TEXMEDCONNECT USER GUIDE

FOR MCO LTSS PROVIDERS

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

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Overview

TexMedConnect is a free, online claims submission application provided by Texas Medicaid & Healthcare Partnership (TMHP). Managed care organization (MCO) Long-term Services and Supports (LTSS) providers can use TexMedConnect to submit claims, perform Claim Status Inquiries (CSI), and submit appeals.

An MCO LTSS provider is any provider who provides LTSS services under a specific National Provider Identifier (NPI) and taxonomy combination and submits claims through Medicaid Managed Care. An MCO LTSS provider will have to enroll through this process when the NPI combination they bill LTSS services does not have an active, associated Atypical Provider Identifier (API).

TexMedConnect:

- Delivers an integrated, web-based application.
- Provides a stable and secure environment for claims submission.
- Is accessible from any computer with Internet access.

TexMedConnect for MCO LTSS providers supports Institutional Outpatient claims (837I) and Professional claims (837P) for Health Insurance Portability and Accountability Act (HIPAA) - compliant transactions. Institutional Outpatient claims are used for services rendered in a hospital. Professional claims are used for services rendered by an individual provider.

Basic knowledge of browsing the web and using other web-based applications is helpful when using TexMedConnect.

Requirements

TexMedConnect is a web-based application and requires Internet capabilities as follows:

- Internet service provider (ISP)
- Internet browser Microsoft® Internet Explorer® (version 11.0 and later)
- Google Chrome® (version 48 and later)

A broadband connection is recommended but not required.

Getting Support

This section explains whom at TMHP to contact for assistance with technical issues and claims questions. For more contact information, refer to the Contact web page on tmhp.com.

Technical Support

For MCO LTSS provider's technical issues, such as troubleshooting TexMedConnect and TMHP Electronic Data Interchange (EDI) Gateway system issues, contact the TMHP EDI Help Desk at 888-863-3638, Option 4.

Contact your system administrator for assistance with modem, hardware, Internet connectivity, or phone line issues.

Claims Support

For questions about MCO LTSS electronic claims, call the TMHP Contact Center at 800-925-9126.

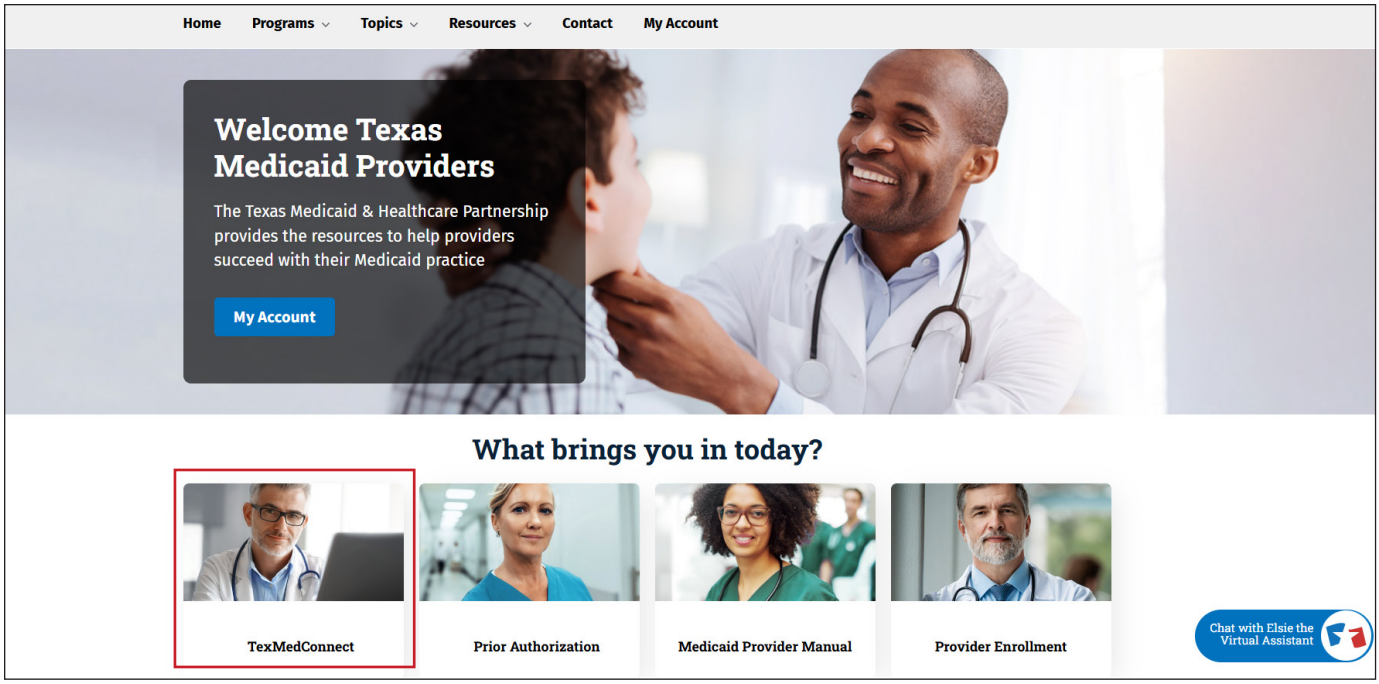
Accessing TexMedConnect

Access TexMedConnect through the TMHP website. To use TexMedConnect, you must already have an account on the TMHP website. If you do not have an account, refer to the Account Management web page on tmhp.com for information on setting one up.

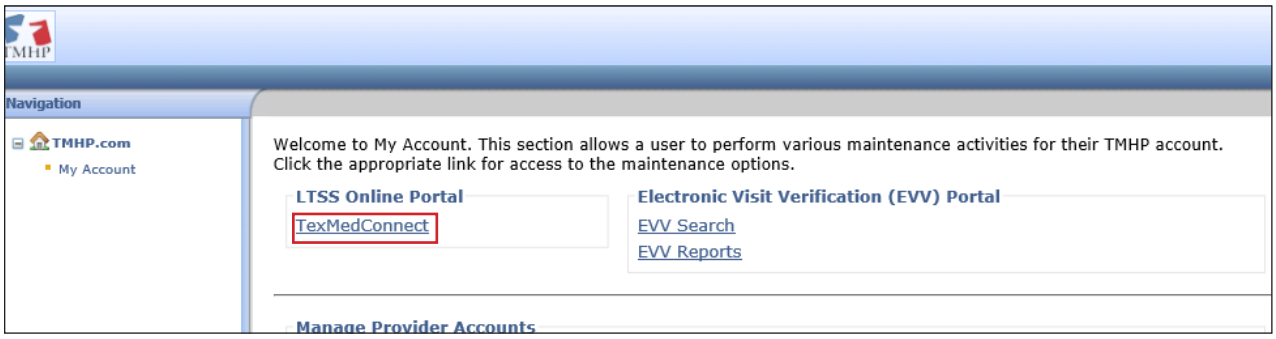
Once you have an account for the TMHP website:

1) Access the TMHP website at tmhp.com.

2) Click **TexMedConnect**. Enter your user name and password.



3) The My Account page will open to display website features you have access to. Click **TexMedConnect**.



Navigation Panel

All of the available menu options for MCO LTSS providers are located under Acute Care in the left navigation panel. A user's access privilege determines which options appear. You can select the activity you would like to perform from the navigation panel.

Eligibility

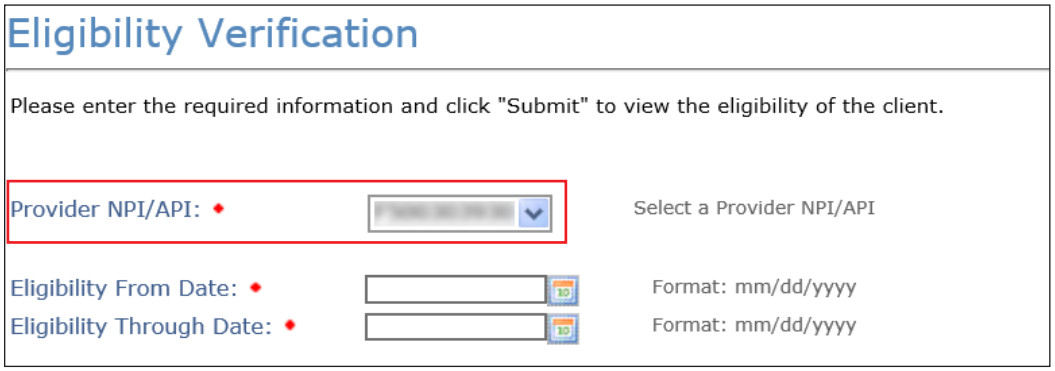
You have the ability to verify a client's eligibility, create a list of clients for whom you would like to verify eligibility, and create eligibility batch reports by NPI or API.

