TEXAS
Health and Human Services

Long-Term Care Provider Bulletin

LTC Provider Bulletin, No. 79 *August 2019*

Daily Care or Hospice Room and Board Service Authorization is Required for Submission of a PASRR NFSS Form Beginning June 27, 2019

WHAT'S NEW

Beginning June 27, 2019, providers need to ensure that a Daily Care (service group [SG] 1/service code [SC] 1) or Hospice Room and Board (SG 8/SC 31) service authorization is valid for the person receiving services when submitting a Preadmission Screening and Resident Review (PASRR) Authorization Request for Nursing Facility Specialized Services (NFSS) form on the Long-Term Care Online Portal.

PASRR NFSS forms need to include and ensure the following:

1. The date of assessment on each assessment tab either:
   - Falls on or after the Daily Care (SG 1/SC 1) service authorization begin date, and before the Daily Care service authorization end date; or
   - Falls on or after the Hospice Room and Board (SG 8/SC 31) service authorization begin date, and before the Hospice Room and Board service authorization end date.
2. The date a user is attempting to submit an NFSS form for an item or service either:
   - Falls on or after the Daily Care (SG 1/SC 1) service authorization begin date, and before the Daily Care service authorization end date; or
   - Falls on or after the Hospice Room and Board (SG 8/SC 31) service authorization begin date, and before the Hospice Room and Board service authorization end date.

PASRR NFSS forms that are submitted without a valid Daily Care service authorization (SG 1/SC 1) or Hospice Room and Board (SG 8/SC 31) service authorization will be rejected, and providers will receive an error message. Nursing facilities (NFs) can then correct the date of assessment or submit the necessary paperwork to establish the daily care service authorization. The NF can resubmit the form when the appropriate service authorization has been established.

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

New Features for Hospice Forms 3071 and 3074 Beginning August 23, 2019

Beginning August 23, 2019, providers will 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 will be verified. Forms will not be forwarded to the Health and Human Services Commission (HHSC) for processing if the individual's First and Last Name do not match the provided Medicaid ID or Social Security number. Likewise, if the individual 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 will 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 will also benefit from the addition of a new Provider Action Required (PAR) workflow, which will allow them to take action, such as correct/inactivate/resubmit, on forms which have been rejected by HHSC processing. Specific error messages will be available for 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.

The **LTC Hospice Providers Forms 3071 and 3074 Webinar** will be held on Thursday, August 22, 2019, from 10:30 a.m. until 12:00 Noon. To register, click on the following link:

https://register.gotowebinar.com/register/6470106260200299277?source=PN

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

Upcoming Training Webinar for Long-Term Care Hospice Providers

TMHP will offer a live training webinar in August 2019 designed to help long-term care (LTC) providers submit forms and assessments accurately and efficiently on the LTC Online Portal. This webinar allows providers the opportunity to take advantage of online training that covers LTC Online Portal topics relevant to their daily operations.

During the live webinar, providers will be able to access training materials, submit questions, and participate in the course. The webinar will be conducted by a TMHP Training Services Representative and will include a question and answer session.

IMPORTANT NOTE: Attendees should already be familiar with the LTC Online Portal. Those who are not familiar with the portal should register for and complete the Long Term Care (LTC) Online Portal Basics Computer-Based Training (CBT) prior to the webinar.

The following is information on the webinar and how to register.

LTC Hospice Providers Forms 3071 and 3074 Webinar

Thursday, August 22, 2019 – 10:30 a.m. to 12:00 Noon

Topics covered:

- Sequencing of Documents.
- What is the purpose of Form 3071?
- Completing and submitting the Form 3071.
- Effective Dates.
- What is the purpose of Form 3074?
- Completing and submitting the Form 3074.
- Correcting Forms 3071 and 3074.
- Provider Workflow Process.
- Your HIPAA responsibilities.
- Reporting Medicaid waste, abuse, and fraud.
- Locating and utilizing additional resources.

To register, click on the following link:
https://register.gotowebinar.com/register/6470106260200299277?source=PN

After registering, a confirmation email will be sent with information about joining the webinar.

For more information, visit the Webinar Registration page, or call the LTC Help Desk at 1-800-626-4117, Option 1. ■

LTC Online Portal MDS 3.0 and MN/LOC Specification Changes Scheduled for October 1, 2019

The federal Centers for Medicare & Medicaid Services announced changes to the Minimum Data Set (MDS) 3.0, which will be effective on October 1, 2019. The Long-Term Care (LTC) Online Portal will change to display the relevant revisions of the MDS 3.0 Comprehensive and Quarterly assessments with an Assessment Reference Date (ARD, A2300) of October 1, 2019, or later. MDS 3.0 assessments with an ARD prior to October 1, 2019, will display in the current format regardless of extraction date.

This use of the ARD does not alter the HHSC-LTC use of the Entry Date (A1600) as the effective date of MDS 3.0 Admission assessments, and the Date Signed as Complete (Z0500b) as the effective date of all other MDS 3.0 assessments.

A small number of these changes will apply to the Medical Necessity and Level of Care (MN/LOC) assessments. These changes will affect only MN/LOCs submitted on October 1, 2019, and after. This includes MN/LOC assessments saved as a draft prior to October 1, 2019, but not submitted until after October 1, 2019.

The following MDS 3.0 Comprehensive and Quarterly assessment fields will be added, deleted, or altered:

Section A Items

New Item: **A0300A –**

A300 Optional State Assessment

Complete only if A0200 = 1

A. Is this assessment for state payment purposes only?

0. **No**

1. **Yes**

Modified: **A0310B**.

Removed response option 02. 14-day scheduled assessment
Removed response option 03. 30-day scheduled assessment
Removed response option 04. 60-day scheduled assessment
Removed response option 05. 90-day scheduled assessment
Removed response option 07. Unscheduled assessment used for PPS4
Removed response option 03. 30-day scheduled assessment
Added response option 08. IPA – Interim Payment Assessment

Removed "s" from Assessments in:

PPS Scheduled Assessment for a Medicare Part A Stay

PPS Unscheduled Assessment for a Medicare Part A Stay

Deleted: **A0310C**

Deleted: **A0310D**

New Item: **A0310G1 –**

G1. Is this a SNF Part A Interrupted Stay?

