TEXAS
Health and Human Services

Long-Term Care Provider Bulletin

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Cures Act EVV Expansion for Medicaid Personal Care Services

By January 1, 2021, Texas Health and Human Services Commission (HHSC) will implement the 21st Century Cures Act Electronic Visit Verification (EVV) requirement for Medicaid personal care services not currently required to use EVV by state law. HHSC already requires EVV for about 90 percent of Medicaid personal care services. Throughout the 2020 calendar year, program providers and financial management services agencies (FMSAs) must take action to meet the EVV start date by January 1, 2021.

To confirm if a Medicaid personal care service is subject to the Cures Act EVV requirement, refer to pages 1-2 of the *Programs, Services and Service Delivery Options Required to Use EVV*.

Cures Act EVV Expansion Timeline

The important dates and milestones that program providers and FMSAs must meet throughout 2020 are below.

Note: *Dates are subject to change.*

Action	Action Due Date	Description
Select an EVV system and begin the onboarding process.	By May 1, 2020	Program providers and FMSAs must select an EVV vendor system or elect to use their own EVV proprietary system and begin the onboarding process.
Practice using the EVV system and EVV claims matching.	July 1, 2020 – Nov. 30, 2020	EVV system practice includes: • Identifying appropriate clock in and clock out methods for members. • Attendants clocking in and clocking out of the system when delivering services. • Correcting visits through visit maintenance. • Reviewing reports. Program providers and FMSAs submitting EVV claims to TMHP receive claims matching results in the EVV Portal. Claims matching results identify if EVV-required services on the claim match the accepted EVV visit transaction in the EVV Portal. **During the practice period EVV claims are not denied for a mismatch.** Includes: • Checking the EVV Portal for claims matching results. • Using claims matching results to identify visits or claims needing correction.

Action	Action Due Date	Description
Complete Required Training	By Dec. 1, 2020	Program providers and FMSAs must complete the following training: • EVV vendor (before gaining access to the EVV system) • EVV policy • EVV Portal CDS employers must complete the following training: • EVV vendor (before gaining access to the EVV system) • EVV policy Refer to the Cures Act EVV Required Training Checklist for more information.
EVV claims matching with denials begins.	Dec. 1, 2020	Beginning Dec. 1, 2020: • All service visits for an EVV-required service must be captured in the EVV system. • Claims without a matching EVV visit transaction accepted into the EVV Portal will be denied for payment. Refer to the EVV Claims Matching Policy for more information.

For more information about the Cures Act EVV Expansion and next steps, visit the HHSC EVV Cures Act webpage. ■

Quality Assurance Performance Improvement (QAPI) and Resident Safety – Roadmap to Quality

Although the regional conferences have ended, the HHS Quality Monitoring Program will continue to offer support for NFs as they work on improving their QAPI programs. Nursing facilities can also request reviews of their QAPI plans.

For individual consultation regarding your facility's QAPI program, contact Sheila Shepherd, MSN, RN, by email at sheila.shepherd@hhsc.state.tx.us, by phone 512-438-5577, or by text 850-867-8669. ■

Effective October 1, 2020, MDS 3.0 Assessments Will be Updated on the TMHP LTC Online Portal to Include RUG III Section

Centers for Medicare & Medicaid Services Announces Delay in Releasing Next Version of MDS 3.0

As of March 19, 2020, the Centers for Medicare & Medicaid Services announced that they are delaying the release of the next version (18.1) of the Minimum Data Set (MDS), and will continue to calculate Resource Utilization Group (RUG) III values on MDS 3.0 assessments. HHSC is continuing with the project to add the data elements for calculation of the RUG III for Medicaid in a new section of the MDS assessment on the TMHP Long-Term Care (LTC) Online Portal. The data elements will be automatically completed using the values from the MDS assessment, and no additional data entry will be required by the nursing facility user.

Additionally, annual revisions, additions, and deletions implemented by the Centers for Medicare & Medicaid Services for the MDS Comprehensive and Quarterly Assessments will be available on the LTC Online Portal user interface and printable PDFs, so that the correct data is displayed. Further information about these changes and the accompanying LTC Online Portal changes will be announced in future news articles on the TMHP LTC web page.

For more information about the annual MDS 3.0 updates, visit the MDS 3.0 Technical Information web page on the Centers for Medicare & Medicaid Services website.

For more information, call the Long-Term Care Help Desk at 800-626-4117, Option 1. ■

Coronavirus (COVID-19)

For information about this rapidly evolving situation, check the website at TMHP.com by clicking below.

www.tmhp.com/Pages/COVID-19/COVID-19-HOME.aspx

Effective August 31, 2020, Billing Provider Information Must Not Match Attending or Rendering Provider Information

Effective August 31, 2020 (Monday), the following fields will be added to the Long-Term Care Institutional TexMedConnect Claims:

For **Attending Provider** in Provider Tab:

- Taxonomy

For **Rendering Provider** in Provider and Details Tab:

- National Provider Identifier (NPI)/Atypical Provider Identifier (API)
- First Name
- Last Name
- Middle Initial
- Suffix

Notes: *Attending Provider in Details tab will be changed to Rendering Provider.*

A draft, individual template, or group template saved with Attending Provider information in details tab prior to August 31, 2020, will not convert to Rendering Provider information.

The NPI/ API for the Billing Provider must be different from the NPI and/or API of the Attending Provider (and Rendering Provider, if included). Claims submitted with one or more of the following combinations will be rejected:

- Same information for Billing Provider NPI/API and Attending Provider NPI/API
- Same information for Billing Provider NPI/API Rendering Provider NPI/API

Users that enter the same NPI and/or API for the Billing Provider as the Attending or Rendering Provider will see the one of following error messages:

- **"Attending provider NPI/API cannot be the same as the Billing provider NPI/API."**
- **"Rendering provider NPI/API cannot be the same as the Billing provider NPI/API."**

Users will need to correct the information in the Billing Provider, Attending Provider, or Rendering Provider fields before continuing.

These changes will also apply for LTC Institutional claims (837I) received from third-party submitters. The updated EDI Companion guide will be provided later to assist those who are submitting these types of claims.

To support this change, additional information about these changes will be announced in future news articles on the TMHP LTC web page. ■

Local Authorities Should Use the PCSP Form to Record Quarterly Meetings Once Every Three Months

Local Authorities (LA) should use the PASRR Comprehensive Service Plan (PCSP) form to submit quarterly Service Planning Team (SPT) meetings every three months. LAs should not record quarterly meetings on the same date as the nursing facility's (NF) initial or annual interdisciplinary team (IDT) meeting because the IDT meeting serves as the first quarterly meeting. If there are any changes to PASRR specialized services between the quarterly SPT meetings, then the LA should submit an LA Update meeting on the PCSP form.

Details about quarterly SPT meetings are available in the PCSP Form for Local Authorities section of the *Long-Term Care Preadmission Screening and Resident Review (PASRR) User Guide*.

For more information, call the TMHP Long-Term Care Help Desk at 800-626-4117, Option 1. ■

Expanded Form Availability for Local Authorities on the Long-Term Care Online Portal

Beginning April 23, 2020, some Local Authority (LA) users gained the ability to search and access additional forms to aid with performing Preadmission Screening and Resident Review (PASRR) Level 1 (PL1) Screening and/or PASRR Evaluation (PE) using the Power Search function on the Long-Term Care (LTC) Online Portal.

To perform these searches, the LA users should request a new LTC Online Portal username with the "LA Evaluator" profile/security permission(s) from their facility's system administrator. Once access has been granted, the user will then need to enter one of the following valid search criteria combinations to access forms:

- Medicaid Number; OR
- Social Security number (SSN) and person's last name; OR
- SSN and date of birth (DOB); OR
- DOB, person's first name, and person's last name.

Note: *If users enter invalid search criteria combinations, they will receive an error message and no forms will be returned.*

Forms returned using the correct identifying information will be view-only (not editable) but can be printed.

For more information, call the TMHP Long-Term Care Help Desk at 800-626-4117, Option 1. ■

Electronic Visit Verification Training Requirements and Resources

Electronic Visit Verification (EVV) training is available in multiple formats from the Texas Health and Human Services Commission (HHSC), the Texas Medicaid & Healthcare Partnership (TMHP), and managed care organizations (MCOs). Per HHSC policy, program providers currently required to use EVV must complete training annually. To help meet this annual training requirement, program providers may reference the EVV Required Training Checklist, which provides detailed information about training and training options currently available, including:

EVV Policy Training

- Complete the HHSC EVV policy computer-based training (CBT) for Programs and Services Currently Required to use EVV on the HHS Learning Portal; or
- Complete MCO EVV policy training by contacting your MCO.

