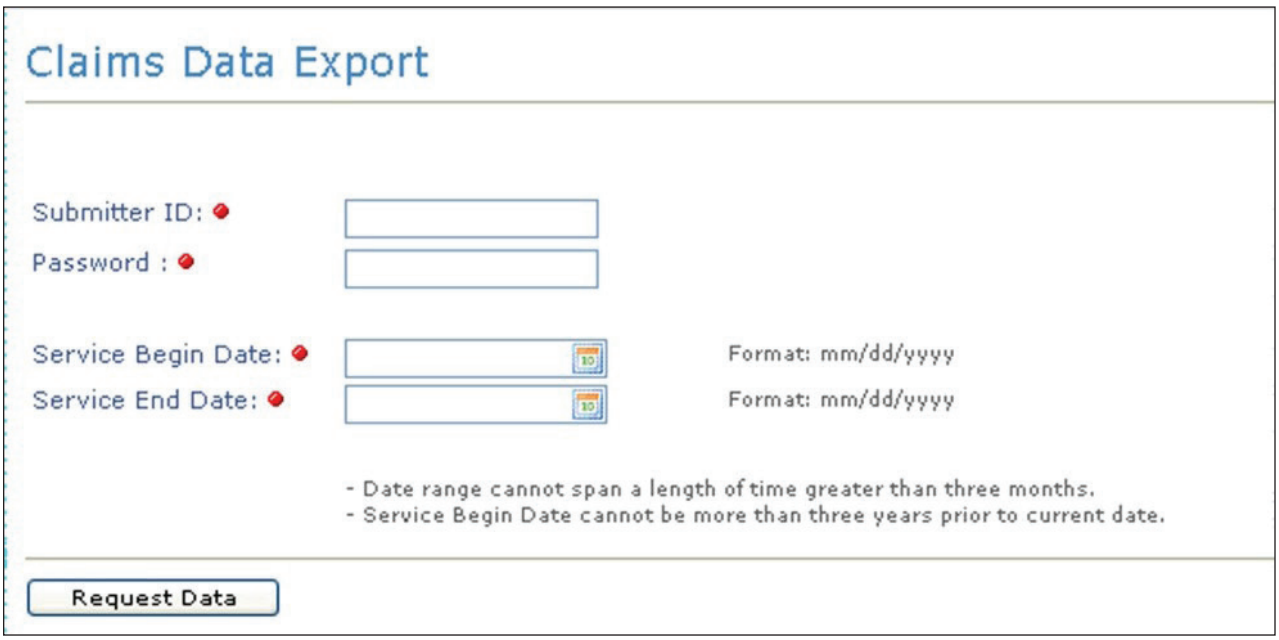
1) Click the **Data Export Request** link under the Claims Data Export section on the left navigation panel

2) Select the NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.

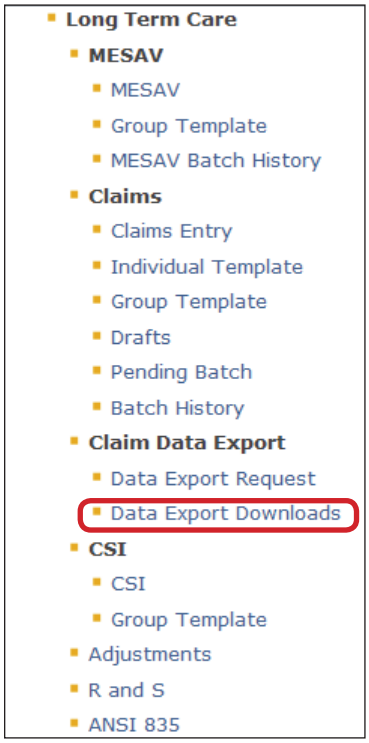


3) Enter your Submitter ID, Password, Service Begin Date, and Service End Date, and then click the **Request Data** button.

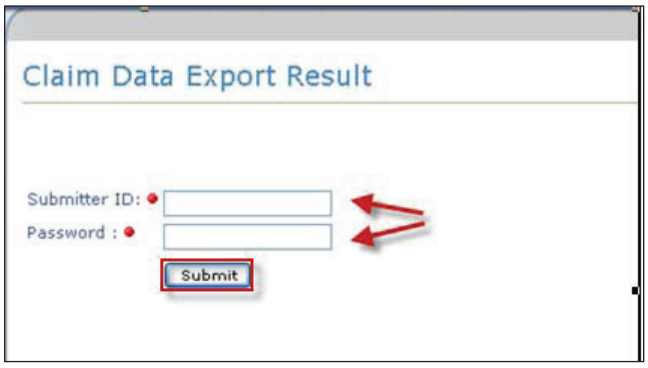
- The date range must be no more than three months long.
- The Service Begin Date cannot be more than three years prior to current date.
- If you do not know your Submitter ID and Password, contact the EDI Helpdesk at 1-888-863-3638, Option 4, from 7:00 a.m. to 7:00 p.m., Monday through Friday.
- The requested data will be available on the next business day.



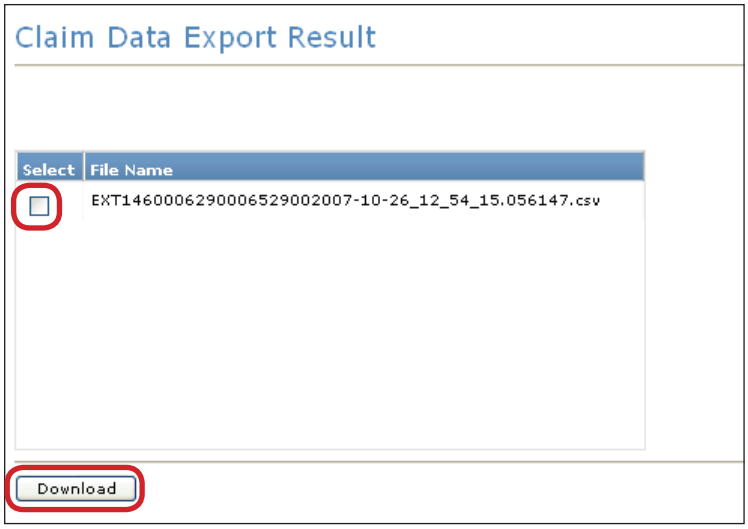
4) To download the requested data, click the **Data Export Downloads** link under the Claims Data Export section on the left navigation panel.



5) Enter your Submitter ID and Password, and click the **Submit** button.

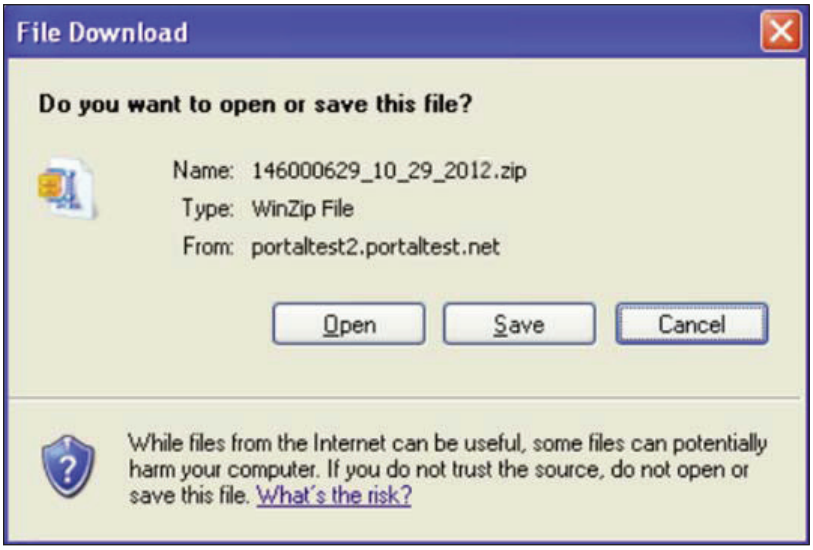


6) The Claim Data Export Result page will display the requested file when it is ready to be downloaded. Check the **Select** box, and then click the **Download** button.



7) A File Download dialog box will be displayed. Click the **Save** button and save the file to a location on your computer.

- The requested data will remain available for download for three months.
- Your computer must be able to open WinZip® files (Zipped files) or you will not be able to open the file once you have saved it.



Claims Status Inquiry (CSI)

Claims Status Inquiry is used to determine the status of submitted claims. There are several ways to perform a CSI:

1) Lookup Fee For Service Claim by Claim Request.
2) Lookup Fee For Service Claim by Client Claim Request.
3) Lookup Managed Care Claim by Transaction Number.
4) Lookup Managed Care Claim by MCO ICN.

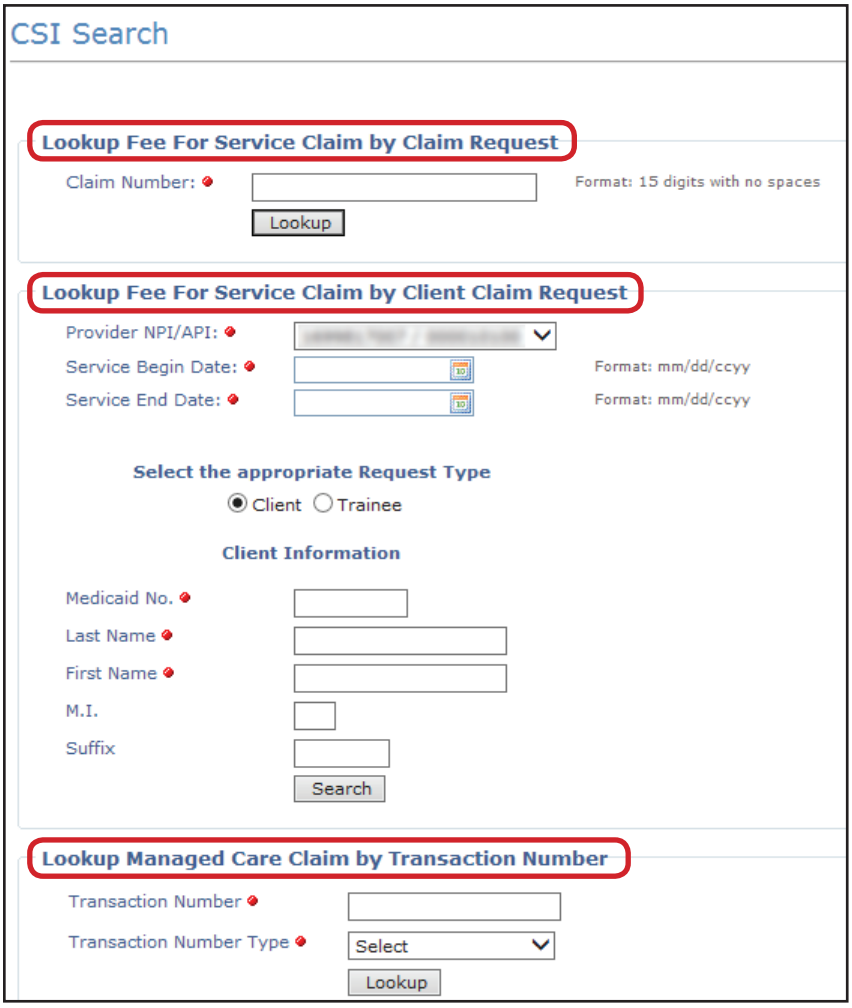
TMHP will Forward certain Institutional Claims to MCOs. These claims can be set to the following statuses:

- ***Forwarded***: means that the claim has been forwarded to (but not yet Accepted or Rejected by) an MCO.
- ***Rejected***: means that the claim has been rejected by TMHP or the MCO it was forwarded to.
- ***Accepted***: means that the claim has been Accepted by TMHP or an MCO.

