HCS AND TXHML WAIVER PROGRAMS
FREQUENTLY ASKED QUESTIONS

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TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

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Section 1: TexMedConnect & Electronic Data Interchange (EDI)

1.1. If I have already set up my Texas Medicaid & Healthcare Partnership (TMHP) user account, does that mean I signed the EDI Agreement?

Setting up your TMHP user account does not necessarily mean you have a signed EDI Agreement on file. To confirm you have an EDI Agreement on file, and for all other EDI-related questions, call the TMHP EDI Help Desk at 888-863-3638, Option 4.

1.2. I have three separate contract numbers (two Home and Community-based Services [HCS] and one Texas Home Living [TxHmL]) in TexMedConnect, but only one is displaying.

If you do not see all of your contract numbers, you need to link your TMHP administrator account to the numbers that are not displaying. For steps on linking your account, refer to the Account Management web page on tmhp.com.

1.3. Is there any material outlining how to register for an EDI account?

Visit the EDI web page on tmhp.com for steps on creating a new EDI account.

1.4. What clearinghouses does TMHP work with?

Providers can view the TMHP Approved Vendors List located on the EDI page of the TMHP website to see the clearinghouses. If a provider is using an existing vendor not on the approved list, the vendor needs to contact the TMHP EDI Help Desk at 888-863-3638, Option 4, to begin testing requirements.

1.5. If we already use TMHP for Electronic Visit Verification (EVV), does that mean we already have a completed EDI on file?

To check if you have an existing EDI agreement on file, contact the TMHP EDI Help Desk at 888-863-3638, Option 4.

1.6. What is TexMedConnect?

TexMedConnect is an online application that lets providers file claims, check claims status, confirm client eligibility, and more. There are two versions of TexMedConnect—Acute-Care and Long-Term Care (LTC). HCS and TxHmL providers utilize the LTC version.

1.7. When I log into my TexMedConnect account, my only option is Acute Care and not LTC. What do I need to do?

For assistance with linking your TMHP user account to an LTC provider type, refer to the Account Management web page on tmhp.com.

1.8. Are daily or weekly payments for EDI transactions separate from TexMedConnect transactions, or are transactions for both systems added together for daily or weekly payments?

All claims for each provider number/contract number are combined into one voucher. TexMedConnect and EDI claims are not separated out for voucher creation or electronic funds transfer (EFT)/payment.

After a voucher is paid (for the group of claims), TMHP does reconciliation to mark all the claims for that voucher as Paid (status "P"). Until then, the claim status will be Approved (status "A"). Providers can use the Remittance & Status (R&S) Reports or the Claims Status Inquiry (CSI) screen to confirm their claims status.

1.9. Are all billing reports available in Portable Document Format (PDF), or can we export the data to Excel®?

The Claims Data Export is in Excel® format, while all the other data reports within TexMedConnect are PDF.

1.10. If we use a clearinghouse, do we need to complete the EDI Agreement or is the clearinghouse responsible for it?

Providers are required to sign the Electronic Data Interchange Agreement for Long Term Care Providers. You should work with your clearinghouse to get this done.

1.11. When I try to log into my TMHP user account, I receive an error message stating, "Username must be different than your EDI submitted ID."

If you are unable to log into your account, you can request a password reset. Upon completion of the password reset, you will be able to log into your TMHP user account. For instructions on how to change a password, refer to the Account Management web page on tmhp.com.

1.12. Is the Submitter Identifier (ID) and Login ID the same?

For TMHP EDI File Transfer Protocol (FTP)/Virtual Private Network (VPN), the Submitter ID and Login ID are the same. Users who experience problems with their Submitter IDs or passwords can contact the EDI Help Desk by telephone at 888-863-3638, Option 4.

For TexMedConnect, the Login and Submitter ID are not the same. You can access TexMedConnect from the Long-Term Care home page of the TMHP website. To use TexMedConnect, you must already have a TMHP user account. For information on TMHP account management, refer to the Account Management web page on tmhp.com.

1.13. What is the personal identification number (PIN) used for?

You will need to request a PIN if you are unable to answer the security questions to begin the process of creating a TMHP user account. For more information on TMHP account creation, refer to the Account Management web page on tmhp.com.

1.14. Does the administrator create a TMHP user account for their staff members, or should staff members create their own accounts and somehow link it with the main administrator's account?

The administrator creates a user account for each additional user. Each user will need their own login credentials. For more information on TMHP account creation, refer to the Account Management web page on tmhp.com.

1.15. Is there a location where we enter our Submitter ID in TMHP?

The only location to enter a Submitter ID within TMHP is in the Claims Data Export. This information can be found within the *TexMedConnect for LTC User Guide*.

1.16. Is there a benefit to having a separate LTC Submitter ID for HCS and TxHmL?

The difference for having a separate LTC Submitter ID for HCS and TxHmL is the login credentials for TMHP EDI FTP/VPN, the receipt of the response files, and the 835 Report. The benefit is if you link all contract numbers to one Submitter ID, then you will receive only one 835 file.

1.17. Do I need multiple authorization PINs for all my billing staff?

Only one PIN is needed for creating the initial TMHP administrator account. The administrator will then create a user account for each additional user. Each user will need their own login credentials. For more information on TMHP account creation, refer to the Account Management web page on tmhp.com.

1.18. Can we have access to both EDI and TexMedConnect?

Yes, you can use both EDI and TexMedConnect.

1.19. Are clearinghouses assigned a single Submitter ID for all providers using their platform, or is each provider assigned their own Submitter ID?

This depends on each vendor and their requirements.

1.20. What is a loop?

A loop and segment are the location where data can be entered. More information on EDI X12 claims submission can be found in the *837P Long Term Care Companion Guide*.

1.21. I was told by the EDI Help Desk that the Apple® default browser, Safari, is not compatible with TexMedConnect. Is this correct?

This is correct. You need to download Microsoft Edge (preferred) or Google Chrome to your machine to access TexMedConnect.

1.22. If we are using a clearinghouse, do we only need to complete the EDI Agreement, but not testing?

If the clearinghouse you are planning to use is currently submitting with EDI to TMHP, you only need to submit a new agreement for each contract number and coordinate with the clearinghouse. No additional testing is required.

1.23. Can we pull reports for individual categories such as nursing, Personal Assistance Services/ Habilitation (PAS/HAB), Supervised Living (SL), or day habilitation?

TexMedConnect users utilizing CSI are limited to searches involving a single individual and for no longer than three months at a time.

1.24. When creating a TMHP account, do we choose the option to create a provider enrollment account, or select an option under the section for Creating an Account to Administer an Existing Texas Medicaid and Other State Healthcare Program Provider?

You need to choose option "Create Account and link to a Long Term Care provider" to create an LTC account. You will also choose option "Create Account and link to a Nursing Facility/Waiver Program provider" to create a Nursing Facility (NF)/Waiver Program account. For more information on TMHP account creation, refer to the Account Management web page on tmhp.com.

1.25. Where do I submit my completed EDI Agreement?

The Electronic Data Interchange Agreement for Long Term Care Providers can be mailed or uploaded using the information listed on page one of the agreement.

1.26. When I try to log into my TMHP user account, it says I need to change my password, but I don't know what my current password is or how to get it.

If you are unable to log into your account, you can request a password reset. Upon completion of the password reset, you will be able to log into your TMHP user account. For instructions on how to change a password, refer to the Account Management web page on tmhp.com.

1.27. Do we link the National Provider Identifier (NPI), the contract/provider number, or both to our TexMedConnect account?

You can link both your contracts and associated NPIs to TexMedConnect.

1.28. Does the account number on the Client tab on TexMedConnect need to be entered manually each time we enter claims?

Yes, the Patient Account Number is a number that the provider uses to identify the individual internally. When manually submitting a new claim entry from the beginning, it will require the provider to enter the Patient Account Number each time. The provider can choose to save the Patient Account Number to an individual template to avoid having to manually enter it.

1.29. Is there training material available to learn how to bill a service through TexMedConnect?

Yes, you may refer to the *TexMedConnect for LTC User Guide*, TexMedConnect for LTC eLearning, HCS and TxHmL TexMedConnect Claims Submission Webinar, and other trainings on TMHP's Learning Management System (LMS).

1.30. How can I check the status of a submitted EDI Agreement?

Contact the EDI Help Desk at 800-925-9126, Option 4, and let the EDI agent know you want to check the status of your EDI Agreement. You must provide the agent with your contract number(s). The EDI agent can validate receipt of the agreement and inform you of the pending time frame for completion.

Note: It can take up to 30 days to process an EDI Agreement once it is submitted.

1.31. I have a TMHP account that I use for a different program (e.g., Community First Choice [CFC], Intermediate Care Facilities [ICF], etc.,). Do I need to setup another account to handle things for HCS?

Refer to the Account Management web page on tmhp.com for information on setting up your TMHP accounts and linking multiple accounts and account types.

1.32. Where can I check a client's Medicaid status, and can I do it prior to the ineligibility status?

You can view a client's Medicaid Eligibility (ME) at any time through your TexMedConnect account by going to Medicaid Eligibility and Service Authorization Verification (MESAV). Reference the *TexMedConnect for LTC User Guide* for details about MESAV ME.

1.33. If using a clearinghouse to submit claims, are authorization reference numbers required?

TMHP does not require authorization reference numbers. There are state-assigned referral numbers that are used and can be found in the individual's MESAV on TexMedConnect.

1.34. How can I change the PIN for my TMHP user account to be able to enroll all my contracts within TMHP My Account?

If you are the account administrator, contact the TMHP EDI Help Desk at 888-863-3638, Option 4, for assistance.

1.35. How do I set up a TexMedConnect account if I already have a TMHP user account?

Refer to the Account Management web page on tmhp.com for information on how to access TexMedConnect.

1.36. Do HCS and TxHmL program providers that enter data in TMHP's system without using a clearinghouse have to submit an EDI Agreement?

If you are a program provider billing claims through TexMedConnect and not through a clearinghouse, TMHP recommends you complete the Electronic Data Interchange Agreement for Long Term Care Providers to ensure you have access to 835 Electronic Remittance and Status (ER&S) data that is older than 90 days.

1.37. What name must be entered for the performing provider on TexMedConnect? May the biller's name be used?

The performing provider is the program provider that provides services to the client. It is possible that the billing provider and the performing provider are the same.

1.38. What information prepopulates on TexMedConnect?

If the claim is entered in TexMedConnect using the member's Medicaid number, most of the member's information will prepopulate. The same occurs with program provider information. Program providers must verify fields with red dots (indicating required fields) in each section tab to make sure information is filled in correctly or to add information, if needed.

1.39. When is the line item control number (LICN) field required?

Refer to the Long-Term Care Bill Code Crosswalks page, located on the Texas Health and Human Services Commission (HHSC) website, for guidance on when the LICN field must be used and which parts of the LICN are required. Generally, the LICN field is used when the claim is related to EVV and when a staff ID is required.

1.40. If I decide to use TexMedConnect, do I need to submit a completed EDI agreement?

We encourage you to complete the Electronic Data Interchange Agreement for Long Term Care Providers so that you have access to the EDI 835 ER&S Report. The 835 is an X12 transaction that will contain remittance advice information. Refer to the *835 Long Term Care Companion Guide* on the TMHP website for additional information and formatting of the 835 ER&S Report.

1.41. What is the difference between billing in EDI and TexMedConnect?

EDI uses standard X12 837 transactions for billing that are generally used by clearinghouses, software vendors, or third-party billing services. For more information on these transactions, visit the EDI web page located on the TMHP website. Billing in TexMedConnect is done through a free, web-based interface that is supported by TMHP.

1.42. How does the LICN field work in TexMedConnect?

TMHP allows claims to be submitted according to HHSC billing guidelines, where the individual who provided the service delivery must be identified using the LICN field. These services are identified in the HHSC LTC Bill Code Crosswalk as either requiring a Staff ID, a Texas EVV Attendant ID, or, in the case of Nursing and Transportation Services, a label indicating the accumulated units.

Refer to the HHSC LTC Bill Code Crosswalk for guidance on when the LICN field must be used and which segments of the LICN field are required. Proper use of the LICN field will prevent claim mismatches, denials, or rejections.

The current instruction for the HCS and TxHmL LICN field in TexMedConnect is the following:

- Positions 1-4 are in military-time format, are always required, and represent the claim sequence number.
    - Positions 1-2 range from 00-23.
    - Positions 3-4 range from 00-59.
    - Format edits apply to certain table-driven service groups (SGs) and service codes.
    - The claim sequence number must be unique when there are multiple claim details for the same service on the same day.
- Positions 5-20 are for either the Texas EVV Attendant ID, Dummy ID, or Staff ID.
    - For billing an EVV service, use the Texas EVV Attendant ID. EVV visit units may be submitted rolled up by the NPI per existing functionality.

- For CFC PAS/HAB claims, you must enter the Texas EVV Attendant ID from the visit displayed in the EVV system. If characters not matching the Texas EVV Attendant ID are entered on an EVV Claim, it will be denied.
- The Texas EVV Attendant ID is not required by HCS and TxHmL programs for in-home respite and in-home day habilitation. Submit information in Positions 1-4 as instructed above in the LICN field to avoid receiving an EVV04 claim mismatch.
- If positions 5-20 are not used, then the NPI or atypical provider identifier (API) will continue to be used for EVV claim matching. Refer to the *Home and Community-based Services and Texas Home Living Best Practices to Avoid EVV Claim Mismatches* for more information.

- For billing Nursing and Transportation Services, use one of the following Dummy IDs:
  - ACCUM.NUR
  - ACCUM.NUL
  - ACCUM.NURS
  - ACCUM.NULS
  - ACCUM.TR
- For billing non-accumulated services, use the Staff ID.
  - "LastName,FirstName" (no spaces)
- Positions 21-30 are for the internal claim ID.
  - The internal claim ID are used to reconcile the 837 claim to 835 Remittance.

1.43. Are diagnosis codes prepopulated in TexMedConnect?

No, diagnosis codes do not prepopulate in TexMedConnect, but this function could be considered in future enhancements.

1.44. How do we know whether to choose LOC1 or LOC8 in TexMedConnect?

The appropriate level of care (LOC) can be found on the MESAV and is based on an approved 8578 Intellectual Disability (ID)/Related Condition (RC) Assessment. This approved LOC helps providers choose the appropriate bill code and modifier for that service on the HHSC LTC Bill Code Crosswalk, but providers do not select the level itself in TexMedConnect. The LOC is generated based on the MESAV record. If the incorrect combination of bill code and modifier is used, the system may deny the claim.

1.45. Many individuals who receive TxHmL and HCS services have multiple diagnosis codes, but it seems that the field in TexMedConnect allows only one code. Is there a specific diagnosis code that is required, or must all diagnosis codes for the individual be entered?

You must use the Primary Diagnosis Code, found on the individual's 8578 ID/RC Assessment, for claims

when the individual has multiple diagnosis codes.

1.46. I printed MESAVs for our HCS clients, but some MESAVs do not appear to be fully set up. Who can I contact to resolve this issue?

If you find incomplete client data on MESAVs, call the TMHP LTC Help Desk at 800-626-4117 (select option 1, then option 1).

1.47. TexMedConnect is showing our office address instead of the client's address. I checked the Client Assignment and Registration (CARE) system, and all of the addresses are correct there. How can we correct this issue?

Client addresses in TexMedConnect are pulled from the Texas Integrated Eligibility Redesign System (TIERS). Update the client's address in TIERS to resolve the issue.

1.48. Is there a report in TexMedConnect to review the temporary discharge dates submitted for an individual who receives HCS or TxHmL services?

TMHP refers to "temporary discharge" as a Client Hold. Client holds may be viewed on MESAV, and each client hold record has a begin date and end date. The begin date is the "temporary discharge" start date.

1.49. What should I do if our agency already uses TexMedConnect?

If you currently use TexMedConnect, be sure to link your contract numbers or set up TMHP user accounts for SG 21 for HCS and SG 22 for TxHmL to submit claims to TMHP. Additionally, you must submit a completed Electronic Data Interchange Agreement for Long Term Care Providers to ensure you have access to the 835 ER&S Report.

For more information on TMHP account management, refer to the Account Management web page on tmhp.com.

1.50. What environment is used to submit an X12 batch submission for testing?

Refer to the *TMHP EDI Connectivity Guide* for connectivity information for each environment.

1.51. If all we have is the EDI extract, how can we pull our data every week without adding another position?

Providers can submit claims daily using EDI or TexMedConnect. Both of these systems provide initial claim acceptance or rejection information. Additionally, providers may receive R&S Reports and/or 835 ER&S Reports which contain additional claim status and adjudication information.

R&S Reports are available through TexMedConnect, and 835 ER&S Reports are available through EDI. The reports also list other claims finalized during the reporting period, pending claims from the previous reporting period, system adjustments, and recoupment claims. Providers are also able to submit a CSI on TexMedConnect to obtain claim status information.

1.52. All our crosswalks to the General Ledger (GL) were remapped with the new data format. Where can we find more information?

Information can be found on the 835 ER&S Report or R&S Report found in TexMedConnect, and by using the Dashboard function on the LTCOP.

1.53. I only signed up for TexMedConnect, but understand that I can sign and submit an EDI Agreement to have access to certain billing reports. If I have multiple contracts, do I need to sign and submit an EDI Agreement for each contract or do I only need one?

For LTC providers to bill and/or receive their 835s, 837s, 270/271s, or 276/277s using a clearinghouse, third-party vendor, or software company, TMHP must receive a completed Electronic Data Interchange Agreement for Long Term Care Providers to generate a submitter ID. If you need to add additional contract numbers to the same submitter ID or Electronic Data Interchange Agreement for Long Term Care Providers, you should complete and submit a Submitter ID Linking Form for Long Term Care Providers located on the TMHP website.

1.54. Is batch reporting available, or do we have to use a third-party vendor and use EDI?

If you choose to use TexMedConnect, TMHP's free web application, you may submit claims and view batches using the batch history.

If you choose to use EDI, you will receive an initial response file for your claims which will indicate whether a claim was initially accepted or rejected. You must work with a third-party billing agency, a clearing house, or use third-party software to create and process X12 transactions.

1.55. Is a straight billing person be able to run basic reports, or is the administrator the only one to run reports?

The CSI function is available to any user who can access TexMedConnect, while the Claims Data Export function is only available to administrators with a submitter ID.

1.56. What information needs to be entered on the "Other Insurance" tab on TexMedConnect?

You only need to select the attestation check box and select to submit the claim for HCS and TxHmL claims entry. No other entry is required on the "Other Insurance" tab.

1.57. Does the "Details" tab show the Healthcare Common Procedure Codes (HCPCS)?

No, the "Details" tab does not show the HCPCS, but it does show the related billing code which can be verified using the Long-Term Care Bill Code Crosswalks page.

1.58. If you save a group template, do you have to change the service dates every week?

You must update the service dates before you submit. You can update everyone in the template at one time, or you can update person-by-person using the check boxes in the template.

1.59. Can TMHP account administrators and general users both submit claims in TexMedConnect?

Yes, both the administrator and general user can submit claims. For the general user account, make sure you have the right permissions added. For more information on TMHP account management, refer to the Account Management web page on tmhp.com.

Section 2: Claims

2.1. Is the billing crosswalk for TMHP different than the crosswalk we used to bill in the CARE system?

HHSC has updated the Long-Term Care Bill Code Crosswalks to include changes for billing to TMHP. The updated crosswalks can be found on the Long-Term Care Bill Code Crosswalks page, located on the HHSC website. The page also provides a link to the EVV bill code crosswalk.

2.2. Does TMHP provide direct payments to the provider?

No, TMHP's Claims Management System runs a daily financial cycle (Monday through Friday) to generate the Payment/Voucher file. The Voucher file is sent to the Centralized Accounting and Payroll/ Personnel System (CAPPS), which issues the EFT payments to providers.

Typically, vouchers are paid on the third business day following the TMHP financial cycle (e.g., vouchers generated for the Monday evening financial cycle are paid on Thursday.)

2.3. Does all billing (PAS/HAB, respite, nursing, special therapies, SL, and Host Home) go through TMHP?

Yes, HCS and TxHmL providers submit claims using TMHP online claim submission tools, TexMedConnect or EDI.

2.4. What is the timeline to correct a claim rejected by TMHP?

Providers have 12 months from the end of the month the date of service (DOS) was performed to successfully submit a clean claim. Claims that are rejected or denied when originally submitted cannot be "corrected;" however, they can be resubmitted as a new claim and are subject to the same timeline as the original claim. For example, a claim submitted in March for a January 1, 2021, DOS is rejected by TMHP. The provider has the remainder of the 12 months from the original DOS to submit the new, corrected claim and meet the timely filing deadline.

2.5. Does Datalogic/Vesta have the capability to send respite, In-Home Day Habilitation, and PAS/HAB services billing through TMHP?

Yes, Datalogic/Vesta is a TMHP-approved EDI vendor. You need to submit an Electronic Data Interchange Agreement for Long Term Care Providers for each contract number to submit claims through EDI. Additionally, you will need to work with Datalogic/Vesta and provide your credentials for TMHP claims submission.

2.6. How do we correct a claim?

Claims that have processed successfully can be adjusted. To learn more on the adjustment process, reference the *TexMedConnect for LTC User Guide*.

2.7. Are transfer agreements still being sent to current providers to hold some units for subsequent billing not entered by the transfer date?

There are no changes to transfer agreements.

2.8. Do we need to mail forms for Adaptive Aids (AA) and dental reimbursements?

No, Form 4116 is no longer required for billing reimbursement. Providers are responsible for entering billing for AA, dental, and Minor Home Modifications (MHM) through TMHP.

2.9. Can you explain the referral number?

The referral number is assigned by HHSC to enable the TMHP Claims Management System to differentiate between two contract numbers that share the same NPI. The referral number appears on the individual's MESAV once the authorization has been granted.