EVV Aggregator and EVV Portal Training

- Complete the TMHP EVV CBT modules 1-6 on the TMHP Learning Management System (LMS)

Additional Training Resources

Program providers may also refer to the HHSC EVV website and the TMHP EVV website for job aids, quick reference guides, the EVV Tool Kit, and webinar presentations about EVV policy, the EVV Portal, and EVV claims submission and billing.

Questions? Email Electronic_Visit_Verification@hhsc.state.tx.us. ■

Update - 2020 Quality in Long-Term Care Conference

Due to the COVID-19 pandemic, Health and Human Services has made the decision to move forward with an online Quality in Long-Term Care conference, rather than the event previously scheduled for the Hyatt Regency Lost Pines Resort. We are committed to providing the same quality of information to support providers and community caregivers using a digital platform. More information will be available soon.

Questions can be emailed to QMP@hhsc.state.tx.us. ■

Dementia Training Opportunities for Nursing Facilities through QMP

Free, comprehensive dementia care training is available through the Quality Monitoring Program (QMP), including:

- *Alzheimer's Disease and Dementia Care Seminar*: An eight-hour training program that teaches staff to provide appropriate, competent, and sensitive care and support to residents with dementia. On completion of the training, participants are eligible to apply for certification through the National Council for Certified Dementia Practitioners. For more information about certification, visit nccdp.org.
- *Texas OASIS Dementia Training Academy*: A two-day training that focuses on dementia basics, including person-centered care and using non-pharmacological interventions to manage behaviors. The OASIS curriculum was developed by Dr. Susan Wehry, and in collaboration with the Health and Human Services Commission, was adapted to meet the unique needs of Texas nursing facilities.
- *Virtual Dementia Tour*: Simulates the physical and mental challenges people with dementia face. It allows caregivers to *experience* dementia for themselves, letting them move from sympathy to empathy and to better understand the behaviors and needs of their residents.

If you are interested in scheduling any of these trainings in your facility, email the request to QMP@hhsc.state.tx.us.

Also available is the Person-Centered Thinking training. This interactive, two-day training is designed to provide nursing facility staff with the skills necessary to help residents maintain positive control over their lives. Participants will be introduced to the core concept of Person-Centered Thinking Training: finding a balance between what's *important to* and *important for* the people they serve. Participants will learn how to obtain a deeper understanding of the people they support and to organize this learning to inform their efforts to help people get the lives they value.

To request the Person-Centered Thinking training in your facility, email QMP@hhsc.state.tx.us. ■

Joint Training Opportunities

Health and Human Services Commission Education Services provides monthly training sessions around the state for both providers and surveyors. The training calendar is updated frequently and includes training opportunities in multiple locations across the state.

Visit the Joint Training web page to see the current training schedule: https://apps.hhs.texas.gov/providers/training/jointtraining.cfm. ■

Center for Excellence in Aging Services and Long-Term Care

The Center for Excellence in Aging Services and Long-Term Care (Center) is a partnership between the Health and Human Services Commission and the University of Texas at Austin School of Nursing. The Center offers a web-based platform for the delivery of best practices, with a focus on geriatrics and disabilities. The content on the website has been adapted to meet the educational needs of a variety of professionals who provide care to residents of long-term care facilities in Texas.

Dr. Tracie Harrison

Under the leadership of Dr. Tracie Harrison, the Center is an educational platform for the delivery of geriatric and disability best practices to providers of long-term care.

Phase V - Infection Control is now available on the website.

Visit the Center for Excellence in Aging Services and Long-Term Care at www.utlongtermcarenurse.com.

Registration is free. ■

Reminder for Resource Utilization Group Training Requirements

Providers are reminded that Resource Utilization Group (RUG) training is required for registered nurses (RNs) who sign assessments as complete. RNs must successfully complete the required RUG training to be able to submit Minimum Data Set (MDS) and Medical Necessity and Level of Care (MN/LOC) Assessments on the Long-Term Care Online Portal. Training is valid for two years and must be renewed by completing the online RUG training offered by Texas State University.

It can take from two to seven business days to process and report completion of RUG training from Texas State University to the Texas Medicaid & Healthcare Partnership (TMHP), depending on current volume of enrollments and completions.

To register for the RUG training, or for more information, visit www.txstate.edu/continuinged/CE-Online/RUG-Training.html. ■

Online Training Courses Now Available in the HHS Learning Portal

Four online training opportunities are now available through the HHS Learning Portal:

- Feeding Assistant Training
  This curriculum was developed for use by participants in a feeding assistant training class and includes both instructor-led and online components. The goal is for residents to receive more assistance with eating and drinking to help reduce the incidence of unplanned weight loss and dehydration. This course must be taught by a licensed health professional (physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; pharmacist; physical or occupational therapy assistant; registered professional nurse; licensed vocational nurse; licensed dietitian; or licensed social worker) or registered dietician, and participants must demonstrate safe feeding techniques by performing two feedings in the Module 9 Practicum under the observation of a licensed nurse.

- Advanced CNA Academy
  This comprehensive, five-module online course will provide nursing facility staff with thorough and sustainable education, information, and resources related to the Advanced Certified Nursing Assistant (CNA). Individual modules examine the role of the CNA in providing quality care, nursing facility rules and regulations, quality care for geriatric residents and residents with intellectual and/or developmental disabilities or mental illnesses, the role of CNAs in supporting resident assessments, and the safety and well-being of residents. Both a final exam and a training survey are required as part of the course. This online course has been approved for 6.0 hours of continuing education credit by HHSC for CNAs. HHSC is an approved provider of continuing education credits for CNAs as governed by 26 TAC Chapter 556, Section 556.9(3)(C).

- PASRR in the Nursing Facility
  A new online Preadmission Screening and Resident Review (PASRR) course for nursing facility (NF) staff is now available. This nine-module, comprehensive online course will provide thorough and sustainable education, information, and resources that are needed to successfully complete all NF responsibilities related to the PASRR process. In addition, this training will detail the complexities of caring for residents with intellectual or developmental disabilities, mental illness, or both. This course has been approved for 7.0 hours of continuing education credit by HHSC for the following professions: licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed nursing facility administrators, nursing facility activity directors, qualified intellectual disability professionals, certified nurse aides, and licensed psychology professionals.

- Meaningful Engagement to Enhance Quality of Life
  Designed for nursing facility activity directors, licensed nurses, certified nurse aides, and ancillary staff, this online training explains evidence-based best practices to help staff develop meaningful and relevant person-centered activity programs and implement individualized activities that reflect each resident's preferences, customary habits, and lifestyle. This online

course has been approved for 4.0 hours of continuing education credit by HHSC for the following professions: CNAs and nursing facility activity directors (NF-AD).

To take these courses, visit the HHS Learning Portal and create a secure user account. After creating your account, navigate the portal to find the course, or use the course links provided above.

Email questions to QMP@hhsc.state.tx.us. ■

Webinars Available for Nursing Facility, Hospice, Community Services Waiver Programs Providers, and MCOs

Long-term care (LTC) training sessions are available in webinar format. LTC providers are able to take advantage of live, online training webinars, as well as replays of those webinars, that cover topics relevant to tasks performed on the LTC Online Portal. These webinars target nursing facility (NF) and hospice providers, Community Services Waiver Programs providers, and managed care organizations (MCOs).