Claims handled by TMHP (not an MCO) can be set to the following statuses:

- ***I:*** In Process
- ***D:*** Denied
- ***A:*** Approved for Payment
- ***FT:*** Forced Transfer
- ***S:*** Suspended
- ***T:*** Transferred
- ***P:*** Paid
- ***PF:*** Paid Forced Transfer
- ***PT:*** Paid Transfer
- ***PZ:*** Zero Net Balance to the Provider

Three years of claims history are available. The system returns a maximum of 250 results for each search. If your search returns more than 250 results, you may want to use the Claim Data export function. The CSI Search screen is shown below:

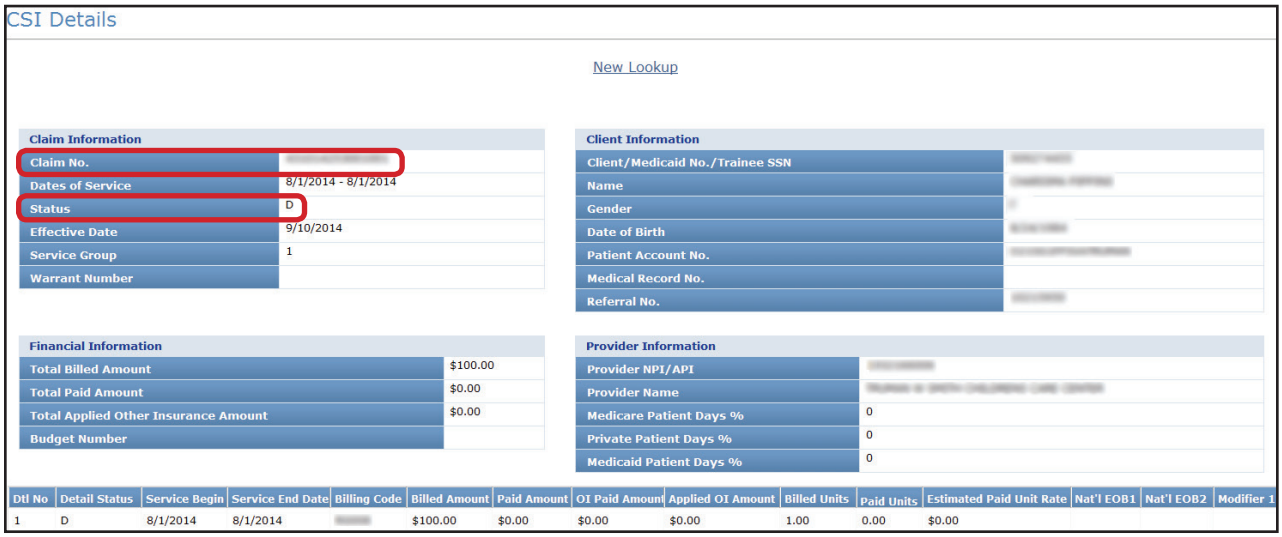


CSI Search: Lookup Fee For Service Claim by Claim Request

1) To search for a Claim by Claim Request enter the Claim Number in the Claim Number field and click the **Lookup** button.

2) The CSI Details page will display and auto populate most of the fields, including the status of the claim. For Service Groups 1, 6, and 8, the detailed claim information includes the Total Applied Other

Insurance Amount, as well as the OI Paid Amount and Applied OI Amount.

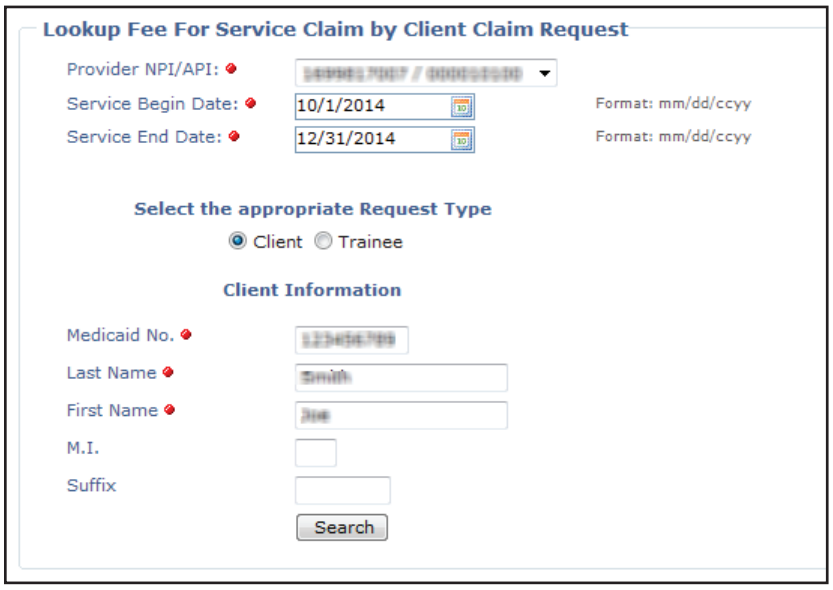


CSI Search: Lookup Fee For Service Claim by Client Claim Request

When searching by client information, the following conditions apply:

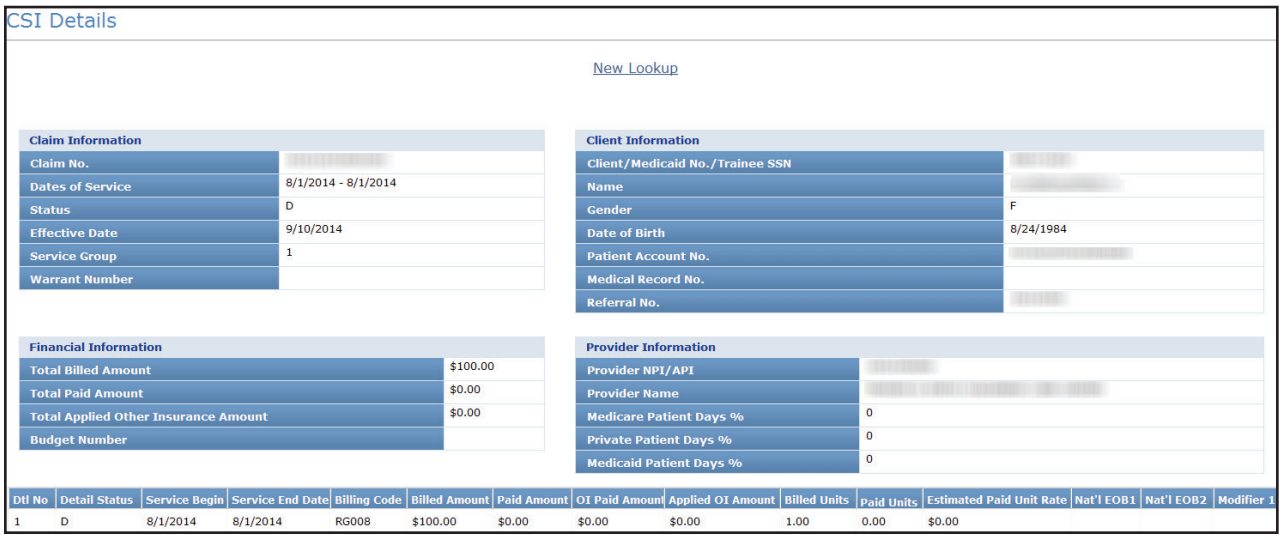
- You must enter both a Service Begin Date and a Service End Date. The End Date cannot be more than three consecutive months from the Begin Date.
- The Service Begin Date cannot be more than 36 months before the current date.
- You must complete all of the fields indicated by a red dot.

1) Click the **CSI** link under the CSI section on the navigation panel. The search criteria page will display.



2) You must complete all of the fields that are indicated by a red dot.
3) Click the **Search** button.

4) The CSI Search Details page will display and auto populate with the client information.



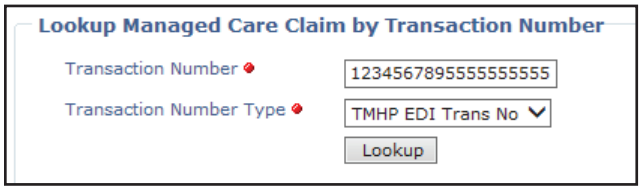
CSI Search: Lookup Managed Care Claim by Transaction Number

This section allows Providers to use a Transaction Number to search for claims that have been forwarded to MCOs. An EDI Transaction Number (ETN) is needed to search for these forwarded claims. An ETN is not the same as an MCO internal control number (MCO ICN) or as an ICN associated with fee-for-service (FFS) claims. An ETN is a 28 character, alphanumeric value, the first eight characters of which are the Batch ID.

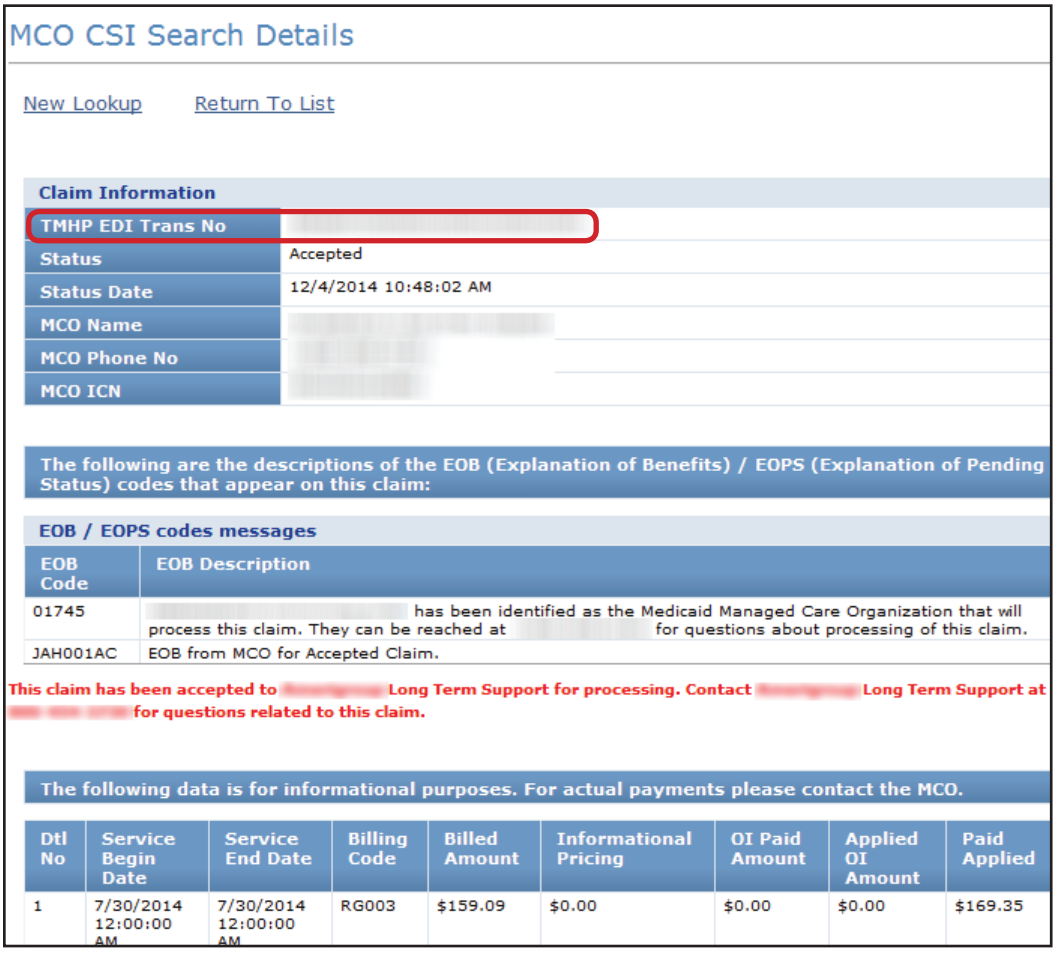
The status of the claim is shown in the Claim Information section on the line labeled Status. There are three possible statuses for a Claim that has been forwarded to an MCO:

- ***Forwarded***;
- ***Accepted*** (by the MCO); or
- ***Rejected*** (by the MCO).

1) In the Transaction Number field, enter the ETN of the claim for which you are searching, choose **TMHP EDI Trans No** from the Transaction Number Type drop-down box, and click the **Lookup** button.



2) The MCO CSI Search Details page will display and auto populate with the ETN in the Claim Information section.



MCO CSI Search Details

New Lookup Return To List

Claim Information

TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	
MCO Phone No	
MCO ICN	

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

EOB / EOPS codes messages

EOB Code	EOB Description
01745	has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at for questions about processing of this claim.
JAH001AC	EOB from MCO for Accepted Claim.

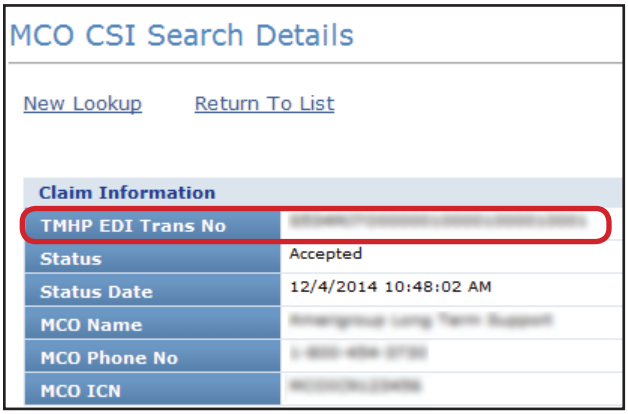
This claim has been accepted to Long Term Support for processing. Contact Long Term Support at for questions related to this claim.