Eligibility Verification (EV)

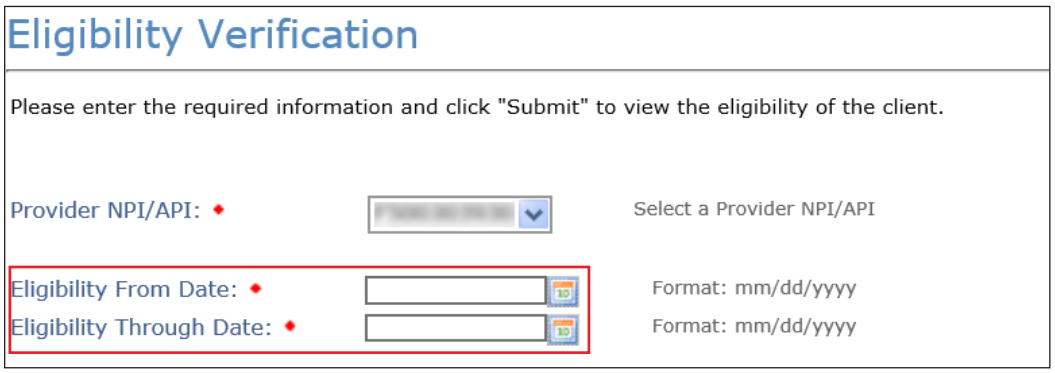
To verify a client's eligibility, follow these steps:

1) Select **Eligibility** from the navigation panel.

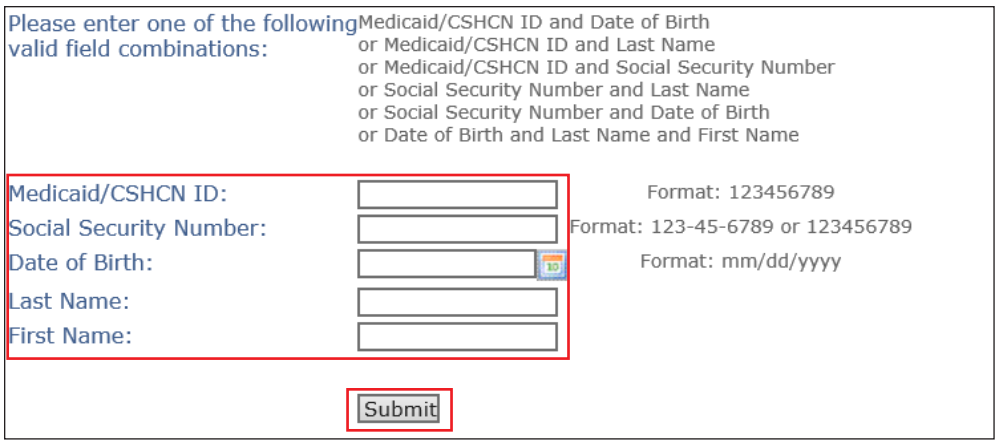
2) Use the Provider NPI/API drop-down list to select an NPI or API.



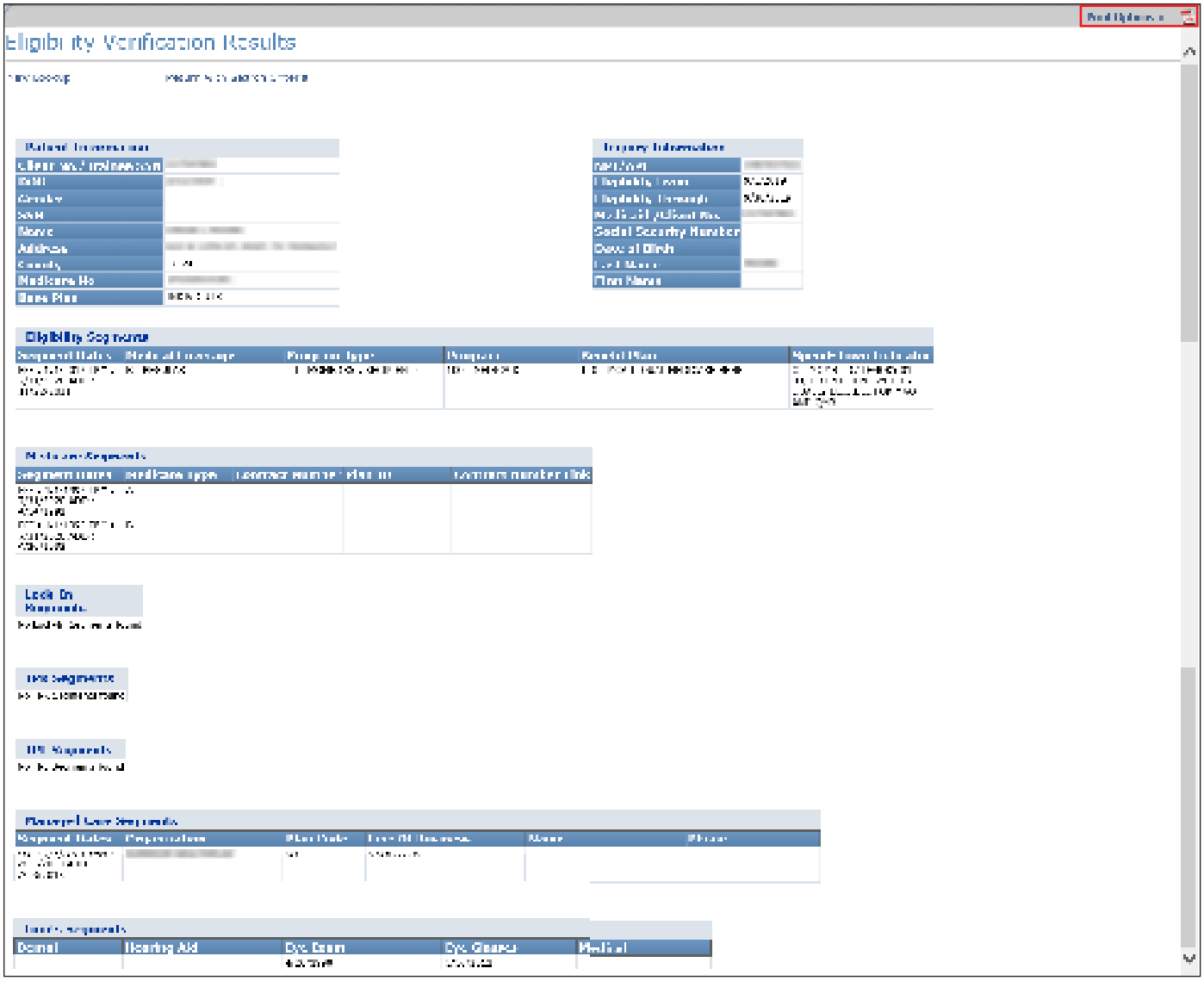
3) Enter an Eligibility From Date and Eligibility Through Date manually, or use the calendar icon.



4) You must also enter information in the Medicaid/CSHCN ID field or Social Security Number field and either the Date of Birth, Last Name, or First Name fields. Click **Submit**.



5) Eligibility verification results appear. Click the PDF icon in the top right corner of the Eligibility Verification Results page to view and print results.



6) Click **New Lookup** to return to the Eligibility Verification screen. Click **Return with Search Criteria** to return to the Eligibility Verification screen with the last search criteria in the fields.

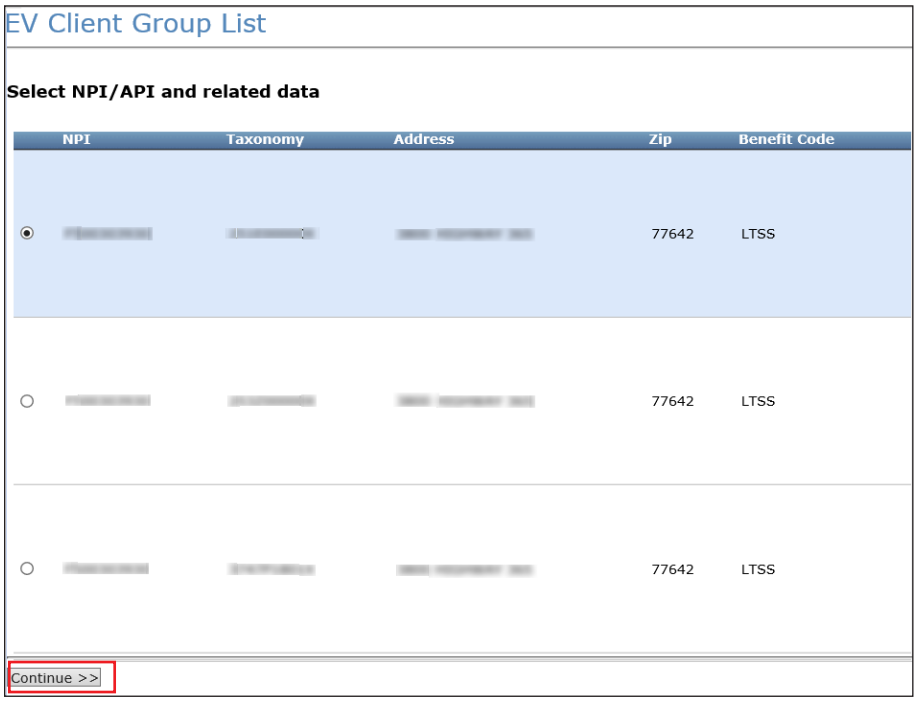
Client Group List

The client group list allows you to create a list of clients for whom you would like to verify eligibility. You can create up to 100 groups for each NPI or API. Each client group can contain up to 250 clients.