The webinars that are currently offered include:

- LTC Community Services Waiver Programs Webinar - Provides information that assists Community Services Waiver providers with using the LTC Online Portal to complete and submit the Medical Necessity and Level of Care (MN/LOC) Assessment
- LTC Form 3618: Resident Transaction Notice and Form 3619: Medicare/Skilled Nursing Facility Patient Transaction Notice Webinar
- LTC Nursing Facility Minimum Data Set (MDS) Assessment and Long-Term Care Medicaid Information (LTCMI) Webinar
- LTC Nursing Facility PASRR/NFSS Webinar, Part 1
- LTC Nursing Facility PASRR/NFSS Webinar, Part 2
- LTC Hospice Form 3071 Election/Cancellation/Discharge Notice and 3074 Physician Certification of Terminal Illness Webinar

For a list of webinar descriptions, upcoming broadcast dates, registration links, recordings of past webinars, and Q&A documents, visit the Webinar Registration page at www.tmhp.com/Pages/LTC/ltc_webinar.aspx. ■

Computer-Based Training on the TMHP Learning Management System

The following long-term care (LTC)-specific computer-based training (CBT) courses are currently available on the Texas Medicaid & Healthcare Partnership (TMHP) Learning Management System (LMS):

LTC Online Portal Basics

This interactive CBT provides a basic overview of the LTC Online Portal, including information about creating an administrator account, and an overview of the features of the blue navigational bar and the yellow Form Actions bar. Demonstrations and simulations appear throughout the CBT to provide opportunities for an interactive experience.

TexMedConnect for Long-Term Care (LTC) Providers

This CBT demonstrates effective navigation and use of the LTC TexMedConnect web application. Providers will learn how to:

- Log in to TexMedConnect.
- Verify a client's eligibility.
- Enter, save, and adjust different types of claims.
- Export Claim Data.
- Find the status of a claim.
- View Remittance and Status (R&S) Reports.

This interactive CBT provides a basic overview of the LTC Online Portal

Accessing the TMHP LMS

The TMHP LMS can be accessed through the TMHP website at www.tmhp.com/Pages/Education/Ed_Home.aspx, or directly at http://learn.tmhp.com.

Users must have a user name and password to access CBTs and LTC webinar recordings in the LMS. To obtain a user name and password, providers must create an account by clicking the **Registration** link at the top right-hand corner of the LMS home page. After creating an account, providers can access all available training materials in the LMS.

For questions about the LTC training CBTs and webinars, call the TMHP Help Desk/Call Center at 800-626-4117 or 800-727-5436. For LMS login or access issues, email TMHP Learning Management System (LMS) support at TMHPTrainingSupport@tmhp.com. ■

Update to 'Health Insurance Claim Number (HICN) No Longer Accepted for Medicare Claims'

This is an update to an article titled, "Reminder: Health Insurance Claim Number (HICN) No Longer Accepted for Medicare Claims," which was published on the TMHP website on January 23, 2020.

Beginning April 1, 2018, Medicare beneficiaries were issued a new Medicare ID card with a Medicare Beneficiary Identifier (MBI). The former Health Insurance Claim Number (HICN) format was discontinued effective January 1, 2020, and claims submitted using a Medicare format other than the MBI format were rejected. Some portal forms were similarly affected and use of an incorrectly formatted Medicare number after January 1, 2020, can result in providers receiving the error message "Medicare number format is invalid."

Updating Medicare Number for Death/Discharge

When a user is trying to update a PASRR Level 1 (PL1) Screening form submitted before January 1, 2020, to indicate the person is deceased or discharged with an existing HICN Medicare number in field "B0200B. Medicare No.," where there is an associated PE, the user will not be able to submit an update because the form will display the "Medicare number format is invalid" error. The user must contact the TMHP Long-Term Care Help Desk at 800-626-4117, Option 1, with the PL1 document locator number (DLN) and the correct Medicare number to update the Medicare number format on the PL1 and any associated PASRR forms (e.g., PCSP, NFSS).

TMHP will notify the user once the TMHP process is complete, so the update for the deceased or discharged person can be performed by the PL1 submitter.

Users must not submit a new PL1 for deceased or discharged when the Medicare number is in the invalid format. If a person's former nursing facility (NF) submits a new PL1 to indicate a discharge instead of updating the current PL1, the PL1 submitted by a person's current NF might be inactivated, and the current NF will have to submit a new PL1.

Active PL1

Positive PL1s submitted before January 1, 2020, that don't currently have PEs initiated from them should be reviewed by the PL1 submitter to ensure the Medicare number (if present) is in the correct format before the LA attempts to initiate the PE.

Positive PL1s submitted after January 1, 2020, including those that are part of the Change of Ownership (CHOW) or Form 1012 extension processes, can only be successfully submitted if they utilize the new MBI Medicare number format.

PASRR Evaluation (PE)

PEs submitted for dual PASRR eligibility with only one portion completed prior to January 1, 2020, cannot be finalized when:

- The Medicare ID is not in the MBI format; and
- The form is in the ***Pending Form Completion*** status.

Providers who have forms in this scenario should contact TMHP for assistance.

If, during PE initiation, a Local Authority (LA) receives an error that the Medicare number format is invalid, they should not change the Medicare number or leave the field blank. The LA should contact the submitter of the source PL1 Screening form and ask them to change the Medicare number on the PL1 to the correct format. Once the Medicare number is in the correct format on the PL1, the LA should be able to submit the PE.

For additional information about this change, providers can refer to the Medicare Beneficiary Identifiers (MBIs) webpage on the Centers for Medicare & Medicaid Services website. This change is in accordance with the Medicare Access and CHIP Reauthorization Act of 2015.

For help with form rejections related to the change in Medicare number format, call the TMHP Long-Term Care Help Desk at 800-626-4117, Option 1.

For help with CHOW and Form 1012 extension questions, contact the HHSC PASRR Unit at PASRR.support@hhsc.state.tx.us. ■

PCSP Form Changes and Alerts Update in the Long-Term Care Online Portal as of March 2, 2020

PCSP Form Changes

As of March 2, 2020, all rows in the "Participants Information" section of the PASRR Comprehensive Service Plan (PCSP) form no longer have to be manually deleted when the rows are not needed.

The required participants for each meeting type must still be entered when submitting, updating, or adding a meeting. For example, when an LA Update meeting is submitted to document a discharge, only the LA (IDD and/or MI) needs to be entered in the "Participants Information" section. The remaining two rows do not have to be deleted for the meeting to submit. Therefore, the system will no longer display an "A2500A. Participant Type is required field" error message as it previously has.

Alerts Update

As of March 2, 2020, the Create Alert page on the Long-Term Care (LTC) Online Portal was updated to include new alert options for Health and Human Services Commission Preadmission Screening and Resident Review (PASRR) Unit employees. These new options will be visible but disabled for nursing facility (NF) providers because they are intended for state users only.

Alerts Reminder

NFs and Local Authorities are encouraged to continue checking the LTC Online Portal daily for new alerts to ensure timely receipt of instructions.

For more information, call the Long-Term Care Help Desk at 800-626-4117, Option 1. ■

Common Errors on the New PASRR Comprehensive Service Plan (PCSP) Form

As a reminder, the PCSP form replaced the Interdisciplinary Team (IDT) meeting and PASRR Specialized Services (PSS) forms. Nursing facility (NF) providers use this form to record their initial and annual IDT meetings. Local Authorities (LA's) use this form to record their Quarterly Service Planning Team (SPT) and LA Update meetings.

This article will explain to NF and LA staff how to avoid making the four most common mistakes made on the PCSP form:

1. Submitting a quarterly SPT before the IDT.

   LA's should check the Long-Term Care (LTC) Online Portal using Form Status Inquiry to determine if there is an existing IDT meeting (submitted on a PL1 IDT tab or PCSP Form) for the person already in the LTC Online Portal within the previous 12 months.

   LA's must not submit a Quarterly or LA Update meeting if no IDT meeting exists for this person at the current facility. Doing so will prevent the NF from submitting the IDT on the LTC Online Portal and prevent the person's Long-Term Care Medicaid Information from submitting due to lack of an IDT meeting.

   The LA's first meeting submitted on the LTC Online Portal will be the Quarterly SPT which is scheduled every three months after the initial or annual IDT/SPT team meeting initiated by the NF.

2. Entering the wrong meeting date.

   NFs can update the IDT meeting:

- Within 30 calendar days from when the meeting was submitted or updated.
- Until the LA confirms the IDT meeting.

Prior to clicking on the **Submit Form** button, the NF should double-check all fields on the PCSP form, including the date, for accuracy. Errors should be corrected immediately, prior to the LA's confirmation.

If an LA notices an error, they must contact the NF and ask them to correct the issue prior to the LA confirming the IDT. Once the LA has confirmed the IDT meeting, the NF cannot make updates to the IDT meeting information on the PCSP form.

3. Demographic information (Name, Medicaid or Social Security number, date of birth, etc.) do not match the PASRR Level 1 (PL1) or PASRR Evaluation (PE).