The following data is for informational purposes. For actual payments please contact the MCO.

Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	$159.09	$0.00	$0.00	$0.00	$169.35

3) The status of the claim will be shown in the Claim Information section on the line labeled Status. Recall that there are three possible statuses for a claim:

- ***Forwarded***;
- ***Accepted*** (by the MCO); or
- ***Rejected*** (by the MCO).



MCO CSI Search Details

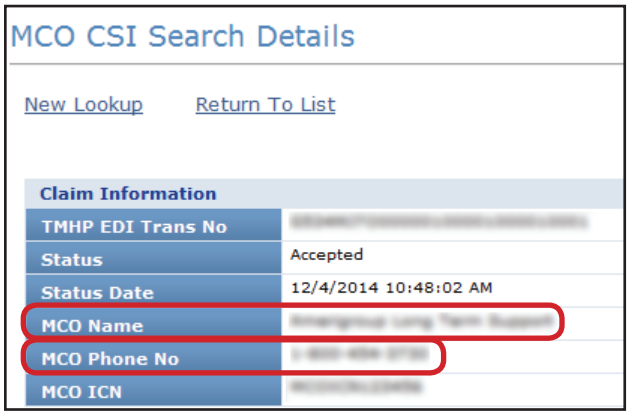
New Lookup Return To List

Claim Information

TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	
MCO Phone No	
MCO ICN	

4) The name and contact information of the MCO that received the forwarded claim is located in the Claim Information section.

NOTE: *If there are any issues or questions regarding a claim that has been forwarded to an MCO, providers must contact the MCO directly. TMHP cannot answer questions regarding claims rejected by an MCO.*

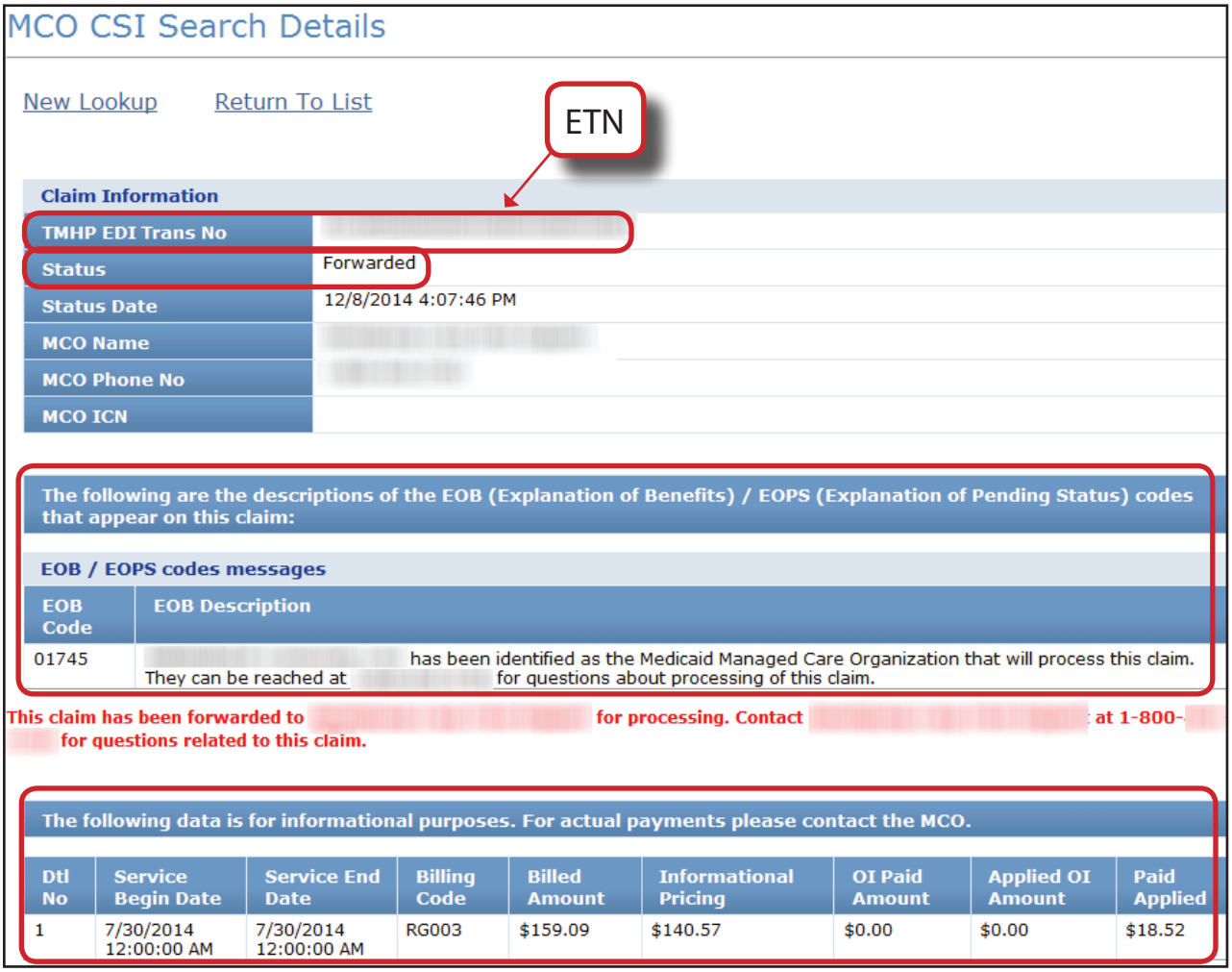


5) The name and contact information of the MCO is identified in multiple places on the screen. Once a claim has been forwarded to the MCO, providers must work directly with the MCO regarding any issues with the claim.

When TMHP forwards a claim to an MCO, TMHP will assign an EOB Code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB Code.

The last section on the screen, the Detail Service Line, will list information such as the Billing Code and details in the Informational Pricing column (how TMHP would have priced the claim if processed as FFS

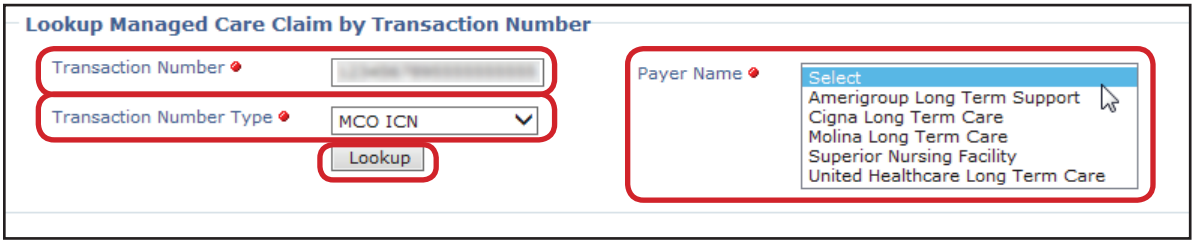
for Nursing Facility Daily Care [Service Group 1, Service Code 1] and Medicare Coinsurance [Service Code 3]).



CSI Search: Lookup Managed Care Claim by MCO ICN

Providers can use an MCOs ICN to search for claims that have been forwarded to MCOs. The ICN is assigned by the MCO that accepted the claim.

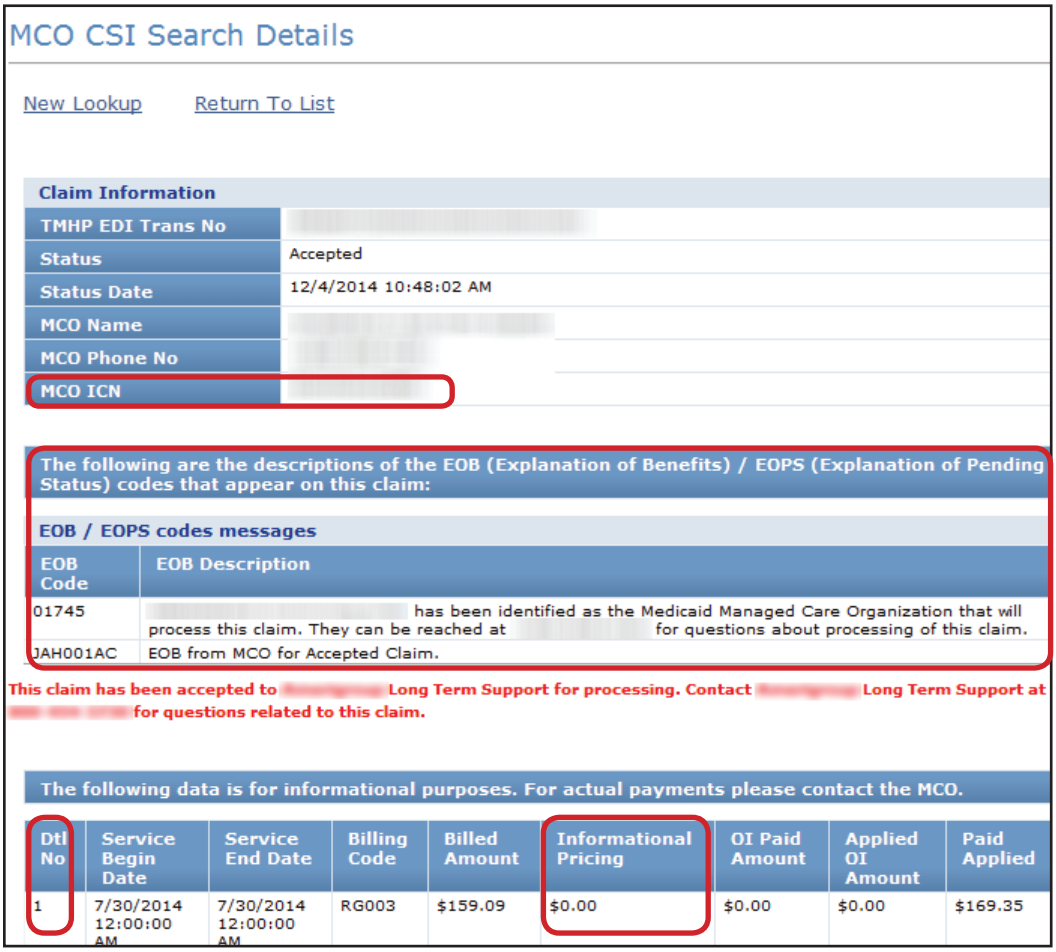
1) In the Transaction Number field enter the **MCO ICN** of the claim for which you are searching, choose MCO ICN from the Transaction Number Type drop-down box. Because multiple MCOs may have similar ICN numbering strategies, you must choose the appropriate Payer Name from the drop-down box, and then click the **Lookup** button.



2) The MCO CSI Search Details page will display and auto populate with the MCO ICN in the Claim Information section. This MCO CSI Search Details screen will be identical to the one that is generated when searching using an ETN or clicking the hyperlink from the Batch History screen.

TMHP will assign an EOB Code that is specific to that MCO. A description of that EOB and the telephone number of the MCO will be listed next to the EOB Code.

The last section on the screen, the Detail Service Line, will list information such as the Billing Code and in the Informational Pricing column (how TMHP would have priced the claim if processed as FFS for Nursing Facility Daily Care [Service Group 1, Service Code 1] and Medicare Coinsurance [Service Code 3]).



MCO CSI Search Details

New Lookup Return To List

Claim Information

TMHP EDI Trans No	
Status	Accepted
Status Date	12/4/2014 10:48:02 AM
MCO Name	
MCO Phone No	
MCO ICN	

The following are the descriptions of the EOB (Explanation of Benefits) / EOPS (Explanation of Pending Status) codes that appear on this claim:

EOB / EOPS codes messages

EOB Code	EOB Description
01745	has been identified as the Medicaid Managed Care Organization that will process this claim. They can be reached at for questions about processing of this claim.
JAH001AC	EOB from MCO for Accepted Claim.

This claim has been accepted to Long Term Support for processing. Contact Long Term Support at for questions related to this claim.

The following data is for informational purposes. For actual payments please contact the MCO.