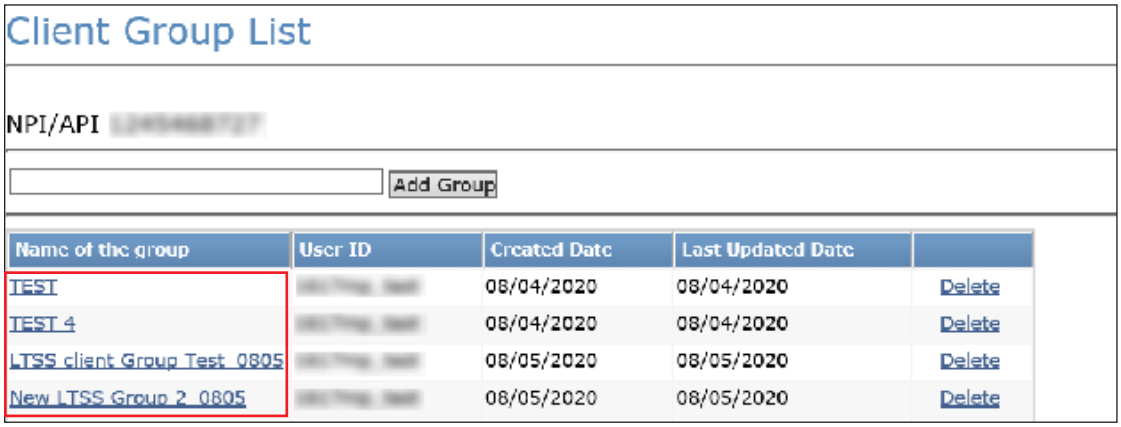
To verify eligibility through the client group list, follow these steps:

1) Select **Client Group List** from the navigation panel.

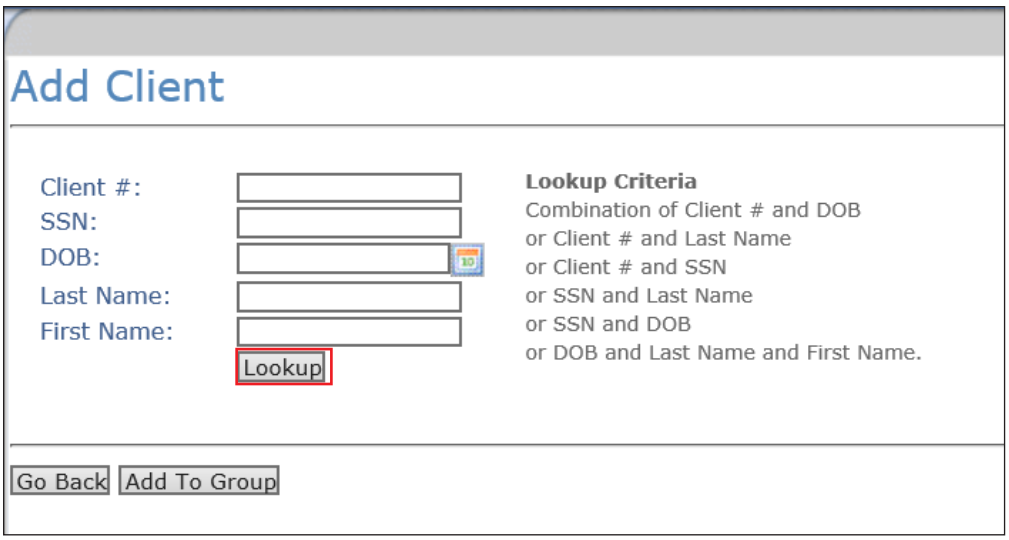
2) Select the NPI or API on the EV Client Group List screen. Click **Continue**.



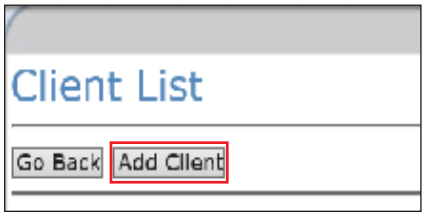
3) Click the name of the group to view the client list. Click **Delete** to remove an existing client group list. You can also type a group name and click **Add Group** to create a new client group list.



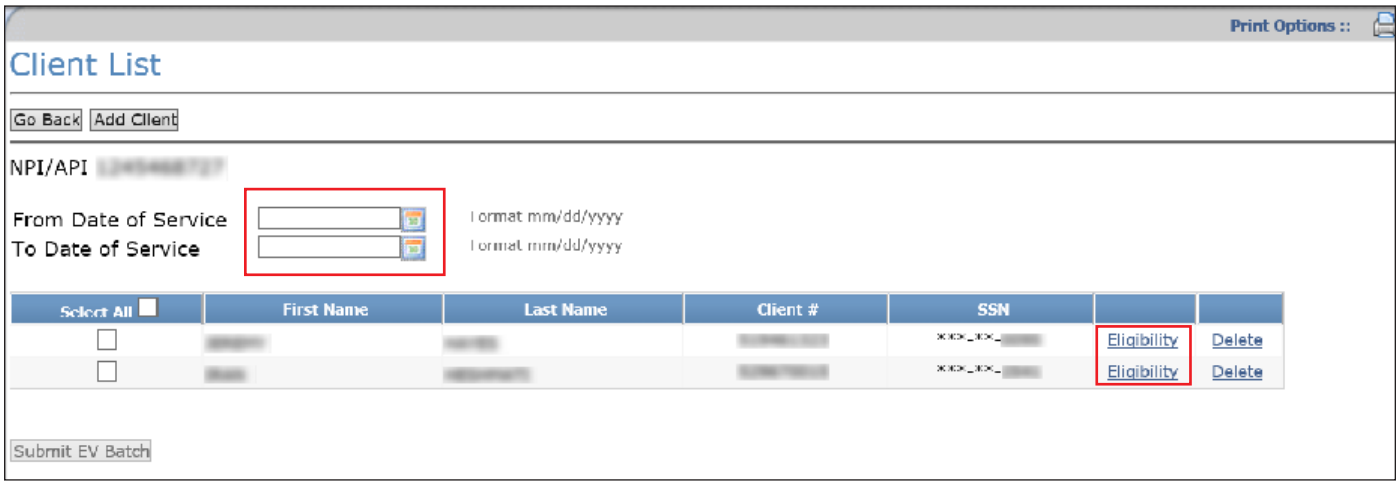
a) To create a group, enter a Client number or social security number and date of birth, last name, or first name. Click **Lookup**. Then, click **Add to Group**.



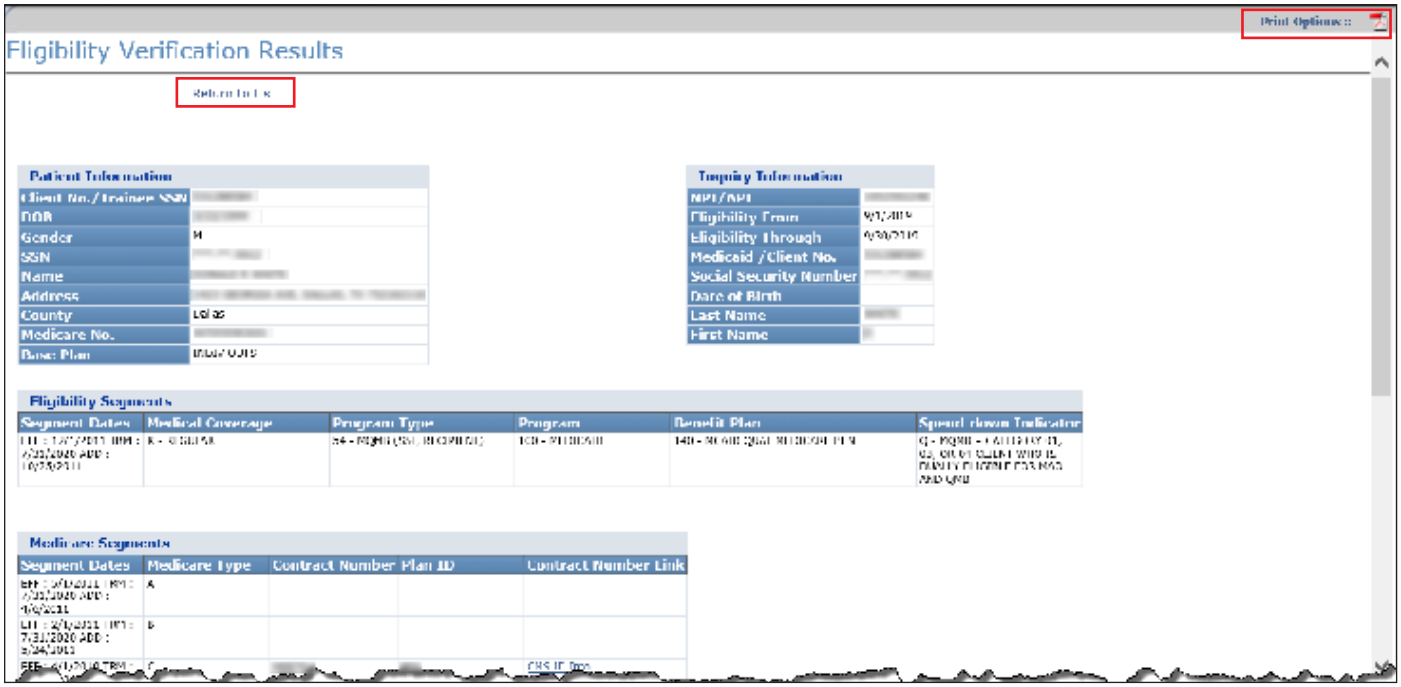
4) You can click **Add Client** to add more clients to the group.