   Demographic information for the person on the PCSP form is pre-populated from the PE. Ensure the information on the PE is correct and matches the information on the PL1. If information on either the PL1 or PE is incorrect, the submitter will receive an error code indicating:

   "Individual's identifying information is not valid. Please review Individual's identifying information for Last Name, SSN, and Birth Date."

4. Selecting the wrong status for PASRR specialized services information.

   The NF for an IDT, or the LA for a Quarterly or LA Update meeting, must select the appropriate status for each enabled service listed in the Meeting Type column in Sections A2800 through A3110 which reflect the most current status for that service.

   Options on the drop-down lists for the Specialized Services include:

- ***Individual/LAR Refused*** – Person and/or LAR refused these services at the time of the meeting.
- ***New*** – the first time a service is recommended.
- ***Ongoing*** – when a service has already started and will be continued.
- ***Discontinued*** – when an ongoing service (e.g., habilitative therapies, mental illness specialized services) will be stopped as agreed to by the team or when the person no longer wants the service.
- ***Item Received*** – when the person has received durable medical equipment (DME)/Wheelchair - this can be noted during an LA Update or Quarterly meeting.
- ***Pending*** – should be used when:
  - Services or DME have been requested but not yet started or received;
  - Individuals who have applied for, but do not have Medicaid at the time of the meeting (Medicaid pending); or
  - Individuals will require alternate funding sources (other than Medicaid) to obtain specialized services.
- ***Not Needed*** – should be used when the team agrees that the recommended service, customized manual wheelchair (CMWC), or DME is not needed at the time of the meeting.
- ***Completed*** – to be used when assessments have been completed.

If "4. ***Discontinued***" or "7. ***Not Needed***" are selected for any of these specialized services, then comments will be required in field A3200 or A3300 to explain these options.

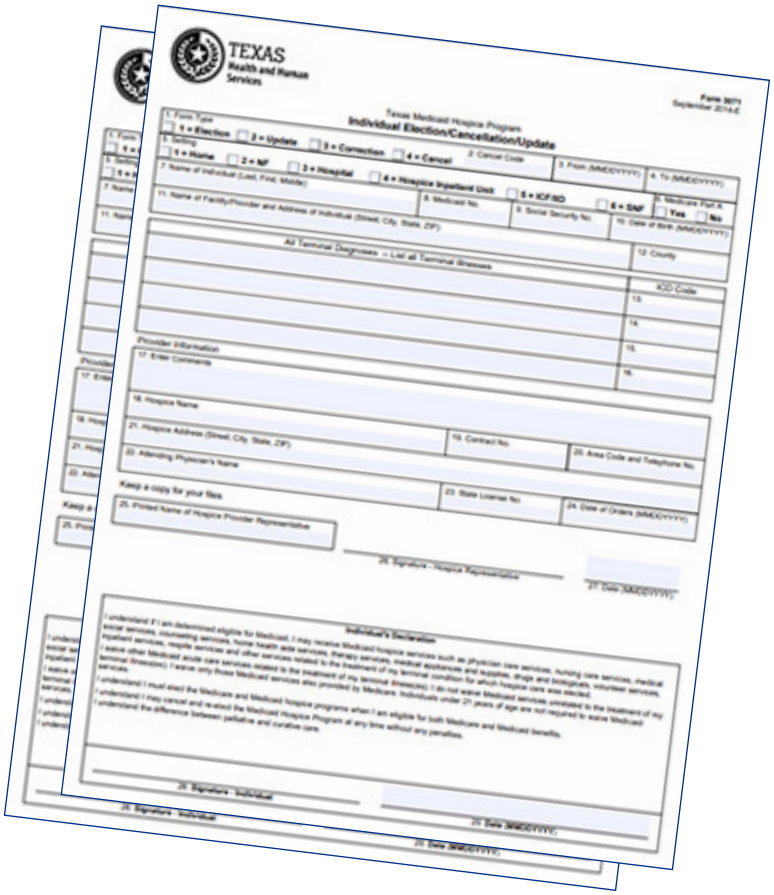
Comments must be included to explain when services for people who are Medicaid pending will begin services or when the person does not have Medicaid and alternate sources will be explored and when they are anticipated to begin services.

For more information, call the Long-Term Care Help Desk at 800-626-4117, Option 1. ■

The Latest Features for Hospice Forms 3071 and 3074

Providers have the ability to closely monitor and interact with hospice forms 3071 Individual Election/Cancellation/Update and 3074 Physician Certification of Terminal Illness on the Long-Term Care (LTC) Online Portal by viewing the form status.

Upon submission of the 3071 or 3074, individual Medicaid information and eligibility are verified. Forms will not be forwarded to the Health and Human Services Commission (HHSC) for processing if the person's First and Last Name do not match the provided Medicaid ID or Social Security number. Likewise, if the person does not have Medicaid eligibility approved for hospice services, the forms will not continue to process. They will remain in ***pending*** status until the eligibility is established or the issue is corrected.



In addition to the existing "Save as Draft" and "Print" form actions; providers also have access to the following form actions (depending on the user's security permissions and/or the current form status):

- Add Note
- Correct this form
- Inactivate Form
- Reactivate Form
- Resubmit Form
- Use as Template

Providers also benefit from the addition of a new Provider Action Required (PAR) workflow, which allows them to take action, such as correct/inactivate/resubmit, on forms which have been rejected by HHSC processing. Specific error messages will appear in the History section of each rejected form to assist with resolving issues.

To utilize these new form actions and processes in the LTC Online Portal, providers must have the correct security permissions enabled. For help with these permissions, contact your local account administrator.

For more information, call the LTC Help Desk at 800-626-4117, Option 1. ■

RHC 'High' Rate Overbilling Reviews

On October 1, 2019, Hospice Utilization Review (UR) began reviewing hospice agency routine home care (RHC) billing to ensure compliance with the allowable 'high' rate billing for the initial 60 days of hospice services. The Centers for Medicare & Medicaid Services authorized an increase in the RHC rate for the initial 60 days of hospice services, which tends to carry higher costs of care for providers. This change was authorized under the *FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements* published August 6, 2015, and implemented by the Health and Human Services Commission (HHSC) on January 1, 2016. UR has begun reviewing RHC billing to ensure accurate billing at the 'high' rate. Click the link below to view the update in its entirety:

www.govinfo.gov/content/pkg/FR-2015-08-06/pdf/2015-19033.pdf.

RHC 'high' rate overbilling reviews ensure compliance with the guidelines set out in Information Letter 19-14, "Recoupment of Overbilling on Routine Home Care First 60 Days," dated August 1, 2019. The general guidelines are outlined below, under the link:

https://apps.hhs.texas.gov/providers/communications/2019/letters/IL2019-14.pdf

When a person elects Medicaid hospice services, and is receiving RHC, the hospice provider will be eligible for increased per diem rates during the first 60 days of service based on the following:

- The day is an RHC level of care day.
- The day occurs during a person's first 60 days of hospice services.
- If a person receiving hospice services is discharged and readmitted to Medicaid hospice within 60 days of the discharge, the prior hospice days will follow the person and count toward the person's initial 60 days of hospice services. The total number of days the person received hospice services will be used to determine whether the hospice may claim the high or low RHC rate.
- If a person receiving hospice service is discharged from hospice and does not receive services for 60 days, the re-election of hospice services resets the person's 60-day window payable at the RHC 'high' rate; and
- The hospice provider, based on a conversation with the person receiving services or their representative, is required to determine if and when the person had a prior hospice election to determine whether the hospice provider may bill the high or low RHC rate.

Two billing codes have been created under the RHC rate for submission of high and low RHC claims. The billing code used for the lower rate (61 days and ongoing) is T0100 and the billing code for the first 1 through 60 days of service is T0101. Both of these billing codes are under Service Group 8/Service Code 1.

Compliance reviews began October 1, 2019. Reviews will be conducted on an ongoing basis and hospice agencies will be notified of HHSC's intent to recoup via determination letters. If overbilling is identified, the provider will receive a determination letter stating HHSC's intent to recoup the overbilled 'high' rate. Determination letters will include information identifying the overbilling. The letter will include steps to file an appeal as well as contact information if the provider has questions.