0. No
1. Yes

Deleted: **A0600B** (or comparable railroad insurance number) from the item label

*Deleted: **A1500** ("mental retardation" in federal regulation):

Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?

*Delete: A1510B ("mental retardation" in federal regulation):

B. **Intellectual Disability**

*Modified: A2400.

Complete only if A0310G1=0

Section D Items

Deleted:**D0350**

Deleted: **D0650**

Section E Items

*Corrected: **E0900** The skip pattern wording from "Behavioral" to "Behavior:" Response option

0. **Behavior not exhibited** Skip to E1100, Change in Behavior or Other Symptoms

Section I Items

Modified: **I0020**.

Complete only if A0310B=01 or 08

Deleted: **I0020** Deleted response option 14, Other Medical Condition

Deleted: **I0020A** Deleted item and boxes

New Item: **I0020B ICD Code**

New Item: **I0100. Cancer (with or without metastasis)

New item: **I0400. **Coronary Artery Disease** (**CAD**)

New Item: **I1300. **Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

New Item: **1500. Renal Insufficiency, Renal Failure, or ESRD

Modified: **I5900. Bipolar Disorder Section J Items**

Modified: **J1800** Skip pattern changed:

0. **No** Skip to J2000, Prior Surgery
1. **Yes** Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

New Item: **J2100** New item and responses added:

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

0. **No**
1. **Yes**
8. **Unknown**

New item: **J2300**. **Knee Replacement** - partial or total:
New Item: **J2310. Hip Replacement** - partial or total
New Item: **J2320**. **Ankle Replacement** - partial or total
New Item: **J2330**. **Shoulder Replacement** - partial or total
New Item: **J2400**. **Involving the spinal cord or major spinal nerves**
New Item: **J2410**. **Involving fusion of spinal bones**
New Item: **J2420**. **Involving Iamina, discs, or facets**
New Item: **J2499**. **Other major spinal surgery**
New Item: **J2500**. **Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
New Item: **J2510**. **Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
New Item: **J2520**. **Repair but not replace joints**
New Item: **J2530**. **Repair other bones** (such as hand, foot, jaw)
New Item: **J2599**. **Other major orthopedic surgery**
New Item: **J2600**. **Involving the brain, surrounding tissue, or blood vessels** (excludes skull and skin but includes cranial nerves)
New Item: **J2610**. **Involving the peripheral or autonomic nervous system** - open or percutaneous
New Item: **J2620**. **Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
New Item: **J2699**. **Other major neurological surgery**
New Item: **J2700**. **Involving the heart or major blood vessels** - open or percutaneous procedures
New Item: **J2710**. **Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
New Item: **J2799**. **Other major cardiopulmonary surgery**
New Item: **J2800**. **Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
New Item: **J2810**. **Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
New Item: **J2899**. **Other major genitourinary surgery**
New Item: **J2900**. **Involving tendons, ligaments, or muscles**
New Item: **J2910**. **Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
New Item: **J2920**. **Involving the endocrine organs** (such as thyroid, parathyroid), neck, lymph nodes, or thymus – open
New Item: **J2930**. **Involving the breast**
New Item: **J2940**. **Repair of deep ulcers, internal brachytherapy, bone Marrow, or stem cell harvest or transplant**
New Item: **J5000**. **Other major surgery not listed above**

Section K Items

Modified: **K0510C1** Item and column 1 box deleted:

1. While NOT a Resident

Modified: **K0510D1** Item and column 1 box deleted:

1. While NOT a Resident

Modified: **K0710** Column 1 While NOT a Resident and the instructions for completing column 1 deleted

Delete **K0710A1** Deleted item and column 1 box, While NOT a Resident

Delete **K0710B1** Deleted item and column 1 box, While NOT a Resident

Section O Items

Delete: **O0100L2** Item and row deleted

New items: **O0425**. **Part A Therapies** Complete only if A0310H = 1

New items: **O0425A**:

A. Speech-Language Pathology and Audiology Services

1. Individual minutes – record the total number of minutes this therapy was administered to the resident individually since the start date of the resident's most recent Medicare Part A stay (A2400B)

2. Concurrent minutes – record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

3. Group minutes – record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, skip to O0425B, Occupational Therapy

4. **Co-treatment minutes** – record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

5. **Days** – record **the number of days** this therapy was administered for at **least 15 minutes a day** since the start date of the resident's most recent Medicare Part A stay (A2400B)

New items: **O0425B**:

B. Occupational Therapy

1. Individual minutes – record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

2. Concurrent minutes – record the total number of minutes this therapy was administered to the resident concurrently with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B)

3. Group minutes – record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, skip to O0425C, Physical Therapy

4. Co-treatment minutes – record the total number of minutes this therapy was administered to the resident in **co-treatment** sessions since the start date of the resident's most recent Medicare Part A stay (A2400B)

5. Days – record the **number of days** this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

New items: **O0425C**:

C. Physical Therapy

1. Individual minutes – record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

2. Concurrent minutes – record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

3. Group minutes – record the total number of minutes this therapy was administered to the resident **as part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B) **If the sum of individual, concurrent, and group minutes is zero, skip to O0430, Distinct Calendar Days of Part A Therapy**

4. Co-treatment minutes – record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

5. Days – record **the number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

New Item: **O0430**. **Distinct Calendar Days of Part A Therapy**

Complete only if A0310H = 1

Record the number of **calendar days** that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes since the start date of the resident's most recent Medicare Part A stay (A2400B)

Modified the instructional language to: "Complete only if A0310E = 0 and if the following is true for the prior assessment: A0310A = 01-06 or A0310B = 01."

Deleted: **O0450A**

Deleted: **O0450B**

Section V Items

***Modify V0100** Modified the instructional language to:

Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01-06 or A0310B = 01.