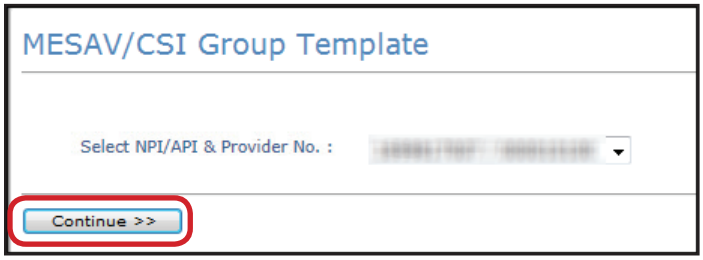
Dtl No	Service Begin Date	Service End Date	Billing Code	Billed Amount	Informational Pricing	OI Paid Amount	Applied OI Amount	Paid Applied
1	7/30/2014 12:00:00 AM	7/30/2014 12:00:00 AM	RG003	$159.09	$0.00	$0.00	$0.00	$169.35

Creating a CSI Group Template

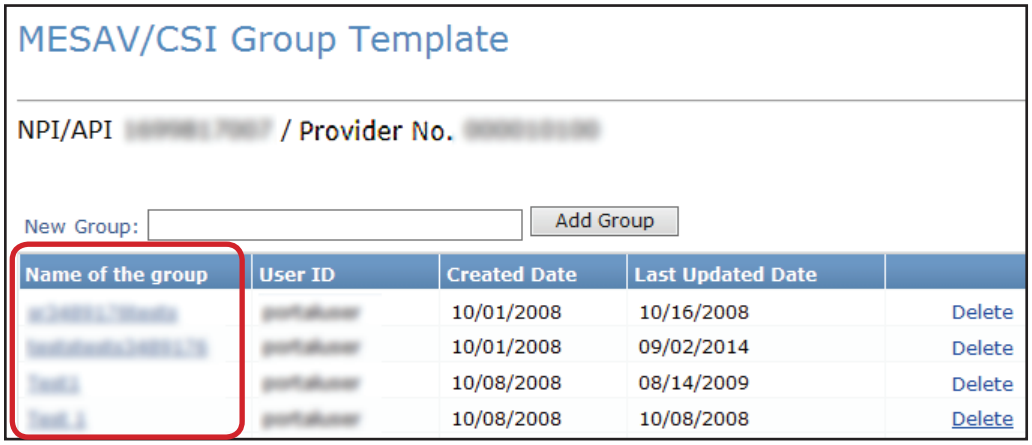
The Group Template feature allows you to create a list of people for whom you would like to verify eligibility. To create a CSI group template and add a person:

1) Click the **Group Template** link under the CSI section on the navigation panel.

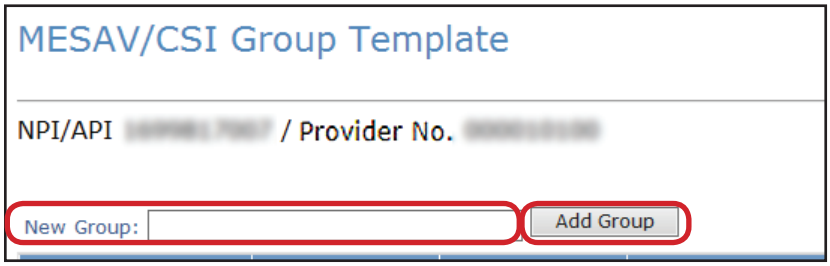
2) The MESAV/CSI Group Template screen will open. Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and then click the **Continue** button.



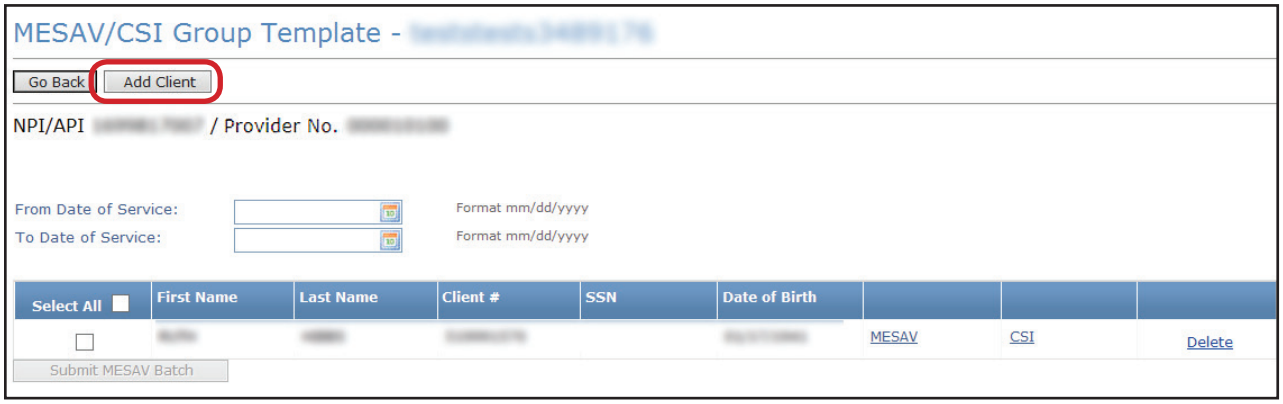
3) If you have already created a group and want to add a person to one of the existing Group Templates, click the link from the list that is displayed under the Name of the group column and skip to Step 5.



4) If you have not created a group or want to add a person to a new Group Template, enter the New Group name of your choice, and click the **Add Group** button.

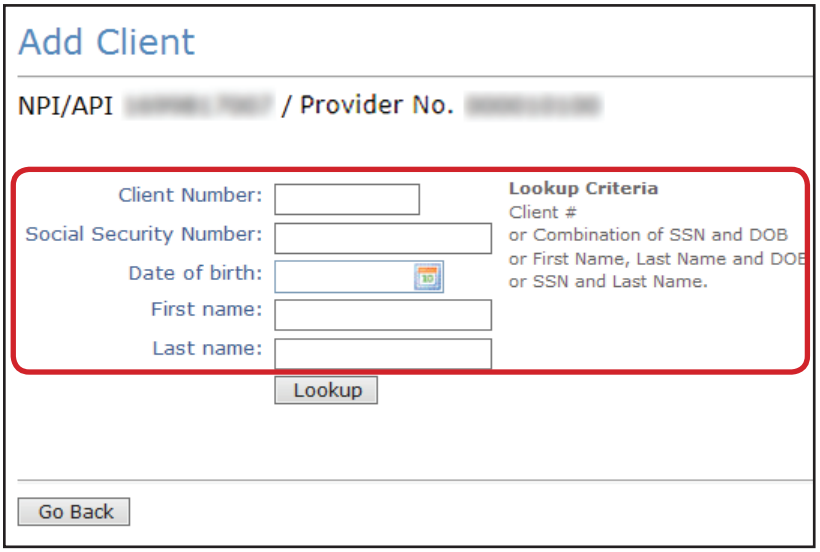


5) To add a person to the Group Template, click the **Add Client** button.

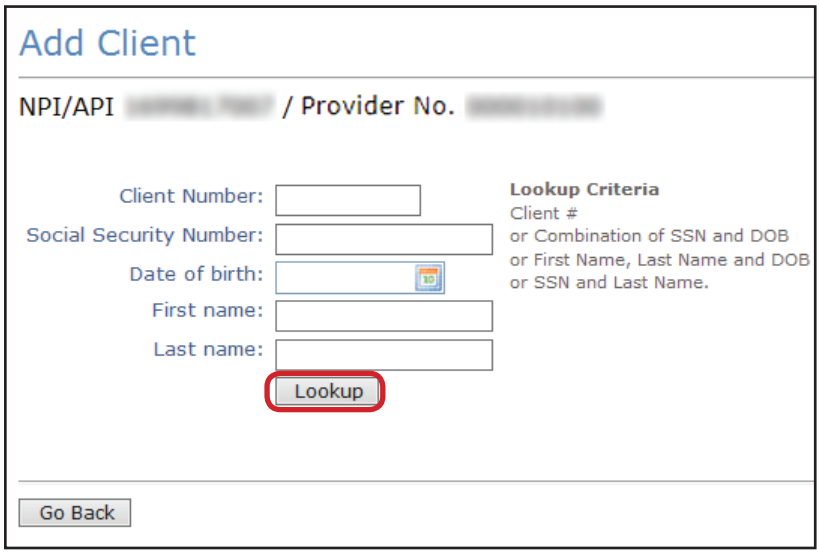


6) The Add Client page will open. Enter the person's information. If you do not have the person's Client Number, you must use one of the following combinations to find the person:

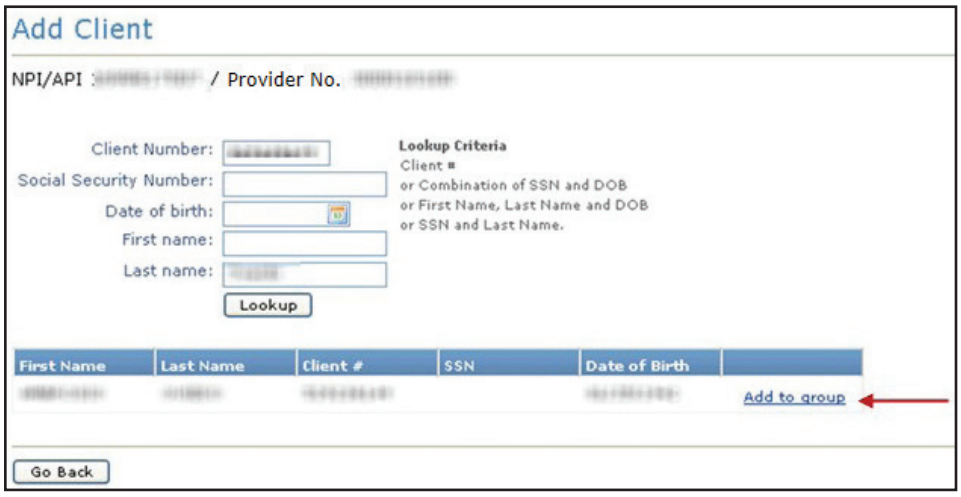
- Social Security Number and Last name
- Social Security Number and Date of birth
- Last name, First name, and Date of birth



7) Click the **Lookup** button.



8) To add the person, click the **Add to group** link.



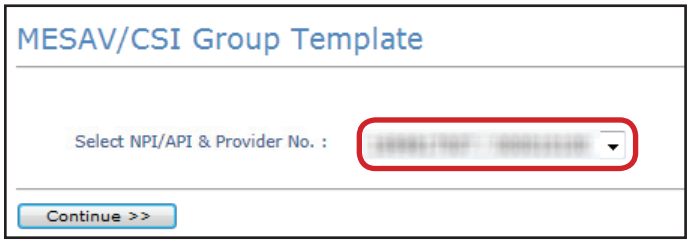
9) The person will be added to the CSI Group Template that you are working on.
   - You can create up to 100 groups for each NPI or API and provider number.
   - Each group can contain up to 250 people.
   - You can view, add, and delete people from the list.

Submitting a CSI Group Template

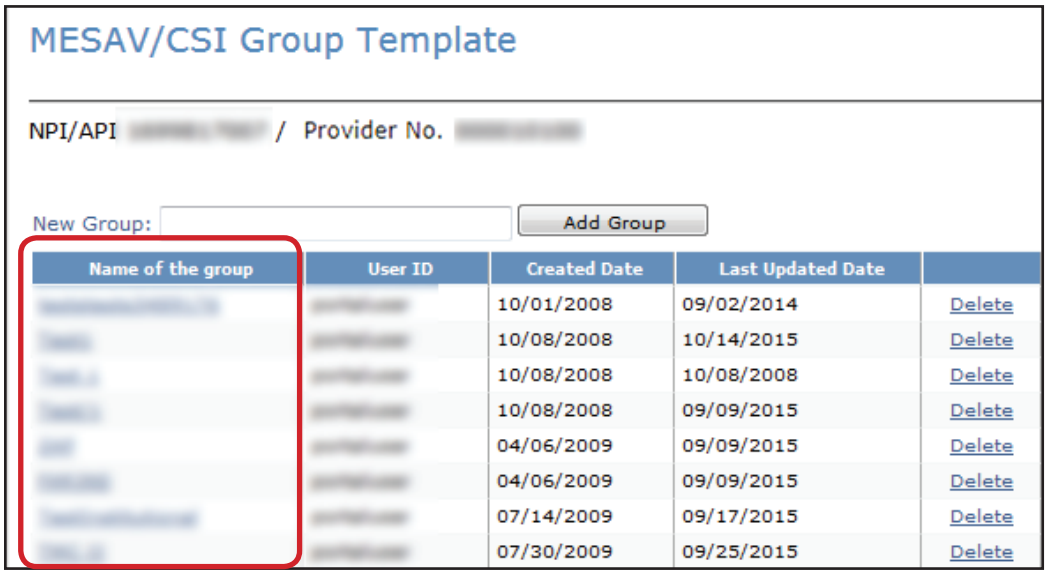
To verify eligibility using a group template:

1) Click the **Group Template** link under the CSI section on the left navigation panel.