Review the FAQs attached to Information Letter 19-14, and direct all unanswered questions to MHUR@hhsc.state.tx.us. ■

Eligibility Information Available for Hospice Providers

As a reminder, hospice providers seeking eligibility information can pull Medicaid Eligibility and Service Authorization Verification (MESAV) using any of the following field combinations through TexMedConnect. This service can be accessed 24 hours a day, 7 days a week.

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

Listed below are the most common eligibility types that are valid for hospice services:

Program Type	Coverage Code
Type 12, 11	P
Type 13, 51	R
Type 01, 03, 07, 08, 09, 10, 14, 15, 18, 19, 20, 21, 22, 29, 37, 40, 43, 44, 45, 46, 47, 48, 55, 61, 63, 67	R or P

For more information on TexMedConnect and utilizing MESAV, call the TMHP Long-Term Care Help Desk at 800-626-4117, Option 1. ■

Claims Identified for Potential Recoupment Reports Available

Providers are reminded that TMHP generates the Claims Identified for Potential Recoupment (CIPR) Provider Report on a weekly basis, and TMHP maintains each CIPR Provider Report for six months after it is generated. Reviewing the CIPR Provider Report regularly helps providers avoid unexpected recoupments. The CIPR Provider Report lists claims that have been identified for potential recoupment as a result of TMHP identifying new or changed long-term care-relevant insurance policies for clients with paid claims during the policy coverage period. The CIPR Provider Report lists potentially impacted claims and the insurance company information for the corresponding long-term care-relevant policy.

For each claim identified on the CIPR Provider Report, providers must file a claim with the appropriate third-party insurance for the services previously paid by Medicaid. After receiving the response from the third-party insurance, providers must then adjust the claim listed on the CIPR Provider Report, and include the Other Insurance (OI) Disposition information received from the third-party insurance. For more information about OI billing information, consult the *TexMedConnect Long-Term Care User Guide*.

For each claim identified on the CIPR Provider Report, providers must file a claim with the appropriate third-party insurance for the services previously paid by Medicaid.

A claim will continuously appear on the CIPR Provider Report until it is adjusted with a valid OI disposition reason. If a claim identified on the CIPR Provider Report is not adjusted within 120 days from the date the claim first appeared on the CIPR Provider Report, then the Health and Human Services Commission (HHSC) will recoup the previously paid claim.

Useful Links:

Accessing R&S and CIPR Reports from the Website – This PDF provides instructions for locating, viewing, downloading, and printing the CIPR Provider Report.

TexMedConnect Long-Term Care User Guide – The User Guide provides information on how to submit a claim, adjusting claims, viewing Other Insurance on the Medicaid Eligibility and Service Authorization Verification (MESAV), and how to fill out the Other Insurance/Finish Tab section of the claim.

Contact Information

For questions about submission of long-term care fee-for-service claims and adjustments, call the TMHP Long-Term Care (LTC) Help Desk at 800-626-4117, Option 1.

For questions about Other Insurance information, including OI updates and OI MESAV discrepancies, call the TMHP LTC Help Desk at 800-626-4117, Option 6. ■

Proper Handling of Medicaid Overpayments by LTC Fee-for-Service Providers

It is important for providers to follow proper procedures when a Medicaid overpayment has been discovered. The correct way to refund money to the Health and Human Services Commission (HHSC) for a long-term care (LTC) fee-for-service (FFS) Medicaid overpayment always starts with a claim adjustment.

Claim adjustments that have processed to ***Approved-to-pay (A)*** status will automatically refund money to HHSC by reducing payments for future billing. Claims that process to ***Transferred (T)*** status will require repayment by check or by deduction; deductions are set up by HHSC Provider Recoupments and Holds. If the adjustment claim processes to ***T*** status or the provider is no longer submitting new LTC FFS claims to offset the negative balance, then the provider should call HHSC Provider Recoupments and Holds to determine the appropriate method for returning the money. Providers should always contact HHSC Provider Recoupments and Holds before submitting a check for an overpayment.

Providers should always contact HHSC Provider Recoupments and Holds before submitting a check for an overpayment.

Things to remember:

- To return an LTC FFS Medicaid overpayment to HHSC, providers should always process an adjustment claim in TexMedConnect or via their third-party submitter. Some examples of overpayments requiring an adjustment claim include:
  - Original paid claim was billed with too many units of service.
  - Original paid claim did not properly report LTC-relevant Other Insurance payments or coverage.
  - Original paid claim was billed with the wrong revenue code and/or Healthcare Common Procedure Coding System (HCPCS) code.
- If submitted properly, LTC FFS claim adjustments to return money to HHSC will not deny for the one-year claim filing deadline edit (Explanation of Benefits [EOB] F0250).
  - LTC FFS claim adjustments must include a negative claim detail to offset the original paid claim and a new claim detail to repay the claim at the correct (lower) amount. The net total of the adjustment claim must be negative.
- Providers SHOULD NOT use TMHP Form F0079 Texas Medicaid Refund Information Form to report LTC FFS overpayments. This form is exclusively used for acute care claims.

Contact Information:

Entity	What they can do…
HHSC Provider Recoupments and Holds 512-438-2200, Option 3	• Provide the current outstanding balance after adjustment claims are processed • Facilitate payment to HHSC for outstanding negative T claims by provider check or deduction • Facilitate payment to HHSC for an outstanding negative balance (A or T claims) by provider check or deduction from an associated contract when the provider is no longer billing new LTC FFS claims
TMHP LTC Help Desk 800-626-4117, Option 1	• Assist with filing an adjustment claim • Assist with understanding the provider's Remittance and Status (R&S) Report

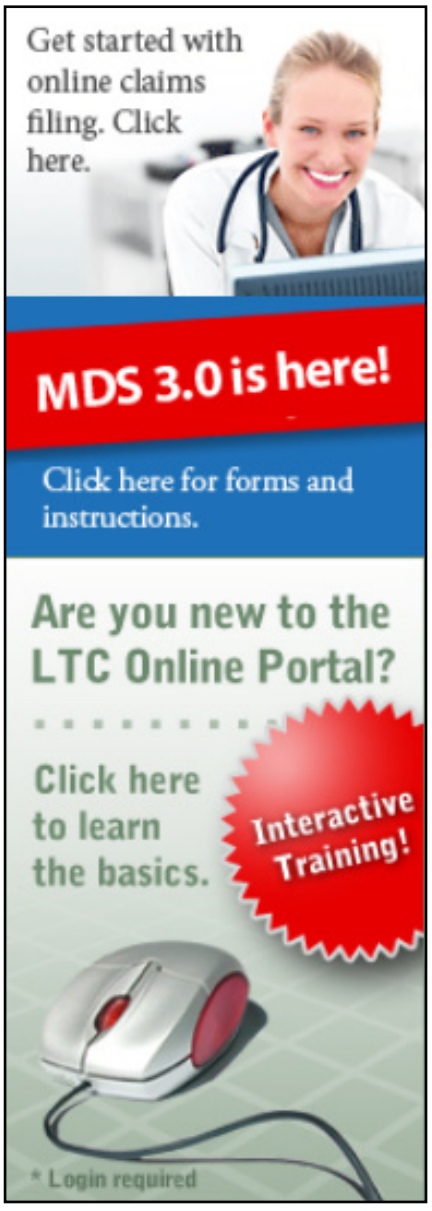
The Quality Monitoring Program (QMP) and the TMF Quality Improvement Organization continue to collaborate on the Texas Nursing Facility Quality Improvement Coalition Facebook page. Many great resources and educational opportunities are shared on this Facebook page, designed to improve the quality of care and quality of life for all people residing in a Texas nursing facility. In addition, this page is a means of communicating updates on current and future initiatives.

Like and follow the Texas Nursing Facility Quality Improvement Coalition Facebook page today!

Long-Term Care Home Page on TMHP.com

Long-term care (LTC) has its own dedicated section on TMHP.com. All the content found under the Long-Term Care tab at tmhp.com is up-to-date information and resources such as news articles, LTC Provider Bulletins, User Guides, and webinar information and registration.

Additionally, there are links to the different Texas Medicaid & Healthcare Partnership (TMHP) applications such as TexMedConnect, the LTC Online Portal, the Learning Management System (LMS), and the ability to search all of TMHP.com.



To locate the Long-Term Care tab, click **providers** on the green bar at the top of TMHP.com, and then click **Long-Term Care** on the yellow bar.