2.10. How long does it take to generate an internal control number (ICN)?

Generation of an ICN for TMHP claims is virtually instantaneous as long as the claim is not rejected at the beginning of the claims process. Rejected claims will not receive ICNs.

2.11. Does TMHP generate R&S Reports every time billing is submitted?

Providers can submit claims daily; however, R&S Reports are generated twice a week and are available every Saturday and Wednesday. R&S Reports generated on Saturday list claims processed from the previous week between the close of business (COB) Tuesday through COB Friday. R&S Reports generated on Wednesday list claims processed from the previous Friday (after COB) through COB Tuesday of the current week.

The R&S Reports also list other claims finalized during the reporting period, pending claims from the previous reporting period, system adjustments, and recoupment claims.

2.12. How can I find out what my Submitter ID is?

Contact the TMHP EDI Help Desk at 888-863-3638, Option 4, for assistance.

2.13. Can we have a separate Submitter ID for a sender and receiver for one provider number?

You can choose to use the same Submitter ID or obtain a different one. Regardless of your choice, you need to submit a completed Electronic Data Interchange Agreement for Long Term Care Providers.

2.14. If I have an Intermediate Care Facilities (ICF) Submitter ID, do I also need a separate HCS Submitter ID?

You can use the same ICF Submitter ID, or you can obtain a different one. Regardless of your choice, you need to submit a completed Electronic Data Interchange Agreement for Long Term Care Providers.

2.15. Are we able to separate our contracts for each NPI, or do we have to link all our contracts to the same NPI?

To get an NPI assigned for each contract, you need to repeat the process for obtaining an NPI that you completed previously. If you decide not to have an NPI assigned for each contract, there are other options available, such as:

- Linking your HCS and TxHmL contracts and associated NPIs to your existing TMHP LTC user account.

- Creating a new TMHP LTC user account and linking specific contracts and NPIs to differentiate between contracts and claims.

For more information on TMHP account management, refer to the Account Management web page on tmhp.com.

2.16. Where does the authorization for AA, MHM, and Dental (DE/DEV) services appear during claims submission?

Form 4116 is no longer required for submission to HHSC. Form 4116 for MHM, Pre-Minor Home Modifications (PMHM), AA, and DE/DEV services is entered into the TMHP system as part of the IPC. Providers then bill their claims directly in TexMedConnect based upon the IPC and service authorization found on the MESAV screen.

2.17. Is all billing done under TMHP, or do we submit claims simultaneously in CARE and TexMedConnect?

Providers must submit all HCS and TxHmL claims through TMHP.

2.18. Will historical claims data remain available in CARE and for how long?

Historical claim data will remain in CARE for five years, after which the claims are archived.

2.19. Is there a time cut-off to submit billing, or can you submit billing 24/7?

TexMedConnect allows for billing 24 hours a day, 7 days a week, except for times of scheduled system maintenance and/or service outages.

2.20. Do we have until the last day of the month that the service was delivered one year later to bill? For example, if the service was provided on April 1, 2021, will we have until April 30, 2022, to bill?

HCS and TxHmL providers must submit claims within 12 months after one of the following, whichever is later:

- The last day of the month in which the service was provided, the AA or medical supply was delivered, or the MHM was completed.
- The date the individual's eligibility for the service was determined.

2.21. Does TMHP require the individual's diagnosis code when submitting claims? Is it required when submitting claims via 837 electronically? Does this diagnosis code need to match what is on the individual's 8578 ID/RC Assessment?

The individual's diagnosis code is required on the claim. At least the Principal Diagnosis code is expected to be submitted on the claim. TMHP does not match the diagnosis code with the individual's 8578 ID/RC Assessment.

2.22. Is an authorization number required to bill HCS services through TMHP electronically via 837?

All providers must use the claim information along with the individual's service authorization information. The Claims Management System derives the SG, service code, and bill code.

2.23. Is there a way to report the contract number instead of the referral number for each service on a claim?

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. You can access the referral number by searching an individual's eligibility within MESAV.

2.24. Do we submit HCPCS or bill codes on a claim?

Providers are required to submit claims using National Codes: Revenue (REV), Current Procedure Terminology (CPT), and HCPCS using the HHSC LTC Bill Code Crosswalk. The HHSC LTC Bill Code Crosswalk is a code set used to match the National Codes to the Texas LTC local codes (bill codes).

2.25. Are responses 999 or TA1?

999 responses are Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard rejections, and TA1 refers to files that are incorrectly formatted. Providers will receive these two types of rejections, if applicable.

2.26. How do we set up templates for billing?

For information on setting up templates, reference the *TexMedConnect for LTC User Guide*, the TexMedConnect for LTC eLearning, or the three-part MESAV video series on the TMHP YouTube Channel under the HCS and TxHmL playlist.

2.27. Does TMHP require the attending physician NPI to be different from the billing provider NPI (like in ICF)? If so, does TMHP require the primary care provider (PCP) NPI for all of our HCS clients?

An attending provider is not applicable for professional claims. You can submit the performing provider NPI and name and the referring provider NPI and name on these claims, but these are optional fields. Only the billing provider information is required to pay these claims.

2.28. Is the Texas Provider Identifier (TPI) needed on submitted claims?

No, TMHP uses the NPI, physical address, and service authorization number to crosswalk to the contract number.

2.29. What should we do when submitting a claim and the place of service is home, but there is another claim by the same provider on the same day; however, the place of service is office?

TMHP has created multiple service codes since there will be multiple authorizations.

2.30. If a claim is denied, do we have to rebill or will it pay once the individual is no longer on hold? Currently if an individual shows on the HCS Denied Report, it gets paid once the issue is resolved.

All claims that have been denied will remain in that status unless rebilled by the provider.

2.31. Where can I learn more about submitting multiple claims at once?

You can learn more about batch claims by referencing the *TexMedConnect for LTC User Guide*.

2.32. We would like clarification on the procedure for billing Registered Nursing (RN). In a scenario where we have eight nurses who saw an individual on the same day for varying lengths of time, can we add those times together and enter it on one line? Or do we combine visits less than eight minutes and bill those together under the one Provider ID and then bill visits that were over eight minutes on eight separate lines of nursing under eight separate Provider IDs?

Accumulation of service time cannot be done per day in either scenario noted above. Accumulation of the RN service times can be done on *a single calendar month on the last day of the month*. The time does not have to be less than eight minutes to accumulate the time on a single calendar month.

Example 1: An RN provides registered nursing services to one individual three times during a single calendar month: July 1, 2021, 8:30-8:55 a.m. (25 minutes); July 6, 2021, 4:15-4:20 p.m. (5 minutes); and July 25, 2021, 8:00-8:05 p.m. (5 minutes).

Without accumulating service times, two units of service for registered nursing are billable for the service time of 25 minutes. The service times of five minutes are not billable because they are less than eight minutes each. If all three service times are accumulated into one service time of 35 minutes (25 + 5 + 5), two units of service for registered nursing are billable.

If the first service time of 25 minutes is billed as two units of service on the day it was provided, and the second and third service times are accumulated into one service time of 10 minutes (5 + 5), which is billable as one unit of service on the last day of the month, July 31, 2021, three units of service for registered nursing are billable (2 + 1).

Example 2: Nurse A provides seven minutes of registered nursing to an individual. During the same month, Nurse B provides seven minutes of licensed vocational nursing to the same individual. You could not accumulate the time and neither service would meet the minimum requirements for billing a unit of their respective nursing component.

To learn more about the accumulation process, reference Sections 4460 and 3610(b) of the *Home and Community-based Services (HCS) Program Billing Requirements*.

2.33. Which claim file indicator should be selected when billing through TexMedConnect?

Providers should use the professional claim form and use "MC" (Medicaid) as the claim file indicator.

2.34. How does TMHP know the rate from the group since it may vary?

TMHP uses the rate(s) already determined by HHSC.

2.35. What is the difference between the individual template and group template?

The individual template is used to enter claims for one specific individual, while the group template can be used to store up to 250 individuals.

2.36. Does the referral number remain the same as long as the individual is in the same SG (SG 21 for HCS and SG 22 for TxHmL)?

Yes, the referral number remains the same for the contract/individual combination. The referral number is a unique number that associates one contract to one individual.

2.37. What claim type should be used for the CARE-related services that are billed through TMHP?

All claims for HCS and TxHmL services must be billed as professional claims.

2.38. What service codes should we use for HCS and TxHmL?

Providers use SG 21 for HCS and SG 22 for TxHmL. You can reference the Long-Term Care Bill Code Crosswalks page.

2.39. Has the new 837 Long-Term Care Companion Guide been released for migrating claim submissions to TMHP?

Yes, the new *837P Long Term Care Companion Guide* is now available on the TMHP website.

2.40. What happens if a provider submits a claim to TMHP that undercharges or overcharges?

Billing codes are set as fixed rates in the Claims Management System to ensure claims are paid at the approved rate based on the units of service that have been submitted for payment.

2.41. How do I coordinate professional and dental claim types?

Providers can use the 837P for professional claim types, and the 837D for dental claim types.

2.42. What is the difference between codes LC1 and LN1?

LC1 is for LOC and LN1 is for Level of Need (LON).

2.43. Residential support services use the same HCPCS code and modifier for all LONs. If I submit an 837P for these services, how does TMHP know which LON is being billed?

TMHP uses the approved LON on the individual's current 8578 ID/RC Assessment to determine the unique bill code and bill rate.

2.44. Exactly what services are billed through TMHP?

Services billed through TMHP include HCS services, TxHmL services, and CFC services for HCS and TxHmL clients. Reference the Long-Term Care Bill Code Crosswalks page to view a list of services.

2.45. What information is required on a claim submitted through TMHP?

Reference the *TexMedConnect for LTC User Guide* and the TexMedConnect for LTC eLearning located on TMHP's LMS for detailed information on claim submission.

2.46. If an individual is admitted during the 180-day wait time for approval of Medicaid Identification (MI) and ME, is the provider not get paid during that time?

As soon as eligibility is verified, the provider can begin billing.

2.47. Do level and service authorizations need to be in the LTCOP before we can bill?

Yes, HCS and TxHmL assessments and forms used to create service authorizations and level records must

have been successfully submitted and approved in the LTCOP before they can be used for billing.

2.48. Do we need to mail forms for AA and dental reimbursements?

No, Form 4116 is no longer required for billing reimbursement. Providers are responsible for entering billing for AA, dental, and MHM through TMHP.

2.49. Can we submit paper claims to TMHP?

No, all claims must be submitted electronically using EDI or TexMedConnect.

2.50. In the HCS program, we are instructed to return someone to services on the last day they are out of the program so that services will be paid on the date that they return to the program. How is the return-to-service date affected with TMHP, and we be able to bill for services on the return date?

The program provider can bill for services as long as the dates entered on the claim match the service authorization date from MESAV, which is found on TexMedConnect, and there is not an active client hold for any of the billed dates.

2.51. How do I set up claim entry and payment?

HCS and TxHmL program providers submit claims using TMHP's online claim submission tools: TexMedConnect or EDI.

Reference the *TexMedConnect for LTC User Guide* and the TexMedConnect for LTC eLearning located on the TMHP LMS for detailed information on claim submission. You can also reference the EDI web page located on the TMHP website.

2.52. How do you process billing for dental, nursing, day habilitation, and SL/foster services?

All claims are billed using the professional claim type. Dental service codes starting with "5A" and HCPCS starting with "D" are billed using the dental claim type. Claims that go through EDI or a third-party biller use 837P for professional claims and 837D for dental claims.

2.53. Is there a Paid Claim Status Report or a Services Provided by IPC Report?

Program providers may track units used on the IPC service authorization using MESAV on TexMedConnect or the EDI X12 EV transaction.

Reference the "Remittance and Status (R&S) Reports" section of the *TexMedConnect for LTC User Guide* for an explanation of pending/denied or approved to pay claim statuses.

2.54. How do I bill for Consumer Directed Services (CDS)?

You must bill CDS claims as professional claims.

2.55. When multiple employees are working, can we bill multiple times for the same service on the same day? Do we add together for a daily total?

Yes. The LICN field must be used to identify the staff for whom you are billing. Each line item is used for each day.

2.56. If claims are submitted appropriately, should providers expect two 835 files?

Yes, 835 ER&S Reports are generated twice a week. You will receive one file on Wednesday and one file on Saturday. The 835 ER&S Report will be delivered to the submitter ID that has been linked to your contract number on the EDI Agreement or Linking Form. You may also obtain claim status through TexMedConnect on the CSI screen or by obtaining the R&S Report.

2.57. What is the difference between the Staff ID and EVV Attendant ID?

Certain claims that are submitted for payment must identify the service provider that is delivering the specific service. Use the Staff ID for non-EVV required services that need service provider identification. Use the EVV Attendant ID for EVV required services. The Staff ID is the service provider's LastName,FirstName (no spaces) or a dummy ID for services that are accumulated. The EVV Attendant ID is the last four numbers of the passport or social security number (SSN) plus the last name.

2.58. What happens to a submitted claim that is missing a required Staff ID or EVV Attendant ID?

TexMedConnect will reject claims submitted for services that require a Staff ID or EVV Attendant ID and do not have one entered.

2.59. Which services allow the dummy ID codes to be used for claim submission?

Currently, the two services that allow a dummy ID to be used are Nursing (including all sub-components) and Transportation.

Nursing accumulation that is billed on the last day of the calendar month can use the following dummy ID codes:

- ACCUM.NUR
- ACCUM.NUL
- ACCUM.NURS
- ACCUM.NULS

Transportation accumulated in a single calendar day can use dummy ID code ACCUM.TR.

2.60. Which services require a Staff ID to be used?

The following HCS and TxHmL service components require a Staff ID in the claim submission:

- Professional Therapies:
  - Occupational Therapy (OT)
  - Physical Therapy (PT)
  - Speech/Language/Pathology Therapy (SP)
  - Dietary (DI)
  - Audiology (AU)

    - Behavioral Support (BES)
    - Social Work (SW) (HCS only)
    - Cognitive Rehabilitation Therapy (CRT) (HCS only)
- Nursing (for claims that are not accumulated on the last day of the calendar month):
    - Licensed Vocational Nursing (NUL)
    - Registered Nursing (NUR)
    - Specialized Licensed Vocational Nursing (NULS)
    - Specialized Registered Nursing (NURS)
- Supported Home Living-Transportation (TR) (HCS only)
- Community Support-Transportation (TR) (TxHmL only)
- Supported Employment (SE)
- Employment Assistance (EA)

2.61. Which services require an EVV Attendant ID to be used?

CFC PAS/HAB requires the EVV Attendant ID of the service provider that delivered the service and appears on the EVV visit.

2.62. Where is the Staff ID or EVV Attendant ID entered on the billing claim?

You must enter the Staff ID or EVV Attendant ID in the LICN field to identify the service provider that delivered the service.

2.63. Where do I find the unit rate for claim submission?

The unit rate of services can be found on the TMHP LTCOP. The 3608 and 8582 IPC Forms have an "IPC Services/Cost" tab that shows the unit rate of each service. The unit rate of the service is prepopulated on the form based on the individual's LON. This unit rate may be used for claims entry.

Refer to the *3608 HCS Individual Plan of Care Item-by-Item Guide* or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for details on the "IPC Services/Cost" tab and unit rate fields.

2.64. Are we required to manually enter all pay rates, including those for Host Home services?

When submitting individual claims, you must enter the number of units and the unit rate for each service delivered, including Host Home services. Unit rates for HCS and TxHmL services are not prepopulated in TexMedConnect, but this function could be considered in future enhancements.

The payment of HCS and TxHmL claims is based on the LON. TMHP's Claims Management System uses the correct unit rate based on the LON to process the claims.

2.65. What do I do if I am submitting a billing claim for a service that does not require a Staff ID or EVV Attendant ID?

There are two scenarios in which a service does not require a Staff ID or EVV Attendant ID:

1. The service does not require an LICN. You may leave the LICN field blank.
2. The service requires an LICN, but does not require a Staff ID or EVV Attendant ID. You may leave positions 5-20 blank on the LICN field. However, positions 1-4 (claim sequence number) are required and must still be entered.

Refer to the HHSC LTC Bill Code Crosswalk for guidance on when the LICN field must be used and which parts of the LICN field are required.

2.66. Can you explain Apply Co-pay, Apply Applied Income, and Apply Neither?

Both Apply Co-pay and Apply Applied Income are individual responsibilities. Applied Income is required for institutional services such as NF, ICF, and Hospice daily care, whereas co-pays are required on select services including assisted living. Not all services require Apply Applied Income or Apply Co-pay, and both are not required for HCS and TxHmL claims. You will use Apply Neither on the group template.

2.67. How do we apply different dates to a group template? Can we see what information is in a batch set of claims? Can you tell us how this works with a group of claims?

Only one group template can be used for one service date at a time. You can define the start and end date (both should be the same date), the number of units, and the unit rate for all the claims in the group template.

You can select all the individuals that you want to bill for on a certain date by selecting the individual templates under the "Select All" column. Be sure not to check "Select All." Submit and repeat this step for the other individuals with different dates.

To save the claims in a batch from the group template, you first need to make sure that the individual template has the "Save to Batch" radio button selected. When you submit the claims from the group template, these claims will then go to the Pending Batch section. From there you will select "Pending Batch" under the claims section on the Navigation Panel, select the appropriate NPI or API from the NPI/API drop-down box and the appropriate provider number from the Provider Number drop-down box, and click the "Continue" button. After that, select "Submit Batch."

2.68. For the staff ID, do we need to enter the professional's staff ID for each claim or is there a screen like the one in the CARE system called "Provider ID" where the ID was stored for each professional service?

You must enter the staff ID in the LICN field for each claim that requires a staff ID. You may create a group template and save the staff ID in the template to avoid reentry. If the staff ID changes, you must update it manually. Refer to the Long-Term Care Bill Code Crosswalks page, located on the HHSC website, to identify services that require a staff ID.

2.69. What do we do regarding bids or packets? If there is an amount on the plan and we submit the claim, will it be reimbursed?

Form 4116 is no longer required for submission to HHSC. Form 4116 for MHM, PMHM, AA, and DE/DEV services is entered into the LTCOP as part of the IPC. Providers will then bill their claims directly in TexMedConnect based upon the IPC and service authorization found on the MESAV screen, located on TexMedConnect. Program requirements regarding bids and packets are separate from claims submission. Refer to program billing requirements regarding documentation requirements.

2.70. When looking at the CARE Report Crosswalk, I do not see any HCS weekly reports related to billing. I am specifically looking for how the information from the HC2015, HC2017, and GC2040 Reports will be available. What is the process like for these reports?

You can use the R&S Report for reconciling the GC2040 Report. The file will not be in the same format as the HC2015 and HC2017 Reports.

2.71. What are the steps to gather cumulative cost report information like we have previously done on the C73 screen in the CARE system?

Refer to the Provider and LIDDA CARE Screen Crosswalk, located on the HHSC website, to see where in the TMHP systems information can be found. Most of the information will be found on TexMedConnect under CSI.

2.72. The R&S EDI extract does not have LON for both HCS and ICF that is critical for billing and cost report information. Will it have the same data as the GC2040 Report?

The R&S Report doesn't report LON, but does report dates of claims, claims paid, and units billed. You can use MESAV to review authorization dates, LON date ranges, and units used. You can also set up a MESAV group template to help automate data entry. This can take up to 24 hours to generate.

2.73. Will we bill individually by employee, or can we total all the employee hours for each calendar date to bill as one entry?

Claims may be rolled up by accumulation of services for nursing services and/or transportation services using the approved Dummy IDs. You may also bill individually depending on your specific needs. Refer to program billing requirements to determine if accumulation is allowed.

2.74. Can services be uploaded from my software into a batch and then submitted to TMHP?

Yes, you can submit batch claims. Refer to the *837P Long Term Care Companion Guide* and the *TMHP EDI Connectivity Guide* for information on submitting batch claims.

You may also refer to the *TexMedConnect for LTC User Guide* to learn more about submitting batch claims using TexMedConnect.

2.75. Will the start time need to be added for staff ID-required services?

No, a start time of the service event is not required. However, the sequence number is required for all services that require a staff ID. Refer to the HHSC LTC Bill Code Crosswalk for guidance on when the LICN field must be used and which parts of the LICN field are required.

2.76. Can claims for multiple NPIs be submitted under the same 837P?

Yes, you can submit multiple NPIs on an 837P batch file.

2.77. Where can I find detailed information about rates for HCS and TxHmL claims?

Refer to the Rate Tables located on the Provider Finance Department page of the HHSC website. Payment rates are listed on each of the program pages, along with other helpful tools like reporting information and training content.

You can also find rates on a client's IPC Form using the LTCOP.

2.78. How do I create a group template in MESAV?

Refer to the "MESAV" section of the *TexMedConnect for LTC User Guide* for detailed steps on creating a group template, or you can view the three-part MESAV video series on the TMHP YouTube Channel under the HCS and TxHmL playlist.

2.79. What is the difference between a draft, individual template, group template, and batch?

A draft can occur when trying to submit a single claim, but the user is unable to finalize claim submission. The user can save the data already entered as a draft until claim submission can be completed. Once the draft has been finalized and submitted, the record is deleted.

An individual template can be used when a single client is going to receive ongoing treatment and the treatment is billed on a periodic basis. Once created, an individual template can be reused.

A group template is similar to an individual template, but allows users to add multiple clients and can be used to submit recurring claims for the group of clients. Group templates are grouped by provider number. If a user is authorized to submit claims for multiple vendor/contract numbers, the user cannot use the same group template for multiple provider numbers.

A batch submission is a grouping of individual claims manually entered and saved to a batch. Each individual claim is entered up to the "Other Insurance/Finish" tab, then the user can choose to submit the claim or save it to the batch.