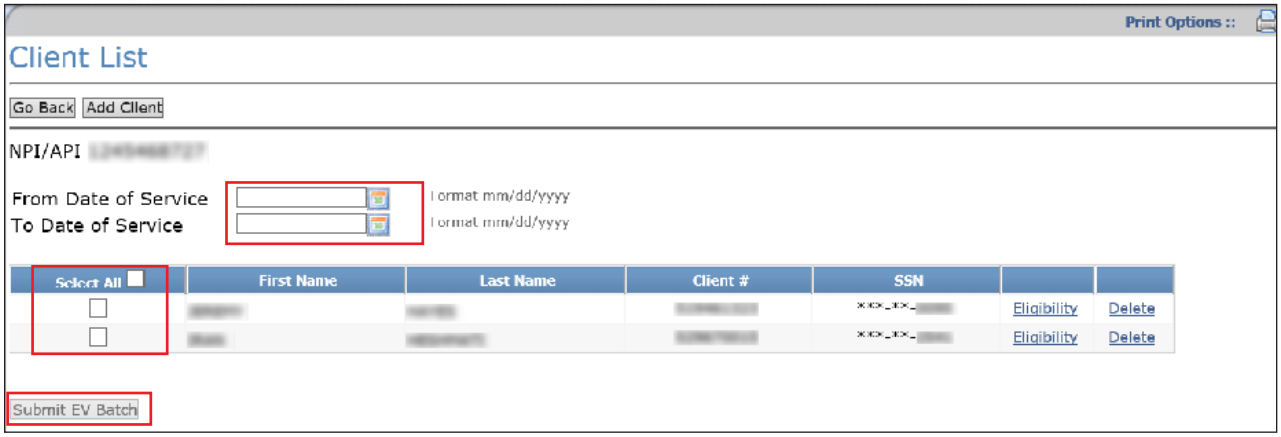
5) Enter a date range in the From Date of Service and To Date of Service fields manually, or use the calendar icon. Click **Eligibility** to view the Eligibility Verification Results.



6) Eligibility verification results appear. Click the PDF icon in the top right corner of the Eligibility Verification results page to view and print results. Click **Return to List** to return to the Client List screen.



7) To submit an eligibility report for one or more clients in a client group list to batch, enter a date range in the From Date of Service and To Date of Service fields manually, or use the calendar icon. Click individual check boxes to select clients for a batch report, or click **Select All** to create a batch report for all members of the client group list. Click **Submit EV Batch**.

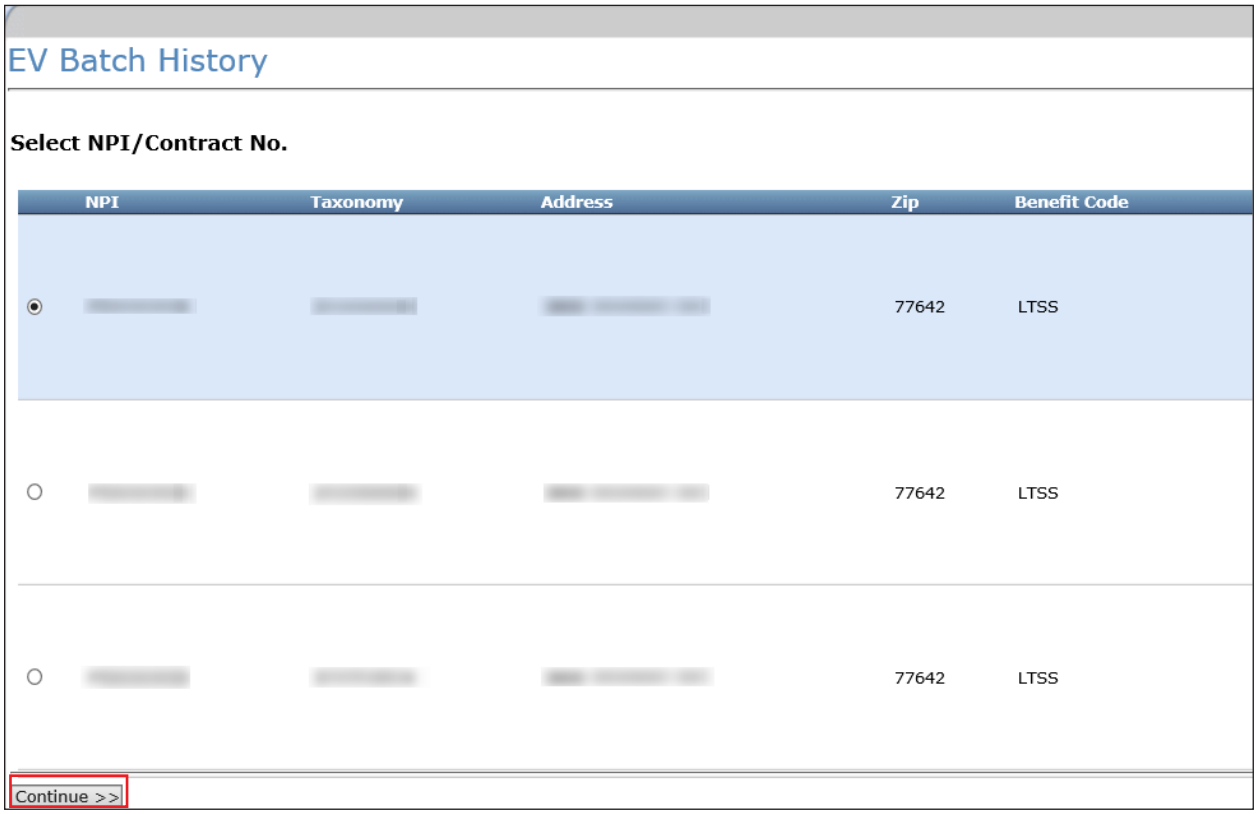


EV Batch History

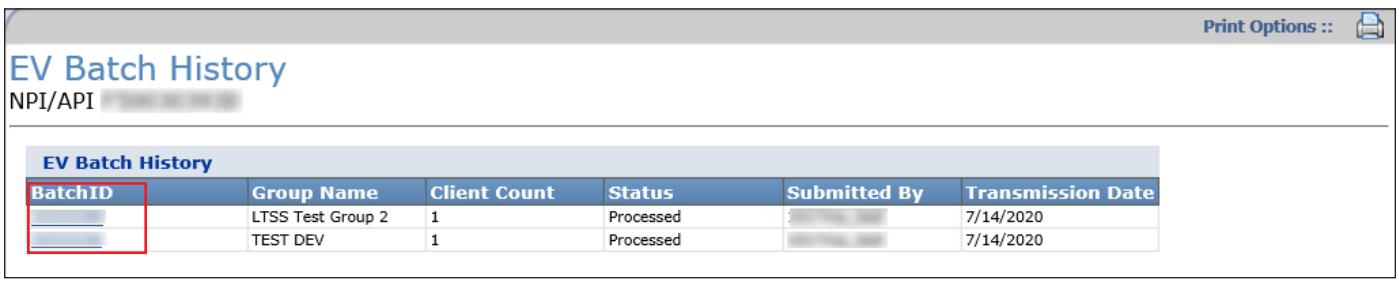
To view eligibility batch reports, follow these steps:

1) Select **EV Batch History** from the navigation panel.

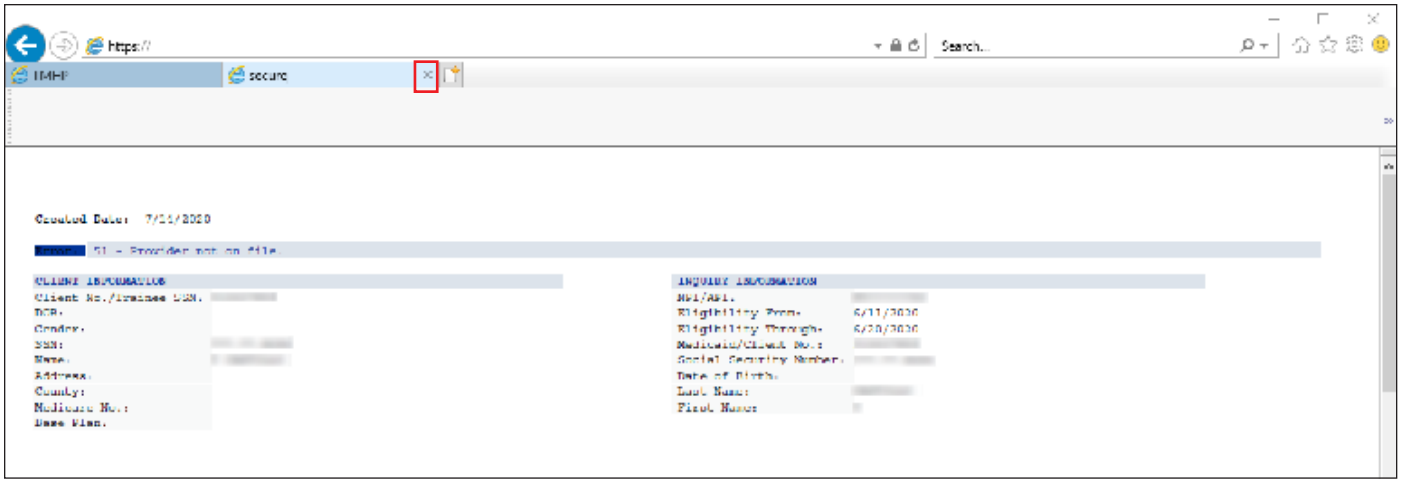
2) Select an NPI or API on the EV Batch History screen. Click **Continue**.