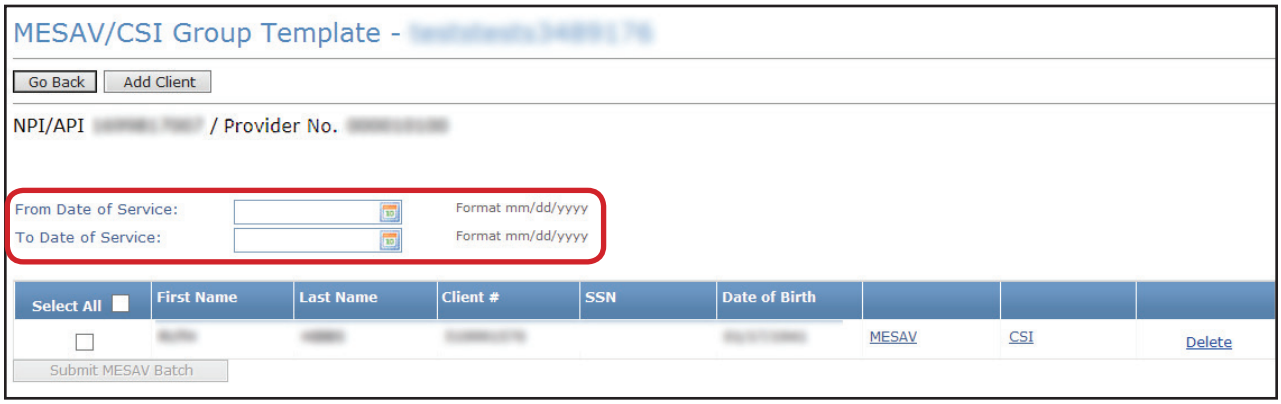
2) Select the appropriate NPI or API and provider number from the NPI/API & Provider No. drop-down box, and click the **Continue** button.



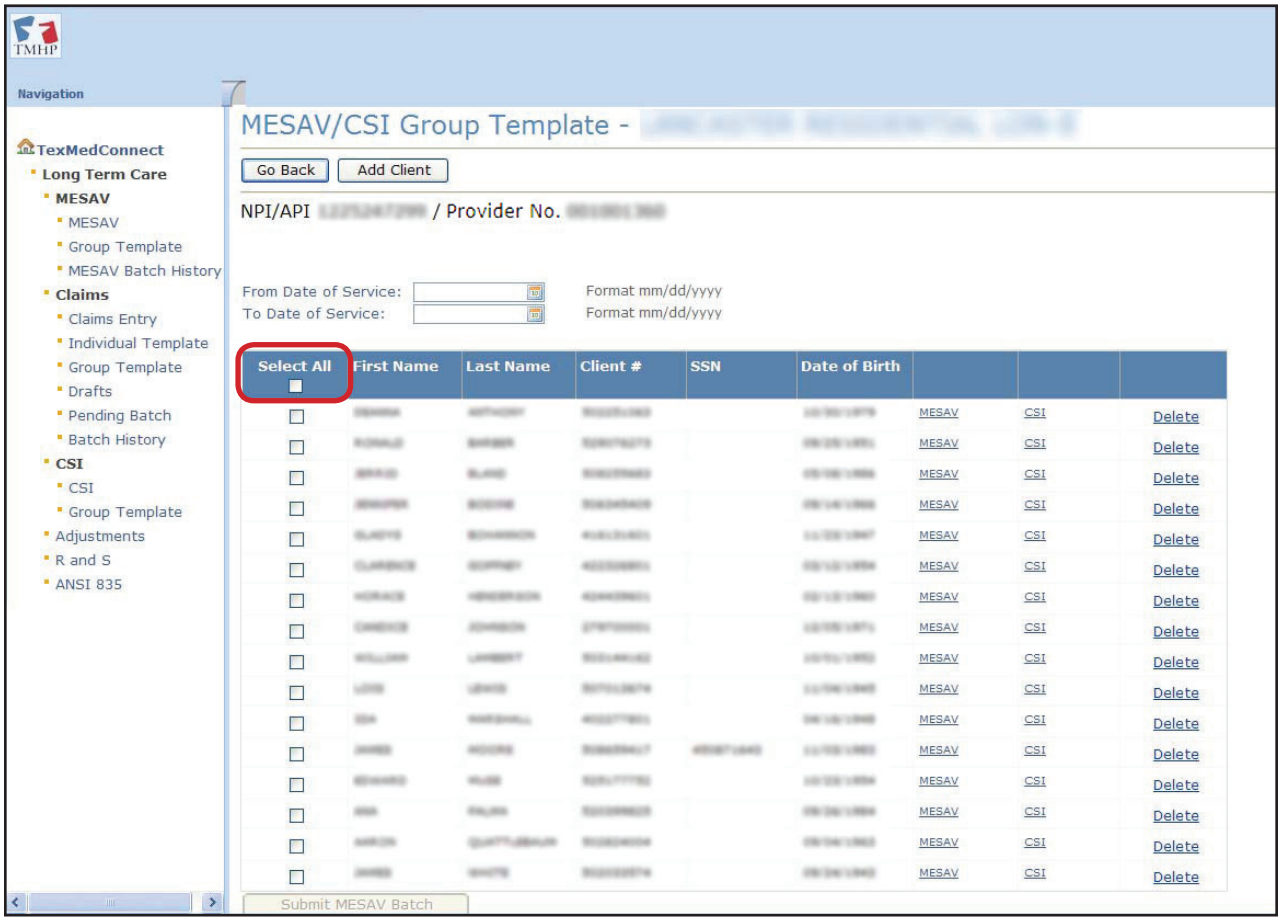
3) Select one of the templates listed under **Name of the group** to open the group list.



4) Enter a date range in the From Date of Service and To Date of Service fields. The date range can be up to three months long.



5) Check the individual boxes of the templates that you want to submit, or to submit all of the templates, check the **Select All** box.



6) Click the **Submit MESAV Batch** button at the bottom left of the screen. The batch will process and be ready for viewing within 24 hours.

Adjustments

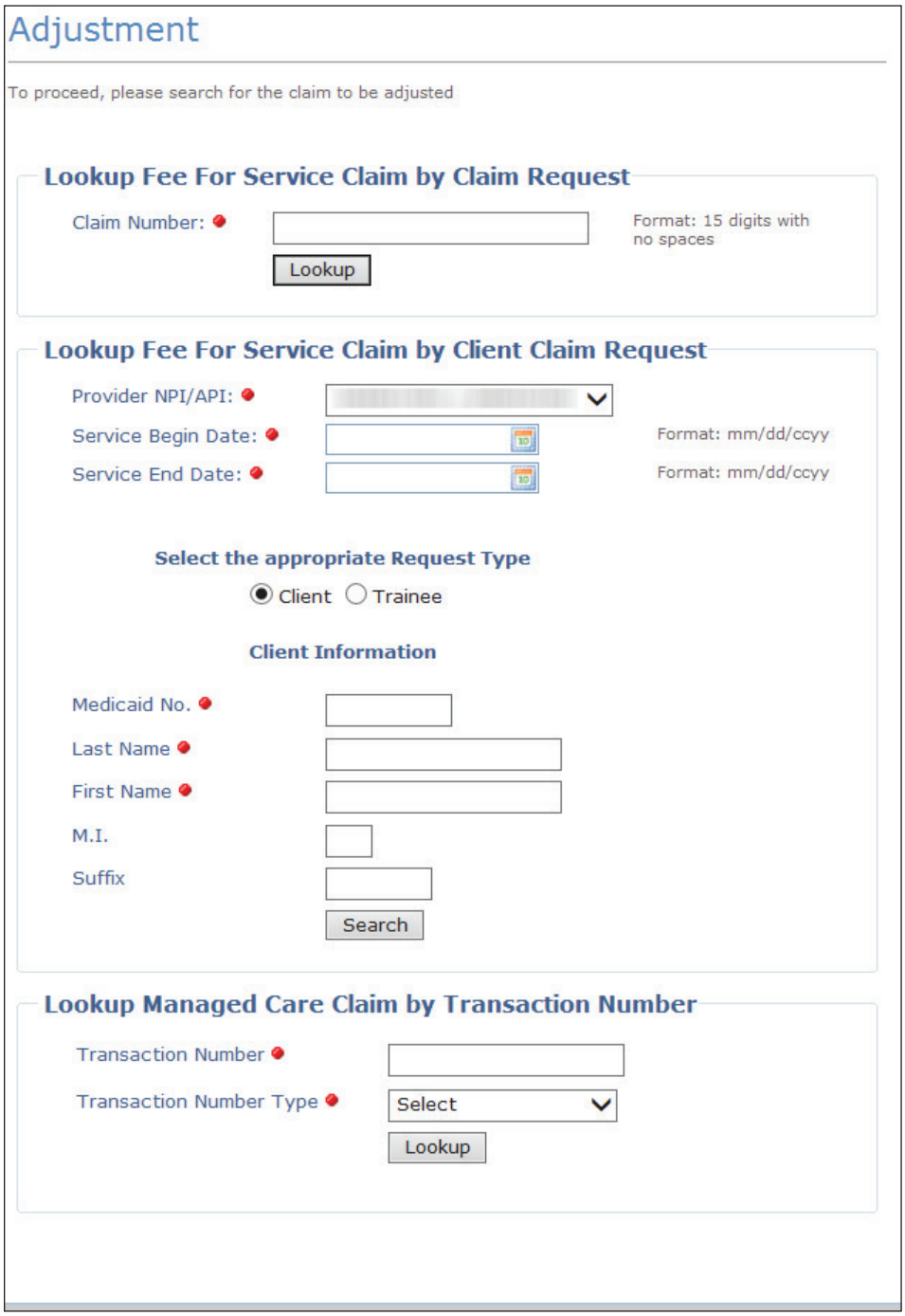
Creating an Adjustment for a Fee-For-Service Claim

An adjustment is a change made to a previously paid claim. Adjustments reimburse Health and Human Services (HHS) for overpayments and to reimburse providers if units were underbilled and must be paid correctly. Only claims that are set to status ***Paid*** can be adjusted using TexMedConnect. If you submit an Adjustment, you must return the amount that you were paid, not the amount that was billed.

NOTE: *Providers must contact MCOs directly to make adjustments to claims forwarded by TMHP.*

1) To make an adjustment on a fee-for-service claim, click the **Adjustments** link under the CSI section on the navigation panel.

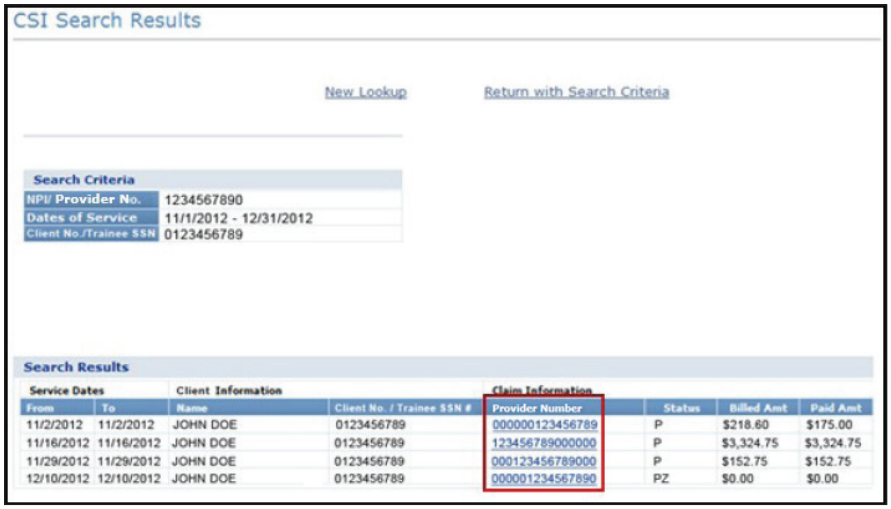
2) Option one, enter the claim number, and click the **Lookup** button.