Once the user enters and saves all the claims they want to include in the batch, the batch can be submitted and processed. Future claims for clients included in the batch would have to be re-entered and submitted.

Refer to the *TexMedConnect for LTC User Guide* for more information. You can also view the three-part MESAV video series on the TMHP YouTube Channel under the HCS and TxHmL playlist.

2.80. Where would we enter the provider ID when submitting claims?

The provider ID is the vendor/provider number selected from the drop-down field on the initial claims entry page. Refer to the *TexMedConnect for LTC User Guide* for more information.

2.81. Do we need a claims screen for both CARE and TMHP?

The CARE system and TexMedConnect are two different systems.

2.82. If we bill for 250 consumers, what is the best way to bill?

For this example, you would use the claims group template. The group template allows users to add multiple clients and submit recurring claims for the group of clients.

2.83. What does the service code mean?

The service code is a grouping of services (billing codes, HCPCS, and modifiers). When claims are submitted, the billing codes, HCPCS, and modifiers for the services rendered must be specified. Data is then combined to the appropriate service code.

The system will then determine if the individual is authorized to receive the service specified and if funds are available for the claim to be reimbursed.

Refer to the Long-Term Care Bill Code Crosswalks page for more information on billing codes and HCPCS associated to a service code.

2.84. If a claim is not submitted successfully, will we be redirected to make corrections?

Yes. TexMedConnect will provide error messages letting you know what needs to be corrected for the claim to be submitted successfully.

2.85. Will we know if a submitted claim is approved immediately after submission by clicking the assigned confirmation number?

Yes. When you click the claim ICN, you will be directed to the CSI page and can view the claim status. Claims will be immediately moved to one of the following statuses: Approved, Denied, or Suspended.

2.86. Are we able to do span date billing?

The following services can complete span date billing:

- Day Habilitation
- Host Home/Companion Care
- Residential Support
- Supervised Living

When using span billing for these services, you should enter the first and last dates of service in the Service Dates Start and End fields in the Details tab.

2.87. How many spaces are required in positions 5-20 of the LICN field which includes a provider internal claim ID (positions 21-30)?

The number of spaces is dependent on the number of characters entered in positions 1-20. If values were not entered in the first 20 positions, then 20 spaces would be required.

If the first characters were specified, then the difference between 20 and the number of characters already specified would be the number of required spaces. For example, if a user entered 1130John,Smith (14 characters), then they would need to add six spaces and then add the provider internal claim ID.

2.88. What does it mean that the sequence number should be in military time? Are we entering the time of service, the time of billing, or is it just a unique four digits?

The value must be entered in military time, but it doesn't mean you have to specify the actual time the service was provided.

Services allowed multiple times on the same date of service will be considered a duplicate if the service date, procedure, and LICN values are the same. If the LICN values are different (e.g., 1000 and 2000), then services will be considered unique and the claim service will not be denied as a duplicate.

2.89. If support staff provides CFC and respite, can we submit one claim with multiple lines, or should we submit each one individually?

You can bill multiple claim services on separate detail lines of a single claim.

2.90. How can we access Explanation of Benefits (EOB) codes?

A Long-Term Care (LTC) Explanation of Benefits Table can be accessed on the TMHP website by clicking the "Reference Material" section on the Long-Term Care page.

2.91. When creating batches, should we save each batch under LON groups?

Batch claims can be submitted for different clients, claim types, LON, level of service, and so on.

2.92. If I don't have the unit rate, will the system add the dollar amount?

You must enter a unit rate on the "Details" tab for the claim to be successfully submitted. The rate will then be applied to the claim when it is processed, and if an incorrect rate was entered, the claim will be paid based on the HHSC assigned rates.

2.93. How long can templates be saved?

Once created, templates will remain available unless deleted by the user or if not used for 365 days. You can save up to 250 templates.

2.94. If we do not have a dental requisition fee code, do we use the same dental services code for all services submitted by the provider, or should we group all the services under one code?

Dental requisition fees for HCS and TxHmL are defined as service code 41E. Dental requisition fees are considered professional services, and services should be billed using the professional claim option. Refer to the Long-Term Care Bill Code Crosswalks page for associated billing codes, HCPCS, and modifier codes that need to be included in billing.

2.95. Are prior authorizations needed?

Prior authorizations are not required for HCS and TxHmL services. Approved IPC Forms serve as authorization to receive a defined number of approved services.

2.96. Are we required to run a MESAV every time before we enter a claim?

It is not required, but it is recommended as a best practice. We suggest running a MESAV before billing

since information on the MESAV may have updated.

2.97. Is the referral number automatically populated each time upon claim entry, or are we required to generate it by running a MESAV?

The referral number will prepopulate once you enter the Medicaid number on TexMedConnect during claim entry.

2.98. Do we need a copy of the MESAV?

No, PDF copies of MESAVs are current at the time of printing, but may not be accurate afterwards. We recommend electronically running MESAVs each time before billing for the most up-to-date information.

2.99. Will MESAV show if an individual has dental coverage?

The "Service Authorization" section in MESAV indicates the billable or allowable service for the individual and will show the service code and the service code description.

2.100. Under the "Levels" section on MESAV, will it show both LOC and LON as it does for the ICF program?

Under the "Levels" section on MESAV, you will see the appropriate levels based on the program the individual is associated with.

2.101. You mentioned that in step 2 of claims submission we could use the client ID in both boxes. Does that include the client ID and patient account number? Are they the same exact number if we do not have a patient account number?

The patient account number is used by the facility to identify the individual. If you do not have one, you can enter the individual's Medicaid number or SSN in the field.

2.102. What's the difference between LICN type 4 and the blanks on the Long-Term Care Bill Code Crosswalks?

On the Long-Term Care Bill Code Crosswalk, column E is for the LICN field. Numbers from 1 to 4 indicate that these services will need LICN information added to the claim, while services without a number in the LICN field do not need LICN information on the claim.

2.103. There are some codes on the Long-Term Care Bill Code Crosswalk without a CPT/HCPCS. Which one should be used?

On the "Claims Detail" tab, services that do not have both the HCPCS and CPT codes will use the bill code in the field that is for the procedure code (not the procedure qualifier).

2.104. Can you have professional and dental claims on the same batch?

Yes, professional and dental claims can be added to the same batch.

2.105. Can multiple services be billed on one claim, such as residential and periodic?

Yes, you can bill multiple services on one claim as each service will have its own service authorization as long as the claim type is the same. You cannot bill dental services and professional services on one claim.

2.106. Do I submit claims for HCS and TxHmL services at $1 per unit or at the rate given in dollars for the service type?

Claims regarding MHM, AA, taxes, fees, etc., will be authorized and billed with the units as dollars (1 unit = $1).

Other services, such as Supported Employment, will be billed in 15-minute units, meaning you cannot bill for less than 15 minutes or as a partial unit.

Some services, such as day habilitation, will be billed as one unit per day, with partial units possible (billed as .25, .50, or .75, depending on the number of hours performed).

You must enter a unit rate on the "Details" tab for the claim to be successfully submitted. The rate will then be applied to the claim when it is processed, and if an incorrect rate was entered, the claim will be paid based on the HHSC assigned rates.

The unit rate of services can be found on the "IPC Services/Cost" tab of the 3608 and 8582 IPC Forms. The unit rate of the service is prepopulated on the form based on the approved LON on the individual's current 8578 ID/RC Assessment.

For help on how to bill units versus dollar amount for different services, contact the Provider Finance department at rad-ltss@hhsc.state.tx.us or at 512-424-6637. You may also refer to the *HCS Rates* and the *TxHmL Rates*.

2.107. According to my billing personnel, a Host Home/Companion Care program provider needs to have an NPI number. We have never been required to do that for HCS. Is that template going to be revised?

If you are a non-medical provider, you can use an API that is based on your contract number in place of an NPI.

2.108. Do we have to submit a location in both the "Details" tab and in the "Claims" tab? What do we do if we perform the same service at multiple locations on the same day?

You must submit a location on both the "Claims" tab and the "Details" tab. The Details data is what TexMedConnect uses when processing the claim. You can use separate detail rows for each location if you perform the same service on the same day.

2.109. What is the difference between a Professional Dental Claim and a Non-Professional Dental Claim?

All dental claims are billed as the Dental claim type. There are no "Professional" or "Non-Professional" dental claims.

2.110. Where does the qualifier "AD" go on the Dental claim submission?

You do not need to enter the "AD" qualifier on dental claims. When you select "Dental" as the claim type,

the qualifier is inserted automatically.

2.111. Every September rates change, but the new rates aren't announced for a while. Are claims corrected retroactively?

If a claim has already been paid at the old rate, the system automatically adjusts the claim when the new rates are updated in the system. Claims that are submitted after the system has been updated are paid at the new rate.

2.112. Do we have to submit claims every day, since we can't submit claims for date ranges?

You don't have to submit a claim on the same day that you perform a service, and you can submit claims as often as you want. However, you must submit one date per claim line for services that don't allow span dates.

2.113. What happens if I put the wrong diagnosis code on a claim? For example, "mild" is entered instead of "moderate". Will the claim successfully process or be re-couped in the future for not matching?

TMHP requires a valid diagnosis code for the claim to process, but does not validate it other than to determine that it is a valid code. The diagnosis code is not checked against the code on the individual's 8578 ID/RC Assessment, for example. The diagnosis code entered on a claim does not effect the claims amount calculation, so there will not be any recoupment due to an incorrect code that is entered.

2.114. Dental is not listed by units, and dentists bill in dollar amounts. How are the units decided?

Dental continues to be entered in dollar amounts.

2.115. How will EVV work with the new Day Habilitation service for contractors and FMSAs?

There are not any changes to the way providers bill for a service that is provided by a contractor or sub-contractor or FMSAs paying employees for services delivered. The provider or FMSA paying will receive the service delivery logs and/or EVV records for in-home Individualized Skills and Socialization. The TMHP system will allow for the billing of those service events to occur. There is no difference in how in-home Day Habilitation is currently billed or any other service provider of professional therapies. In-home Individualized Skills and Socialization does not have to be provided by a licensed Individualized and Socialization provider.

2.116. Do we need to enter billing based on the IPC date? If the IPC starts on June 6, 2023, do we have to break up entry when billing?

You must first check the MESAV for the service authorization dates, compare that information with the levels, and then bill accordingly. If there is a split in the levels or authorization, then you must bill according to the split.

Section 3: Long-Term Care Online Portal (LTCOP)

3.1. What is the LTCOP?

LTCOP is an acronym for the Long-Term Care Online Portal. The LTCOP is a web-based, user-friendly system that houses many forms including HCS and TxHmL forms many providers are already familiar with and is managed by TMHP.

The portal can be used for the administration of LTC programs. For more information on what the LTCOP is used for, reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and the *Long-Term Care (LTC) User Guide for Online Portal Basics, General Information, and Program Resources*.

3.2. Do I need to have a TMHP NF/Waiver Program account if I am an HCS provider?

Yes, you need to select the **NF/Waiver Program** option when creating your TMHP user account so that you may submit, manage, and print forms from the LTCOP. For more information on TMHP account creation, refer to the Account Management web page on tmhp.com.

3.3. Are there webinars that review the assessments and forms we manage in the LTCOP?

Yes. The live webinars have ended, but recordings of the webinars are available on the 1915(c) Waiver Programs page of TMHP's LMS. Refer to the LTC Online Portal Training for HCS and TxHmL Waiver Programs Webinar and the LTC Online Portal Enhancements for HCS and TxHmL Providers and LIDDAs Webinars.

3.4. Is the LTCOP the same as the Intellectual and Developmental Disability (IDD) Operations Portal?

No, the LTCOP is not the same as the IDD Operations Portal. The LTCOP will allow providers to submit, manage, and print HCS and TxHmL forms.

3.5. Is the LTCOP user-friendly?

The LTCOP is a web-based, user-friendly system that houses HCS and TxHmL forms many providers are already familiar with. Additionally, training materials including Item-by-Item Guides and a Provider User Guide are available on the TMHP LMS.

3.6. Does the LTCOP provide information for the Cost Report, such as units provided?

Using either TexMedConnect MESAV or the EDI X12 EV transaction, providers are able to track the units used on the 3608/8582 IPC service authorization.

3.7. Is the TMHP account administrator the only one who can submit claims and forms? Should they create a separate TMHP user account to access these functions?

The administrator is the first individual who creates and activates a TMHP user account. Once the administrator links themselves to a contract number, they can create users and set permissions based on the user's responsibilities. The original administrator can also create users with administrative permissions for the same contract number.

3.8. Our account administrator set up all our TMHP accounts and assigned us as users. Do I need to request a PIN by mail to have access to the TMHP accounts?

No, you do not need to request a PIN. The account administrator is the one who requests a PIN to activate the TMHP account. Once the administrator has access, they set up any additional user accounts and grant permissions based on the user's responsibilities.

3.9. When we try to create our TMHP account, we get the following message: "The reCAPTCHA field is required." We can't see a "reCAPTCHA" field. How do we fix this?

TMHP strongly recommends creating your accounts using Microsoft Edge®. This ensures that the "reCAPTCHA" field is accessible.

3.10. How do we add the option to view the HCS and TxHmL forms on our TMHP administrator account?

Refer to the Account Management web page on tmhp.com for information on TMHP account management.

3.11. As an account administrator, which form permission boxes do I need to check when creating TMHP NF/Waiver users so that they can access HCS and TxHmL forms?

Permissions are based on the services your organization is contracted to provide and the related tasks the user is responsible for. For more information on permissions, refer to the Account Management web page on tmhp.com.

3.12. After assessments and forms have been completed on the LTCOP, are we be able to print hard copies?

Yes, all forms that are available for submission through the LTCOP can be printed, including those migrated from the CARE system.

3.13. How long does it take to correct a form entered in error?

Users can access the LTCOP at any time, and once a form is corrected, the workflow is processed. You will know a form has been corrected if it is in status ***Processed/Complete***.

To correct a form entered in error, you can use the "Correct This Form" button to update data on a form, or you can use the "Inactivate" button to void the form, and then submit a new one.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

3.14. If the MI check fails, are we to assume there was an issue with the migration of CARE data to the LTCOP?

The MI check is part of the regular process of a form being submitted. This is to ensure an individual's Medicaid data is active when a form is being processed and most likely will not indicate an error in the initial migration of data from the CARE system.

MI checks, on forms submitted through the LTCOP, are verified through HHSC's Service Authorization System (SAS) system, not the CARE system.

3.15. Are Local Intellectual and Developmental Disability Authorities (LIDDAs) notified by the LTCOP when a 3616 Request for Termination of Waiver Program Services Form has been entered?

When a 3616 Request for Termination of Waiver Program Services Form is submitted by the provider, the form will move to status ***Pending LA Review***. The LIDDA can use the Form Status Inquiry (FSI) function to search for forms in status ***Pending LA Review***.

3.16. Are program provider required to follow and monitor each entry in the History trail until completion?

While it is not required to follow the History trail of each form as it passes through the workflow, it is considered a best practice and will enable you to stay aware of any changes in the form's status that may require submitter intervention.

3.17. What should I do if I don't see the 8578 ID/RC Assessment as a Type of Form option on my LTCOP account?

Refer to the Account Management web page on tmhp.com for information on TMHP account management.

3.18. Will information that is entered into an 8578 ID/RC Assessment and 3608 or 8582 IPC Form, using the LTCOP, auto populate when the IPC Revision or Renewal is completed for each one?

An IPC Revision is prepopulated from the previous 3608 or 8582 IPC Form from which the IPC Revision is generated. Use the FSI function on the LTCOP to locate an existing 3608 or 8582 IPC Form.

When submitting an individual's Renewal IPC, the "Use as Template" button can be used to pull form data from the original IPC to a new one. If you choose to use a template, keep in mind that old rates might populate onto the new IPC. Therefore, it's important you verify that the data populated on the new IPC is accurate before submitting it. If you see that only the rates have changed, you can use the "Use as Template" button, but you must remove and reselect the services for the new rates to populate before submitting the IPC.

If you notice information such as the address, location code, or residential type has changed since the original IPC was submitted, and the information no longer applies to the current IPC year, you'll need to enter a new IPC from the Submit Form page. Do not use the "Use as Template" button. Also, keep in mind that the "Use as Template" button won't work for Revision IPCs.

3.19. Do I use the LTCOP to renew or change a client's level and service authorization records?

Yes, you must use the LTCOP to renew or change a client's level and service authorization records.

3.20. Are all Individual Movement (IMT) Forms entered and managed on the LTCOP for HCS clients?

Yes, all IMT Forms must be entered and managed in the LTCOP for both HCS and TxHmL.

IMT Forms are used to document an individual's suspension, change in county, change in address, change of LIDDA, or change of Service Coordinator (SC). Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and the *Individual Movement Form Item-by-Item Guide* for more information.

3.21. If an assessment or form is denied or if additional information is needed, will I be notified through email or do I have to look in the LTCOP?

To locate an assessment or form that is denied or needs your attention, use the FSI function on the LTCOP to search by form status (e.g., ***Denied*** or ***Remanded***). You can also search by the form's assigned Document Locater Number (DLN).

Forms that have been submitted through the LTCOP can be tracked by the assigned DLN, and may also be searched by form type or by individual. Forms may also appear in the "Current Activity" section of your LTCOP account. This ensures you are always able to check the status of forms and be aware if any updates or changes need to be made to aid in processing and submission.

3.22. Will the LTCOP generate reports that will let us know which 8578 ID/RC Assessments are close to expiring?

LIDDAs and providers can use the Dashboard in the LTCOP to determine which 8578 ID/RC Assessments and IPC Forms are expiring within 60 days.

3.23. Is there training on how to create a LIDDA profile in the LTCOP with the correct permissions?

Refer to the Account Management web page on tmhp.com for information on creating TMHP accounts and managing user permissions.

3.24. As a Financial Management Services Agency (FMSA), is the LTCOP the best place to get a copy of a client's 8578 ID/RC Assessment and IPC Form?

Yes, you can locate these forms by using the FSI function of the LTCOP.

3.25. We've created our TMHP user account. Can we use the same username to access the LTCOP?

If you have already established your TMHP user account login information, you can use the same username on the LTCOP. For more information on TMHP account management, refer to the Account Management web page on tmhp.com.

3.26. Does the LTCOP generate a letter for each 3608 or 8582 IPC Renewal, or are they only generated if a change was made by HHSC during the approval process?

For 3608 or 8582 IPC Forms, letters are generated whenever HHSC-LTC modifies the services requested on the IPC Form during the approval process. For example, a letter is generated when certain services requested within the IPC Form are denied or reduced by HHSC-LTC during their approval process. If all the services are approved, a letter is not generated.

3.27. Are we able to see IPC costs when entering 3608 or 8582 IPC Revisions into the LTCOP, or does the LTCOP only display over-cost warnings?

IPC costs for current 3608 or 8582 IPC Revisions are displayed on the form.

3.28. When submitting an 8578 ID/RC Purpose Code (PC) 3 Continued Stay Assessment in the LTCOP, do I enter the LIDDA's vendor number or the program provider's vendor number?

LIDDAs use their vendor number when entering 8578 ID/RC PC 3 Continued Stay Assessments for TxHmL and HCS consumers self-directing their services. Program providers enter their program vendor number when entering 8578 ID/RC PC 3 Continued Stay Assessments for all other HCS consumers.

3.29. Are there step-by-step instructions on how to enter assessments and forms on the LTCOP?

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for step-by-step instructions on how to enter each assessment and form.

3.30. Do you have to enter something in the "Text to be added to form history" field on the LTCOP's Status Change Confirmation page?

No, you are not required to enter information in this field as part of the submission process, but we do recommend entering anything needed for future reference for your agency or HHSC.

3.31. The LTCOP is showing ICF options. Will this be updated or changed in any way?

Existing LTCOP functions for ICF continue to be available.

3.32. On our LTCOP account, we only see Forms 3074 and 3071, but we don't see the 8578 ID/RC Assessment or IPC Form. Is there something that we are missing?

This could be a result of not having both the LTC (billing) and NF/Waiver (forms) options added during your TMHP user account setup. Both of these options are required if you intend to submit claims and forms.

If you do have these options added to your TMHP user account, you may not have the correct permissions assigned. You may need to contact your account administrator for help determining if you have the correct permissions assigned. For more information on TMHP account management, refer to the Account Management web page on tmhp.com.

3.33. Do program providers need to add an individual's information to the LTCOP?

An individual's information can be auto populated on forms. When submitting a form through the Submit Form page on the LTCOP, make sure that you enter the individual's Medicaid ID or name and date of birth (DOB) before you click the **Enter Form** button. The system will retrieve the individual's information and prepopulate it on the form you are entering.
Note: If data does not prepopulate, you must enter information manually on the form.

3.34. Are we able to see a screen like the CARE system's C64 and C65 for a complete list of 8578 ID/RC Assessments and IPC Forms that are about to expire or have expired?

The Dashboard function, available to users with the assigned permissions, have "Past Due" and "Due" tiles that display the count of 8578 ID/RC Assessments and IPC Forms that have expired or are about to expire. Users can click those counts to view the latest information for individuals who fall into those categories.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the Dashboard function.

3.35. Can we check the C72 screen on the LTCOP?

C72 information can be viewed on the LTCOP using the Dashboard or Individual Search functions. Under the Dashboard function, users can select the **CARE ID** hyperlink under the "Individuals by Program" tile and view the individual's information under the "Estimated Annual Cost" section.

Users can also select the **Individual Search** option under the "Search" drop-down menu located on the blue navigational bar. After search criteria has been entered and the results list appears, click the **CARE ID** hyperlink from the Individual List page and view the individual's information under the "Estimated Annual Cost" section.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the Dashboard and Individual Search functions.