*Deleted: **V0100B** Response options deleted:

02. 14-day scheduled assessment
03. 30-day scheduled assessment
04. 60-day scheduled assessment
05. 90-day scheduled assessment
07. Unscheduled assessment used for PPS

*New Item: **V0100B** Response option added:
08. **IPA** – Interim Payment Assessment

Section X Items
New Item: **0570A** New item and responses added:
X0570. Optional State Assessment (A0300A on existing record to be modified/inactivated)
A. Is this assessment for state payment purposes only?
0. No
1. Yes

Modify: **X0600B**
Removed response option 02. 14-day scheduled assessment
Removed response option 03. 30-day scheduled assessment
Removed response option 04. 60-day scheduled assessment
Removed response option 05. 90-day scheduled assessment
Removed response option 07. Unscheduled assessment used for PPS
Added response option 08. **IPA** – Interim Payment Assessment
Removed "s" from "Assessments" in: PPS Scheduled Assessment for a Medicare Part A Stay PPS Unscheduled Assessment for a Medicare Part A Stay
Delete: **X0600C**
Delete: **X0600D**
Delete: **X0900E**

Section Z Items
Delete: **Z0100A**. Deleted the text in parentheses:
(RUG group followed by assessment type indicator)
Delete: **Z0100B** Delete "RUG" in item label
Delete: **Z0100C**
Delete: **Z0150A**
Delete: **Z0150B**
Delete: **Z0200A** Deleted "RUG" in item label
Delete: **Z0200B** Deleted "RUG" in item label
Delete: **Z0250A** Deleted "RUG" in item label
Delete: **Z0250B** Deleted "RUG" in item label
* Only applicable for MDS Comprehensive Assessments
** Only applicable for MDS Quarterly Assessments

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

Coming Soon: New Processes for Submitting Forms and Claims for HCS and TxHmL Providers

Beginning March 2, 2020, Home and Community-based Services (HCS) and Texas Home Living (TxHmL) providers will submit claims for dates of service on or after March 1, 2020, using TexMedConnect or the Electronic Data Interchange (EDI). To become an EDI submitter, visit the TMHP EDI website for more information.

Forms Submission

Beginning March 2, 2020, HCS and TxHmL providers will be able to submit forms online through the Long-Term Care (LTC) Online Portal. These updates will help improve accuracy and will allow for more timely processing and payments for providers.

The following forms will be available for submission on the LTC Online Portal on March 2, 2020:

- 3608 Individual Plan of Care
- 3615 Request to Continue Suspended Services
- 3616 Request for Termination of Waiver Program Services
- 8578 Intellectual Disability/Related Condition Assessment
- 8582 Individual Plan of Care
- Provider Location Update Form (PLU)
- Individual Movement Form (IMT)
  - Local Intellectual and Developmental Disability Authority (LIDDA) Reassignments
  - Client Demographic Information Update
  - Service Coordinator Updates
  - Initiate Client Suspensions

To prepare for this update, HCS and TxHmL providers are encouraged to visit the Long-Term Care web page on the TMHP website. There, providers can find Medicaid and LTC training materials, navigational videos, and published bulletins containing news for LTC providers.

More information about this change will be available in future articles on the TMHP website and in upcoming *Long-Term Care Provider Bulletins*.

For any questions related to the HCS & TxHmL Forms and Claims Migration Project, email HCS_TxHml_Form_Migration@hhsc.state.tx.us.

For EDI-related questions, call the EDI Help Desk at 1-888-863-3638. ■

RHC 'High' Rate Overbilling Reviews

On October 1, 2019, Hospice Utilization Review (UR) will begin 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 (CMS) 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 will review 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 will ensure compliance with the guidelines set out in Information Letter 15-79, "Increased Medicaid Hospice Routine Home Care Payment Rates," dated December 31, 2015. The general guidelines are outlined below, under the link:

https://apps.hhs.texas.gov/providers/communications/2015/letters/IL2015-79.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 will begin 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.

There will be a provider letter distributed prior to 10/1/19 including frequently asked questions. In the interim, direct all questions to MHUR@hhsc.state.tx.us. ■

Major Changes to Electronic Visit Verification on September 1, 2019, and January 1, 2020

On September 1, 2019, providers currently required to perform Electronic Visit Verification (EVV) will experience changes to current EVV requirements, such as claims submission, claims matching, and online viewing of visit data for billing.

Changes to EVV Beginning September 1, 2019

A new EVV Portal tool will be accessible that will assist enrolled providers, contracted providers, and Financial Management Services Agencies (FMSAs) with reporting and billing functions. The EVV Portal is an online system that will allow users to perform searches and view reports associated with EVV visit data, such as their accepted and rejected visits and claims matching results.

The EVV Portal provides visibility into the EVV Aggregator, which is a centralized database that will collect, validate, and store all statewide EVV visit data transmitted from the EVV vendor system(s).

Claims Submission: Providers currently required to use EVV must submit all claims for EVV-relevant services in fee-for-service and Medicaid managed care to TMHP via TexMedConnect or Electronic Data Interchange (EDI) for the new claims matching process to be performed. Providers who submit claims to their managed care organization (MCO) on or after September 1, 2019, will have their claims denied or rejected for resubmission to TMHP. Once the matching process has been performed, all claims will be forwarded to the appropriate payer for final adjudication and processing. For questions regarding access to TexMedConnect or EDI, call the TMHP EDI Help Desk at 1-888-863-3638.

Claims Matching: When a claim with EVV-relevant services has been received at TMHP, it will be matched against the EVV visit data that was previously sent to the EVV

Aggregator by the EVV vendor system(s). If the following data elements do not match an accepted EVV visit, the claim will be denied:

- Medicaid ID
- EVV visit date and claim date of service
- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Healthcare Common Procedure Coding System (HCPCS) code
- HCPCS modifiers, if applicable
- Billed units

Payers will no longer pay any unmatched claims. For providers using a third-party submitter, the third-party submitter should be notified to prepare for this change.

Billing Requirements: Providers may continue to submit EVV-relevant claims with a range of service dates (which are also known as span dates of service billing) or by single date of service according to the billing guidelines of your managed care payer or TMHP for fee-for-service.

If your payer requires that a single line item represent a single EVV visit, then the EVV claim(s) must be billed according to that requirement. EVV-relevant claim line items must have a matching EVV visit.