3) Option two, if you do not know the claim number, you can search for the claim using the person's information. Enter the required information, and click the **Search** button.

- The date range must be no more than three months long.
- You must enter both a Service Begin Date and a Service End Date.
- The Service Begin Date cannot be more than 36 months before the current date.
- You must complete all of the fields that are indicated by a red dot.

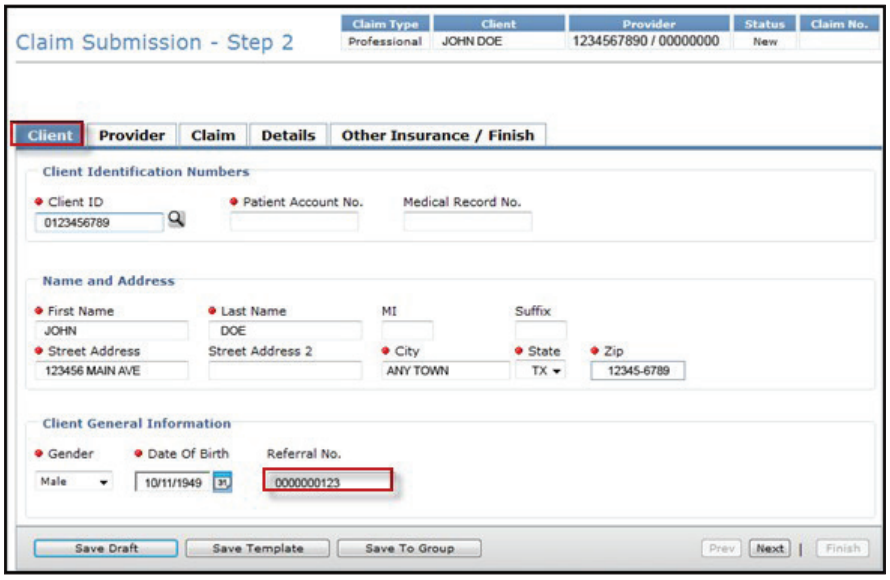
4) The search result is displayed. If more than one claim number with the same service dates and bill code is displayed as a result of your search, you can only adjust the claim with the most current processing (or status) date. Click the claim number to begin adjusting the claim. Providers can determine the most recent claim by comparing the Claim Status Dates, also known as the Effective Date. To determine which claim is the most recent, click on the hyperlink for each claim in the list for your date range and compare the effective dates of each claims. Whichever claim has the most recent Effective Date is the one that needs to be adjusted.



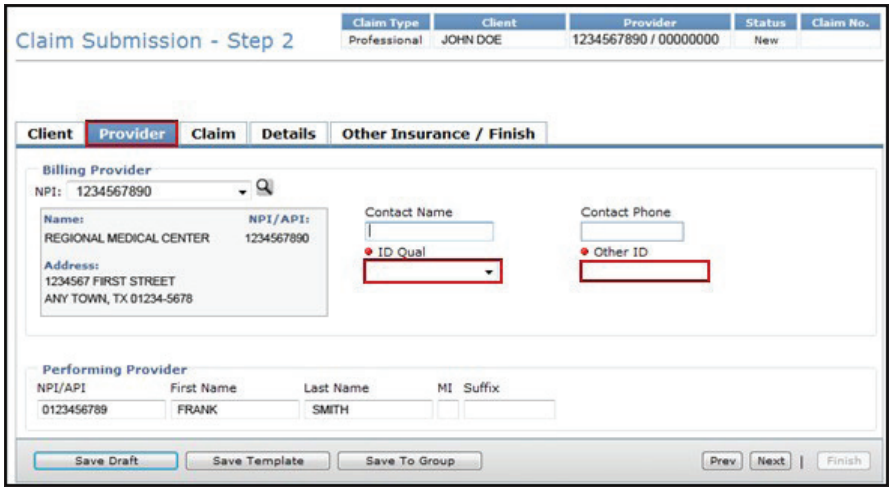
5) Select the appropriate Claim Type from the drop-down box, and click the **Adjust Claim** button.

6) Verify that all of the required fields that are indicated by a red dot are populated for each tab.

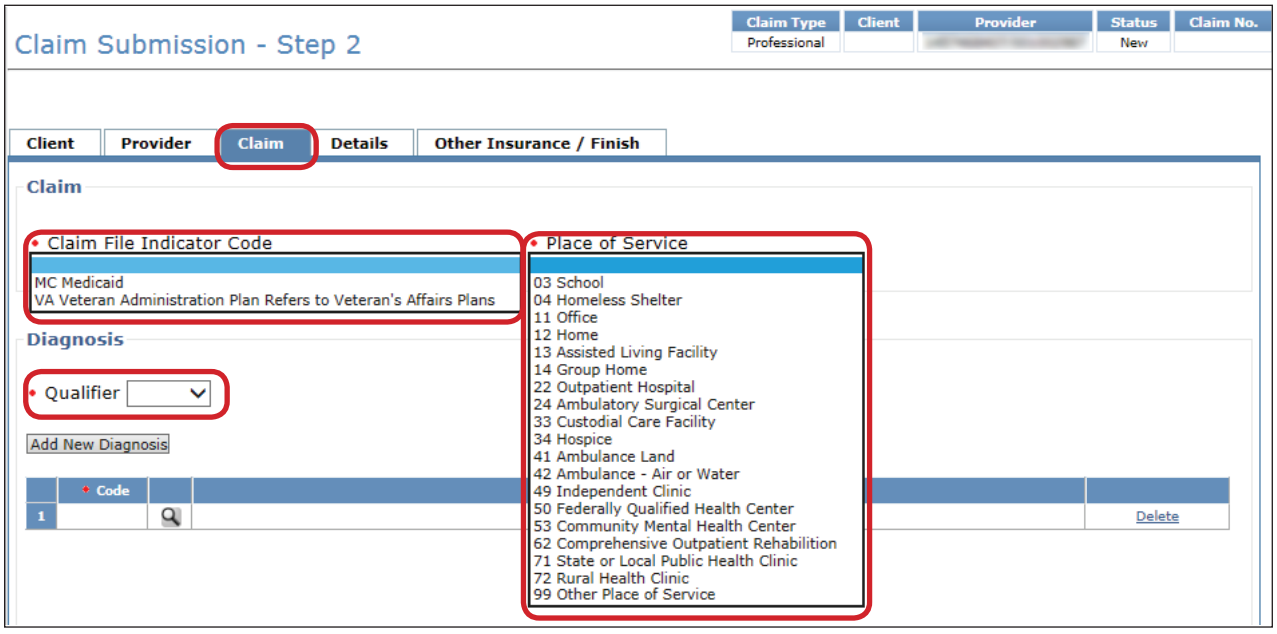
7) ***Client Tab***. Verify that the information is correct and that there is a referral number on the Professional claim.



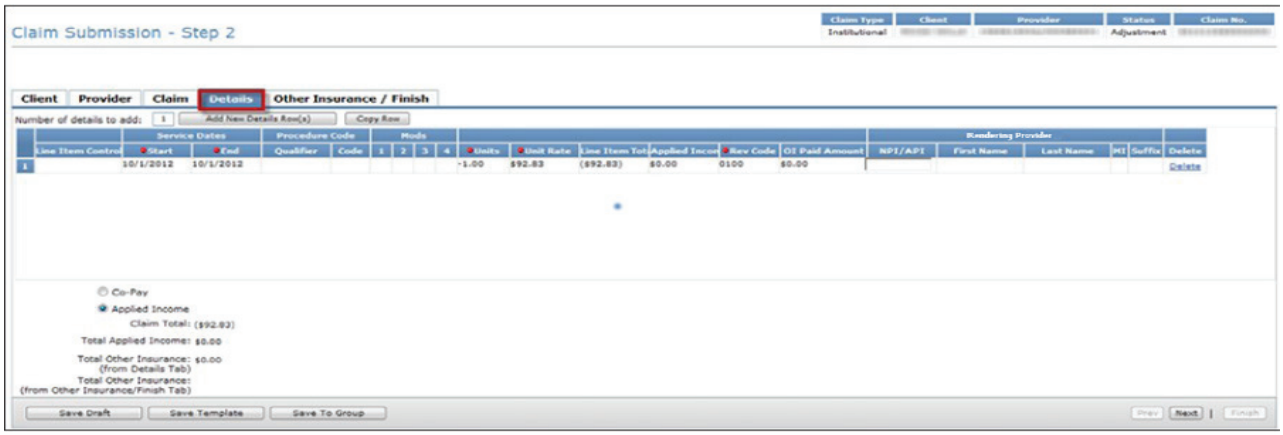
8) *Provider Tab*. Select the ID qualifier from the ID Qual drop-down box and enter the Other ID number in the Other ID field.



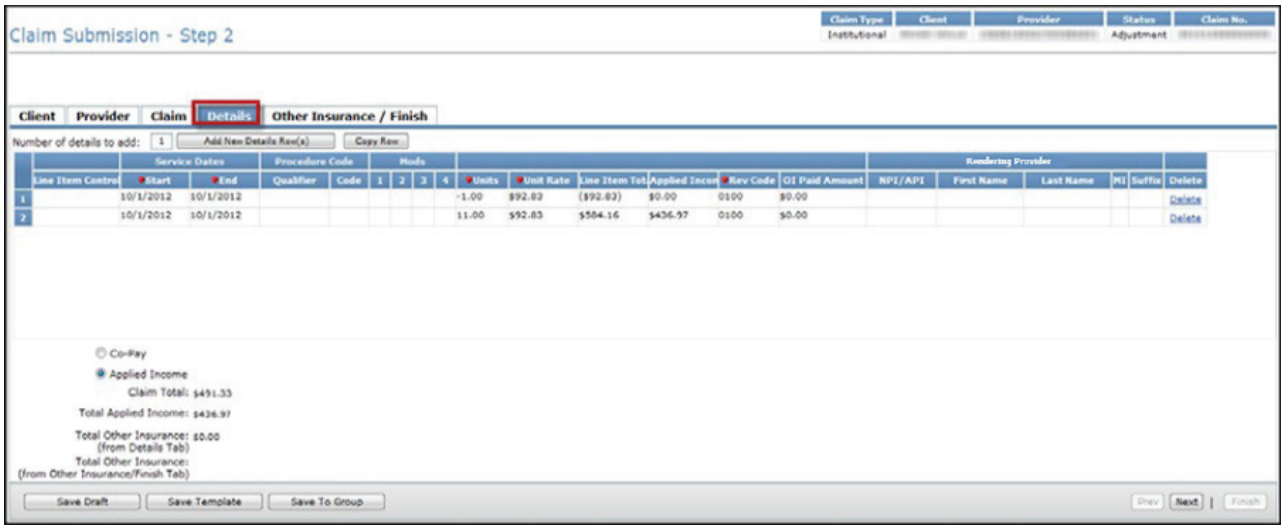
9) *Claim Tab.* Select a Claim File Indicator Code from the drop-down box. Select a Place of Service from the drop-down box. Both institutional and professional claims require a valid diagnosis code. Inputting an invalid diagnosis code may result in an error message (and a subsequent inability to submit a claim) in TexMedConnect. Use the Qualifier field to indicate whether the diagnosis code is an ICD-9 or ICD-10 code.



10) ***Details Tab***. On the details tab, the system will auto populate the negative row(s) with the data that was initially paid on the initial claim. The fields Unit, Unit Rate, and Line Item Total will be auto populated and read only. The fields OI and AI/Co-Pay on the negative row(s) will always be auto populated with 0. The user should not attempt to modify these fields on the negative row(s). If the initial claim to be adjusted had multiple details, all the claim detail rows will show up as negative line details. If the provider does not wish to adjust all the rows on the initial claim, they will need to delete the rows they do not wish to adjust by using the **Delete** button on the right side of the row. The line item total will be in parentheses. If the adjustment is to return the entire amount of the claim, there is no need to click the **Add New Details Row(s)** button.