3.36. Is there a person we can speak to for help with entering forms on the LTCOP?

HCS and TxHmL program providers who need assistance with form submittal can call the TMHP LTC Help Desk at 800-626-4117 (select option 1, then option 1). Users can also reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* or Item-by-Item guides located on the TMHP LMS.

3.37. I have two contract numbers: one for HCS and one for TxHmL, but the My Worklist tab only displays the HCS contract number. How can I add the TxHmL contract number?

You can link your TxHmL provider number to the same TMHP user account. For more information on administering provider identifiers, refer to the Account Management web page on tmhp.com.

3.38. What capabilities are there for forms to be connected and completed using an electronic system that transfers over from that system so that program providers can enter forms in one place?

The LTCOP will communicate with other related systems belonging to HHSC and TMHP to validate data and process forms. Once forms are submitted on the LTCOP, they will be saved with a DLN that program providers and LIDDAs will use to search for forms, monitor form statuses, and view a step-by step history of a form's workflow.

3.39. Who has access to the Dashboard and Worklist options?

Every HCS and TxHmL program provider and LIDDA is able to view the Dashboard and Worklist functions. Contact your TMHP account administrator to have the necessary permissions added to your TMHP user account.

For more information on TMHP account management, refer to the Account Management web page on tmhp.com.

3.40. Will we need to use the LTCOP and CARE system to pull different reports for 8578 ID/RC Assessments and IPC Forms?

CARE reports and data are available in a few locations. Reference the Provider and LIDDA CARE Report Crosswalk and the Provider and LIDDA CARE Screen Crosswalk posted on HHSC website for details.

3.41. Can forms saved as drafts be located using the FSI function?

Only forms that have been successfully submitted to the LTCOP and assigned a DLN can be searched using the FSI function. Forms saved as drafts are available under "Drafts" in the Worklist drop-down menu on the blue navigational toolbar.

3.42. Can program providers see the LIDDA History trail for consumers and vice versa?

Program providers can see their clients' forms, including information added by LIDDA in the History trail. The same is true for LIDDAs as long as clients are currently with the program provider and the LIDDA.

3.43. Where can I find training on how to use the LTCOP?

Training can be found on TMHP's LMS including the *Long-Term Care (LTC) User Guide for Online Portal Basics, General Information, and Program Resources*, LTC Online Portal Basics eLearning, and *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*. You can also view short training videos on the TMHP YouTube Channel under the HCS and TxHmL playlist.

3.44. How do I access the blue navigational bar on my LTCOP account?

After logging into your LTCOP account, the blue navigational bar will display at top of the screen. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the blue navigational bar.

3.45. Are LIDDA vendor numbers prepopulated? If not, how do we obtain this information as a program provider?

Yes, LIDDA information is prepopulated when program providers submit forms on the LTCOP.

3.46. Do we add location codes, submit suspensions, etc., using the LTCOP, or do we still complete those tasks in the CARE system?

All of these functions are completed in the LTCOP. Reference question 6.2 for a list of functions remaining in CARE.

3.47. Do we need to input all current clients into the LTCOP?

No, the LTCOP is not a client database. Only form information is stored on the LTCOP. When a submitter enters a CARE ID or Medicaid number on a form, client data is retrieved from other HHSC systems and populated on the form.

3.48. Does the LTCOP allow us to download a client roster into Microsoft® Excel®?

Yes, you are able to export a client roster through the LTCOP Dashboard.

3.49. Where can I access the Individual Search function on the LTCOP?

You can access Individual Search by clicking the Search drop-down located on the blue navigational bar.

3.50. How long will deceased individuals appear in an Individual Search results list?

As of now, there is not a time limit for how long deceased individuals will show in the Dashboard. Individuals who are terminated for a different reason will show up as terminated until they are again pre-enrolled into HCS or TxHmL. If enrolled in other programs other than HCS or TxHmL, they will show as terminated in the Dashboard since the Dashboard is specific to HCS and TxHmL programs.

3.51. How can I see the actively enrolled individuals for HCS on the LTCOP?

You can view the information two ways:

- On the Dashboard, click **Enrolled** or the blue section on the graph on the Individual by Status tile.
- Select **Individual Search** under the Search drop-down, enter an individual's information, select **Enrolled** from the Status drop-down field, and then click **Search**.

3.52. Are there certain types of TMHP user accounts that won't have access to the Dashboard?

TMHP administrator accounts are not able to access the Dashboard function. If you are using an administrator account, you will need to use a general user account with the right permissions to access the Dashboard. You must use an NF/Waiver user account, not an LTC user account, to access the Dashboard. For more information on user accounts and managing user permissions, refer to the Account Management web page on tmhp.com.

3.53. Where can I find step-by-step instructions for assigning SCs?

LIDDAs who submit forms can use the HCS or TxHmL Pre-enrollment Form, 8578 ID/RC PC 2 Assessment, 3608 or 8582 Enrollment IPC, and IMT—Service Coordinator Update to assign SCs to individuals. Reference the *Long-Term Care (LTC) Online Portal User Guides for Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs* for instructions on entering and submitting these forms.

Section 4: Assessments and Forms

4.1. Is the suspension option only available to LIDDAs on the "Purpose" drop-down field for the IMT Form?

The "Purpose" drop-down field is visible to users with access to the IMT Form on the LTCOP.

LIDDAs only submit IMT—Suspension Forms for individuals who only have CDS services. Otherwise, the IMT—Suspension Form is submitted by program providers.

4.2. What are the reasons I would submit a 3616 Request for Termination of Waiver Program Services Form and IMT—Suspension Form?

Termination reasons are listed on the "Termination Reason" drop-down field on the LTCOP, while suspension reasons are listed on the "Suspension Reason" drop-down field on the LTCOP. The 3616 Request for Termination of Waiver Program Services Form is used for reasons such as death, and the IMT—Suspension Form is used for reasons such as hospitalization.

Reference the *3616 Request for Termination of Services Form Item-by-Item Guide* and the *Individual Movement Form Item-by-Item Guide* for complete lists of termination and suspension reasons.

4.3. Will the following forms be completed by the LIDDA unless otherwise stated: 3608 or 8582 IPC, 3615 Request to Continue Suspension of Services, and the 3616 Request for Termination of Waiver Program Services?

3608 and 8582 IPC Enrollment Forms are entered by LIDDAs, 3608 and 8582 IPC Renewal and Revision Forms are entered by program providers, and 3608 and 8582 Transfer Forms are entered by LIDDAs.

3615 Request to Continue Suspension of Services Forms are entered by LIDDAs.

3616 Request for Termination of Waiver Program Services Forms are entered by LIDDAs only for individuals who self-direct all services. Otherwise, the form is submitted by program providers for HCS and TxHmL. When the LIDDA submits the termination request, the program provider is notified in the LTCOP to review and acknowledge the form. Likewise, if the program provider submits the termination request, the LIDDA must review and acknowledge the form before it is submitted to HHSC-LTC. If the individual does not have a program provider and only has an FMSA, the form skips the review process and moves directly to the Authorization Process for HHSC-LTC staff to review the form.

4.4. Is the Pre-enrollment Form replacing the L01 screen in the CARE system?

The HCS or TxHmL Pre-enrollment Form is replacing the CARE L01 and CARE L03 screens in the CARE system.

4.5. Do LIDDAs still have six days to review 8578 ID/RC Assessments?

Yes, this time frame is not changing.

4.6. What is required in the justification packet for an LON increase?

LON justification packets will have the same expectation as outlined on the Level of Need (LON) Resources page.

4.7. If an individual's Inventory for Client and Agency Planning (ICAP) Assessment score does not match the LON and the program provider is not seeking LON increase, where do you document this when submitting the 8578 ID/RC Assessment?

Reference the *8578 Intellectual Disability/Related Condition Assessment Item-by-Item Guide* for information related to form fields.

Policy has not changed related to the data required on the 8578 ID/RC Assessment.

4.8. Do I need to submit a paper hard copy of the IPC Form to the LIDDA when there is a pending IPC Form for approval?

You will not be required to submit the 3608 IPC Form through the LTCOP unless requested.

4.9. Has the renewal process changed? It seems like there are more steps in the LTCOP.

Data entry for a renewal is comparable in the LTCOP, but instead of multiple screens, information is entered on different tabs.

4.10. Do we print, ask the LIDDA and Legally Authorized Representative (LAR) to sign the form, and then add it to the LTCOP, or do we need signatures in the LTCOP?

Forms are electronically submitted in the LTCOP. Hard copies that need to be printed and signed are available from the HHSC website.

4.11. Where do HCS providers enter or modify locations?

HCS providers open, update, and close locations using the Provider Location Update (PLU) Form.

4.12. Can I increase an individual's LON on the TxHmL 8578 ID/RC Assessment?

Per the Texas Administrative Code (TAC), LON in TxHmL can be changed at any time.

4.13. Do providers submit 8578 ID/RC Assessments for clients using the CDS option?

8578 ID/RC Assessments are only entered by LIDDAs if an individual is receiving all CDS services. Additionally, 8578 ID/RC PC 2 Assessments are only entered by LIDDAs for enrollment.

4.14. Do we need to monitor submitted 8578 ID/RC Assessments until they are approved?

We encourage you to monitor the assessment workflow to determine if additional information is needed for approval of the 8578 ID/RC Assessment.

4.15. Is the LIDDA required to enter the reason for disagreement on a form during the LIDDA review process?

Yes, the LIDDA is required to enter a reason if they disagree with a request.

4.16. Do we physically sign the 8578 ID/RC Assessment?

Policy related to signature requirements have not changed.

4.17. Which department approves the 8578 ID/RC Assessment?

Program Eligibility and Support (PES) authorizes LOC and Enrollment LON (PC 2); UR authorizes LON requests made at renewal (PC 3) and mid-cycle (PC 4).

All authorizations of the 8578 ID/RC Assessments are done on the LTCOP.

4.18. For transfers involving two LIDDAs, is the receiving LIDDA required to be involved in the HCS transfer meeting? How much time is the receiving LIDDA given to submit the IPC Transfer?

The receiving LIDDA is not involved in the transfer meeting. For more information, see the Transfers and Local Intellectual and Developmental Disability Authority (LIDDA) Reassignments section of the HCS Handbook.

4.19. Is the IMT—Suspension Form replacing the C18 screen when clients go to a hospital or another facility?

Yes, you use the IMT Form to enter a suspension instead of the C18 screen in the CARE system.

4.20. Are 8578 ID/RC PC E Assessments required?

Yes, the 8578 ID/RC PC E Assessment is used to remove a billing hold for an 8578 ID/RC Assessment entered more than 180 days past the expiration of the previous assessment. 8578 ID/RC PC E Assessments only need to be entered if you are requesting a billing hold be removed.

4.21. Currently LIDDAs submit most forms for TxHmL. Will this change?

No, responsible parties for data entry remain the same.

4.22. Do we fax the 8578 ID/RC Assessments and IPC Forms to the person doing data entry?

Data entry is still the responsibility of the program provider.

4.23. Are non-waiver 8578 ID/RC Assessments handled by TMHP?

No, CFC-Non-waiver 8578 ID/RC Assessments remain in the CARE system with the K screens.

4.24. For the 3608 IPC Form, do we have the SC and individual or guardian sign before submitting the form?

Policies related to hard copies, signatures, document transmission, and documentation retention have not changed.

4.25. For the 8578 ID/RC PC 3 Assessment, does information auto populate from the CARE system's C23 screen?

Reference the *8578 Intellectual Disability/Related Condition Assessment Item-by-Item Guide* for information on which fields are prepopulated.

4.26. Should we submit IPC Forms 30 days before the expiration date?

The LTCOP supports IPC submissions before the expiration date.

4.27. When do we start the renewal process for the 8578 ID/RC Assessment and the IPC Form?

Both 8578 ID/RC Assessments and 3608 or 8582 IPCs are valid for one year. We recommend you submit the renewal before the current 8578 ID/RC Assessment or 3608 or 8582 IPC Form expires.

You can submit a renewal 60 calendar days before the current form's expiration date through the LTCOP.

4.28. Do LIDDAs still enter 8578 ID/RC PC 2 No Current Assessments for enrollment? Do program providers enter 8578 ID/RC PC 3 Continued Stay Assessments and 8578 ID/RC PC 4 Change Level of Need on Existing Assessments?

LIDDAs enter all 8578 ID/RC PC 2 No Current Assessments for enrollment.

LIDDAs submit 8578 ID/RC PC 3 Continued Stay Assessments for TxHmL and for all HCS consumers who are self-directing their services, while program providers enter 8578 ID/RC PC 3 Assessments for all other HCS consumers.

LIDDAs and HCS program providers can submit 8578 ID/RC PC 4 Change Level of Need on Existing Assessments. LIDDAs also submit 8578 ID/RC PC 4 Assessments for consumers self-directing all services.

4.29. What should we do if we need to complete a transfer on an annual IPC but also need to update the current IPC before the new annual or transfer effective date?

If the current IPC has an effective date prior to the upcoming annual (renewal) or transfer effective date, submit a correction form of the current IPC Form first. After the correction process is completed, the new transfer will be based on the corrected service data.

4.30. Are there forms located on the LTCOP for CFC?

The 8578 ID/RC Assessment and 3608 or 8582 IPC Form should be used for CFC services. The 8578-CFC Form is not currently available on the LTCOP.

4.31. What is the Transfer process when transferring to a new LIDDA?

The current LIDDA will submit the IMT—LA Reassignment Form to inform the new LIDDA when an individual moves to their contract area, and the newly assigned LIDDA must acknowledge the form. Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* or the *Individual Movement Form Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type.

4.32. Does the ID/RC Check run automatically on a daily basis?

Yes, the ID/RC Check runs automatically on the 3608 or 8582 IPC Enrollment Form until a matching, authorized 8578 ID/RC PC 2 No Current Assessment is found. The 8578 ID/RC PC 2 No Current Assessment must be approved by HHSC-LTC prior to matching with the 3608 or 8582 IPC Enrollment Form.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

4.33. If the LIDDA does not take action on an 8578 ID/RC PC 3 Continued Stay Assessment within the allowed six-calendar day review period, do we have to resubmit the assessment?

After six-calendar days with no LIDDA review, the 8578 ID/RC PC 3 Continued Stay Assessment will move to the HHSC-LTC review queue.

4.34. In the event the 8578 ID/RC PC 3 Continued Stay Assessment is entered after it has expired, is it automatically backdated, or will the begin and end dates change?

The LTCOP will automatically prepopulate the 8578 ID/RC PC 3 Continued Stay Assessment begin date to be the previous level expiration date plus one day.

4.35. LON increases sometimes require us to change the effective date, but TMHP's LTCOP will prepopulate the 8578 ID/RC PC 4 Change Level of Need on Existing Assessment effective date. How can we change this?

You will need to contact HHSC-LTC for assistance with cases where the date needs to be changed on the 8578 ID/RC PC 4 Change Level of Need on Existing Assessment.

4.36. If we need to delete a 3608 IPC Renewal due to an error that must be corrected, do we call Provider Claims Services (PCS) as we normally do for the ICF program?

The same rule applies to HCS and TxHmL programs for deletion or invalidation of an IPC that has been processed.

4.37. Is the initial suspension entered by the program provider?

The IMT—Suspension Form is submitted by program providers for both HCS and TxHmL, unless all services are CDS, in which case the form is submitted by the LIDDA.

4.38. Will program providers access the IMT—LA Reassignment Form workflow, or do we need to follow up with LIDDAs?

Program providers can access forms of individuals who are currently assigned to them. If the IMT—LA Reassignment Form is not associated with a provider transfer, the program provider can view the form.

If a provider transfer is part of the process, since the IMT—LA Reassignment Form happens prior to the provider transfer, the receiving program provider will not be able to view the IMT—LA Reassignment Form, but the transferring program provider can view the IMT—LA Reassignment Form. The receiving program provider should follow up with the LIDDA on the status of an IMT—LA Reassignment Form

and provider transfer.

4.39. When a 3615 Request to Continue Suspension of Services Form is set to status *Provider Action Required*, will an explanation be included of what action is needed?

As best practice, the HHSC reviewer will provide the details of information required in the notes section of the respective form whenever forms are moved to status ***Provider Action Required***. Reference "Appendix B: Assessment and Form Statuses" of the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for a list of statuses and associated provider and LIDDA actions.

4.40. After 270 days, is it the responsibility of the LIDDA to enter continuation of services or termination of services?

During the final review, 270 days after the original suspension request expires, the LIDDA is required to document the final review and either return the individual to services, terminate the individual, or request a continuation of suspension.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the IMT—Suspension process.

4.41. If an individual is on suspension, how do I proceed to a termination?

This will be handled systematically in the LTCOP. IMT—Suspension Forms will have form action buttons that include a button to terminate services. On click of the button, the user will be directed to enter the end date on the 3616 Request for Termination of Waiver Program Services Form.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

4.42. Does the 3616 Request for Termination of Waiver Program Services Form need to be uploaded to the HHS portal for terminations?

Yes, nothing is changing with regard to required documentation for terminations.

4.43. Are LIDDAs required to keep hard copies in each individual's local electronic health record when entering 8578 ID/RC Assessments and IPC Forms through the LTCOP?

Yes, LIDDAs are required to maintain an individual's records as described in their performance contract and the LIDDA Handbook. Policy related to hard copies, signatures, and record retention is not changing.

4.44. Are we still sending hard copies of 8578 ID/RC Assessments and IPC Forms to the Mental Health and Mental Retardation (MHMR) Department and submitting them to the LTCOP?

Policy is not changing regarding hard copy requirements.

4.45. Can an individual transfer to another provider or service delivery option on the effective date of their renewal?

On the LTCOP, you can submit an IPC Transfer at Renewal Form. You will select the **IPC Type as**

Transfer option, and check the **Transfer at Renewal** checkbox which will prepopulate the IPC begin date and end date. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information. You can also view the Entering a Transfer in the Correct Order video on the TMHP YouTube Channel under the HCS and TxHmL playlist.

4.46. What is the difference between the 3608 IPC Form and the 8582 IPC Form?

The 3608 IPC Form is used for the HCS Program, and the 8582 IPC Form is used for the TxHmL Program.

4.47. Is there a way to add a service that is not listed on the Transfer Worksheet?

Yes, LIDDAs can click the **Add Provider Totals Information** button to add a service on the Transfer Worksheet when completing the IPC Transfer Form.

4.48. Does the HCS program provider use the IMT to update an address for Host Home individuals, and does this effectively change the location that the individual is assigned to? For example, an individual receiving Host Home services is moving to another home in the same LIDDA catchment area and staying with the same HCS program provider (with the same vendor number).

If an individual receiving Host Home services is moving to another home, the HCS program provider will need to submit the IMT—Individual Update Form to update the individual's address and location code.

Since the LIDDA catchment area and the HCS program provider remain the same, an IMT—LA Reassignment Form or IPC Transfer Form is not required. In this case, submitting the IMT—Individual Update Form can effectively change the address and location of the individual.

Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* or the *Individual Movement Form Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type.

4.49. Do we need to submit an IMT—Form for every transfer we do as a LIDDA?

The appropriate IMT—Form is required if the individual has a location update or change in LIDDA (LA Reassignment) while a transfer is submitted. Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* or the *Individual Movement Form Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type.

4.50. On the IMT—Suspension Form, there are fields to enter the LIDDA's information and required data. Is there a list of provider numbers and other required information?

When entering an IMT—Suspension Form, a list of provider numbers associated to the account is available on the Submit Form page's "Vendor Number" drop-down field. Reference the *Individual Movement Form Item-by-Item Guide* for detailed information on required form fields.

4.51. For the IMT—Individual Update Form, what is the average amount of time required for the LTCOP to process an address update if there are no errors?

If there are no errors, an IMT—Individual Update Form can be processed within a few minutes after it is submitted on the LTCOP and will move to status ***Processed/Complete***.

4.52. Is the IMT Form only used by program providers for suspensions?

The IMT Form is used for four purposes:

- **Suspension**: submitted by program providers for HCS and TxHmL, unless all services are CDS in which case the form is submitted by LIDDAs
- **Individual Update**: submitted by only program providers
- **LA Reassignment**: submitted by only LIDDAs
- **Service Coordinator Update**: submitted by only LIDDAs

4.53. When an individual moves from the TxHmL Program to the HCS Program, we normally have to wait for the HCS IPC Form start date to submit the 3616 Request for Termination of Waiver Program Services Form. We then wait for the program provider to complete their screen in the CARE system, acknowledging that they are no longer going to be the individual's TxHmL program provider before the LIDDA can complete their CARE screen and continue with the enrollment process. Is the process the same or can we submit the 3616 Request for Termination of Waiver Program Services Form after the enrollment meeting is completed?

To move an individual from the TxHmL Program to the HCS Program, submit the 3616 Request for Termination of Services Form to end TxHmL services. Then, submit the following forms for HCS enrollment:

- Pre-enrollment Form
- 8578 ID/RC PC 2 No Current Assessment
- 3608 IPC Enrollment Form

4.54. Do we submit IPC Forms and revisions on the LTCOP that need to be approved by UR?

Yes, IPC Forms and revisions need to be submitted on the LTCOP and are reviewed by UR based on the data submitted.

4.55. If there is an error on an 8578 ID/RC Assessment or IPC Form that has already gone through the workflow, are we able to correct it, or do we have to "back out" an annual IPC Form to submit the revision to the previous IPC Form and then resubmit the annual IPC Form?

If there is an error on an 8578 ID/RC Assessment or IPC Form, you can click the **Correct this form** button, located on the Forms Actions bar, to correct the error.

If there is a need to revise a previous IPC Form after a subsequent annual IPC Form has been submitted, you need to inactivate the subsequent annual IPC Form and then submit the revision of the previous IPC Form. After the IPC Revision Form is in status ***Processed/Complete***, you need to submit the annual IPC

Renewal Form. HHSC-LTC recommends that LIDDAs and providers contact UR if needing to inactivate an IPC Renewal.