If your payer allows span dates for billing EVV services, then the EVV claim(s) may be billed as span dates with the following criteria met for the EVV matching process:

- Each date within the span of dates must have one or more associated EVV visit(s) and;
- The total units on the claim must match the combined total units of the matched EVV visits for the span dates.
- If a date within the span does not have an associated EVV visit, the claim will deny for no EVV match.
- If the total units of the matched EVV visits for the date span does not match the units billed on the claim, the claim will deny for no EVV match.

Results of the claims matching process can be viewed in the EVV Portal and are communicated to the associated payer for further adjudication of the claim.

For questions regarding your payer's billing requirements, contact your payer.

Changes to EVV Beginning January 1, 2020

On January 1, 2020, the 21st Century Cures Act, a federal law requiring states to implement the use of an EVV Vendor system for **all** Medicaid personal care services (PCS), will go into effect.

To prepare and guide enrolled providers, contracted providers, FMSAs, and Consumer Directed Services (CDS) employers in this expansion and use of EVV, the Health and

Human Services Commission (HHSC) is providing the EVV Tool Kit throughout the 2019 calendar year. The EVV Tool Kit contains information and resources, such as:

- Web alerts posted on the 1st and 15th of each month.
- Live webinar question and answer sessions on the 22nd of each month.

The EVV Tool Kit and additional information about EVV and the Cures Act is available on the HHSC EVV website.

Subscribe to GovDelivery and receive alerts about EVV and when new materials have been posted online.

The following HHSC programs and services will be required to use EVV beginning January 1, 2020:

Program	Services and Service Delivery Options Requiring EVV (January 1, 2020)
1915(c) Deaf Blind with Multiple Disabilities Waiver	Community First Choice (CFC), Personal Assistance Services (PAS)/Habilitation (HAB), and In-Home Respite (Agency and CDS)
1915(c) Home and Community-based Services Waiver	CFC PAS/HAB, In-Home Respite, and Day Habilitation - provided in the home (Agency and CDS)
1915(c) Texas Home Living Waiver	CFC PAS/HAB, In-Home Respite, and Day Habilitation - provided in the home (Agency and CDS)
1915(c) Youth Empowerment Services Waiver	In-Home Respite (Agency) 1
1915(i) Home and Community Based Services (HCBS) Adult Mental Health	Supported Home Living-Habilitative Support and In-Home Respite (Agency) [1]
1915(k) Community First Choice (including STAR Members who receive these services through the traditional Medicaid model)	CFC PAS and CFC HAB (Agency, CDS, and the Service Responsibility Option [SRO])
Personal Care Services provided under the Texas Health Steps Comprehensive Care Program (including STAR members who receive these services through traditional Medicaid model)	Personal Care Services (Agency, CDS, and SRO)
STAR Health – Medically Dependent Children's Program (MDCP) Covered Services	In-Home Respite and Flexible Family Supports (Agency, CDS, and SRO)
1 SRO/CDS Option is not available in the 1915(c) Youth Empowerment Services or the 1915(i) HCBS Adult Mental Health programs.	

The following HHSC programs and/or services are currently required to use EVV; however, as of January 1, 2020, people using the SRO/CDS option must use EVV.

Program	Services and Service Delivery Options Currently Required to Use EVV	Services and Service Delivery Options Requiring EVV (January 1, 2020)
1915(c) Community Living Assistance and Support Services waiver	CFC PAS/HAB and In-Home Respite (Agency)	CFC PAS/HAB and In-Home Respite (CDS)
Community Attendant Services	PAS (Agency)	PAS (CDS and SRO)
Family Care	PAS (Agency)	PAS (CDS)
Primary Home Care	PAS (Agency)	PAS (CDS and SRO)
STAR Health	CFC PAS, CFC HAB, and Personal Care Services (Agency)	CFC PAS, CFC HAB, and Personal Care Services (CDS and SRO)
STAR Kids	CFC PAS, CFC HAB, and Personal Care Services (Agency)	CFC PAS, CFC HAB and Personal Care Services (CDS and SRO)
STAR Kids - MDCP Covered Services	In-Home Respite and Flexible Family Supports (Agency)	In-Home Respite and Flexible Family Supports (CDS and SRO)
STAR+PLUS	CFC PAS, CFC HAB, and Personal Assistance Services (Agency)	CFC PAS, CFC HAB, and Personal Assistance Services (CDS and SRO)
STAR+PLUS Home and Community Based Services	Personal Assistance Services, In-Home Respite, and Protective Supervision (Agency)	Personal Assistance Services, In-Home Respite, and Protective Supervision (CDS and SRO)

Send questions to HHSC EVV Operations at Electronic_Visit_Verification@hhsc.state.tx.us. ■

New Explanation of Benefits Implemented for Recoupment of Long-Term Care Fee-for-Service Claims

On April 27, 2019, HHSC implemented new explanation of benefits (EOBs) related to a recoupment of certain long-term care (LTC) fee-for-service (FFS) claims.

The new EOBs are:

- Electronic Visit Verification (EVV) visit maintenance not completed prior to claim submission **(EOB I1001)**
- Incorrect Electronic Visit Verification (EVV) data entered **(EOB I1002)**
- Missing Electronic Visit Verification (EVV) data **(EOB I1003)**
- Electronic Visit Verification (EVV) Reason Code (Incorrect or failed to add required free text) **(EOB I1004)**
- One or more Electronic Visit Verification (EVV) disallowance reasons **(EOB I1005)**
- Unallowable phone type used for Electronic Visit Verification (EVV) **(EOB I1006)**
- A change to the Units Authorized for this Client has been submitted by a State Auditor **(EOB F0246)**

Recoupments for these reasons are typically the result of a contract monitoring review. If providers have claims recouped for any of the above EOBs, they will see these recoupments claim listed (along with the associated EOBs) on their Remittance and Status (R&S) Reports. Providers are encouraged to use and share this information with their staff to expedite the troubleshooting process when claims are recouped.

Claims for all dates of service recouped for any of the above reasons will deny if rebilled. Providers will see the denied claims with **EOB F0347** (Services were recouped by a state auditor and repayment is not allowed) on their R&S Reports.