3) Select a **Batch ID** to review the eligibility report results. The report opens in a new browser window in a PDF format.



4) Use your browser print functions to print the report results. Click the **X** on the browser tab to close the report and return to the EV Batch History results screen for the selected NPI or API.



Filing a Claim

You have the ability to submit the following claim types for a selected NPI or API:

- Institutional Outpatient
- Professional

Required data must be entered on each claim submission tab for the selected claim type. Click each tab to navigate through the screens. Ensure the data entered meets field edit requirements (such as social security number [SSN] must be nine digits, and future dates are not allowed for the patient date of birth or date of death).

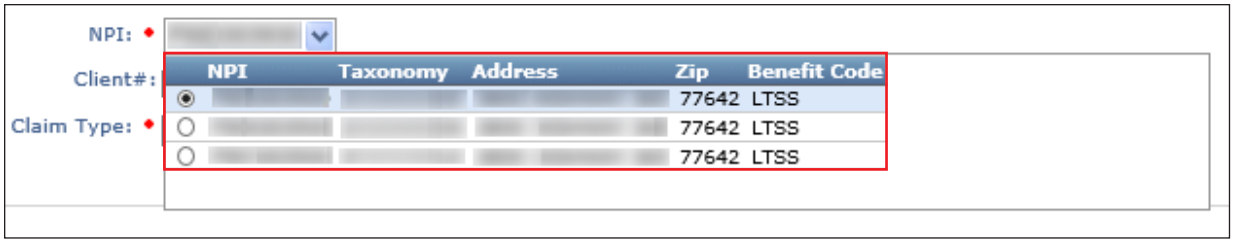
After the claim information is entered, you can either submit the claim, save a draft, or save the individual claim as a template. Once a claim is submitted successfully, you will receive information about claim routing and a TMHP EDI Transaction Number (ETN).

Claims Entry

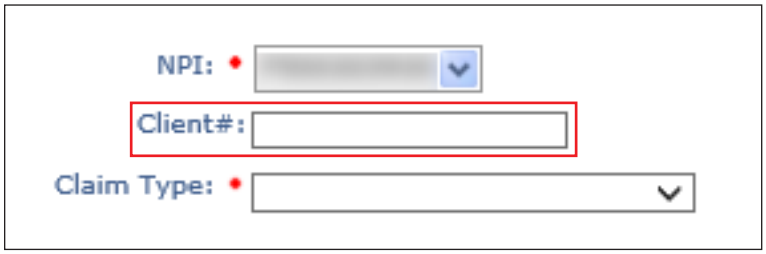
To enter the details of a claim, follow these steps:

1) Select **Claims Entry** from the navigation panel.

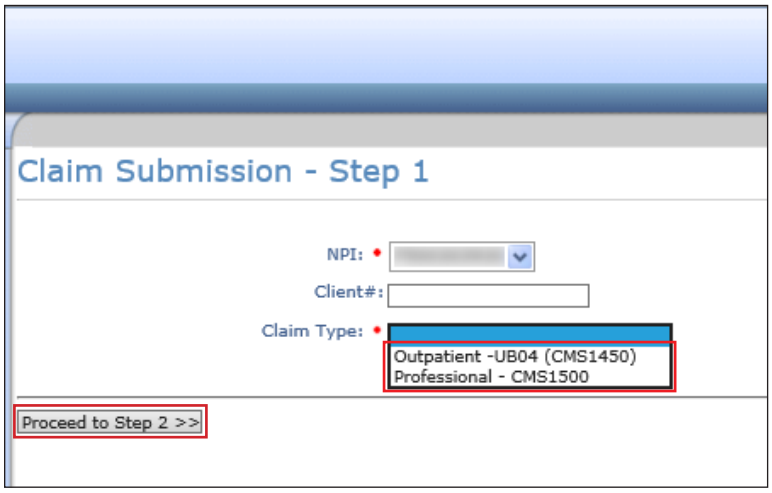
2) Use the NPI drop-down list to select an NPI or API. A list of NPIs or APIs and related data (such as taxonomy, physical address, and benefit code selections) is displayed based on the user's access.



3) Enter the client number for the claim (optional). The client number is the Medicaid ID number. When a client number is entered, the system populates most of the required fields on the Client tab. If you do not enter the client number, you must enter all required fields manually on the Client tab.



4) Use the Claim Type drop-down menu to select **Outpatient** or **Professional**. Click **Proceed to Step 2.**



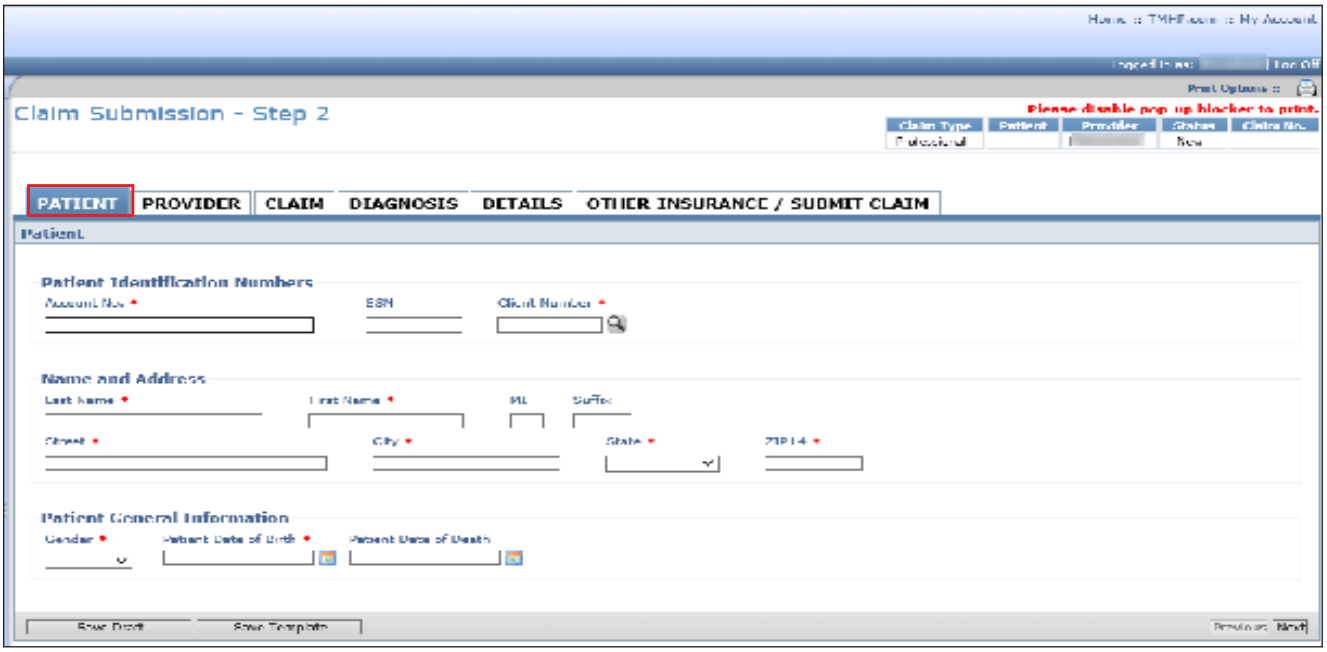
Professional Claim

The Claims Entry screen appears for the Professional claim type. Required fields (indicated by a red dot) must always be completed on each tab. If you entered the client number on the Claims Entry screen, many of these fields are pre-populated, but can still be edited.

You can use the Next and Previous buttons on each tab to save claim data and move through the claims entry steps.