4.56. Is the SC agreement or disagreement considered "entering forms" on the LTCOP?

No, "entering forms" is usually referred to as completing a form during the form submission process. There is an "Enter Form" button on the Submit Form page of the LTCOP. 8578 ID/RC Assessments and IPC Forms submitted by program providers through the LTCOP will be moved to status ***Pending LA Review***. When viewing the form on the LTCOP, the LIDDA (SC) will see agreement and disagreement buttons located at the top of the form on the "Forms Actions" bar.

4.57. How are LIDDAs notified of pending forms that need to be reviewed?

Forms that require a LIDDA's review or acknowledgment will be moved into statuses ***Pending LA Review***, ***Pending New LA Review***, ***Suspension Review Due***, ***Suspension Review Overdue***, ***Suspension Continuation Review Due***, or ***Suspension Continuation Review Overdue***. The form status will depend on the form type and purpose code. LIDDAs can utilize the FSI function on the LTCOP to search for forms in these statuses.

4.58. When a LIDDA reassignment is submitted by the current LIDDA, does the new LIDDA receive an alert on the Alerts page?

Yes, the new LIDDA will receive an alert on the Alerts page letting them know an IMT—LA Reassignment Form has been submitted.

4.59. How do we submit address changes for individuals?

You will need to submit an IMT—Individual Update Form from the Submit Form page on the LTCOP. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and *Individual Movement Form Item-by-Item Guide* for more information.

4.60. Where do we create new location codes?

To create a new location code, HCS program providers can submit the PLU Form and select **Add Location** as the action type. The address of the new location should not be the same as any existing location codes of the program provider.

To assign an individual to the new location, ensure the PLU Form is in status ***Processed/Complete***. You will then need to submit an IMT—Individual Update Form. The new location code will be displayed on the IMT Form in the location code list of the "New Location Code" field.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Home & Community-based Services Provider Location Update Item-by-Item Guide*, and *Individual Movement Form Item-by-Item Guide* for more information.

4.61. Where do we close a location code?

It is important to ensure all individuals who are assigned to the location have been reassigned to other locations before closing a location code. IMT—Individual Update Forms may be submitted to change

the location code for the individuals if the individuals' residential type does not need to change. If the residential type needs to change, an IPC revision must be submitted for this change. After reassigning the individuals to new locations, HCS program providers can close the old location code by submitting the PLU Form and selecting "End Location" as the Action Type.

Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type.

4.62. Does a 3615 Request to Continue Suspension of Services Form have to be initiated to terminate an individual from the program before the 3616 Request for Termination of Waiver Program Services Form can be initiated?

A 3616 Request for Termination of Waiver Program Services Form can be initiated in three ways depending on the business scenario:

- If an individual has been on suspension between 265 and 270 days, there should be an IMT—Suspension Form pending for the 270-days suspension review. The LIDDA can initiate a 3616 Request for Termination of Waiver Program Services Form during the process of the 270-days suspension review.
- If an individual has a 3615 Request to Continue Suspension of Services Form in status ***Suspension Continuation Review Due*** or ***Suspension Continuation Review Overdue***, the LIDDA can initiate a termination during the process of the suspension continuation review.
- A 3616 Request for Termination of Waiver Program Services Form can be initiated directly from the Submit Form page on the LTCOP.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on how to submit the 3616 Request for Termination of Waiver Program Services Form.

4.63. I know that I need to open a new location and close the older location if a host home family moves from one home to another home. If they move back to their previous home, can I submit a PLU Form to reopen and use that location again?

If a service location is ended by the program provider, it cannot be reopened. The program provider must submit a PLU Form to add the ended location as a new location to reopen it.

4.64. Can program providers enter the Pre-enrollment Form?

Only LIDDAs can submit Pre-enrollment Forms.

4.65. Are 8578 ID/RC Assessment submission steps the same as ICF?

Yes, the submission steps are the same. However, the form fields are different. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and *8578 Intellectual Disability/Related Condition Assessment Item-by-Item Guide* for

more information on submission steps and form fields.

4.66. Can an 8578 ID/RC Assessment start date be changed in the event the IPC effective date is set past the 8578 ID/RC Assessment start date?

For enrollments, the start date of the 8578 ID/RC PC 2 No Current Assessment will prepopulate on the assessment automatically and cannot be changed by the submitter. If the date needs to be changed, contact HHSC.

For renewals, the start date of the 8578 ID/RC PC 3 Continued Stay Assessment will prepopulate based on the cycle of the previous year and cannot be changed if "Yes" is selected in Field **58a. Would you like to renew on the Individual's regular assessment cycle?**.

4.67. Do we still need to terminate an individual from the TxHmL Program before completing the Pre-enrollment Form for the HCS Program?

Yes, you must terminate an individual from the TxHmL Program before submitting the Pre-enrollment Form for the HCS Program.

4.68. Does the LIDDA or program provider enter the 8578 ID/RC PC E Gaps in Assessment?

8578 ID/RC PC E Gaps in Assessments are submitted by LIDDAs for all TxHmL individuals and HCS individuals using the CDS option. Program providers submit 8578 ID/RC PC E Gaps in Assessments for all HCS individuals not using the CDS option.

4.69. Should LIDDAs enter the 8578 ID/RC Assessment and receive approval before entering the Pre-Enrollment Form?

No, the LIDDA will enter the Pre-enrollment Form prior to submitting the 8578 ID/RC PC 2 No Current Assessment. The Pre-enrollment Form must be in the status ***Pre-enrolled*** before submitting the 8578 ID/RC PC 2 No Current Assessment.

4.70. Where can I find the Community Services Interest List (CSIL) Form number?

IDD Services has created Form 8591, Community Services Interest List (CSIL) Data Entry, to replace the CARE W21 Data Entry Form. IDD Services will notify LIDDAs through an email broadcast when the form is available on the HHSC website.

4.71. Why is the 8578 ID/RC Assessment now tied to the ME status for LON increase and continued stay?

The LON authorization or denial for an increase is not tied to ME. However, the LTCOP does a point-in-time check when processing forms.

4.72. As a program provider, do I still receive a paper format of the IPC Transfer Form to complete, or does only the LIDDA enter the transfer on the LTCOP and then send me an indicator to submit my reserved hours in the LTCOP?

There are no changes to the completion of the transfer paperwork or policies around transfer requirements. The receiving LIDDA will enter the transfer into the LTCOP.

4.73. Have the 8578 ID/RC Assessment, IPC Form, and other forms changed? They appear different on the LTCOP.

No, forms have not changed.
Note: The PDF version of the 8578 ID/RC Assessment and IMT Form includes fields for all five waiver programs and might look different than the view in the LTCOP.

4.74. Do we still submit paper copies of completed forms?

There are no changes with regard to paper forms.

4.75. Can you define off-cycle and on-cycle renewals?

For example, an individual's regular cycle (effective period covered by the form in question) is January 1st to December 31st. If the program provider submits an off-cycle renewal, it must be before the established LOC expires, which in this instance is December 31st.

The program provider is not allowed to submit an off-cycle renewal after December 31st. An off-cycle renewal submitted after December 31st is considered an on-cycle renewal. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

4.76. Why is a renewal called off-cycle if it is on time?

An 8578 ID/RC PC 3 Continued Stay Assessment is considered off-cycle if "No" is entered in Field **58a. Would you like to renew on the individual's regular assessment cycle?**. The cycle can only be changed if the assessment is renewed on time and the provider would like to request a begin date that is earlier than the previous level expiration date. This changes the assessment cycle and is considered an off-cycle renewal.

4.77. How will program providers know the SC ID when submitting the IPC Revision Form?

An individual's SC information will prepopulate on the form when the program provider initiates the IPC Revision Form from an existing IPC Form.

4.78. Where can I find Item-by-Item guides for entering each form on the LTCOP?

Item-by-Item guides for each form type can be accessed through the TMHP LMS.

4.79. Will a change in the county of service automatically occur when the IMT—LA Reassignment Form and IPC Transfer Form are submitted?

For a transfer that requires a county change, LIDDA change, and contract change, LIDDAs will complete the following:

- The current LIDDA will submit the IMT—LA Reassignment Form to assign the individual to the new LIDDA and update the individual's county and address. After the IMT—LA Reassignment Form is in status ***Processed/Complete***, the new LIDDA will be reflected in both the TMHP and HHSC systems.
- The new LIDDA will submit the IPC Transfer Form if the contract is being changed.

Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type along with who submits each form.

4.80. Are LIDDAs required to complete an IPC Form when there is a reassignment to a new LIDDA?

This depends on the scenario:

- If there is only a change in LIDDA, only the IMT—LA Reassignment Form is required to be submitted by the current LIDDA.
- If there is a change in program provider along with the LIDDA change, the current LIDDA must submit an IMT—LA Reassignment Form and the receiving LIDDA must submit an IPC Transfer Form.
- If there is a change in the client's residential type along with the LIDDA change, the current program provider must submit an IPC Revision Form and the current LIDDA must submit an IMT—LA Reassignment Form.

You are strongly encouraged to reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for a list of scenarios and assistance with selecting an IMT Form purpose and IPC Form type, along with who submits each form.

4.81. You mentioned that an IPC Form may need to be submitted along with the PLU Form. If there is not a change of amount, services, or LIDDA, and there is only a change in location, is there a need for an updated IPC Form?

If there is only a change in location and the residential type did not change, then an IPC Revision Form is not needed. However, if the residential type changed along with the location, you must submit an IPC Revision Form.

Reference Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, or *8582 TxHmL Individual Plan of Care Item-by-Item Guide* for more information.

4.82. If additional hours are added to an IPC form, how do we know the date the hours were added?

The revision date can be found on the IPC Revision Form on the LTCOP. Once the form is in status ***Processed/Complete***, the revision will be reflected in MESAV.

4.83. Are we able to see when an 8578 ID/RC Assessment is up for renewal?

On the LTCOP Dashboard, LIDDAs and providers will see their clients due for renewal in the tile labeled "LOC/LON Assignments due in 60 days." A count is displayed in the tile. On click of the count, a list of impacted individuals is displayed.

4.84. What does it mean to remand a form?

If HHSC LTC staff or the LIDDA reviewer believes that corrections are needed during the Authorization Process or the LA Review Process, the assessment or form may be returned to the original submitter to make corrections, add notes, or inactivate the assessment or form. This is known as the "Remand Process" and applies to multiple forms.

4.85. After submitting a form, is it necessary to send it to the workflow each time?

After a form is successfully submitted on the LTCOP, a unique DLN is generated. The system automatically moves each form to the workflow.

4.86. Is the 8578 ID/RC Assessment and IPC Form changing on the HHSC website?

An updated hard-copy template of the IPC Form is published on the HHSC website. There are no changes to the 8578 ID/RC Assessment.

4.87. On the LTCOP, the IPC Form is a 16-page document under the "Printable Forms" section. Do we use that version of the IPC Form, or do we use the standard IPC Form found on the HHSC website?

The 3608 and 8582 IPC Forms on the HHSC website should be used.

4.88. Are temporary discharges still entered, and does MESAV show hospitalizations?

HCS and TxHmL providers enter "temporary discharges" on the TMHP LTCOP by submitting the IMT—Suspension Form with the proper suspension reason. The list of suspension reasons on the IMT—Suspension Form includes hospitalization. After the IMT—Suspension Form moves to status ***Processed/Complete***, a client hold record will be shown on the MESAV.

4.89. Is there training on how to submit assessments and forms in the LTCOP?

Yes. Refer to the 1915(c) Waiver Programs page of the TMHP LMS website for HCS and TxHmL trainings, including user guides, item-by-item guides, and webinars. You must create an account the first time that you access the LMS and log in with those credentials thereafter. Refer to the *LMS Registration and Navigation Job Aid for Providers* or email TMHPTrainingSupport@tmhp.com for assistance. You can also view short training videos on the TMHP YouTube Channel under the HCS and TxHmL playlist.

4.90. When a form's status is updated, is the status updated for all other forms listed for that individual in the LTCOP? For example, when the 8578 ID/RC Assessment status is updated, is the Pre-enrollment Form automatically updated to the same status?

Generally, the form status only reflects changes of that specific form. However, the status of a form can be affected when the form is pending the completion of another form or forms.

The following are a few examples:

- The Pre-enrollment Form will remain in status ***Pre-enrolled*** until the 8578 ID/RC PC 2 Assessment and IPC Initial Enrollment Form are submitted.

- The Pre-enrollment Form automatically updates to status ***Pending Enrollment*** when the 8578 ID/RC PC 2 Assessment and IPC Initial Enrollment Form are submitted and are waiting to get to a finalized status of ***Processed/Complete***.
- The Pre-enrollment Form automatically updates to status ***Enrolled*** when the 8578 ID/RC PC 2 Assessment and IPC Initial Enrollment Form are approved and in the finalized status of ***Processed/ Complete***.
- The Pre-enrollment Form automatically updates to status ***Denied*** when the 8578 ID/RC PC 2 Assessment or IPC Initial Enrollment Form is denied.
- The status of the IMT Form and 3615 Request to Continue Suspension of Services Form automatically updates when a suspension is ended and the individual is either returned to service or terminated.

Refer to the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for further details and additional scenarios.

4.91. When a Revision IPC is entered in TMHP, does that put all future billing on hold until the Revision IPC is approved or otherwise adjudicated? In one example, PT was added mid-year in a revision. Does this entry of the revision freeze all ability to bill for anything until the Revision IPC is approved?

Providers can continue billing if a revision is in status ***Pending DADS Review***, under these circumstances:

- The service was already authorized on a ***Processed/ Complete*** form in the current IPC cycle.
- The provider has not used all the amounts or units authorized.
- There are no other holds for the period in which the provider is submitting billing.

For the example above, only the PT would be unavailable for billing until the review is complete, assuming there were unused units/dollars in the other service authorizations.

IPCs are not rejected. However, services may be reduced or denied. In most cases, UR prorates to allow billing until a decision is made. Exceptions to this are when services have already been reduced or denied in the current IPC cycle and there is no new supporting documentation, or if an individual is not eligible for a service such as dental for a minor on an HCS IPC.

4.92. I can't print forms or assessments. I can see the print button, and my printer is set to default. What suggestions may help me?

This may be a browser issue. Clear the browsing history and try again. Keep in mind that you may need to shut down your computer and then restart it.

4.93. Where do we get Form 8599, IPC Cover Sheet? Is that due for every IPC Renewal or Revision?

Form 8599, IPC Cover Sheet can be found on the HHSC website. The form is not due for every IPC Renewal or Revision. For form instructions, use the link provided above. For more details on when to use Form 8599, refer to the Clarification on HCS and TxHmL IPCs status in "Pending DADS Review" web article on TMHP's 1915(c) Waiver Programs web page.

4.94. Why do I get a message saying that I am not assigned to the client when I try to enter a Transfer IPC? I know that the IMT has already been submitted between LIDDAs.

Providers and LIDDAs are not able to submit assessments or forms for individuals they are not currently associated with. This helps prevent out-of-sequence form submissions and eliminates the need for HHSC-LTC staff to make corrections on behalf of the provider or LIDDA. The IMT will need to be in status ***Processed/Complete*** before the Transfer IPC can be entered.

4.95. How long will it take the IMT to update on the provider list?

If the IMT was submitted by the provider, the provider can view it immediately after it was submitted. If an IMT—LA Reassignment was submitted by a LIDDA, the receiving provider will be able to see the form after the Transfer IPC moves to status ***Processed/Complete***.

4.96. How do I re-enter an IMT that was entered incorrectly?

Contact PCS at 512-438-2200, option 5, to have the form that was submitted in error inactivated. Once it is inactivated, you can resubmit a new IMT.

4.97. What is the time frame for enrollments or transfers to be active in the system, and how do we know if there is an issue with the form?

There is not a time limit for forms to process. To find out if there is an issue with an enrollment or transfer, contact TMHP at 800-626-4117 (select option 1, then select option 1). Currently, providers are not able to see an enrollment or transfer IPC until the IPC is in status ***Processed/Complete***.

4.98. How do you complete a temporary discharge for a client refusing all services?

An individual does not get placed on temporary discharge or suspension if they are refusing services. The program provider must notify the SC. The SC must conduct a service planning team (SPT) meeting to discuss the individual's wants and needs, and determine if there are other services that match the individual's goals, if the individual should transfer to another program provider, or if the individual should terminate from the program.

4.99. If an IPC exceeds the authorization limit, can the provider still submit it as long as a note is included before initiating the appeal process?

Yes, the IPC can still be submitted and will trigger a review. However, for TxHmL, the IPC must not exceed the amount specified in TAC Rule §262.101.

Section 5: LTCOP Enhancements

5.1. When will the enhancements be available?

The LTCOP enhancements have been available as of July 3, 2023.

5.2. Why would it be necessary to add attachments to forms? Does this replace the requirement to upload to the IDD Operations Portal, meaning that the portal will become obsolete?

The LTCOP attachments is a new function to assist the submitter in providing any documentation that is required or requested by HHSC. The requirements and policy associated with what documents are necessary is not changing, and any documentation you were required to submit in the IDD Operations Portal will be the same documents that you will submit in the LTCOP.

This function has been available as of July 3, 2023. For forms that were submitted prior to July 3, 2023, and are still in flight, the required documents should still be uploaded in the IDD Operations Portal. For forms submitted on or after July 3, 2023, you will upload the required documents to the LTC Online Portal. The appropriate HHSC department will then review the attached documents in the LTCOP. The IDD Operations Portal did not become obsolete on July 3, 2023, and will still be used for current processes other than HCS and TxHmL form submission.

5.3. Is provider location information on the administrative log in only?

No, provider location information is available for all HCS and TxHmL providers under the Search drop-down on the blue navigational bar in the LTCOP.

5.4. Did Staff ID migrate from CARE, or are these based on entries we have made since May 1, 2022, for services rendered?

As of June 29, 2023, Staff ID migrated from CARE, and data was loaded into the new Staff ID function in the LTCOP.

5.5. Will we be able to use Provider Location Search like we do in CARE? Will we be able to close them now, if needed?

Provider location information is read-only. It will display both open and closed locations. All updates to provider locations will need to be made using the current forms and processes.

5.6. What kind of information is available in the Staff ID function for vendor staff updates? Is this function an update to how we grant access to employees for certain TMHP user account functions?

Staff ID provides additional information on staff included on claims submitted. Submitted claims will be matched during the claims review process to information found on the Staff ID function.

The Staff ID function also supports data maintenance. For example, staff onboarding or rolling off. Providers are able to search for staff records after the LTCOP validates the search, and then they are able to add, edit, delete, and reactivate records. Permissions for employees will continue to be granted using the current processes. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on Staff ID and

the information it provides.

5.7. Are Staff IDs needed when submitting claims, or should we continue to use full names as we currently do?

You should continue to include staff information in applicable claims as you do today.

5.8. Are attachments the hard copies of documents that we would normally send to the LIDDA? For example, the hard copy of the IPC for HHSC UR.

HHSC has not changed the processes and procedures involving sharing documentation between providers and LIDDAs. In addition to uploading forms to the LTCOP, providers are still required to provide hard copies to the LIDDAs.

5.9. Should we start attaching a hard copy of the IPC to the Attachments tab on the LTCOP?

Hard copies should be attached in the LTCOP if listed as a required document on the Attachments tab or requested by HHSC LTC.

5.10. When entering an 8578 ID/RC Assessment or IPC and uploading attachments, will the SC assigned to that individual be automatically notified that there are attachments?

The LIDDA/SC will be able to view the attachments by clicking the Attachments tab on the 8578 ID/RC Assessment or IPC. However, they do not receive an automatic notification.

5.11. When an 8578 ID/RC Assessment or IPC is attached, does the LIDDA have access to it to approve it, or do we still need to send it to the LIDDA?

LIDDAs will have access to the attachments; however, some LIDDAs may still request that you send the signed hard copy to them.

5.12. Do we still have to attach ICAPs?

Yes, ICAPs should be added as attachments to the LTCOP, as required.

5.13. If we don't attach a hard copy when submitting an IPC or 8578 ID/RC Assessment, will this hold up the form from processing?

Yes, UR or PES will not review the form without the required documents, and as a result, this will cause the form to move into status ***Pending DADS Review***.

5.14. Is a Person-Directed Plan (PDP) as a required document for entering an annual IPC. What happens when we don't receive that before the IPC renewal date?

The PDP can be added at any time. The attachment function supports uploading and downloading documents during form submission and after forms are submitted successfully. Deleting attachments is limited to during form submission or when the form is in certain statuses prior to it being fully processed.

5.15. It was mentioned that it is not the LIDDA's responsibility to notify a provider of location issues. I assume the exception would be for Transfer IPCs since they would not necessarily know there is an issue as they would not see an error generated when a Transfer IPC is entered, correct?

That is correct. For Transfer IPCs, the receiving provider should be informed if the location being assigned to the individual is having an issue. The receiving provider will not be able to monitor the Transfer IPC status until it is in status ***Processed/Complete***.

5.16. Which staff members are required to be uploaded in the system? Are these nurses, direct care staff, or other staff members?

A program provider may enter and maintain Staff IDs for all of their agency's employees or contractors using the LTCOP. However, the requirements are that a Staff ID is entered, maintained, and updated for all employees or subcontractors that deliver hourly services (i.e., nursing, transportation, CFC, PAS/HAB, licensed professional therapies, etc.).

5.17. Is a PDP now a required document that we have to upload for the 8578 ID/RC Assessment PC2?

A PDP is not required for every enrollment. If an LOC review is needed, HHSC will remand the form to the submitter and request that they upload the Determination of Intellectual Disability (DID) and ICAP to the Attachments tab. The PDP does not need to be submitted unless you are requesting an LON increase or if it was requested by PES.