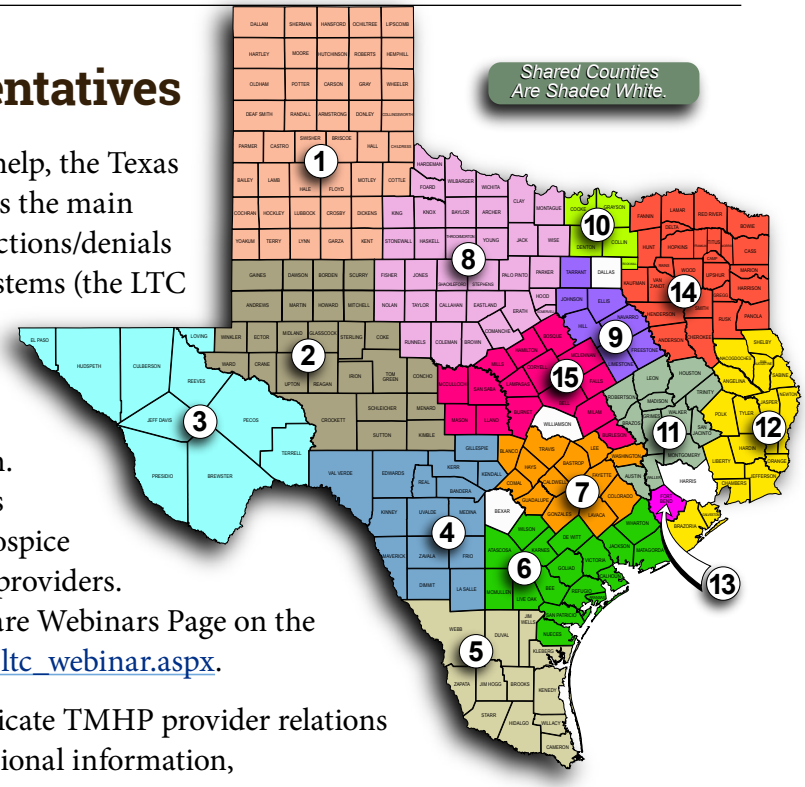
The Long-Term Care home page features recent news articles by category and news articles that have been posted within the last seven days. In the upper right-hand corner, there are links to both the LTC Online Portal and TexMedConnect. Both of these links require a user name and password.

On the left-hand navigational bar, there are links to:

- Program Information/FAQ, including frequently asked questions.
- Information Letters, LTC providers are contractually obligated to follow the instructions provided in LTC Information Letters.
- Reference Material, including manuals, User Guides, and other publications.
- Forms, and form instructions, which includes the various downloadable forms needed by long-term care providers.
- Provider Support Services, where providers can locate their Provider Relations Representative, find all of the telephone numbers for the Contact Center and relevant state and federal offices.
- Provider Education, which lists all of the provider education opportunities offered by TMHP, workshop and webinar registration, computer-based training modules, a link to the LMS, and written training materials.
- Helpful Links for long-term care providers.

Providers are encouraged to frequently visit TMHP.com for the latest news and information. ■

Provider Relations Representatives



When Long-Term Care (LTC) providers need help, the Texas Medicaid & Healthcare Partnership (TMHP) is the main resource for general inquiries about claim rejections/denials and how to use automated TMHP provider systems (the LTC Online Portal and TexMedConnect).

Providers can call TMHP at 800-925-9126 with questions and to request on-site visits to address particular areas of provider concern. TMHP webinars for LTC Community Services Waiver Programs and nursing facility (NF)/Hospice providers are also offered specifically for LTC providers. For current schedules check the Long-Term Care Webinars Page on the TMHP website at www.tmhp.com/Pages/LTC/ltc_webinar.aspx.

The map on this page, and the table below, indicate TMHP provider relations representatives and the areas they serve. Additional information, including a regional listing by county, is available on the TMHP website at www.tmhp.com/Pages/SupportServices/PSS_Reg_Support.aspx.

Territory	Regional Area	Representative
1	Amarillo, Childress, Lubbock	Kendra Davila
2	Midland, Odessa, San Angelo	Stacey Jolly
3	Alpine, El Paso, Van Horn	Isaac Romero
4	Carrizo Springs, Del Rio, Eagle Pass, Kerrville, San Antonio	Jacob Vasquez
5	Brownsville, Harlingen, Laredo, McAllen	Yvonne Garza-Garcia
6	Corpus Christi, San Antonio, Victoria	Araceli Wright
7	Austin, Bastrop, San Marcos	Josh Haley
8	Abilene, Wichita Falls	Brooke Livingston
9	Corsicana, Dallas, Denton, Fort Worth, Grayson	Vanessa Whitley-Parker
10	North Dallas	Jaime Vasquez
11	Bryan College Station, Houston	Christopher Morales
12	Beaumont, Galveston, Nacogdoches	Ebony Brown
13	Houston, Katy	Israel Barco
14	Longview, Marshall, Palestine, Northeast Texas	Carrita Mitchell
15	Killeen, Temple, Waco	Korey Reeder

*Bexar, Dallas, Harris, and Williamson Counties are shared by 2 or more provider representatives. These counties are divided by ZIP Codes. Refer to the TMHP website at www.tmhp.com for the assigned representative to contact in each ZIP Code.

TMHP LTC Contact Information

The Texas Medicaid & Healthcare Partnership (TMHP) Call Center/Help Desk operates Monday through Friday from 7:00 a.m. to 7:00 p.m., Central Time (excluding TMHP-recognized holidays).

When calling the TMHP Call Center/Help Desk, providers are prompted to enter their 9-digit Long-Term Care (LTC) provider number using the telephone keypad. When the 9-digit LTC provider number is entered on the telephone keypad, the TMHP Call Center/Help Desk system automatically populates the TMHP representative's screen with that provider's specific information, such as name and telephone number.

Providers should have their 4-digit Vendor/Facility or Site Identification number available for calls about Forms 3618 and 3619, Minimum Data Set (MDS), Medical Necessity and Level of Care (MN/LOC) Assessment, and Preadmission Screening and Resident Review (PASRR).

Providers must have a Medicaid or Social Security number and a medical chart or documentation for inquiries about a specific person.

For questions, providers should call the TMHP Call Center/Help Desk at the following telephone numbers:

- Austin local telephone number at 512-335-4729.
- Toll free telephone number (outside Austin) at 800-626-4117 or 800-727-5436.

After dialing the phone numbers above, **Choose Option 1: Customer service/general inquiry** for questions about:

- General inquiries.
- Using TexMedConnect.
- Claim adjustments.
- Claim status inquiries.
- Claim history.
- Claim rejection and denials.
- Understanding Remittance and Status (R&S) Reports.
- Forms.
- Forms 3071 and 3074.
- Forms 3618 and 3619.
- Resource Utilization Group (RUG) levels.
- Minimum Data Set (MDS).
- LTC Medicaid Information (LTCMI).
- Medical Necessity and Level of Care (MN/LOC) assessment.
- PASRR Level 1 Screening, PASRR Evaluation, and PASRR Specialized Services submission status messages.

Choose Option 2: To speak with a nurse about:

- Medical necessity.
- Custom Powered Wheelchair Form 3076.
- Forms pending denial.
- Medical necessity denial letters.

Choose Option 3: Technical Support for questions about:

- TexMedConnect – technical issues, account access, portal issues.
- Modem and telecommunication issues.
- Processing provider agreements.
- Verifying that system screens are functioning.
- American National Standards Institute (ANSI) ASC X12 specifications, testing, and transmission.
- Getting Electronic Data Interchange (EDI) assistance from software developers.
- EDI and connectivity.
- LTC Online Portal, including technical issues, account access, portal issues.

Choose Option 5: Request fair hearing for questions about:

- Individual appeals.
- Individual fair hearing requests.
- Appeal guidelines.

Choose Option 6 for questions about LTC other insurance information and updates.

Choose Option 7 to repeat this message.

Electronic Visit Verification (EVV) Contact Information

For questions about Claims, providers should call the TMHP EDI Helpdesk at: 888-863-3638, Option 4 including questions about:

- Electronic Data Interchange (EDI) – Submitting Claims for EVV.
- Claim Rejections (excluding Long-Term Care [LTC] claim rejections with error code F, RJ, and/or AC).

For questions about EVV Claims Processing, contact the entity that pays or denies your claims (i.e., the managed care organization [MCO]. See page 28 for a list of MCO phone numbers).