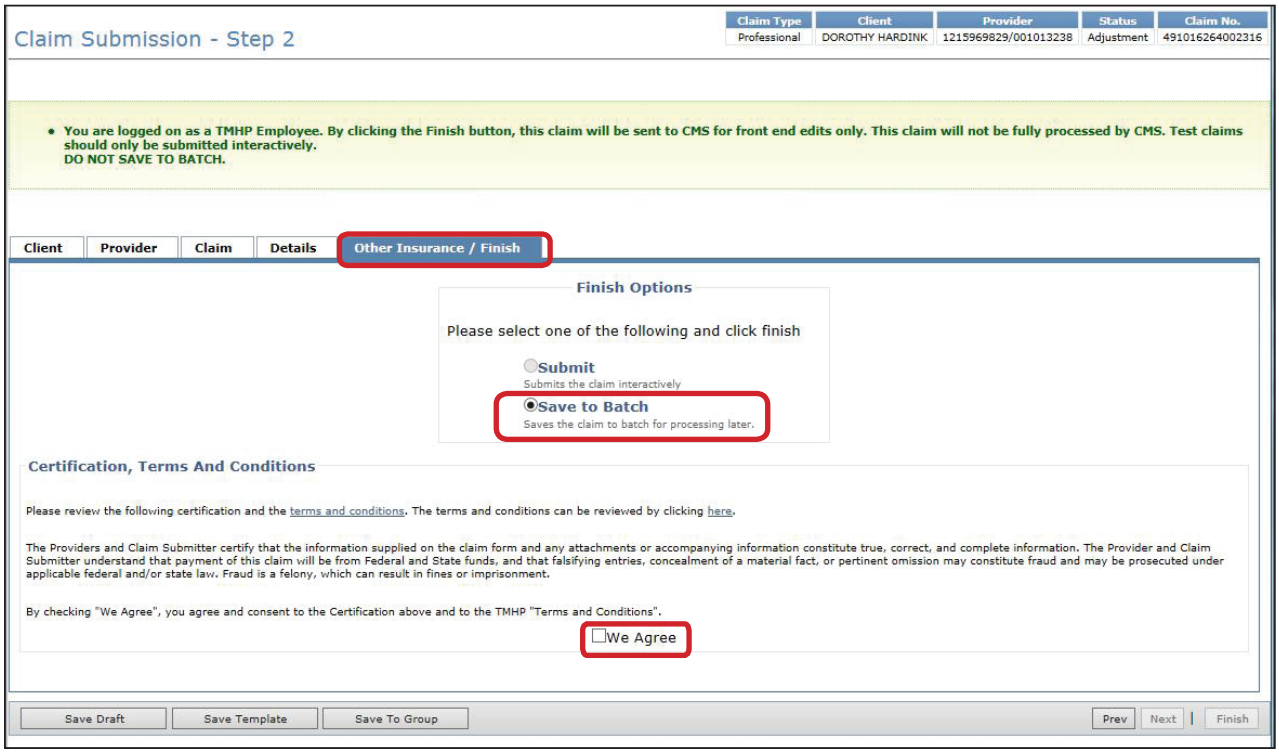
11) To bill positive units for the same adjusted claim, click the **Add New Details Row(s)** button. On the new row, you will add the dates of service and the accurate number of units that are to be paid. After the rate is entered, tab over to the Applied Income field. The Applied Income or Co-Pay will be calculated automatically. At the bottom left of the screen, the Claim Total and the Total Applied Income or Co-Pay that was deducted from the positive line will display. The provider should also fill in the OI field on the positive line (if applicable).



Saving and Submitting an Adjustment

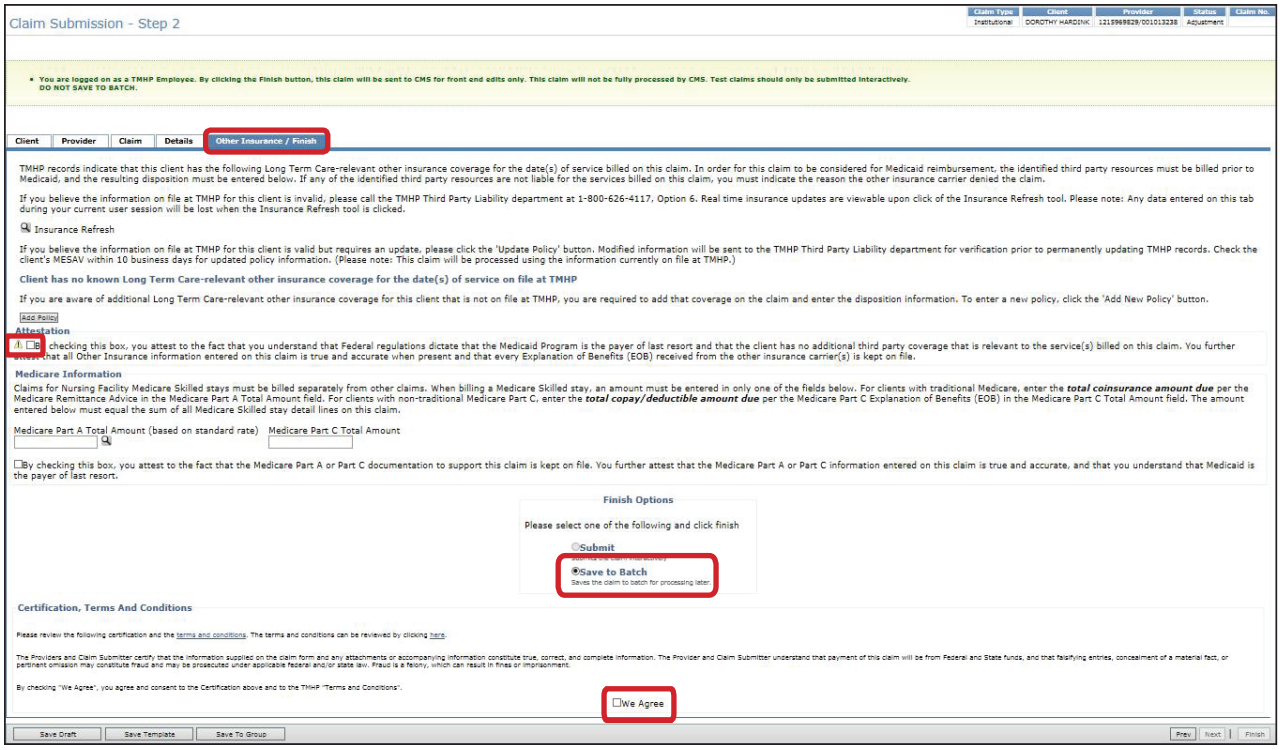
All adjustments must be submitted as batches.

1) To save a Professional or Dental claim adjustment as a batch, click the **Other Insurance / Finish** tab, click the **Save to Batch** radio button, check the **We Agree** box, and then click the **Finish** button in the lower right corner.



2) **For Institutional Claims**, check the box under Attestation, click the **Save to Batch** radio button, check the **We Agree** box, and then click the **Finish** button.

Note: *For claims in Service Group 1, 6, and 8, the OI Paid Amount entered in the Details tab will have to equal the OI Paid Amount in the Other Insurance/Finish Tab.*



Review your batch history to ensure that the adjustment was successfully processed. The submission of the pending batch is initially **Accepted** but can be **Rejected** once additional system edits are applied. Refer to the Submitting a Batch section of this User Guide for information about submitting batches.

Remittance and Status (R&S) Reports

R&S Reports are generated on Mondays and Wednesdays.

- R&S Reports generated on Mondays cover claims submitted the previous week between Tuesday after close of business until close of business on Friday.
- R&S Reports generated on Wednesdays cover claims submitted from the previous Friday after close of business until close of business Tuesday of the current week.

The R&S function on the left navigation panel has two options:

- PDF: Displays the R&S in a PDF version of the paper R&S.
- ANSI 835: Allows you to download the American National Standards Institute (ANSI) 835 version of the R&S Report. This file is for providers who use third-party billing software or third-party billing agents.

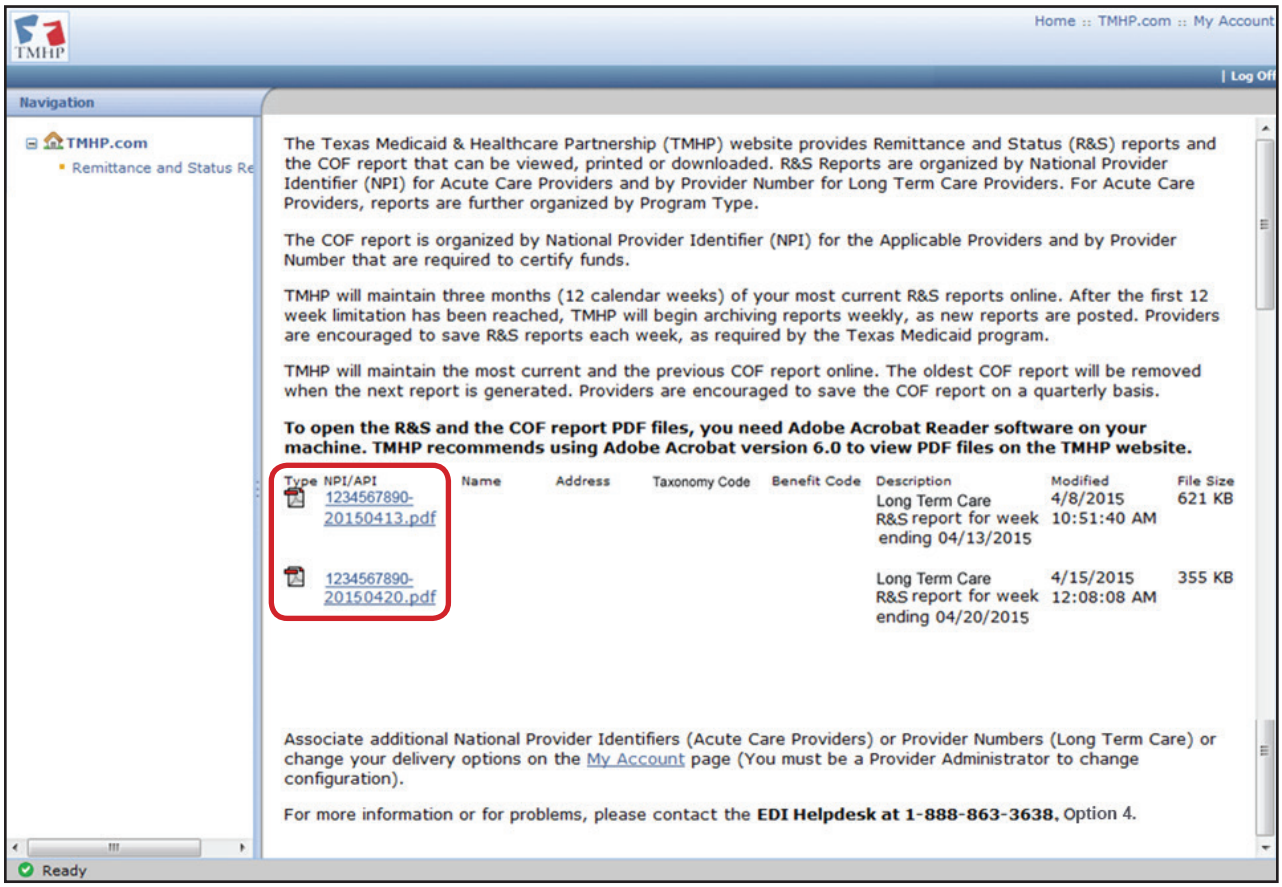
Note: *An additional resource that can assist Long-Term Care providers with R&S Reports is the Remittance and Status Reports for LTC Providers Quick Reference Guide (QRG). Click the link provided and refer to the TMHP website to access the QRG.*

Viewing the PDF Version

To view the PDF version of the R&S Report:

1) Click the **R and S** link on the left navigation panel.

2) Select the NPI or API for which you'd like to view R&S Reports. Some providers will only have one NPI or API, while other providers will have more than one.