Section 6: General Questions

6.1. Is the provider number the same as the NPI number?

In TMHP systems, the 9-digit number on your provider agreement is referred to as your provider number. An NPI is a 10-digit number assigned randomly by the National Plan and Provider Enumeration System (NPPES). An NPI must be obtained before a provider can enroll as a Texas Medicaid provider.

6.2. Is the CARE System phasing out? How will we know what is moving to TMHP and what is staying in CARE?

CARE is not phasing out with this migration. However, the HCS and TxHmL form and claim submission on CARE is phasing out. Additional functions remaining in CARE include:

- 1185 Permanency Plan Status Report
- 249 PPR Approval Status (Inquiry)
- 309 Permanency Plan Review
- 686 Critical Incident Update
- 286 Critical Incidents Data Inquiry
- C97 WS/C Authority Review Notations
- 410 Add Case to ID/Demographics
- 325 Register individual: CARE-ID
- 360 Death/Separation of individual: Add/Change/Delete

6.3. Is the client ID the same as the CARE ID or Medicaid ID? Will the same CARE ID be used?

The client ID is known as the Medicaid ID in TMHP systems. TMHP also uses the CARE ID as secondary identification. Providers will use the client/individual number, also known as the Medicaid ID number, for all form submissions and claims entered into the TMHP system.

6.4. Are the provider numbers already assigned for HCS and TxHmL the ones that are currently filed through CARE or are new provider numbers be needed?

HHSC continues to use the 9-digit provider/contract number that identifies the contract under which an individual is receiving services.

6.5. What is the difference between the provider number, the vendor number for HCS, the contract number, the component code, the NPI, the Taxpayer Identification Number (TIN), and the Employer Identification Number (EIN)?

The provider/contract number is the 9-digit number given by the HHSC Contracts Administration which identifies the contract under which the individual is receiving services.

The vendor number is generally a 4-digit number that is comprised of the existing Component Code

preceded by a zero.

The component code is a 3-digit unique code that identifies a state hospital, state school, state center, community center, or a private provider.

The NPI is a 10-digit number which is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number that covered health-care providers, all health plans, and health-care clearinghouses must use in the administrative and financial transactions adopted under HIPAA.

The TIN is a 9-digit identification number used by the Internal Revenue Service (IRS) in the administration of tax laws.

The EIN is also known as the Federal Tax Identification Number and is used to identify a business entity.

6.6. Is there a list of contacts available to providers?

Refer to the Provider Quick Reference Contact List for HCS and TxHmL for a list of areas and how they can support.

6.7. Did the service codes for HCS services change? Did Level of Need (LON) change?

Some service codes for HCS and TxHmL have changed. Providers can refer to the Long-Term Care Bill Code Crosswalks to view the changes. HHSC still uses the LON.

6.8. Is the referral number assigned to the individual at admission to the HCS or TxHmL programs during the enrollment process?

The referral number is assigned by HHSC when the initial IPC is approved.

6.9. Will the Travis Questionnaire W21 be moved to TMHP, or will it remain in the CARE system?

The Travis Questionnaire is now in the CSIL application and is now called the Questionnaire for Waiver Program Interest Lists.

CSIL is accessed through the HHS Enterprise Portal.

6.10. What if a client doesn't appear on our account?

Only individuals associated with your contract will appear on your roster. There could be several reasons as to why the client does not appear, such as eligibility, incorrect information, delay in transfer, etc.

6.11. If we need to add more dental funds on the same day we receive the dental bill, will it be denied and terminated?

A revision can be submitted at any time.

6.12. Why is the DADS acronym still being used?

The DADS acronym is a legacy term, and any references to "DADS" will be replaced with "HHSC" in the LTCOP in future enhancements.

6.13. During the 180-day wait time for approval of MI and ME, is the program provider expected to admit the individual?

Program provider expectations are not changing related to enrollment activities, and they are still expected to follow TAC rules regarding the enrollment process.

6.14. Is the HCS Program a lifetime program?

Individuals enrolled in the HCS program must maintain eligibility criteria as outlined in TAC Rule §263.101.

6.15. Why would a consumer be placed on suspension?

The suspension reasons for HCS and TxHmL are listed in the TAC and are not changing. You can also reference the *Individual Movement Form Item-by-Item Guide* for a list of suspension reasons listed on the IMT Form's "Suspension Reason" drop-down field on the LTCOP.

6.16. What does "individual association" mean?

Provider to Individual association is referencing a documented relationship that is established by the submission of certain forms. This is to ensure that program providers only see information for clients that are assigned to them and have that relationship officially documented on those forms.

6.17. How do I setup direct deposit and EFT?

Providers with questions about how to sign up for or obtain direct deposit or how to sign up for EFT, contact HHSC Accounting at 737-867-7580 or vendor@hhs.texas.gov.

6.18. Is the vendor number the component code?

The vendor number is based on the component code.

6.19. Is a program provider the LIDDA?

No, program providers are the agencies providing services to their clients. LIDDAs serve as the point of entry for publicly funded Intellectual or Development Disabilities (IDD programs), whether the program is provided by a public or private entity.

6.20. What is a coach review?

Coach review is a term used to indicate a form is being reviewed by HHSC-LTC staff or a Coach.

6.21. What is Location Availability?

Location Availability is part of the Capacity Verification Process. Before an individual can be added to a program provider's list, the LTCOP verifies that the program provider has both the availability in their contract with HHSC-LTC to serve the individual, and that the program provider location has an open spot for the individual.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information.

6.22. What list of things do we need to complete to enroll with TMHP?

Reference the Provider Enrollment page on the TMHP website to begin the enrollment process.

6.23. I contract with several program providers. Do I need TMHP user account login credentials for each program provider?

You can use the same login credentials for multiple program provider numbers. Using the same credentials will enable you to see all your contract numbers from one account. For more information on TMHP account management, refer to the Account Management web page on tmhp.com.

6.24. Do the login credentials for the TMHP My Account also work for the TMHP LMS?

No, the TMHP My Account and TMHP LMS are different systems. For information on TMHP account management, refer to the Account Management web page on tmhp.com. To create a TMHP LMS account, visit learn.tmhp.com.

6.25. What is location capacity?

Each location has a capacity count that is stored in the HHSC system. When an individual is assigned to a location, the capacity of the location will be minus one, and when an individual is moved out of the location, the capacity of the location will be added one. The LTCOP will check the HHSC system to confirm the capacity of a location before an individual is assigned to the location.

6.26. Where can we locate "Appendix A: Scenarios for Selecting an IMT Purpose and IPC Type?"

You can find Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, *Individual Movement Form Item-by-Item Guide*, *3608 HCS Individual Plan of Care Item-by-Item Guide*, and *8582 TxHmL Individual Plan of Care Item-by-Item Guide*.

6.27. How do HCS program providers place a cap on its program? Can we complete this in the LTCOP, or must we contact the HCS Contracts department?

This process has not changing. Program providers must continue to submit their request directly to the Waiver Provider Enrollment (WPE) team at IDDWaiverContractEnrollment@hhsc.state.tx.us.

6.28. If a location has been "closed," how can we "reopen" it to allow an individual to move to that location?

If a location has been "closed," you can add a new location with a new location code for that location by submitting the PLU Form. Once the PLU Form is in status ***Processed/Complete***, the individual can be assigned to that location by submitting the IMT—Individual Update Form.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the PLU Form.

6.29. Where can we access TMHP's LMS?

You can access TMHP's LMS at learn.tmhp.com.

6.30. What does DLN mean?

A Document Locator Number is the unique number assigned to a document or form after it has been successfully submitted on the LTCOP.

6.31. Will the TMHP My Account be secure like the CARE system?

Yes, the TMHP My Account is a secure portal.

6.32. What is FMSA?

FMSA is the acronym used for Financial Management Services Agency and was previously known as Consumer Directed Services Agency (CDSA). FMSAs provide financial management services to individuals or LARs who serve as the employer of their service providers. Any individual or LAR electing the CDS option is required to use an FMSA.

6.33. How do I make updates to a provider office and mailing address?

Providers do not have the ability to make changes to their contract or contact information in the LTCOP. Changes to a contract office and mailing address should be sent to WPE at IDDWaiverContractEnrollment@hhsc.state.tx.us.

6.34. Are Medicaid numbers, instead of the CARE ID, required on all billing documents kept in the client's chart, or do we keep the CARE ID on documents for auditing purposes?

HHS service delivery logs will be updated to remove the "CARE ID" field. The individual's Medicaid number should not be listed on service delivery logs. CARE IDs and Medicaid IDs are not required elements on written documentation.

6.35. What is the difference between an HHSC LTC staff and an HHSC LTC Coach?

The difference is based on permission and access levels.

6.36. When assigning permissions to staff, is there a way to assign them to multiple staff members at one time?

No, there is not a current method to assign permissions to multiple individuals at the same time.

6.37. Is a temporary discharge (such as hospitalization) the same as a temporary suspension?

The IMT—Suspension Form on the LTCOP is for temporary suspension cases, and the allowed suspension reasons include hospitalization. Reference the *Individual Movement Form Item-by-Item Guide* to view a complete list of suspension reasons.

6.38. If a consumer moves, but there is not a change in LIDDA or services provided, is a new location code needed or is the one in place updated?

If an individual moves (as in, his/her own home address changed), the program provider or LIDDA can submit an IMT—Individual Update Form to update the individual's address. If an individual moves from one location to another location associated to the same program provider, the program provider can

submit an IMT—Individual Update Form to update the individual's new location code. The new location code for the individual can be an existing location of the program provider.

Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* and *Individual Movement Form Item-by-Item Guide* for more information.

6.39. Are program providers able to change the LON or LOC status for an individual, or are SCs the only ones who can change this?

The 8578 ID/RC PC 4 Request Change of LON Assessment can be submitted by the program provider on the LTCOP. Only LIDDAs submit the 8578 ID/RC PC 2 Enrollment Assessment to enter and change the LON/LOC during the enrollment process.

6.40. Where and how can I find the diagnosis code of a client? I do not see it in MESAV.

The diagnosis code is the ICD10 code and can be found on the 8578 ID/RC Assessment's "Diagnosis" tab. For additional assistance obtaining client diagnosis codes, email the HCS or TxHmL Policy departments at hcspolicy@hhs.texas.gov or txhmlpolicy@hhs.texas.gov.

6.41. Where can we see if an LON increase was approved?

Providers can use the FSI function of the LTCOP to search for 8578 ID/RC PC 4 Change Level of Need on Existing Assessments and its status. When the assessment moves to HHSC review, HHSC staff will either approve or modify the LON change. This will move the assessment status to either ***LON Approved*** or ***LON Modified***. If there are no errors with the assessment, it continues in the workflow to the MI check process, ME check process, and SAS process until its completion. Once completed, the assessment will be in status ***Processed/Complete***.

6.42. Is the funding in CARE separate from the funding in MESAV?

The funding process has not changed, so it will be the same under both CARE and TMHP.

6.43. If an NPI is not available for our office, what will we need to log into our TMHP user accounts? Will each employee have their own username and password?

All health-care and HIPAA-covered organizations must obtain an NPI from the Centers for Medicare & Medicaid Services (CMS). The organization's NPI must be used in all HIPAA-standard transactions. For more information about NPIs, visit the National Provider Identifier Standard (NPI) page of the CMS website.

You must enter the NPI for your organization during TMHP user account setup. Individual usernames and associated permissions are assigned and must be used to log in for day-to-day use.

6.44. What will happen to the FileZilla reports?

The approved claims, claims exception, and R&S reports for CARE-initiated claims will continue to go to the FileZilla folders.

Claims processed through TMHP will not have reports or files going to FileZilla. The approved claims and claims exception reports will be done by TaskmasterPro, which sends a TMHP claims file that is then

processed and put in folders on Globalscape.

The file that is currently being tested in conjunction with TaskmasterPro is the TMHP replacement for the CARE Service Utilization file. It will go to the FileZilla folders in place of the current CARE file.

6.45. Can a new user request access to CARE?

LIDDAs must add and update HCS and TxHmL interest list records in the CSIL application. If an individual does not have a CARE ID, the LIDDA must register the individual in CARE. The LIDDA will receive a system-generated CARE ID and must then assign a local case number in CARE before adding the CSIL record.

6.46. Can LIDDAs register new people in CARE?

LIDDAs must add and update HCS and TxHmL interest list records in the CSIL application. If an individual does not have a CARE ID, the LIDDA must register the individual in CARE. The LIDDA will receive a system-generated CARE ID and must then assign a local case number in CARE before adding the CSIL record.

6.47. What is the provider contract capacity?

The provider contract capacity is data found in the HHSC-LTC Provider system. The CAP is the max amount of individuals a facility is set to serve, and sometimes a facility will want to either reduce or increase their "CAP."

If providers would like to increase or decrease their CAP for their contract number, submit the following on agency letterhead, if possible, to IDDWaiverContractEnrollment@hhsc.state.tx.us:

- Legal entity name
- Contract number
- Component code
- Signature of the individual listed on Form 2031
  Note: To update the current signature authority on file, submit an updated Form 2031.

6.48. Do all our consumers have to enroll using their Medicaid number?

If an individual's Medicaid ID is not available during the process of enrollment, a CARE ID may be used on the LTCOP to enroll the individual. If the individual has a Medicaid ID, use the Medicaid ID to enroll the individual.

6.49. Must we use a VPN to access the LTCOP or TexMedConnect?

No, you will use the production version of the LTCOP and TexMedConnect, which is a website that is open to the public. People who have set up their TMHP user accounts may log into these systems. VPNs were only used during testing of the systems.

6.50. If we created usernames and passwords several months ago, are we able to update our passwords?

TMHP recommends changing your password every 30 days as a best practice to keep your user account

secure. If you are unable to log into your account, you can request a password reset. Upon completion of the password reset, you will be able to log into your TMHP user account. For instructions on how to change a password, refer to the Account Management web page on tmhp.com.

6.51. We've submitted our application packet to enroll with TMHP. How do we know if it was approved?

You can email the TMHP Provider Relations (PR) mailbox at provider.relations@tmhp.com for assistance.

6.52. Is the MESAV eligibility start and end date the Medicaid date or IPC date?

The dates entered by the user to determine eligibility are the dates for which claim services are to be provided and what the provider uses to determine program eligibility. The effective date and end date are the client's eligibility dates for the program that are indicated in the results.

6.53. Is the ANSI 835 format like the FileZilla Reports?

The 835 files are in X12 format. Refer to the *835 Companion Guide* to view TMHP specific details on the 835 that is produced or on the X12 website for information on the full implementation.

6.54. How do we access the Globalscape EFT Service Maintenance Request Form?

Email DLHHSCProductionOpsSFTP@hhsc.state.tx.us for assistance with the form.

6.55. Will the CARE C73 screen equivalent for Cost Reports be able to pull data for a specific service and date range?

Yes, you can find this information on Claims Data Export within MESAV. Information can be exported to an Excel spreadsheet and can be filtered, as needed. However, the data exported cannot be pulled by specific service.

6.56. What address should we use for a placeholder administrator location?

Use your corporate address. If you are concerned about it triggering a review, you can open and close as needed.

6.57. When utilizing a placeholder location, does the move need to be dated the same day or a different day? Should there be a one day gap?

They can be on the same day. It is more about the sequence of form entry. Make sure the forms are in status ***Processed/Complete*** before entering the next one.

6.58. Where in TMHP can MHM information be found?

Some information for MHM can be found in this FAQ and the Provider and LIDDA CARE Report Crosswalk.

6.59. I am unable to bill, even after updating my TMHP user account permissions. Who can help?

Contact the TMHP LTC Help Desk at 800-626-4117 (select option 1, then option 1).

6.60. What is meant by Fair Hearing Process?

This is the appeals process that can take place when an individual is denied enrollment into the HCS or TxHmL program due to not meeting program LOC eligibility criteria, or financial eligibility criteria, or if the IPC is reduced or denied. The individual or LAR has a right to request a fair hearing to appeal and the information on how to do so is included in the notice.

6.61. Will we need to start using EVV for therapists in HCS?

Yes. EVV will be required for occupational and physical therapy provided in the home. Reference the "Programs and Services Required to Use EVV" section of the HHS Electronic Visit Verification (EVV) web page for more information.

6.62. Where do you find the service caps for each service?

Service limits can be found in TAC Rule §263.304 for HCS and TAC Rule §262.304 for TxHmL. The service caps triggering review are variable and are not published. Person-directed planning should be based on the individual's needs rather than avoiding UR. You can also review previous HHS HCS Webinars and HHS TxHmL Webinars where this topic was addressed.

Section 7: LIDDA Questions

Slot Tracking: Public Provider Contract Capacity Information

7.1. Where is public provider contact information located?

The Slot Tracking system is the system of record for public provider contract capacity information.

7.2. How can the LIDDA or public provider determine if an individual has been transferred out or separated from the public provider's contact?

Use the FSI feature on the LTCOP to check the status of the Transfer IPC or termination form.

CSIL

7.3. The Interest List Request Date field is auto-filled. If we save the record without changing the date and the date is incorrect, we must submit a backdate request to fix the error. Can this be changed so that the date is not auto-filled?

The requirements for the Interest List Request Date field are not changing. However, Local Procedure Development and Support (LPDS) is working with HHSC Information Technology (IT) to add a warning message that will prompt LIDDA staff to change or confirm the date before saving the record. In the meantime, remember to change or confirm the date before saving the record.

LPDS cannot change an interest list request date without written documentation. If the interest list request date is incorrect, the LIDDA must follow the requirements in the "7900 Requesting Changes to a Person's HCS or TxHmL Interest List" section of the LIDDA Handbook to request a correction.

7.4. Is there a limitation on how far we can backdate a biennial contact date in the CSIL application?

There is no longer a limitation on the Date of This Contact field in the CSIL application. Refer to IDD Services Broadcast Message No. 2022-03, and report any CSIL data entry issues to InterestListPreEnroll_LIDDAHelp@hhs.texas.gov.

7.5. How do I change the county of residence on an individual's CSIL record?

Instructions for updating the county on an individual's residence in CSIL are on page 36 of the *Community Services Interest List (CSIL) User Guide for LIDDAs*. The user guide can be found in the *Appendix V, Community Services Interest List User Guide* of the LIDDA Handbook. Report any CSIL data entry issues to InterestListPreEnroll_LIDDAHelp@hhs.texas.gov.

7.6. Does updating the county of residence in CSIL automatically transfer the permanency plan to the new LIDDA in the CARE system?

No, permanency activities were out of scope for this phase of the project. To transfer interest list records to another LIDDA's service area, the county of residence must be changed in CSIL. Then, the county of residence must also be changed in CARE to transfer the activities that remain in CARE.

7.7. How do LIDDAs pull the Missing Local Case Number report from CSIL?

The report is located on the CSIL homepage under the "Reports" section. Click the "Missing Local Case Number Report" hyperlink.

7.8. Does the CSIL application automatically update the interest list service county when the residence city is changing?

No. However, the residence county and service county must match. If they do not, the system will override the service county to match the residence county. If a user attempts to change the service county, an error message is displayed stating that the residence county must be changed instead.

7.9. Who does the LIDDA contact if an update needs to be made in CSIL, but the Edit hyperlink is unavailable to add or close the user role?

Refer to IDD Services Broadcast Message 2022-143, which includes an attachment titled, "LIDDA Quick Reference Contact List for HCS and TxHmL." This list specifies that the contact for assistance with CSIL inquiry or data entry is IDD Services LPDS at InterestListPreEnroll_LIDDAHelp@hhs.texas.gov.

CARE

7.10. Where can LIDDA staff access a list of actions that must continue in CARE?

Any CARE functionality not related to HCS and TxHmL programs remain in CARE. As of February 2023, the following HCS and TxHmL processes remain in CARE:

- Screen 325, Register Client: Client ID
- Screen 410, Add Case to ID/Demographics
- Screen 309, Permanency Plan Review (PPR)
- Screen 249, PPR Approval Status
- Screen 1185, Permanency Planning Status Report
- Screen 360, Death/Separation of Client

Per the LIDDA Handbook, LIDDAs must continue to use CARE screen C63 to search for an individual's current Medicaid information. The expectation is for LIDDA staff to continue CARE entry unless instructed otherwise. IDD Services frequently sends broadcast messages to LIDDA directors with information and instructions, which are expected to be shared with LIDDA staff.

7.11. For enrollments, individuals have 30 days to select a provider. Where should the LIDDA obtain a current provider choice list? How does the LIDDA confirm the provider still has availability after 30 days?

LIDDAs must use CARE screen C95 to print a current provider choice list. To confirm the chosen provider still has availability, check the screen again before contacting the provider and scheduling meetings.

7.12. Can the provider choice lists be filtered to print fewer pages?

Yes, you can tailor the list to the individual's specifications using the optional fields on the CARE C95 header screen.

7.13. When a residence county is updated in CSIL, should the residence county also be updated in CARE?

Yes, it should be updated in CARE.

7.14. Why do individuals with an assigned SC continue to populate on the HC062510 Consumers Without Service Coordination Assignments report?

As of July 1, 2023, all screens regarding service coordination are no longer used in the CARE system. They have all been transferred over to the TMHP LTCOP. HHSC is currently working with TMHP on obtaining the correct screen permissions for each LIDDA. A broadcast will be sent out detailing how to obtain the necessary screens in TMHP.

Letters

7.15. When will LIDDAs be able to print a denial letter from the LTCOP?

We do not have an estimated time frame for when this will be fixed. If a help desk ticket was opened to report an issue with printing a denial letter and no update has been received, escalate this issue by sending an email to LTCOPS-Escalations@tmhp.com with the ticket number, the date and time the issue was reported, and if known, the customer service representative who took the call. In the meantime, LIDDAs can contact the HHSC area that processed the denial to request the denial letter.