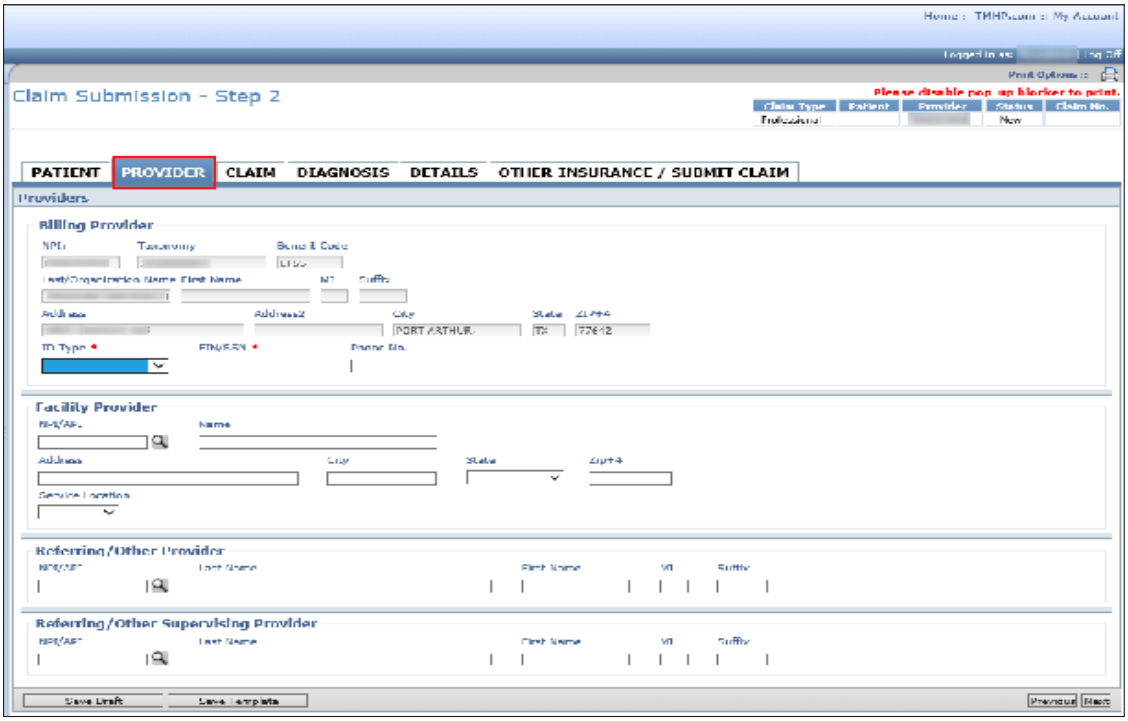
Patient Tab

On the Patient tab, complete all required fields. Make sure to enter a nine-digit ZIP code in the ZIP+4 field.



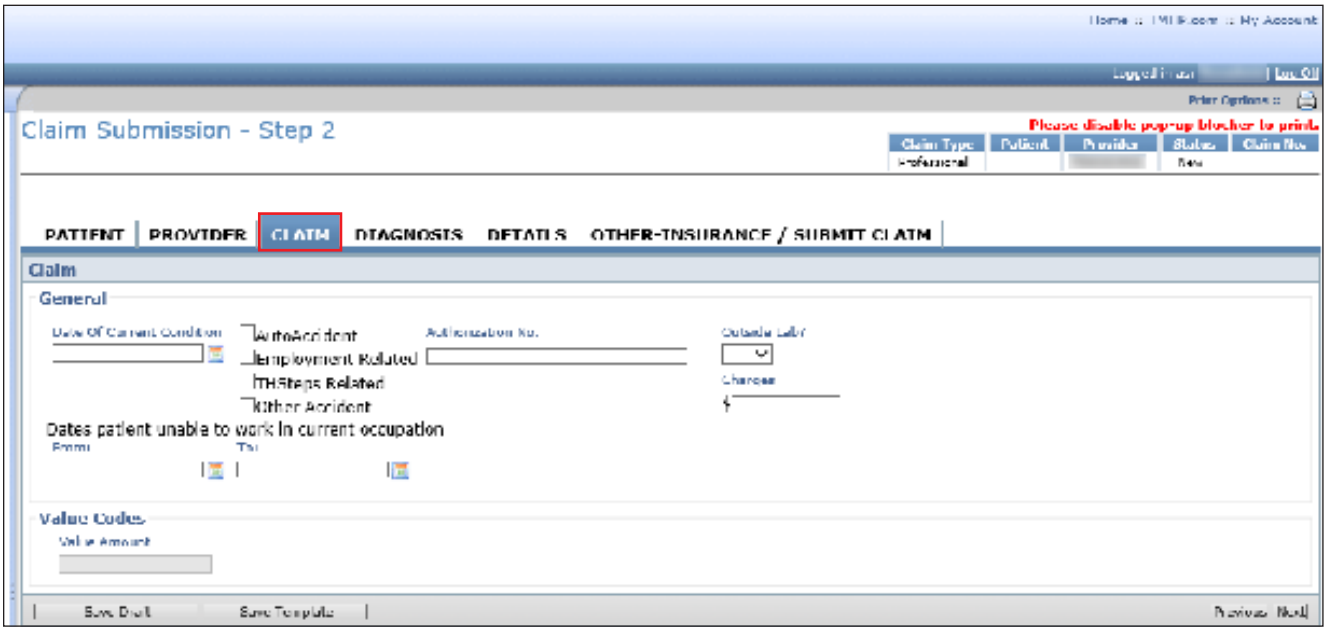
Provider Tab

On the Provider tab, complete all required fields. Some billing provider fields pre-populate. All other required data (such as ID Type) must be entered manually.



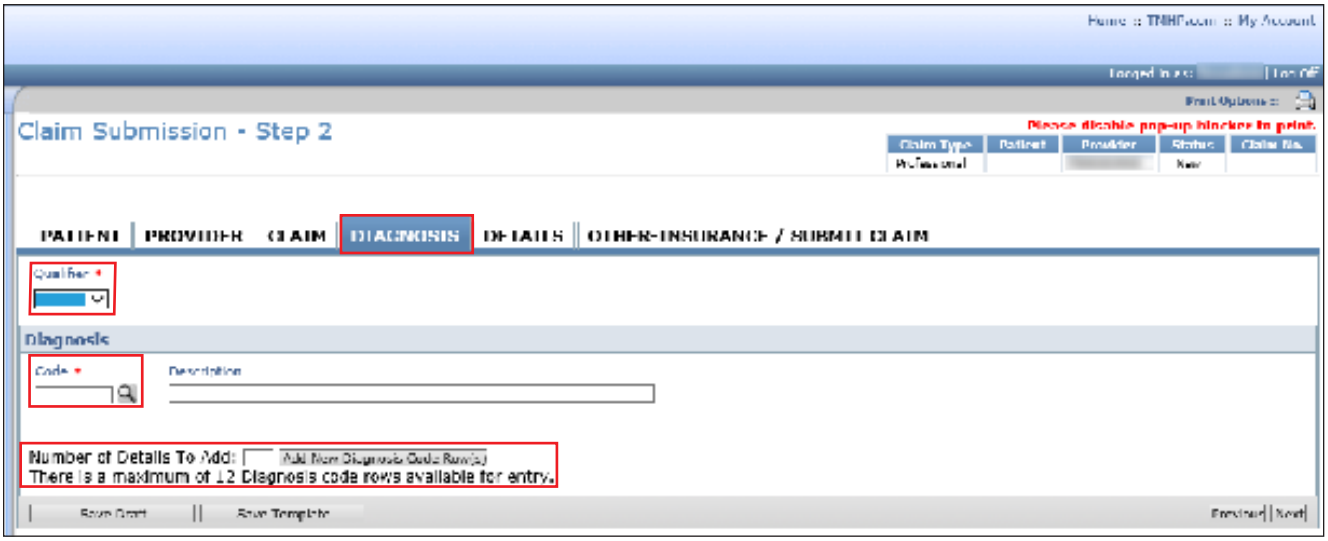
Claim Tab

On the Claim tab, complete all required fields when applicable.



Diagnosis Tab

On the Diagnosis tab, complete all required fields.



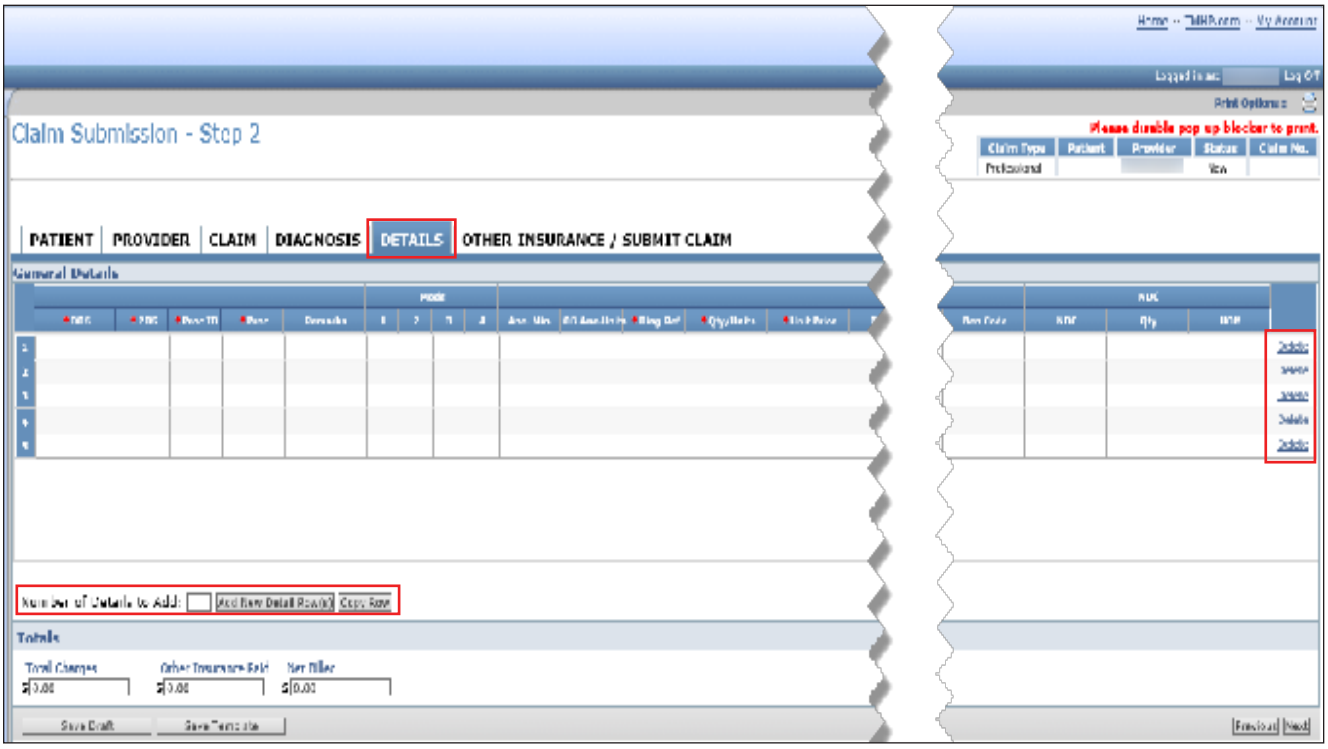
Use the Qualifier drop-down list to select International Statistical Classification of Diseases and Related Health Problems (ICD-9) or ICD-10 to ensure the correct ICD diagnosis code is found in the Code lookup field. The qualifier selected must be valid for the diagnosis code entered, based on the date of services.