For questions about EVV Claims Processing that are specific to TMHP call:

- LTC: 800-626-4117, Option 1, then Option 6.
- Acute Care: 800-925-9126, Option 7.

For EVV general complaints questions, contact:

- HHSC Program Providers email: Electronic_Visit_Verification@hhsc.state.tx.us.
- MCO Program Providers at your MCO's EVV mailbox (See page 28).

For questions about MCO complaints, email: HHSC Managed Care Compliance and Operations at: HPM_Complaints@hhsc.state.tx.us.

For questions about EVV Vendor complaints, email the TMHP EVV mailbox at: EVV@tmhp.com.

If you have questions about policy and compliance, contact:

For general EVV questions about policy and compliance, email the HHSC EVV Operations mailbox at: Electronic_Visit_Verification@hhsc.state.tx.us. Questions may include:

- Rules.
- Programs and Services Required to Use EVV.
- The 21st Century Cures Act.

For general EVV questions about policy and compliance reviews, contact HHSC Program Providers at: Electronic_Visit_Verification@hhsc.state.tx.us or the MCO Program Providers at your MCO's EVV mailbox (See page 28 for a list of email addresses). Questions may include:

- Allowable Phone Identification and Recoupment.
- Compliance Oversight.
- Reason Codes.
- EVV Usage.
- Policy and Requirements.
- EVV Reports and Understanding EVV Reports.
- Visit Maintenance and Unlock Request Policy.
- Reason Codes.

For questions about EVV Aggregator or the EVV Portal, email the TMHP EVV mailbox at EVV@tmhp.com or contact the EVV Vendor (See EVV Vendor list on page 28). Questions may include:

- General Support.
- EVV Provider Onboarding.
- EVV Reports in the Vendor System.
- EVV Visit Transactions – Includes Accepted and/or Rejected EVV Visit Transactions.

For questions about TexMedConnect and **Electronic Data Interchange** call the TMHP EDI Helpdesk at: 888-863-3638, Option 4. Questions may include:

- File Submission Errors.

- Form Processing (i.e., EDI Agreement, TPA, and TPAEF).
- PIMS Assistance.
- Submitter IDs – Creation and Modification.
- TexMedConnect and EDI – Account Setup, Submitting Claims for EVV.

For questions about training on the EVV Vendor System, contact the EVV Vendor (See EVV Vendor list on page 28). Questions may include:

- General questions.
- Accessing Reports.
- EVV Clock In and Clock Out Methods.
- Making Corrections through Visit Maintenance.

For questions about TMHP Systems training, email questions to the TMHP EVV mailbox at: EVV@tmhp.com.

Note: For non-system related EVV Policy questions email the HHSC Program Providers at: Electronic_Visit_Verification@hhsc.state.tx.us or the MCO Program Providers at your MCO's EVV mailbox (See page 28 for a list of email addresses). Questions may include:

- EVV Aggregator.
- EVV Portal and EVV Standard Reports.
- Claims submission.

EVV Vendor list

DataLogic Software, Inc./Vesta:

Phone: 844-880-2400
Email: info@vestaevv.com

First Data Government Solutions/AuthentiCare:

Phone: 877-829-2002
Email: AuthenticareTXSupport@firstdata.com

MCO EVV Contact Information

Contact Information for MCOs.

Name of MCO	Phone	Email
Aetna	844-787-5437	evvmailbox@aetna.com
Amerigroup	800-454-3730	TXEVVSupport@amerigroup.com
Blue Cross Blue Shield	877-784-6802	BCBSTX_EVV_Questions@bcbstx.com
Children's Medical Center Health Plan	800-947-4969	cmchpevv@childrens.com
Cigna-Health Spring	877-653-0331	providerrelationscentral@healthspring.com

Name of MCO	Phone	Email
Community First Health	855-607-7827	cfhpevv@cfhp.com
Cook Children's Health Plan	800-964-2247	CCHPEVV@cookchildrens.org
Driscoll Children's Health Plan	877-324-7543	evvquestions@dchstx.org
Molina Healthcare of Texas	866-449-6849	mhtxevv@molinahealthcare.com
Superior Health Plan	877-391-5921	SHP_.EVV@superiorhealthplan.com
Texas Children's Health Plan	800-731-8527	EVVGroup@texaschildrens.org
United Health Group	888-887-9003	uhc_evv@uhc.com

Electronic MDS Submissions Contact Information

If you have questions about electronic Minimum Data Set (MDS) submissions, contact the QIES Technical Support Office (QTSO) at help@qtso.com or 800-339-9313.

HHSC Contact Information

The following is HHSC contact information for questions listed.

If you have questions about the **12-month rule**, contact:

- Community Services - Community Services Contract Manager.
- Institutional Services (NFs)—Provider Claims Services: 512-438-2200, Option 1.
- IDD Services—Provider Claims Services: 512-438-2200, Option 1.

If you have questions about **Community Services contract enrollment** or **Hospice Services contract enrollment**:

- Email: ContractedCommunityServices@hhsc.state.tx.us.
- Voice mail 512-438-3550.

If you have questions about **ICF/IID and nursing facility contract enrollment** call 512-438-2630.

If you have questions about **Days paid and services paid information for cost reports**, use TexMed-Connect to submit a batch of CSIs.

If you have questions about **Rate Analysis** contacts visit this website: rad.hhs.texas.gov/long-term-services-supports. Contact information is listed by program.

If you have questions about **how to prepare a cost report** (forms and instructions) and approved rates posted, contact this website: rad.hhs.texas.gov/long-term-services-supports then select the appropriate program.

If you have questions about how to sign up for, or obtain **direct deposit**, or how to sign up for **electronic funds transfer,** call Accounting at 512-438-2410.

If you have questions about how to obtain **IRS Form 1099-Miscellaneous Income,** call Accounting at 512-438-3189.

If you have questions about **Medicaid eligibility, applied income**, and **name changes**, contact a Medicaid for the Elderly and People With Disabilities (MEPD) worker, or the Integrated Eligibility and Enrollment (IEE) Call Center at telephone number 2-1-1 or visit the website: https://yourtexasbenefits.hhsc.texas.gov/.

If you have questions about **PASRR policy and rules**, email PASRR.Support@hhsc.state.tx.us. Email is preferred so that we may review your question and do any necessary research before responding.

For additional learning opportunities, information, and forms: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/preadmission-screening-resident-review-pasrr.

If you have questions about **Payment Issues** (If payment has not been received after more than 10 days from the date of billing) call the HHSC Payment Processing Hotline at: 512-438-2410.

If you have questions about **Personal Needs Allowance** (PNA) call Provider Claims Services at: 512-438-2200, Option 2.

If you have questions about **PASRR Quality Service Review** call a PASRR Quality Service Review Program Manager at: 512-438-5413.

If you have **Targeted Case Management** Service Authorization questions for Local Intellectual and Developmental Disability Authorities (LIDDAs), contact the HHSC Regional Claims Management Coordinator at website: https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts.

If you have questions about Service Authorization questions for **Guardianship Program** call the HHSC Office of Guardianship at: 512-438-2843.

If you have questions about **Deductions and provider-on-hold** questions for **Institutional Services (nursing facilities)**, contact the HHSC Regional Claims Management Coordinator at website: https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts or Institutional Services (NFs)—Provider Claims Services at: 512-438-2200, Option 3.

If you have questions about **Deductions and provider-on-hold** questions for **Community Services** call the Community Services Contract Manager or IDD Services at: 512-438-4722.

If you have questions about **Invalid or inappropriate recoupments** for nursing facilities and hospice services call Provider Claims Services at: 512-438-2200, Option 3.

If you have questions about **Status of warrant/direct deposit after a claim has been transmitted to Accounting** (fiscal) by TMHP, contact the Comptroller's website at: www.window.state.tx.us. Choose the State-to-Vendor-Payment Info-Online-Search link or call Accounting at: 512-438-2410. When calling Accounting, provide the Provider/contract number assigned by HHSC.

Note: *Allow 5-7 business days for processing of claims before verifying payment information.*

If you have questions about **Texas State University Resource Utilization Group** (RUG) training, call the Office of Continuing Education Online course at: 512-245-7118 or visit the website at: www.txstate.edu/continuinged.

If you have questions about Long-Term Care (LTC) Provider Recoupments and Holds (PRH) including torts and trusts and/or annuities for which the state is the residual beneficiary, call Provider Claims Services at: 512-438-2200, Option 4.