Providers must continue to use existing appeal processes which are offered prior to recoupment. However, if a provider believes repayment should be allowed for these recouped services, they must contact the HHSC Contract Specialist assigned to their contract. Repayment will be considered if the state made an error while recouping the claims.

For questions related to your R&S Report, call the TMHP Long-Term Care Help Desk at 1-800-626-4117, Option 1. ■

Registration Still Available - 2019 HHS Quality in Long-Term Care Conference

Health and Human Services (HHS), in collaboration with The University of Texas at Austin School of Nursing, will once again be hosting this free, two-day educational event. The 2019 HHS Quality in Long-Term Care Conference will include nationally- and internationally-recognized speakers presenting on current health-care trends and evidence-based best practices related to long-term care, aging, and disabilities. Attendees will also have an opportunity to network with peers and community partners from around the state and receive promotional materials from vendors.

Day 1: *Empowering Nurses Across the Long-Term Care Continuum*: This training provides a professional focus on topics such as opioids and addiction, dementia, mental health, intellectual and developmental disabilities, aging, trauma-informed care, person-centered thinking, and technology related to disabilities.

Day 2: *Connecting the Dots: Improving Quality and Safety across the Long-Term Care Continuum*. Gain knowledge of information relevant to multiple health-care disciplines, community providers, family members, and consumers. Topics will include trauma-informed care, palliative care, aging, and person-centered thinking.

Dates and Location:

August 12-13, 2019
Sheraton Georgetown Hotel & Conference Center, Georgetown, Texas

To register for the conference,

go to the HHS Learning Portal and create an account:
https://learningportal.dfps.state.tx.us/course/index.php?categoryid=23.

By clicking on the link, you will be prompted to log in (if you already have an account) or create a new account. Follow the instructions to create a log-in account and be sure to save your password!

Once you enter the site with your new account, return to the registration page, and follow the instructions for selecting your three breakout sessions for each day that you plan to attend. Be sure to select only one color-coded presentation per breakout session for each day you plan to attend.

You will be able to print your schedule for the conference – if you misplace your copy, you can always return to the learning portal and reprint it. We will not have a copy of your schedule at the conference.

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

Register Now - Quality Assurance, Performance Improvement, and Resident Safety Training

This free, two-day training will provide nursing facility (NF) staff with the knowledge and skills required to develop, initiate, and evaluate different approaches to quality assurance, performance improvement, and resident safety.

Topics to be covered include:

- Definitions of quality
- Regulations and standards related to quality management in long-term care
- Quality management tools
- Patient safety and infection control
- Change and organizational culture
- Evidence-based practices, and integrated approaches to quality programs

After completing the training, participants will be able to initiate new quality processes in their facility or build upon current quality processes and teach the curriculum to other staff members. Health and Human Services will also offer an in-depth evaluation of new or existing NF quality processes.

Dates and Locations:

- October 16-17, 2019 – Fort Worth
- October 30-31, 2019 – Abilene
- November 13-14, 2019 – Austin
- December 4-5, 2019 – El Paso
- December 18-19, 2019 – San Antonio
- January 8-9, 2020 – Edinburg
- February 5-6, 2020 – Corpus Christi
- February 19-20, 2020 - Houston

To register for the conference, visit https://www.surveygizmo.com/s3/4906199/Quality-Assurance-Performance-Improvement-and-Resident-Safety-Training.

More information is available on the conference webpage: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/nursing-facilities/quality-assurance-performance-improvement-resident-safety-training.

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

SAVE THE DATE: ICF/IID Provider and Surveyor Conference

Join us for the annual Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) Provider and Surveyor Conference.

Date:
October 9-10, 2019

Location:
Wingate by Wyndham
Round Rock, TX

1209 N Interstate 35 Frontage Rd,
Round Rock, TX 78664

New course offerings will include an individual rights panel, legislative updates, active treatment for individuals with high behavioral and medical needs, among others.

New course offerings will include:

- An individual rights panel
- Legislative updates
- Active treatment for individuals with high behavioral and medical needs, among others.

Registration will open August 2019:
www.surveymonkey.com/r/2019ICFRegistration

Direct questions to Katharine McCormick, katharine.mccormick@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.

Person-Centered Thinking: An interactive, two-day training 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.

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

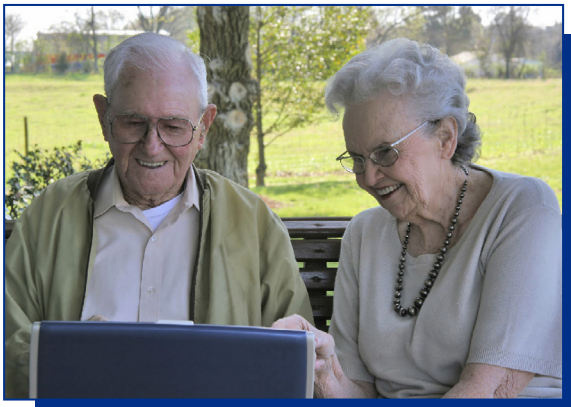
Joint Training Opportunities

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.

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.

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

REMINDERS

Reminder: 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 1-800-626-4117, Option 1. ■

PASRR in the Nursing Facility: Putting the Pieces Together Computer-Based Training

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 free online course has been approved by the Health and Human Services Commission for 7.0 hours of continuing education credit for social workers, licensed professional counselors, licensed marriage and family therapists, licensed NF administrators, NF activity directors, qualified intellectual disabilities professionals, certified nursing assistants, and licensed psychology professionals.

To complete the PASRR in the NF online course, visit https://learningportal.dfps.state.tx.us/course/view.php?id=36, select **enroll me**, and then create a user account in the HHS Learning Portal. After creating your account, navigate the portal to find the course, or simply return to the previous link to go directly to the course. ■

Reminder: 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*.

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 1-800-626-4117, Option 1.

For questions about Other Insurance information, including OI updates and OI MESAV discrepancies, call the TMHP LTC Help Desk at 1-800-626-4117, 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.