Input the diagnosis code to the highest degree of specificity. Click the magnifying glass icon to look up the code description.

To add additional diagnosis code rows, enter the **Number of Details To Add** (up to 12) and click **Add New Diagnosis Code Row(s)**.

Details Tab

On the Details tab, complete all required fields.



The Total Charges on each row are automatically calculated based on the Qty/Units x Unit Price. It is important to note that for EVV claims, the units on the EVV claim must match the units on the EVV transactions for the date of service, or the claim will be denied.

Consult the current HHSC published list of EVV services to know which services are set to bypass the EVV06 claims units match edit. In the list, find your service. Go to the Units Matched During EVV Claims Matching? column to determine if the units on the EVV claim must match the units on the EVV visit transactions for that service.

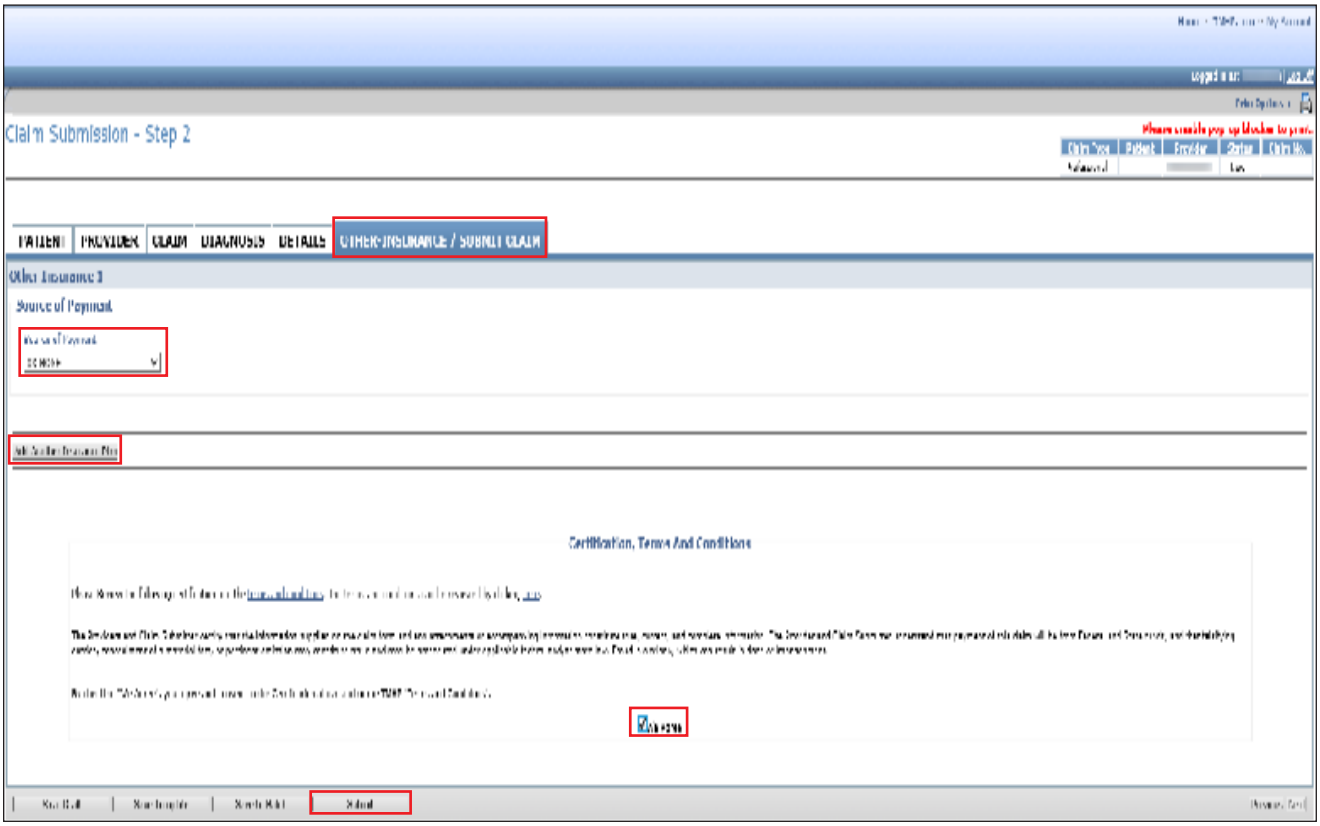
Additionally, the Total Charges at the bottom of the screen is automatically calculated, based on the Total Charges for each row entered.

To add additional detail rows, enter the **Number of Details To Add** (up to 28) and click **Add New Detail Row(s).** To duplicate a detail row, click on the row number and click **Copy Row.**

Click **Delete** in the far right column to remove a row.

Other-Insurance/Submit Claim Tab

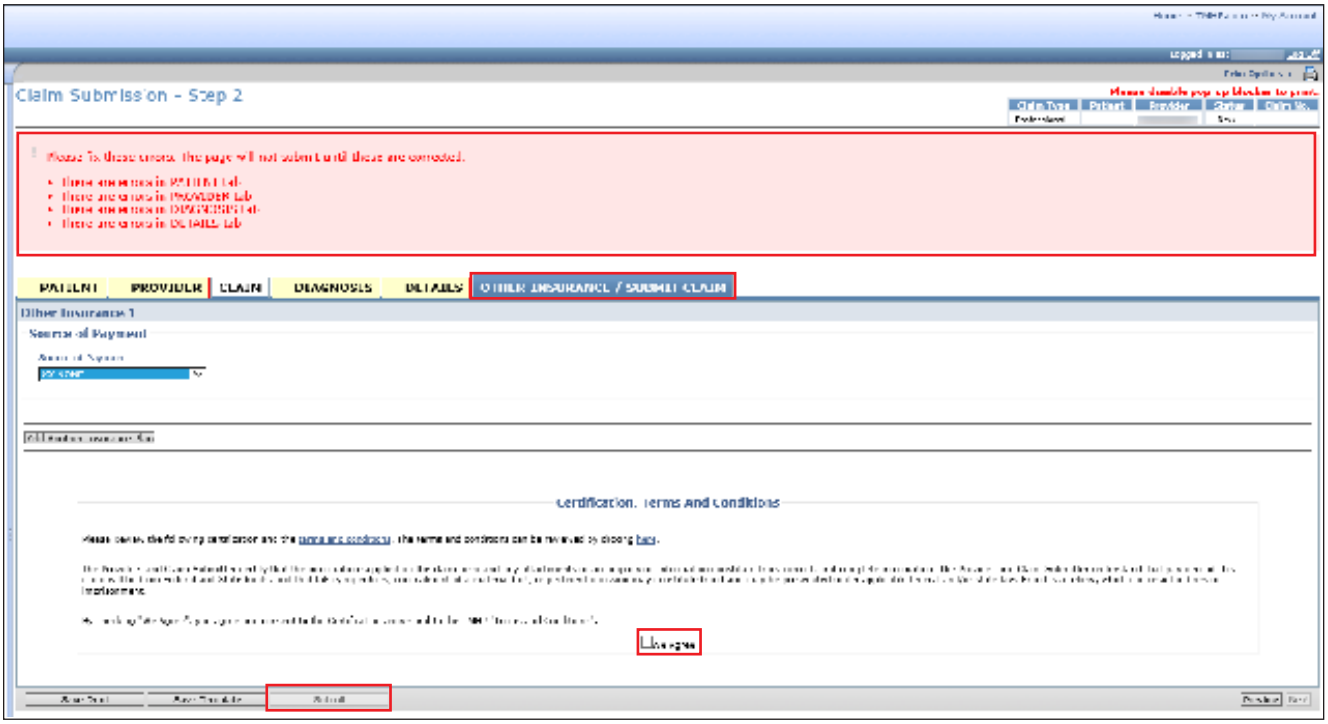
On the Other-Insurance/Submit Claim tab, you can select an option from the **Source of Payment** drop-down list. Enter insurance information into all required fields. Click **Add Another Insurance Plan** to create new insurance that is not on file.