Enrollments

7.16. Does the LIDDA need to upload supporting documents for all enrollments?

The LIDDA only uploads supporting documents for enrollments upon request. If supporting documentation is needed for an 8578 ID/RC PC 2, PES staff will set the form status to ***Remanded to Submitter*** and include a note in the assessment's History trail describing the documents needed for their review. If supporting documentation is needed for an Enrollment IPC Form, UR will contact the submitter by email to request the documents needed for their review.

7.17. Who can the LIDDA contact for assistance with enrollment forms?

Contact PES at enrollmenttransferdischargeinfo@hhs.texas.gov. The TMHP LTC Help Desk staff can also provide form submission assistance. Contact the LTC Help Desk at 800-626-4117 (Option 1, Option 1). To escalate the issue, send the ticket number to LTCOPS-Escalations@tmhp.com.

7.18. When an individual is transferring from a facility to HCS, is an IMT needed for the transfer/enrollment?

Terminology is very important when speaking to providers or HHSC and TMHP staff. An individual does not "transfer" from a facility to HCS. The individual is "discharged" from the facility to "enroll" in

HCS.

The 8578 ID/RC Assessment and 3608 or 8582 IPC are used for HCS or TxHmL enrollments. However, after enrollment, the IMT may be required to assign the individual to another LIDDA's service area so that the individual's HCS or TxHmL services can be transferred to a provider in the new service area.

7.19. Can providers correct 8578 ID/RC Assessments and IPC Forms? We had a situation where a service was being discontinued and no claims had been made, but the provider did not reduce the service to zero when they submitted the IPC Form. The provider said they entered the form as instructed by HHSC and cannot edit it.

Providers cannot edit any enrollment form, and there are many fields they cannot edit on the 8578 ID/RC Assessment. For the IPC Form, services should not be reduced to anything less than one. If the service is being discontinued, the service needs to be reduced to one instead of zero.

7.20. What is the time frame for reviewing and processing enrollment forms after submission?

If enrollment forms are pending longer that four weeks after submission, contact IDD PES at enrollmenttransferdischargeinfo@hhs.texas.gov.

HCS or TxHmL Pre-enrollment Form

7.21. If the status of the HCS or TxHmL Pre-enrollment Form is *Enrolled*, but the Individual Details page still shows the form status as *Pre-enrolled* or *Pending Enrollment*, who should be notified?

Send an email to the assigned slot monitor or to InterestListPreEnroll_LIDDAHelp@hhs.texas.gov.

7.22. When an individual is leaving TxHmL to enroll in HCS, should the Pre-enrollment Form for HCS be submitted immediately after Form 8601 Verification of Freedom of Choice is uploaded, or after Form 3616 Request for Termination is in status *Processed/Complete*?

The 3616 Request for Termination Form for TxHmL must be in status ***Processed/Complete*** *before* the Pre-enrollment Form for HCS is created. Refer to IDD Services Broadcast 2022-86 titled, "Complete Texas Home Living Terminations Before Submitting Home and Community-based Services Enrollment Forms" added on August 3, 2022.

8578 ID/RC

7.23. Can LIDDAs receive a notification when PES remands an 8578 ID/RC PC 2 Assessment?

LIDDAs can use FSI to search for an 8578 ID/RC PC 2 Assessment in status ***Remand to Submitter***. After uploading the requested document, submitters must click the "Add Note" button, located at the top of the assessment, to add a note stating that the documents have been uploaded. This action places the assessment back in status ***Pending DADS Review***, which informs PES that the assessment is ready for a final review. The assessment stays in status ***Pending DADS Review*** until PES completes the review process.

7.24. When the LON changed, CARE reverted it to the original LON for TxHmL. The LTCOP does not do that. Does the LIDDA need to submit a packet for a TxHmL LON change?

If a LON change is being requested, a packet is required. If not, contact UR at deskURLONIPC@hhs.texas.gov or 512-438-5055 to request a reconciliation.

7.25. What is the time frame for an 8578 ID/RC Assessment review to be completed?

PES strives for a 10-day time frame for 8578 ID/RC PC 2 or PC 3 Assessments without a LON increase request. All LON increase requests are referred to UR, and UR has a 21-day time frame for completing the review.

7.26. In CARE, an 8578 ID/RC PC E Assessment was no longer required to fill a gap. Has that changed?

Yes, if an 8578 ID/RC PC 3 Assessment is submitted more than 180 calendar days after the latest approved 8578 ID/RC Assessment expired, an 8578 ID/RC PC E Assessment is required.

7.27. What can we do if a 8578 ID/RC PC 2 Assessment is pre-populating with provider information from a previous enrollment which has been terminated?

This is a known issue currently being researched. In the meantime, to prevent pre-populated data on the assessment, do not enter a CARE ID or Medicaid number on the Submit Form page.

7.28. Should "+" or "N" be entered for the Medicaid number on a 8578 ID/RC PC 2 Assessment when the individual does not have a Medicaid number?

Refer to the *8578 Intellectual Disability/Related Condition Assessment Item-by-Item Guide* which states, "If the applicant's Medicaid number is pending, enter only the plus symbol (+). Do not enter an "N" as "N" is not applicable to the HCS or TxHmL programs." TMHP also provided additional guidance in the HCS and TxHmL Waiver Programs: Trending Issue Support, Volume 20 article.

7.29. Why are 8578 ID/RC Assessments set to status *Remanded to Submitter* if there isn't anything the LIDDA needs to amend, and the form is pending approval prior to entering status *Pending IPC Match*?

HHSC PES can remand assessments and forms, including the 8578 ID/RC PC 2, to request supporting documentation. If a form was submitted prior to July 3, 2023, and is in flight, then the required documents should still be uploaded in the IDD Operations Portal. Forms that are submitted on or after July 3, 2023, will require the documents to be attached to the form in the LTCOP. Reference "Appendix B: Assessment and Form Statuses" of the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for a list of statuses and associated provider and LIDDA actions.

3608/8582 IPCs

7.30. Can a description be added to the drop-down list in the Residential Type field?

This has been updated as part of the LTCOP Enhancements. The descriptions are as follows:

- 1 = own home/family home
- 2 = host home/companion care
- 3 = 3-person residence
- 4 = 4-person residence

7.31. If an IPC Form is submitted with incorrect information and is in status *Pending DADS Review*, can we inactivate it?

Regardless of the form status, never inactivate or correct an Enrollment IPC Form. For assistance, contact HHSC PES at 512-438-2484 or enrollmenttransferdischargeinfo@hhs.texas.gov.

For other IPC types, if the status of the IPC Form is ***Pending DADS Review*** or ***Pending Coach Review***, the LIDDA can use the "Correct this form" button to make the changes. However, for assistance on forms where the "Correct this form" button is not available, the LIDDA must contact PES for Enrollment or Transfer IPC Forms at 512-438-2484 or enrollmenttransferdischargeinfo@hhs.texas.gov or UR for Renewal or Revision IPC Forms at 512-438-5055 or deskURLONIPC@hhs.texas.gov.

7.32. Do we need to contact TMHP to let them know when an IPC is in *Pending DADS Review* status?

No, only HHSC PES and HHSC UR staff are authorized to review and approve or deny an HCS or TxHmL IPC Form on the LTCOP. Both PES and UR can search for forms in a ***Pending DADS Review*** or ***Pending Coach Review*** status. However, after it is approved by PES or UR staff, a form may go into status ***Submitted to PCS***. In that case, HHSC PCS staff are authorized to manually process the form through SAS. For assistance, the submitter must call PCS at 512-438-2200, Option 5.

7.33. Does the LIDDA need to take any action when forms are in status *Pending DADS Review* or *Submitted to PCS*?

The form status ***Pending DADS Review*** or ***Pending Coach Review*** means the form is under review by HHSC staff.

If needed, PES staff may request supporting documentation to process enrollment forms, which includes an 8578 ID/RC PC 2 Assessment and an Initial/Enrollment IPC Form. However, PES requires supporting documentation to process a Transfer IPC Form or a termination form. After the LIDDA has submitted the form(s) on the LTCOP, PES completes their review and processes the forms if the supporting documentation has been uploaded to the LTCOP. For assistance with these forms, contact PES at 512-438-2484 or enrollmenttransferdischargeinfo@hhs.texas.gov.

UR requires supporting documentation (i.e., an IPC packet) for Revision and Renewal IPC Forms. After the LIDDA or provider has submitted the form(s) on the LTCOP, UR completes their review and processes the form if the submitter has uploaded the supporting documents to the LTCOP. For assistance with these forms, the submitter may contact UR at 512-438-5055 or deskURLONIPC@hhs.texas.gov.

Forms in a ***Submitted to PCS*** status require manual processing by PCS. For assistance, the submitter must call PCS at 512-438-2200, Option 5.

Refer to the TMHP article titled, "Clarification on HCS and TxHmL IPCs status in Pending DADS Review" posted on December 7, 2022.

7.34. What's the difference between disagreeing with or not acknowledging an IPC Form and remanding it to submitter?

Disagreeing with an IPC Form does not send it back to the provider, and the disagreement is just noted in the form history. Remanding the form sends it back to the provider.

7.35. After inactivating an IPC Form on the LTCOP, does the submitter need to wait for the inactivated form to go into a particular status to submit a new form?

If the form was in a ***Processed/Complete*** status prior to the inactivation, HHSC PCS may need to manually remove the service authorizations from SAS before a new IPC Form can be submitted. PCS can be reached at 512-438-2200, Option 5.

7.36. Is the LIDDA required to notify HHSC every time a form is in *Pending DADS Review*?

If a Renewal or Revision IPC Form goes into a ***Pending DADS Review*** status, it means UR needs to conduct a review before the requested services and service amounts can be authorized. It is not necessary to notify UR of these forms, but the submitter must upload the supporting documentation to the LTCOP for the review.

Some forms will always go to a ***Pending DADS Review*** status for PES to review, such as Transfer IPC Forms and 3616 Request for Termination of Waiver Program Services Forms. It is not necessary to notify PES of these forms, but the submitter must upload the supporting documentation to the LTCOP for PES to conduct a review.

7.37. During a leap year, do we send back an IPC if a provider enters 365 opposed to 366 for Host Home/ Companion Care and Residential Support Services?

Yes, because they will not be able to bill for that extra day. They need 366 entered.

7.38. Where are the unit rates listed for HCS and TxHmL services?

The unit rates for HCS and TxHmL services can be found on the Long-term Services & Supports page of the Provider Finance Department (PFD) website.

3608/8582 Enrollment IPCs

7.39. What is the time frame for a 3608 or 8582 Enrollment IPC review to be completed?

PES strives for a 10-day time frame for enrollment and transfer IPC reviews and runs a report for pending Enrollment and Transfer IPCs daily.

7.40. What do I do if I receive an error message about exceeding units when entering an Enrollment IPC Form?

When the Enrollment IPC Form is submitted, HHSC PES will refer the form to HHSC UR for a desk review. When UR has completed the desk review, PES will proceed with the enrollment process.

3608/8582 Renewal and Revision IPCs

7.41. How do we change CDS units to dollars on an IPC Form that has already been uploaded from CARE?

CDS rates are on the last page of each program rate sheet, which are available on the Provider Finance Department web page. To calculate a dollar amount for CDS, multiply the number of units by the rate. For assistance with correcting an IPC Form, the submitter may contact UR at 512-438-5055 or deskURLONIPC@hhs.texas.gov.

7.42. Should the IPC Form on the LTCOP reflect a dollar amount when a dollar amount is entered?

Yes, the IPC Form on the LTCOP does reflect a dollar amount when a dollar amount is entered. The rate is 1.00. To determine the appropriate dollar amount to enter, multiply the number of units by the current CDS rate for the specific program, which can be found on the Long-term Services & Supports web page.

7.43. What does the LIDDA need to do when the 3608 or 8582 IPC is in status *Pending Location Availability*?

There is no action for the LIDDA to take when an IPC is in status ***Pending Location Availability***. This status means the system is in the process of validating that the location is open and is not already serving at its full capacity.

7.44. Does the LTCOP allow for leap year when calculating the expiration date?

Yes, it does calculate for leap year.

3608/8582 Transfer IPCs

7.45. The most current Estimated Annual Cost information is needed when submitting a transfer, but it is not updated on the Dashboard when an IPC Form is approved. When will this be resolved?

TMHP has resolved this issue. If this issue is still occurring, contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.46. When submitting an IPC Transfer Form on the LTCOP and selecting the Provider Vendor/Contract in Field 41 Provider Choice Vendor/Contract Number, an error message is received that says the provider vendor/contract must match. What does this error message mean?

The field requirements on the IPC Form are based on the IPC type. When submitting any IPC Form on the LTCOP, select the IPC type in Field **11 IPC Type** before entering any other data. This allows the system to apply the correct field requirements.

For a transfer, after you select the IPC type, enter all the other required fields on the first tab except for Field **41 Provider Choice Vendor/Contract Number**. Then, complete the required fields on the Transfer tab and come back to the first tab to complete Field **41 Provider Choice Vendor/Contract Number**. That should solve the issue. However, if you still experience this issue, contact the LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.47. Do we need to complete an IMT prior to entering a transfer?

There are several scenarios where multiple forms must be submitted, and submitting forms in sequential order is important to avoid errors. Refer to Appendix A in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* or the *Individual Movement Form Item-by-Item Guide*.

7.48. Who can we contact when we receive error messages while trying to submit a Transfer IPC?

Contact PES at 512-438-2484 or enrollmenttransferdischargeinfo@hhs.texas.gov for assistance with Transfer IPC Forms.

7.49. An individual who was enrolled in the program prior to migration does not have an Enrollment IPC on the LTCOP. How does the LIDDA launch a Transfer IPC without an Enrollment IPC?

Use the Submit Form page on the LTCOP to submit the Transfer IPC.

7.50. What can we do when the transferring provider has billed past the transfer effective date?

Notify the transferring provider that the claims need to be backed out to allow the transfer worksheet to populate correctly. The provider may contact TMHP for assistance. If the provider is not responsive to backing out the claims, follow the process described in Section 16200, General Complaint Information in the HCS Handbook.

7.51. What should the LIDDA do if the service amounts do not populate when the "Populate Transfer Worksheet" button is clicked on a Transfer IPC Form?

Contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.52. What should the LIDDA do if the provider has submitted a 3616 Request for Termination of Waiver Program Services Form with the same effective date as a transfer?

The LIDDA can contact the provider and ask them to inactivate the form and to wait until the transfer is in a ***Processed/Complete*** status to submit a new 3616 Request for Termination of Waiver Program Services Form. If the provider does not inactivate the form, the LIDDA can contact PES for assistance at 512-438-2484 or enrollmenttransferdischargeinfo@hhs.texas.gov.

7.53. Can HHSC add the Medicaid number to the top of the 3617 Request to Transfer Form?

Thanks for the suggestion. PES will consider the request for future form revisions.

7.54. Who is responsible for submitting a Transfer IPC and the transfer documents?

LIDDAs are responsible for submitting a Transfer IPC on the LTCOP and uploading the transfer documentation to the LTCOP. If a transfer involves two LIDDAs, the transferring LIDDA is responsible for submitting the IMT—LA Reassignment on the LTCOP. Then, the new LIDDA is responsible for acknowledging the IMT—LA Reassignment, submitting the Transfer IPC, and uploading the transfer documentation to the LTCOP.

7.55. Who can the LIDDA contact for assistance with submitting Transfer IPCs?

Contact PES at enrollmenttransferdischargeinfo@hhs.texas.gov.

7.56. An LTC Help Desk representative said it is okay to submit a 3608 or 8582 IPC if Field 9 LA Vendor No. on the "Section Transfer" tab is incorrect. Is this right?

Per IDD Services, LIDDAs should never be instructed to submit a form with incorrect information. TMHP needs to research the issue and fix it. To report misinformation, send the name of the LTC Help Desk representative and the ticket number, or at least the date and time of the call, to TMHP at LTCOPS-Escalations@tmhp.com.

7.57. Do I upload Form 3617 Request for Transfer of Waiver Program Services and the Transfer IPC (Form 3608 HCS-CFC IPC or Form 8582 TxHmL-CFC IPC) to the IDD Operations Portal or the LTCOP?

As of July 3, 2023, the HCS or TxHmL transfer packet containing Form 3617 and the Transfer IPC (Form 3608 or Form 8582) are uploaded and attached to the transfer form in the TMHP LTCOP. Refer to the *LTC HCS and TxHmL Waiver Programs Provider User Guide* for more information on form attachments in the LTCOP.

IMT

7.58. Are providers being instructed to enter the IMT?

The IMT is a multi-purpose/multi-program form. For the HCS and TxHmL programs, the IMT Form is used for submitting suspensions, LA reassignments, individual updates, and SC updates. LA reassignments and SC updates can only be submitted by a user with LIDDA permissions, but suspensions and individual updates can be submitted by a user with LIDDA permissions or a user with provider permissions.

7.59. Can HHSC provide each LIDDA with a contact list for other LIDDAs to speed up enrollments, transfers, and LA Reassignments?

IDD Services Program Improvement will send a broadcast message to LIDDAs when this resource is ready.

7.60. Which form must be processed first: IMT—Individual Update or IMT—LA Reassignment?

Refer to "Appendix A: Scenarios for Selecting an IMT Purpose and IPC Type" in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* or the *Individual Movement Form Item-by-Item Guide* for assistance with selecting an IMT Form purpose and form sequencing requirements.

7.61. Is Form 8575 Notification of LA Reassignment still required when an individual moves to a new LIDDA's service area?

Yes. Refer to Section 8800 of the HCS Handbook.

IMT—LA Reassignments

7.62. After submitting the IMT—LA Reassignment and/or IMT—SC Update, how long does it take for the new information to appear on the LTCOP? Also, the estimated annual cost information is often not for the current IPC Form or doesn't match what is populating on the Transfer IPC Form when we click the "Populate Transfer Worksheet" button. How often is the estimated annual cost updated?

The new information will display the day after the form status is set to ***Processed/Complete***, ***PCS Processed/Complete***, or ***DADS SAS Resolution Complete***. If the changes are not reflecting on the LTCOP the day after the form is completely processed, contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.63. Who should we contact when the current LIDDA information is incorrect on the IMT?

TMHP needs to research the issue and fix it. Contact the LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.64. If an IMT—LA Reassignment is in status *Processed/Complete*, when is the new LIDDA assignment reflected on the Individual Detail page?

It depends on how the transferring LIDDA enters the IMT—LA Reassignment. If the transferring LIDDA enters the new county *and* the new address on the form, the new LIDDA's information is reflected in the Individual Search function on the day after the IMT—LA Reassignment moves to status ***Processed/Complete***. If the sending LIDDA only enters the new county on the IMT—LA Reassignment, the new LIDDA's information is not reflected in the Individual Search function until the address change is also submitted on a separate IMT—Individual Update.

7.65. When entering an IMT—LA Reassignment, should the sending LIDDA enter the new county and the new location code and address or just the new county?

Enter the new county and the new location code and address.

7.66. Who can assist if the new LIDDA cannot locate an IMT—LA Reassignment using the FSI function?

Contact the sending LIDDA to confirm the correct vendor and contract numbers were selected for the form. If the vendor or contract numbers are incorrect, the sending LIDDA must inactivate the form and submit a new form with the correct vendor and contract numbers. If the vendor and contract numbers are correct, the receiving LIDDA can contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1) for assistance.

7.67. Does the sending LIDDA need to submit all TCM claims before submitting an IMT—LA Reassignment to another LIDDA?

No, claims can be submitted up to one year.

IMT—Individual Update

7.68. Who is required to submit the IMT—Individual Update?

If the provider agency service delivery option is used for any services, the provider must submit the form. If the CDS delivery option is used for all services, the LIDDA submits the form.

IMT—Service Coordinator Update

7.69. Will LIDDAs be penalized for an individual not being assigned to a SC? We have transfers pending that we cannot submit because the SC's name is not included in the drop-down field on the LTCOP. We reported this to TMHP and received notice that the issue has been escalated to Tier 3. However, we have not received an update.

LIDDAs must ensure all individuals have an assigned SC. However, HHSC will not penalize LIDDAs for missing SC information on forms while this issue exists on the LTCOP forms. In the meantime, contact PCS at 512-438-2200, Option 5, to report missing SC names.

7.70. How do we remove SCs who no longer work for the LIDDA?

SC information was recently reloaded to address all the SC issues on the LTCOP, and updates are being sent daily; Monday through Friday. To assist us in identifying new issues, contact PCS at 512-438-2200, Option 5, to report the SC names that should not be listed.

7.71. Has the issue that causes the error message, "Service coordinator ID is not valid or inactive" been resolved yet?

An enhancement to resolve the SC ID issues is under review by HHSC and TMHP.

7.72. When making SC assignments, not all SC names are listed on the drop-down.

Make sure the SC's information is properly entered in the LTCOP first. Then, if the forms on the LTCOP still do not display the SC name, contact the LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.73. What can be done to speed up the process of getting a local case number from the previous LIDDA?

If the information has been requested from the LIDDA, but has not been received, contact the LIDDA director for assistance. If that is unsuccessful, send an email to idd_program_improvement@hhs.texas.gov.

7.74. If the SC name is incorrect on a form, but the field is not editable, should the form be submitted with incorrect information?

Do not submit the form with incorrect information. TMHP must research the issue and fix it. Contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.75. Can LIDDAs see the assigned SC in the FSI search results?

Yes, service coordinator names now appear in a column on the FSI search results.

7.76. Which system does the LIDDA use to update SC information?

Enter SC updates in the LTCOP using the IMT—SC Update form.

Location Code

7.77. When entering a Transfer IPC, the system sometimes removes the location code I entered, and the field is disabled. Has this issue been fixed?

On October 7, 2022, TMHP deployed a data fix to resolve this issue. If you continue to experience this, contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.78. When will the existing issue with entering the new location code on an IMT—LA Reassignment be fixed?