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 1-800-626-4117, Option 1	• Assist with filing an adjustment claim • Assist with understanding the provider's Remittance and Status (R&S) Report

Need Help Navigating the LTC Online Portal?

Click HERE to learn the basics

Click HERE to access the LTC Online Portal Basics Computer Based Training (CBT)*

***Login Required**

Computer-Based Training on the Texas Medicaid & Healthcare Partnership 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.

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 1-800-626-4117 or 1-800-727-5436. For LMS login or access issues, email TMHP Learning Management System (LMS) support at TMHPTrainingSupport@tmhp.com. ■

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. ■

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. ■

Visit the Texas Nursing Facility Quality Improvement Coalition Facebook Page

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 Texas nursing facility residents. 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! ■

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.

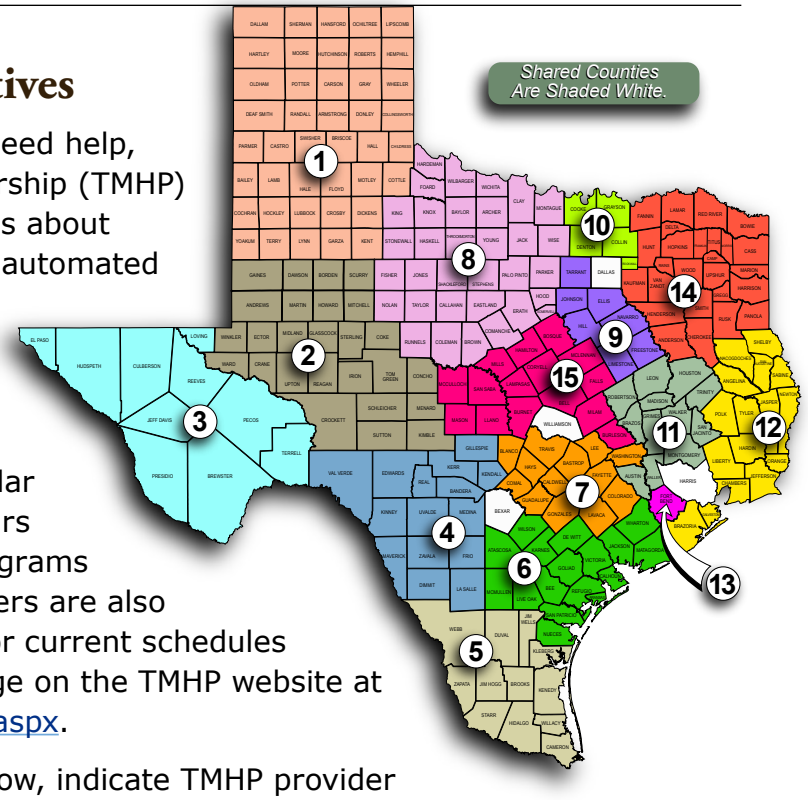
Resource Utilization Group (RUG) training is required for registered nurses (RNs) who sign assessments as complete

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. ■

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 1-800-925-9126 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	Melissa Tyler
11	Bryan College Station, Houston	TBD
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 individual.

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 1-800-626-4117 or 1-800-727-5436

<table>
<tr><th colspan="2">For questions about...</th><th>Choose...</th></tr>
<tr><td>▪ General inquiries
▪ Using TexMedConnect
▪ Claim adjustments
▪ Claim status inquiries
▪ Claim history
▪ Claim rejection and denials
▪ Understanding Remittance and Status (R&S) Reports
▪ Forms</td><td>▪ 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</td><td>Option 1: Customer service/ general inquiry</td></tr>
<tr><td colspan="2">▪ Medical necessity
▪ Custom Powered Wheelchair Form 3076
▪ Forms pending denial
▪ Medical necessity denial letters</td><td>Option 2: To speak with a nurse</td></tr>
<tr><td>▪ TexMedConnect – technical issues, account access, portal issues
▪ Modem and telecommunication issues
▪ Processing provider agreements
▪ Verifying that system screens are functioning</td><td>▪ 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</td><td>Option 3: Technical support</td></tr>
</table>

For questions about...		Choose...
▪ Individual appeals ▪ Individual fair hearing requests	▪ Appeal guidelines	Option 5: Request fair hearing
LTC other insurance information and updates		Option 6
To repeat this message		Option 7

Electronic Visit Verification (EVV) Contact Information

If you have questions about...	Contact...
Claims	
Electronic Data Interchange (EDI) – Submitting Claims for EVV	TMHP EDI Helpdesk: 1-888-863-3638, Option 4
Claim Rejections (excluding Long-Term Care [LTC] claim rejections with error code F, RJ, and/or AC)	
EVV Claims Processing	Entity that pays or denies your claims: Managed Care Organization (MCO): Your MCO via phone (See page 35)
	TMHP: LTC: 1-800-626-4117, Option 1 Acute Care: 1-800-925-9126, Option 2
Complaints	
General Complaints	HHSC Program Providers: Electronic_Visit_Verification@hhsc.state.tx.us
	MCO Program Providers: Your MCO's EVV mailbox (See page 35)
MCO Complaints	HHSC Managed Care Compliance & Operations: HPM_Complaints@hhsc.state.tx.us
EVV Vendor Complaints	TMHP EVV mailbox: EVV@tmhp.com
Policy and Compliance	
General EVV: • Rules • Programs/Services Required to Use EVV • 21st Century Cures Act	HHSC EVV Operations mailbox: Electronic_Visit_Verification@hhsc.state.tx.us