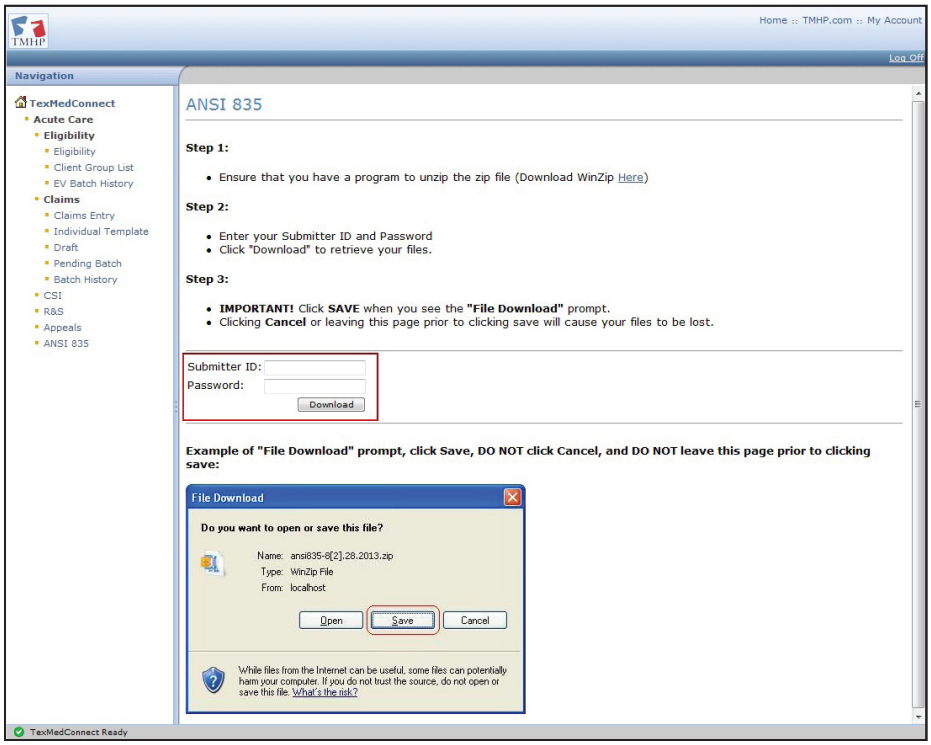
Downloading the ANSI 835 Version

You can access the 835 non-pending Electronic Remittance and Status (ER&S) Report and the pending ER&S Report through TexMedConnect.

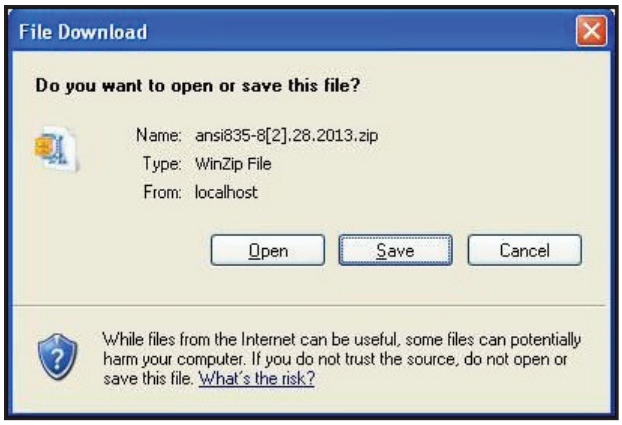
To download the ANSI 835 version of the R&S Report, follow these steps:

1) Click the **ANSI 835** link on the left navigation panel.

2) Enter your Submitter ID and Password, and click the **Download** button. If you do not know your Submitter ID and Password, contact the EDI Helpdesk at 1-888-863-3638, Option 4, from 7:00 a.m. to 7:00 p.m., Monday through Friday.



3) Click the **Save** button and download the file to any location on your computer.



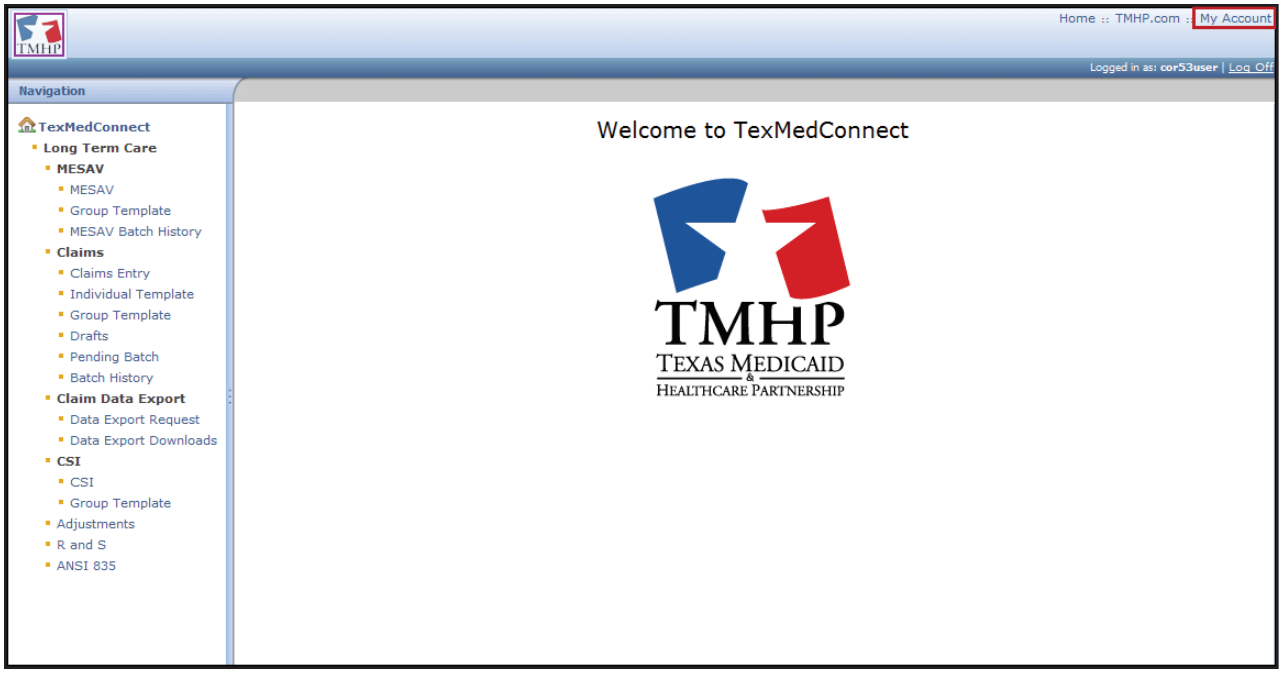
Note: *Third-party software vendors, third-party billing services, and providers who program their own software can find information about all of the requirements for EDI ANSI X12 file types in the EDI Companion Guides, which are located on the EDI page of the TMHP website at www.tmhp.com.*

Claims Identified for Potential Recoupment (CIPR) Reports

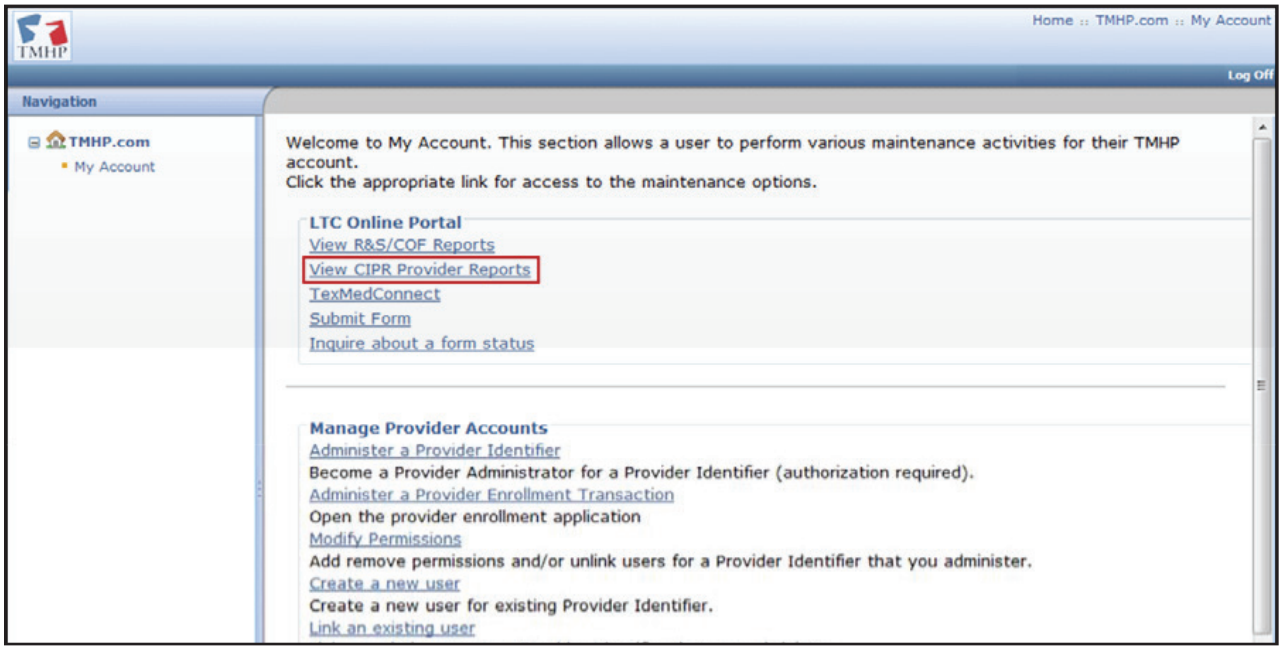
TMHP provides Claims Identified for Potential Recoupment (CIPR) Provider Reports to Long-Term Care providers that can be downloaded and viewed. As TMHP becomes aware of a person's third-party insurance policies with retroactive dates of coverage, claims previously reimbursed by Medicaid will be identified if the claim would have processed differently based on the third-party resource. The CIPR Provider Report contains this list of impacted claims, along with the insurance company information for the corresponding policy. Providers have 120 calendar days to adjust claims on a CIPR report to address the updated OI information. If claims are not adjusted, the identified claims will be recouped after the 120 calendar days.

Reports are generated on a weekly basis, and TMHP maintains each CIPR Provider Report for a six-month period. The CIPR is available in PDF format. TMHP recommends using Adobe Acrobat® version 6.0 or higher to view PDF files on the TMHP website. If the provider believes that the other insurance information on file is incorrect, they should contact TMHP TPL Resource Line at 1-800-626-4117, Option 6.

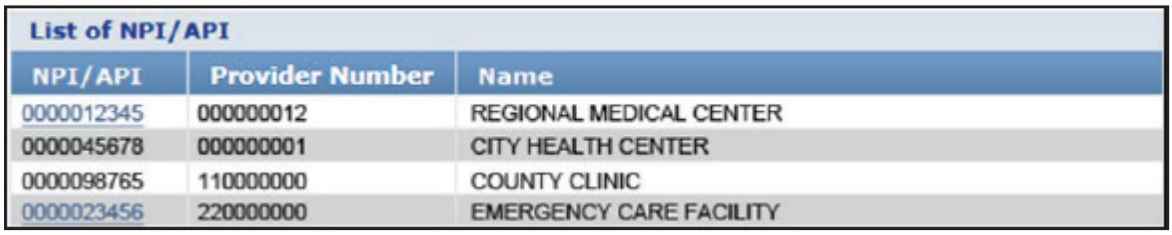
1) Click the **My Account** link in the top right corner of the TexMedConnect Home Page.



2) Click the **View CIPR Provider Report link** under the LTC Online Portal section.



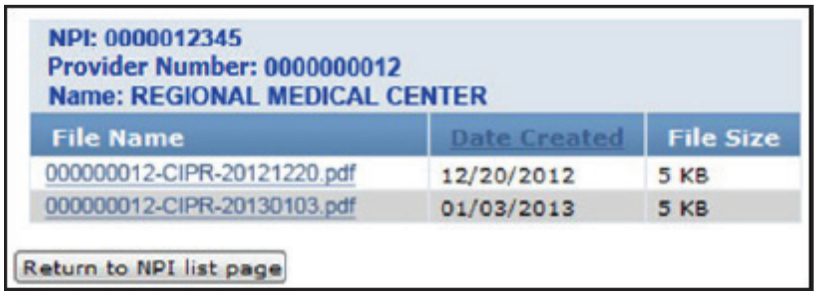
3) Click the NPI/API to view the CIPR Report.



List of NPI/API

NPI/API	Provider Number	Name
0000012345	000000012	REGIONAL MEDICAL CENTER
0000045678	000000001	CITY HEALTH CENTER
0000098765	110000000	COUNTY CLINIC
0000023456	220000000	EMERGENCY CARE FACILITY

4) Click on a File Name hyperlink to view CIPR Provider Reports. Click the **Date Created** column heading to sort.



NPI: 0000012345
Provider Number: 0000000012
Name: REGIONAL MEDICAL CENTER

File Name	Date Created	File Size
000000012-CIPR-20121220.pdf	12/20/2012	5 KB
000000012-CIPR-20130103.pdf	01/03/2013	5 KB

Return to NPI list page

Note: *For each claim identified on the CIPR Provider Report, providers are required to submit a claim to the appropriate third-party resource for the services previously submitted to Medicaid.*