For Questions about Community Care for the Aged and Disabled Programs (CCAD), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Medically Dependent Children Program (MDCP), Home and Community-based Services (HCS), Texas Home Living Waiver (TxHmL), and Hospice Programs

If you have questions about **CLASS Program Policy** call 512-438-3078, 877-438-5658 or email ClassPolicy@hhsc.state.tx.us.

For questions about **HCS Program Policy** call 512-438-4478 or email HCSPolicy@hhsc.state.tx.us.

For questions about **MDCP Program Policy** call 512-438-3501, 877-438-5658, or email MDCPpolicy@hhsc.state.tx.us.

For questions about **TxHmL Program Policy** call 512-438-4639 or email TxHmlPolicy@hhsc.state.tx.us.

For questions about **DBMD Program Policy** call 512-438-2622, 877-438-5658, or email dbmdpolicy@hhsc.state.tx.us.

For questions about **CCAD financial or functional eligibility criteria** or **CCAD service authorization issues** contact the caseworker.
Note: *For more contact information visit:*
https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts.

For questions about **CCAD Program policies and procedures,** email CCADPolicy@hhsc.state.tx.us.

For **Hospice policy** questions email: HospicePolicy@hhsc.state.tx.us.

For questions about **Hospice Program service authorization issues** call Provider Claims Services at: 512-438-2200, Option 1.

For questions about **Home and Community-based Services (HCS) and Texas Home Living Waiver (TxHmL)** billing, policy, payment reviews, or cost report repayment call the Billing and Payment Hotline at: 512-438-5359 or email: HCS.TxHml.BPR@hhsc.state.tx.us.

For questions about **HCS, TxHmL, CLASS, or DBMD** Program Enrollment/Utilization Review (PE/UR): Intellectual Disability-Related Conditions (ID/RC) Assessment Purpose Codes, Level of Need, Level of Care, and Individual Plan of Care (IPC) call HCS or TxHmL at: 512-438-5055 or Fax: 512-438-4249.
Call CLASS or DBMD at: 512-438-4896 or Fax: 512-438-5135.

For questions about **Vendor Holds for HCS/TxHmL** call 512-438-3234 or email: IDDWaiverContractEnrollment@hhsc.state.tx.us.

For questions about **Individual Rights (individual/family complaints concerning LIDDA, HCS and TxHmL waivers)** call IDD Ombudsman at 800-458-9858 or email: OmbudsmanIDD@hhsc.state.tx.us.
Learn more about the IDD Ombudsman at https://hhs.texas.gov/idd-help.

For questions about **invalid or inappropriate CCAD recoupments** call Provider Claims Services at: 512-438-2200, Option 4.

Intermediate Care Facility/Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) and Nursing Facility Programs

If you have questions about the **HHS Quality Monitoring Program** email: QMP@hhsc.state.tx.us.

For questions about **Payment information for cost reports or a Quality assurance fee (QAF)** call 512-438-3597.

For questions about **Health and Human Services Commission Network (HHSCN) connection problems** call 512-438-4720 or 888-952-4357.

For questions about **ICF/IID durable medical equipment (DME), DME authorizations, Home and Community-Based Services (HCS), Texas Home Living Waiver (TxHmL)**, home modifications, adaptive aids, and dental services approvals call Provider Claims Services at: 512-438-2200, Option 5.

For questions about **ICF/IID/Residential Care (RC) Individual Movement Form IMT/service authorization** questions call Provider Claims Services: 512-438-2200, Option 1.

For **Client Assessment Registration (CARE) System Help Desk for ICF/IID** call 888-952-4357. Request HHSC Field Support staff.

For questions about **Program enrollment/Utilization Review (PE/UR), Intellectual Disability-Related Conditions (ID/RC) Assessment Purpose Codes, Level of Need, Level of Care, and Individual Plan of Care (IPC)** call 512-438-5055 or Fax: 512-438-4249.

For questions about **Provider contracts and vendor holds for ICF/IID** or **Provider access to ICF/IID CARE system** call 512-438-2630.

For questions about **MDS 3.0, MDS Purpose Code E, and Forms 3618 and 3619** missing/incorrect information call Provider Claims Services 512-438-2200, Option 1.

For questions about **Rehabilitation and specialized therapy/emergency dental/Customized Power Wheelchair (CPWC)** service authorizations call Provider Claims Services 512-438-2200, Option 6, or Fax: 512-438-2302.

For questions about **Service authorizations for nursing facilities** call Provider Claims Services at: 512-438-2200, Option 1 or Fax: 512-438-2301.

For questions about **invalid or inappropriate recoupments for ICF/IIDs** call the HHSC Help Desk at: 512-438-4720 or 800-214-4175.

For questions about **Consumer Rights and Services** or questions about the Surrogate Decision Making Program (SDMP) for people receiving community-based services through the ICF/IID program call Consumer Rights and Services at: 800-458-9858, email: ciicomplaints@hhsc.state.tx.us, or visit the website at: https://hhs.texas.gov/about-hhs/your-rights/consumer-rights-services.

Acronyms In This Issue

Acronym	Definition
AMA	American Medical Association
ANSI	American National Standards Institute
API	Atypical Provider Identifier
CARE	Client Assessment Registration
CBT	Computer-Based Training
CCAD	Community Care for Aged and Disabled Programs
CDT	Current Dental Terminology
CHOW	Change of Ownership
CIPR	Claims Identified for Potential Recoupment
CNA	Certified Nursing Assistant
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare & Medicaid Services
CMWC	Customized Manual Wheelchair
CPT	Current Procedural Terminology
CPWC	Customized Power Wheelchair
DBMD	Deaf Blind with Multiple Disabilities
DLN	Document Locator Number
DME	Durable Medical Equipment
DOB	Date of Birth
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EVV	Electronic Visit Verification
FARS/DFARS	Federal Acquisition Regulations System/Department of Defense Regulation System
FFS	Fee-For-Service
FMSA	Financial Management Services Agency
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-Based Services
HHSC	Health and Human Services Commission
HHSCN	Health and Human Services Commission Network
HICN	Health Insurance Claim Number
ICF	Intermediate Care Facility
ICF/IID	Intermediate Care Facility for Individuals with an Intellectual Disability
ID/RC	Intellectual Disability - Related Condition
IDD	Intellectual or Developmental Disability
IDT	Interdisciplinary Team
IEE	Integrated Eligibility and Enrollment
IPC	Individual Plan of Care
LA	Local Authority

Acronym	Definition
LIDDA	Local Intellectual and Developmental Disability Authority
LMS	Learning Management System
LTC	Long Term Care
LTCMI	Long Term Care Medicaid Information
MBI	Medicare Beneficiary Identifier
MCO	Managed Care Organization
MDCP	Medically Dependent Children's Program
MDS	Minimum Data Set
ME	Medicaid Eligibility
MEPD	Medicaid for the Elderly and People With Disabilities
MESAV	Medicaid Eligibility and Service Authorization Verification
MI	Mental Illness
MN/LOC	Medical Necessity and Level of Care
NF	Nursing Facility
NF-AD	Nursing Facility Activity Directors
NFSS	Nursing Facility Specialized Services
NPI	National Provider Identifier
OI	Other Insurance
PAR	Provider Action Required
PASRR	Preadmission Screening and Resident Review
PE	PASRR Evaluation
PE/UR	Program Enrollment/Utilization Review
PCSP	PASRR Comprehensive Service Plan
PL1	PASRR Level 1
PNA	Personal Needs Allowance
PRH	Provider Recoupments and Holds
PSS	PASRR Specialized Services
QAF	Quality Assurance Fee
QAPI	Quality Assurance, Performance Improvement
QIDP	Qualified Intellectual Disability Professional
QMP	Quality Monitoring Program
QTSO	QIES Technical Support Office
UR	Utilization Review
R&S	Remittance and Status
RC	Residential Care
RHC	Routine Home Care
RN	Registered Nurse
RUG	Resource Utilization Group
SBIRT	Screening Brief Intervention and Referral to Treatment

Acronym	Definition
SC	Service Code
SDMP	Surrogate Decision Making Program
SG	Service Group
SPT	Service Planning Team
SSN	Social Security Number
TMHP	Texas Medicaid & Healthcare Partnership
TxHmL	Texas Home Living Waiver
UR	Utilization Review