If you have questions about...	Contact...
Reviews for: • Allowable Phone Identification and Recoupment • Compliance Oversight • Reason Codes • EVV Usage	HHSC Program Providers: Electronic_Visit_Verification@hhsc.state.tx.us MCO Program Providers: Your MCO's EVV mailbox (See page 35)
Policy and Requirements	
EVV Reports and Understanding EVV Reports	
Visit Maintenance and Unlock Request Policy	
Reason Codes	
Systems	
EVV Aggregator or EVV Portal	TMHP EVV mailbox: EVV@tmhp.com
EVV Vendor System: • General Support • EVV Provider Onboarding • EVV Reports in the Vendor System • EVV Visit Transactions – Includes Accepted and/or Rejected EVV Visit Transactions	HHSC-Approved EVV Vendors DataLogic Software, Inc./Vesta: Phone: 1-844-880-2400 Email: info@vestaevv.com
TexMedConnect & Electronic Data Interchange: • File Submission Errors • Form Processing (i.e., EDI Agreement, TPA, and TPAEF) • PIMS Assistance • Submitter IDs – Creation and Modification • TexMedConnect & EDI – Account Setup, Submitting Claims for EVV	TMHP EDI Helpdesk: 1-888-863-3638, Option 4
Training	
EVV Vendor System: • General • Accessing Reports • EVV Clock In/Out Methods • Making Corrections through Visit Maintenance	HHSC-Approved EVV Vendors DataLogic Software, Inc./Vesta: Phone: 1-844-880-2400 Email: info@vestaevv.com
TMHP Systems: • EVV Aggregator • EVV Portal & EVV Standard Reports • Claims submission	TMHP EVV mailbox: EVV@tmhp.com
Non-system related: EVV Policy	HHSC Program Providers: Electronic_Visit_Verification@hhsc.state.tx.us
	MCO Program Providers: Your MCO's EVV mailbox (See page 35)

MCO EVV Contact Information

MCO	Contact Information
Aetna	Phone: 1-844-787-5437 Email: evvmailbox@aetna.com
Amerigroup	Phone: 1-855-817-5790 Email: TXEVVSupport@amerigroup.com
Blue Cross Blue Shield	Phone: 1-877-784-6802 Email: BCBSTX_EVV_Questions@bcbstx.com
Children's Medical Center Health Plan	Phone: 1-800-947-4969 Email: cmchpevv@childrens.com
Cigna-Health Spring	Phone: 1-877-653-0331 Email: providerrelationscentral@healthspring.com
Community First Health	Phone: 1-855-607-7827 Email: cfhpevv@cfhp.com
Cook Children's Health Plan	Phone: 1-800-964-2247 Email: CCHPEVV@cookchildrens.org
Driscoll Children's Health Plan	Phone: 1-877-324-7543 Email: evvquestions@dchstx.org
Molina Healthcare of Texas	Phone: 1-866-449-6849 Email: mhtxevv@molinahealthcare.com
Superior Health Plan	Phone: 1-877-391-5921 Email: SHP_.EVV@superiorhealthplan.com
Texas Children's Health Plan	Phone: 1-800-731-8527 Email: EVVGroup@texaschildrens.org
United Health Group	Phone: 1-888-887-9003 Email: 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 1-800-339-9313.

HHSC Contact Information

If you have questions about...	Contact...
12-month claims payment rule	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
Community Services contract enrollment	Email: ContractedCommunityServices@hhsc.state.tx.us Voice mail 512-438-3550

If you have questions about...	Contact...
Hospice Services contract enrollment	Email: ContractedCommunityServices@hhsc.state.tx.us Voice mail 512-438-3550
ICF/IID and nursing facility contract enrollment	512-438-2630
Days paid and services paid information for cost reports	Use TexMedConnect to submit a batch of CSIs
Rate Analysis contacts	Website: rad.hhs.texas.gov/long-term-services-supports. Contact information is listed by program.
How to prepare a cost report (forms and instructions)/approved rates posted contact	Website: rad.hhs.texas.gov/long-term-services-supports then select appropriate program.
How to sign up for, or obtain direct deposit/electronic funds transfer	Accounting: 512-438-2410
How to obtain IRS Form 1099-Miscellaneous Income	Accounting: 512-438-3189
Medicaid eligibility, applied income, and name changes	Medicaid for the Elderly and People With Disabilities (MEPD) worker Integrated Eligibility and Enrollment (IEE) Call Center at telephone number 2-1-1 Website: https://yourtexasbenefits.hhsc.texas.gov/
Intellectual Disability/Developmental Disability (ID/DD) PASRR Policy Questions ▪ PASRR Level 1 Screening Form (PL1) ▪ PASRR Evaluation (PE) ▪ PASRR Specialized Services ▪ Interdisciplinary Team (IDT) Meeting Mental Illness (MI) PASRR Policy Questions ▪ PASRR Level 1 Screening Form (PL1) ▪ PASRR Evaluation (PE)	HHSC ID/DD PASRR Unit 1-855-435-7180 Email: PASRR.Support@hhsc.state.tx.us Website: https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/preadmission-screening-and-resident-review-pasrr HHSC MI PASRR Unit Email: PASRR.MentalHealth@hhsc.state.tx.us
Payment Issues – If payment has not been received after more than 10 days from the date of billing	HHSC Payment Processing Hotline 512-438-2410
Personal Needs Allowance (PNA)	Provider Claims Services 512-438-2200, Option 2
PASRR Quality Service Review	PASRR Quality Service Review Program Manager: 512-438-5413
Targeted Case Management Service Authorization questions for Local Intellectual and Developmental Disability Authorities (LIDDAs)	HHSC Regional Claims Management Coordinator Website: https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts
Service Authorization questions for Guardianship Program	HHSC Office of Guardianship 512-438-2843