The original issue was fixed. However, there may be other reasons the new location code cannot be entered, such as too many locations received in the data load. TMHP is investigating options for a more global fix. For assistance, contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.79. How do I enter a location code during the transfer process?

The issue that caused forms to improperly fail the location availability validation has been fixed. Any forms currently in this status are legitimate issues. Submitters can avoid location and capacity errors by submitting forms in sequential order as described in Appendix A of the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, available under the Reference Material section on the 1915(c) Waiver Programs web page.

7.80. How do we request to correct the location code on an IPC Form?

For assistance with Transfer IPCs, contact PES at 512-438-2485 or enrollmenttransferdischargeinfo@hhs.texas.gov.

7.81. When only the LIDDA is changing, do we select the current location code or new location code in Field 111 New Location Code?

In this scenario, the new location code needs to be entered in Field **111 New Location Code**.

7.82. On the IMT—LA Reassignment, Field 111 New Location Code continues to cause confusion. The field requires the LIDDA to leave the individual's old location code in the field, but we must select the new county. Then, the new LIDDA submits the new location code on the Transfer IPC. Can the field name be changed to "Current Location Code" to resolve the issue?

An enhancement was released in December 2022, to add a check box for indicating whether the provider is also changing. If the box is not checked, the new location code should be entered in Field **111 New Location Code**. If the box is checked, the new location code and the new location type fields become disabled, and the LIDDA submits the new location code/type on the Transfer IPC instead.

7.83. When a LIDDA reassignment has the wrong location code, how do we correct it?

To correct Field **111 New Location Code** on the IMT LA—Reassignment, the transferring LIDDA (the submitter of the form) can utilize the "Correct this Form" button when the form is still in status ***Pending New LA Review***. If the form has moved to status ***Processed/Complete*** but the new location code is found incorrect because the receiving LIDDA is now the individual's new LIDDA, the receiving LIDDA can submit an IMT—Individual Update to put in the correct location for the individual.

7.84. After entering an IMT—LA Reassignment, a message pops up stating, "The new location is not valid for the residential type. An IPC revision must be submitted." However, the residential type is not changing. Must the old location code be entered to resolve this issue?

No, do not input old location codes. If an error message is populating regarding the location code, email PES at enrollmenttransferdischargeinfo@hhs.texas.gov for assistance with a resolution.

Locations

7.85. If a provider's location address is incorrect, who should the LIDDA notify?

Notify the provider that the form cannot be submitted until they correct the location address. The provider can contact the LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.86. What locations are providers required to enter on the LTCOP?

Providers are required to set up a location for all residents where host home/companion care, supervised living, or residential support services are provided.

3616 Request for Termination Form

7.87. Who should I contact about a 3616 Request for Termination of Waiver Program Services Form I submitted that hasn't been approved yet?

To escalate an issue to HHSC PES management, email Ashley Wechsler at ashley.wechsler@hhs.texas.gov and Debra Abercrombie at debra.abercrombie@hhs.texas.gov. Wait five full business days before escalating an issue to PES management.

7.88. Is it the LIDDA or the program provider who is responsible for submitting the 3616 Request for Termination of Waiver Program Services Form?

If the individual is using the CDS option for all services, the LIDDA is required to submit the 3616 Request for Termination of Waiver Program Services Form. However, if an individual is receiving any provider-delivered services, either the LIDDA or the provider can submit the form.

If the form is submitted by the LIDDA, it goes to a ***Pending Provider Review*** status. The provider must review and acknowledge the form before it will move forward in the workflow.

If the form is submitted by the provider, it goes to a ***Pending LA Review*** status. The LIDDA must review and acknowledge the form before it will move forward in the workflow. To prevent duplicate form

submissions, it is best practice to always check for an existing form before submitting any form on the LTCOP.

7.89. Does the LIDDA need to wait for a Transfer IPC Form to be in a *Processed/Complete* status before submitting a 3616 Request for Termination of Waiver Program Services Form for the same individual?

Yes, submit the transfer and wait until it is in a ***Processed/Complete*** status to enter and submit the request for termination. If the individual has a provider, the provider can submit the termination form. So, be sure to check for an existing form before submitting any form on the LTCOP.

7.90. What can LIDDAs do when the provider does not have the "Acknowledge" button to review terminations? The provider has contacted TMHP but has not received a response.

If the provider has opened a help desk ticket for the missing "Acknowledge" button on the 3616 Request for Termination of Waiver Program Services Form and has not received an update, the provider can escalate the issue by sending an email to LTCOPS-Escalations@tmhp.com with the Customer Relationship Management (CRM) ticket number, the date and time the issue was reported, and if known, the customer service representative who took the call.

7.91. An individual who uses the CDS option for all services has no program provider, but when the LIDDA submits a 3616 Request for Termination of Waiver Program Services Form, the form goes to the provider workflow for provider acknowledgment. What needs to happen in these cases?

If a termination form is in ***Pending Provider Review*** status, but the individual has no program provider because they use the CDS option for all services, notify PES at 512-438-2484 or enrollmenttransferdischargeinfo@hhs.texas.gov. PES staff can acknowledge the form.

7.92. Who does the provider contact for assistance with acknowledging the 3616 Form?

Providers do not acknowledge the 3616 Form. The provider submits the form, and then the LIDDA acknowledges it. The LIDDA submits the form only if the individual uses the CDS option for all services, but there is no provider acknowledgment in this scenario.

7.93. When an individual's services are suspended, and the team agrees to terminate services, should the "Terminate Services" button be used on an existing IMT—Suspension to launch the 3616 Form, or should we submit a new form using the Submit Form page?

In this scenario, the best practice is for the provider to use the "Terminate Services" button on the existing IMT—Suspension, which will launch a 3616 Form, and automatically end the suspension. If the provider submits a new form using the Submit Form page, the suspension will not automatically end. The provider must update the IMT—Suspension to end the suspension.

7.94. When an individual is voluntarily terminating from TxHmL to enroll in HCS, does the LIDDA use the Submit Form function to submit the 3616 Form or to complete the IMT? Does the provider use the "Terminate Services" button on the existing IMT—Suspension or the Submit Form function to select the 3616 Form?

If the individual is currently on suspension, the TxHmL provider uses the existing IMT—Suspension

to terminates services. This will automatically end the suspension and will launch the 3616 Form. If the individual is not currently on suspension, the provider will use the Submit Form page to submit the 3616 Form.

In both scenarios, after the provider has submitted the termination form, the LIDDA reviews the form and clicks the "Acknowledge" button to send it to PES for review and processing. The LIDDA then submits the Pre-enrollment Form for HCS after the 3616 Form is in status ***Processed/Complete***.

7.95. What can be done about a provider who submits the 3616 Form without signatures and sends it to the LIDDA to obtain signatures?

The SC should be conducting the service planning meeting and obtain signatures on the form at the time of the meeting.

LIDDAs and providers are encouraged to work together to resolve any issues regarding service provision. Follow the process in Section 16200, General Complaint Information in the HCS Handbook.

7.96. Who is required to submit Form 3616 Request for Termination?

If the provider agency service delivery option is use for any services, the provider submits the form. If the CDS delivery option is used for all services, the LIDDA submits the form.

7.97. Can Form 3616 Request for Termination be submitted before the termination effective date?

Yes, it can be submitted before the termination effective date.

7.98. What is the time frame for reviewing and processing a termination request after submission?

If a termination form is not processed within 14 business days after submission, contact PES at enrollmenttransferdischargeinfo@hhs.texas.gov.

Form 8648 Identification of Preferences (IOP)

7.99. Can the IOP be uploaded to a HHS system?

Thank you for this suggestion. It is on our list of potential future system enhancements.

7.100. When an interest list record needs to be transferred, sometimes the sending LIDDA transfers the interest list without first notifying the new LIDDA as described in the LIDDA Handbook. This results in a missing IOP Form for the new LIDDA. When contacting the sending LIDDA to request the form, the new LIDDA is instructed to contact the records department. What can be done about this?

Speak directly with the sending LIDDA's staff, a supervisor and/or the IDD Director to try and resolve the issue. If that is unsuccessful, send an email with the detailed information to InterestListPreEnroll_LIDDAHelp@hhs.texas.gov.

Individualized Skills and Socialization

7.101. When entering Individualized Skills and Socialization in the LTCOP, anyone with LON 5 or higher exceeds the cost ceiling. Must TxHmL recipients limit the number of days that they receive Individualized Skills and Socialization, whether the services are provided on-site of off-site?

Individualized Skills and Socialization combined with other waiver services must not exceed the amount specified in TAC Rule §262.101. The submitter should calculate the actual hours by determining how much is on-site versus off-site and adding the waiver services together.

7.102. Will the cost ceiling for TxHmL be increased now that Individualized Skills and Socialization is billed at an hourly rate?

The cost ceiling is specified in TAC Rule §262.101.

HHSC - Customer Service/Leadership

7.103. How can I escalate an issue if I'm not receiving a response from PES or UR?

Wait five full business days before escalating an issue to management. To escalate an issue to HHSC PES management, email Ashley Wechsler at ashley.wechsler@hhs.texas.gov and Debra Abercrombie at debra.abercrombie@hhs.texas.gov.

To escalate an issue to HHSC UR management, email Brandi McKinley at Brandi.McKinley@hhs.texas.gov and Barbara Unger at Barbara.Unger01@hhs.texas.gov.

7.104. Will TMHP generate notifications or corrective actions that LIDDAs can use for errors or other issues?

If a LIDDA is required to submit a corrective action plan for any reason, the LIDDA will receive a notice from HHSC and not TMHP.

7.105. Where can I find recordings of the HHSC Monthly Meeting for LIDDAs Regarding CSIL and LTCOP for HCS and TxHmL?

Recordings of the HHSC Monthly Meeting for LIDDAs Regarding CSIL and LTCOP for HCS and TxHmL are emailed to attendees. If you have not received a recording for a specific meeting, email LPDS at InterestListPreEnroll_LIDDAHelp@hhs.texas.gov.

Technical Assistance

7.106. Has TMHP LTC Help Desk staff received training on the differences between a LIDDA user and a provider user? When I call and explain that I am with the LIDDA, they handle the call as if I am a provider user.

Yes. TMHP LTC Help Desk staff have received training on the differences between a LIDDA user and a provider user. To help us identify cases where this is an issue, send an email to LTCOPS-Escalations@tmhp.com with the CRM ticket number, the date and time the issue was reported, and if known, the

customer service representative who took the call.

7.107. What should I do if I have submitted an issue to TMHP, but never received a follow-up?

In the current process, the customer is given a call back when their ticket has been escalated. To help us identify cases where this process was not followed, send an email to LTCOPS-Escalations@tmhp.com with the CRM ticket number, the date and time the issue was reported, and if known, the customer service representative who took the call.

7.108. How do we find information previously available in CARE?

HHSC and TMHP developed crosswalk documents to assist with finding information previously available through a CARE screen or a CARE report. Both crosswalk documents are available on the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) web pages. Under the Resources heading, you'll see the Provider and LIDDA CARE Report Crosswalk and the Provider and LIDDA CARE Screen Crosswalk.

7.109. Providers are contacting LIDDAs about missing service authorizations in MESAV when the IPC Form is in a *Pending DADS Review* status on the LTCOP. When will this be resolved?

The form status ***Pending DADS Review*** means that the IPC Form is under review by HHSC staff. In some cases, IPC Forms were sent to the UR queue due to a rate add-on temporarily implemented by HHSC as part of the ARPA Provider Retention Plan. However, this expired on August 31, 2022, so the issue is phasing out. Check the form history notes for information about the reason for the review, and refer the provider to UR at 512-438-5055 or deskURLONIPC@hhs.texas.gov if they need more information. Service authorizations will appear in MESAV when the plan is authorized by HHSC.

7.110. Where can we locate Appendix A?

Appendix A is in the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide*, available under the Reference Material section of the 1915(c) Waiver Programs web page.

7.111. When will SC information show up on the LTCOP?

SC information was recently reloaded to address all the SC issues on the LTCOP forms, and updates are being sent daily; Monday through Friday. To assist us in identifying new issues and to report SC names that should not be listed, contact PCS at 512-438-2200, Option 5.

7.112. How do LIDDAs get the Power Search option?

For HCS and TxHmL, the Power Search feature is available to HHSC staff only. To find all forms that have been submitted for an individual, LIDDAs can use the Individual Search or FSI features.

7.113. Do I enter the actual last date of services received as the termination effective date on the 3616 Request for Termination of Waiver Program Services Form?

Yes. For any TxHmL or HCS terminations, the termination effective date is the actual last day of services received.

7.114. What is the recommended method to search for forms on the LTCOP?

TMHP recommends using the FSI feature to search for forms you submitted and using the Individual Search feature to see forms submitted by others.

7.115. Can HHSC Help Desk and TMHP LTC Help Desk staff make corrections to the forms at the time of the call?

No, HHSC and TMHP help desk staff do not have authority to change data on the forms. Use the Provider Quick Reference Contact List for HCS and TxHmL that has been shared with all LIDDAs to contact the appropriate area for assistance with a specific form.

7.116. When submitting multiple forms on the LTCOP, it is frequently necessary to clear the browser history between form submissions. Is there a plan to fix this?

TMHP is investigating options for improving portal performance.

7.117. Will TMHP provide training on error messages?

For assistance with understanding a specific error message, contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.118. What is the escalation process for TMHP when there is an Ombudsman complaint?

Send an email to LTCOPS-Escalations@tmhp.com with the ticket number, the date and time the issue was reported, and if known, the customer service representative who took the call. It is also helpful to indicate in the email that the issue is being escalated to address an Ombudsman complaint.

7.119. If a form is submitted with an error, can it be corrected or should it be inactivated?

For the Pre-enrollment Form, certain fields can be corrected by the LIDDA if the form status is ***Pre-enrolled***. However, if the status is no longer ***Pre-enrolled***, the LIDDA must contact the assigned slot monitor.

For an 8578 ID/RC PC 2, the LIDDA can use the "Correct this form" button if the form is not in a ***Processed/Complete*** status yet. However, if the form is in a ***Processed/Complete*** status, the submitter must contact PES for assistance at 512-438-2484 or enrollmenttransferdischargeinfo@hhs.state.tx.us.

For 8578 ID/RC PC 3, 4, or E Assessments and all IPC Forms, the submitter must contact UR at 512-438-5055 or deskURLONIPC@hhs.texas.gov.

7.120. Some of our LIDDA staff are not able to see information on the LTCOP. They have the same user role and access as other staff who are able to see information. How can this be resolved?

For information on managing accounts and modifying permissions, refer to the Account Management web page on tmhp.com. For assistance with LTCOP permissions, contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.121. Are LTC Help Desk staff able to participate in a Microsoft Teams call with LIDDA staff, which would allow the LIDDA to screen share for a better understanding of the issue(s)?

Yes, when calling the LTC Help Desk, let the representative know that a meeting is preferred.

7.122. If LIDDA staff cannot locate a form using the DLN, who should we contact for help?

Contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1).

7.123. Who should be notified if a provider's contract number is not included in the drop-down list on the LTCOP?

Notify the provider that the form cannot be submitted until the provider has resolved the contract issue. The provider may need to review their HHSC contract. If the provider does not plan to renew their HHSC contract, the individual must select another provider.

7.124. How does a host home/companion care provider receive payment if the provider's contract is expired?

A host home/companion care contract is an agreement between the service provider and the program provider. HHSC cannot enforce contract terms between other parties. However, if they choose to, the host home provider may contact the IDD Ombudsman.

7.125. Who does a program provider or FMSA need to contact for assistance with MESAV?

Contact the TMHP LTC Help Desk at 800-626-4117 (Option 1, Option 1). The Provider Quick Reference Contact List for HCS and TxHmL is available on the TMHP 1915(c) Waiver Program web page.

7.126. Is TMHP able to transfer phone calls to HHSC?

No. To contact the appropriate resource, refer to the Provider Quick Reference Contact List for HCS and TxHmL.

7.127. Do LIDDA staff need to submit new access requests for the CSIL and Service Authorization System-Online (SASO) applications after the applications are moved to the new IAMOnline Portal?

Per new instruction from the IAMOnline team, LIDDA staff who currently have application access through the HHS Enterprise Portal will receive an individualized registration link from IAMOnline the same day the application moves to the IAMOnline Portal. LIDDAs must use this link for their current access to migrate to IAMOnline. After account setup, any additional application access will migrate to IAMOnline when the associated application moves.

7.128. Who can LIDDA staff contact for assistance with setting up an IAMOnline Portal account?

Contact the HHS Consolidated Help Desk at 512-438-4720 or 855-435-7181 (toll-free), 7:00 A.M. to 7:00 P.M., CT, Monday through Friday to open a ticket. To escalate the ticket once opened, send the ticket number to beth.feaster@hhs.texas.gov.

7.129. Will the administrator role get access to the Dashboard and Individual Search features?

This is being considered as a future enhancement.

7.130. What can LIDDA staff do if an error message populates when attempting to use the Dashboard feature?

If errors occur in the LTCOP, try clearing the browsing history and cache. Then, close the browser window, reopen it, and try accessing the Dashboard again. If the issue persists, contact the LTC Help Desk at 1-800-626-4117, Monday-Friday, 7:00 A.M. to 7:00 P.M..

7.131. When will the Appendix A tool be available for use?

The Appendix A tool was sent in IDD Services Broadcast 2023-80 on July 13, 2023.

7.132. How do I access the Medicaid Client Portal (MCP)?

The MCP is a TMHP site. Instructions on how to access the site were explained during the HHSC Monthly Meeting for LIDDAs Regarding CSIL and LTCOP for HCS and TxHmL on July 6, 2023. The recording and associated job aid were sent in IDD Services Broadcast 2023-83 on July 17, 2023.

7.133. Who do I contact if error screens instruct to reload the site or action buttons are missing from forms on the LTCOP?

Per IDD Services Broadcast 2022-101, TMHP recommends using the Microsoft Edge browser to access the LTCOP. There are compatibility issues with other internet browsers that may cause users to experience slowness, missing action buttons, display issues, etc. Users should also frequently clear the browser cache to avoid issues. If issues persist, call the TMHP LTC Help Desk at 800-626-4117 or 800-727-5436, Monday-Friday, 7:00 A.M. to 7:00 P.M..

Vendor/Provider Information

7.134. Can vendor numbers be sorted in numerical order on applicable form fields?

Thank you for the suggestion. TMHP will ensure this item is included on the list of future system enhancements.

7.135. Where can we find the NPI? Could the provider's NPI auto-populate on an Enrollment IPC?

To find a provider's NPI, use the Providers by Program tile on the Dashboard. Enter the provider's vendor number (component code) and click the "Search" button. When the search results populate on the screen, click the hyperlink for the provider's contract number. This displays the provider's contract information, including the NPI. You can also search for the NPI on the NPPES NPI Registry.

For enrollments, the provider's information is only entered on the Enrollment IPC. Since it is the first time the provider is being identified, the NPI has to be entered manually on the form.

LTC Online Portal Enhancements

7.136. When is TMHP going to update the service coordinator list to include the current service coordinators?

Service Coordination data migrated from CARE on June 29, 2023, and has been available in the LTCOP Service Coordination functions since July 3, 2023.

7.137. Will we get a packet to add to the original TMHP training materials?

All TMHP training materials have been updated to reflect the new LTCOP Enhancements. Reference the 1915(c) Waiver Programs page on tmhp.com.

7.138. Can we upload attachments to the LTCOP after submitting the IPC? If an IPC needs a cost increase, are we supposed to go in and upload those documents after the IPC has already been entered to justify the cost?

Yes. The attachment function supports uploading and downloading documents during form submission and after forms have been submitted successfully. Deleting attachments is limited and can occur during form submission or when the form is in certain statuses prior to being fully processed. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on form attachments.

7.139. How will these new enhancement functions affect forms entered before the implementation date? For example, forms currently stuck in status *Provider Action Required—Pending Location Availability*.

If a form was submitted before July 3, 2023, and is currently in status ***Provider Action Required—Pending Location Availability***, that indicates the location capacity was reached. The provider must click the "Update Location" button or the "Reactivate Location Availability" button to fix the error. Reference the *Long-Term Care Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Waiver Programs Provider User Guide* for more information on the Capacity Verification Process.

7.140. Is service coordinator entry on the HCS or TxHmL Pre-enrollment Form for the service coordinator handling the enrollment or the assigned service coordinator for the program on behalf of the LIDDA?

On the HCS or TxHmL Pre-enrollment Form, you will select the enrollment service coordinator from the drop-down field, which lists all active service coordinators for the LIDDA. Whoever you select will become the assigned service coordinator in the LTCOP. Some LIDDAs have service coordinators that specialize in assisting with enrollment and can choose to switch to a different service coordinator once the individual's enrollment is complete using the Enrollment IPC. Other LIDDAs may choose to keep the same service coordinator on the IPC. This decision is up to the LIDDA, as the LTCOP will allow them to do it either way.

7.141. Will Maintenance permission for service coordination units cause similar issues as the Dashboard function does to TMHP administrator accounts? Will we still be able to access and submit all forms if we get this permission?

The Maintenance permission for service coordination is compatible with form submission permissions.

7.142. I am an account administrator for TMHP, but I don't see the buttons to make changes to service coordination units. Is there a way to fix this?

Administrator accounts are used to add, remove, and edit permissions for general user accounts. If you need to access forms and other LTCOP functions, it is best practice to create a general user account.

7.143. Where does the service coordinator caseload pull from?

Service coordinator assignments were originally pulled from the legacy system into the LTCOP. Assignment data is now updated and maintained on the LTCOP by the completion of the following forms: HCS or TxHmL Pre-enrollment, 8578 ID/RC PC 2, 3608 or 8582 Enrollment IPC, and IMT—Service Coordinator Update.

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