If you have questions about...	Contact...
Deductions and provider-on-hold questions for Institutional Services (nursing facilities)	Institutional Services (NFs)—Provider Claims Services: 512-438-2200, Option 3
Deductions and provider-on-hold questions for Community Services	Community Services Contract Manager or IDD Services: 512-438-4722
Invalid or inappropriate recoupments for nursing facilities and hospice services	Provider Claims Services: 512-438-2200, Option 3
Status of warrant/direct deposit after a claim has been transmitted to Accounting (fiscal) by TMHP **Note:** Allow 5-7 business days for processing of claim(s) before verifying payment information	Comptroller's website: www.window.state.tx.us Choose the State-to-Vendor-Payment Info-Online-Search link. Accounting 512-438-2410 When calling Accounting, provide the Provider/contract number assigned by HHSC.
Texas State University Resource Utilization Group (RUG) training	The Office of Continuing Education: Online course: 512-245-7118 Website: www.txstate.edu/continuinged
Long-Term Care (LTC) Provider Recoupments and Holds (PRH) including torts and trusts and/or annuities for which the state is the residual beneficiary	Provider Claims Services: 512-438-2200, Option 4
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	
CLASS Program Policy CLASS Interest Line	512-438-3078 or ClassPolicy@hhsc.state.tx.us 1-877-438-5658
HCS Program Policy	512-438-4478 or HCSPolicy@hhsc.state.tx.us
MDCP Program Policy MDCP Interest List Line	512-438-3501 or MDCPpolicy@hhsc.state.tx.us 1-877-438-5658
TxHmL Program Policy	512-438-4639 or TxHmlPolicy@hhsc.state.tx.us
DBMD Program Policy DBMD Interest Line	512-438-2622 or dbmdpolicy@hhsc.state.tx.us 1-877-438-5658
CCAD financial or functional eligibility criteria	Caseworker. For more contact information visit: https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts
CCAD service authorization issues	Caseworker. For more contact information visit: https://hhs.texas.gov/about-hhs/find-us/community-services-regional-contacts
CCAD Program policies/procedures	512-438-3226 or CCADPolicy@hhsc.state.tx.us
Hospice policy questions	Email: HospicePolicy@hhsc.state.tx.us
Hospice Program service authorization issues	Provider Claims Services: 512-438-2200, Option 1

If you have questions about...	Contact...
Home and Community-based Services (HCS) and Texas Home Living Waiver (TxHmL) billing, policy, payment reviews, cost report repayment	Billing and Payment Hotline: 512-438-5359 HCS.TxHml.BPR@hhsc.state.tx.us
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)	HCS or TxHmL: 512-438-5055, Fax: 512-438-4249 CLASS or DBMD: 512-438-4896, Fax: 512-438-5135
Vendor Holds for HCS/TxHmL	512-438-3234 or IDDWaiverContractEnrollment@hhsc.state.tx.us
Consumer rights (consumer/family complaints concerning HCS and TxHmL waiver)	Consumer Rights and Services: 1-800-458-9858 Email: ciicomplaints@hhsc.state.tx.us Website: https://hhs.texas.gov/about-hhs/your-rights/consumer-rights-services
Invalid or inappropriate CCAD recoupments	Provider Claims Services: 512-438-2200, Option 4
Intermediate Care Facility/Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) and Nursing Facility Programs	
HHS Quality Monitoring Program	Email: QMP@hhsc.state.tx.us
Payment information for cost reports	512-438-3597
Quality assurance fee (QAF)	512-438-3597
Health and Human Services Commission Network (HHSCN) connection problems	512-438-4720 or 1-888-952-4357
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	Provider Claims Services: 512-438-2200, Option 5
ICF/IID/Residential Care (RC) Individual Movement Form IMT/service authorization questions	Provider Claims Services: 512-438-2200, Option 1
Client Assessment Registration (CARE) System Help Desk for ICF/IID	1-888-952-4357: request HHSC Field Support staff
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)	512-438-5055 Fax: 512-438-4249
Provider contracts and vendor holds for ICF/IID	512-438-2630
Provider access to ICF/IID CARE system	512-438-2630

If you have questions about…	Contact…
MDS 3.0, MDS Purpose Code E, and Forms 3618 and 3619 missing/incorrect information	Provider Claims Services: 512-438-2200, Option 1
Rehabilitation and specialized therapy/ emergency dental/Customized Power Wheelchair (CPWC) service authorizations	Provider Claims Services: 512-438-2200, Option 6 Fax: 512-438-2302
Service authorizations for nursing facilities	Provider Claims Services: 512-438-2200, Option 1 Fax: 512-438-2301
Invalid or inappropriate recoupments for ICF/IIDs	HHSC Help Desk: 512-438-4720 or 1-800-214-4175
Consumer Rights and Services Surrogate Decision Making Program (SDMP) for people receiving community-based services through the ICF/IID program	Consumer Rights and Services: 1-800-458-9858 Email: ciicomplaints@hhsc.state.tx.us Website: 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
ARD	Assessment Reference Date
CAD	Coronary Artery Disease
CARE	Client Assessment Registration
CBT	Computer-Based Training
CCAD	Community Care for Aged and Disabled Programs
CDS	Consumer Directed Services
CDT	Current Dental Terminology
CFC	Community First Choice
CIPR	Claims Identified for Potential Recoupment
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CPWC	Customized Power Wheelchair
DBMD	Deaf Blind with Multiple Disabilities
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
HAB	Habilitation
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-Based Services
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HHSCN	Health and Human Services Commission Network
ICF	Intermediate Care Facility
ICF/IID	Intermediate Care Facility/Facilities for Individuals with an Intellectual Disability or Related Conditions
IMT	Individual Movement
LIDDA	Local Intellectual and Developmental Disability Authority

Acronym	Definition
LMS	Learning Management System
LTC	Long Term Care
LTCMI	Long Term Care Medicaid Information
MCO	Managed Care Organization
MDCP	Medically Dependent Children's Program
MDS	Minimum Data Set
MEPD	Medicaid for the Elderly and People With Disabilities
MESAV	Medicaid Eligibility and Service Authorization Verification
MN/LOC	Medical Necessity and Level of Care
NF	Nursing Facility
NFSS	Nursing Facility Specialized Services
NPI	National Provider Identifier
OI	Other Insurance
PAR	Provider Action Required
PAS	Personal Assistance Services
PASRR	Preadmission Screening and Resident Review
PCS	Personal Care Services
PE	PASRR Evaluation
PLU	Provider Location Update
PNA	Personal Needs Allowance
PRH	Provider Recoupments and Holds
QAF	Quality Assurance Fee
QMP	Quality Monitoring Program
UR	Utilization Review
R&S	Remittance and Status
RHC	Routine Home Care
RN	Registered Nurse
RUG	Resource Utilization Group
SDMP	Surrogate Decision Making Program
SRO	Service Responsibility Option
TMHP	Texas Medicaid & Healthcare Partnership
TxHmL	Texas Home Living Waiver