After reviewing the Certification, Terms, and Conditions, check **We Agree** to enable the Submit button.

Click **Submit** for the claim information to be automatically verified by TexMedConnect.

If there is any missing or invalid information, an error message will display the location of the error. Click each tab to view the error message detailing fields that must be corrected and correct them. The claim will not submit until the errors are corrected.



Once all errors are corrected, return to the Other-Insurance/Submit Claim tab. Read the Terms and Conditions, then check the **We Agree box**. Click **Submit** to submit the claim.

Once a claim is submitted successfully, you can view information about claim routing and a TMHP ETN. Click the ETN number to open the CSI screen to view claim routing information and the status of the claim, such as *Pending*, *Accepted*, or *Rejected*.

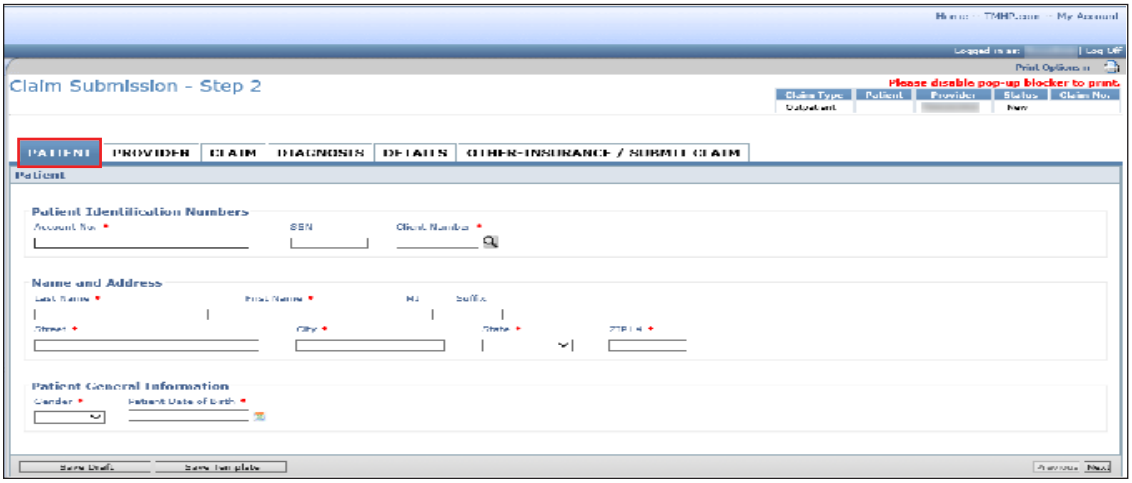
Institutional Outpatient Claim

The Claims Entry screen appears for an Outpatient claim type. Required fields (indicated by a red dot) must always be completed on each tab. If you entered the client number on the Claims Entry screen, many of these fields are pre-populated but can still be edited.

Use the Next and Previous buttons at the bottom of each tab to save claim data and move through the claims entry steps.

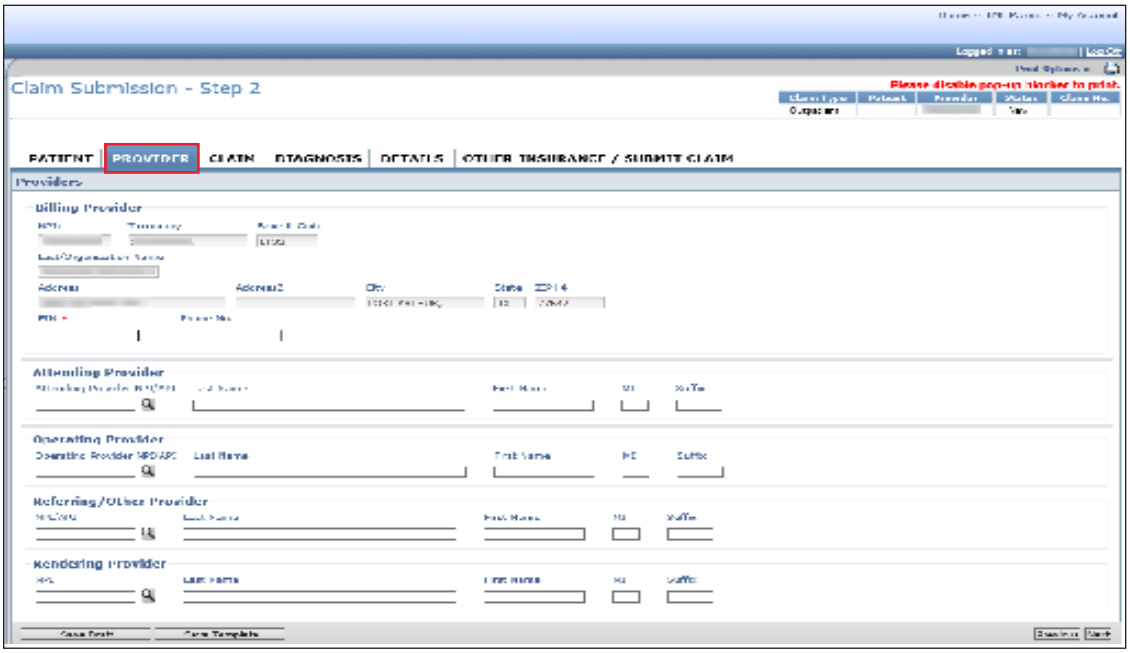
Patient Tab

On the Patient tab, complete all required fields.



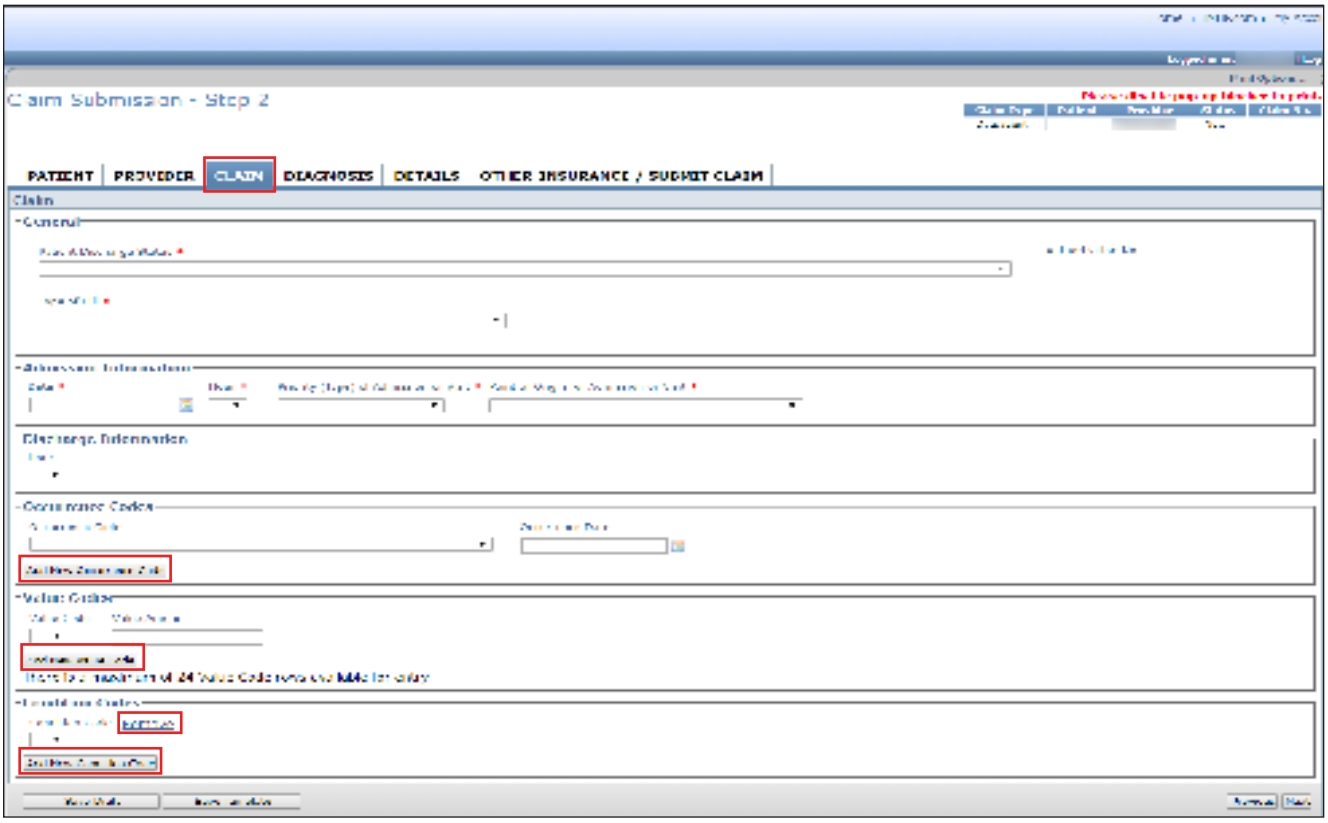
Provider Tab

On the Provider tab, complete all required fields. Some billing provider fields pre-populate. All other required data (such as ID Type) must be entered manually.



Claim Tab

On the Claim tab, complete all required fields.



To add occurrence code rows, click **Add New Occurrence Code**. There is a maximum of four occurrence code rows.

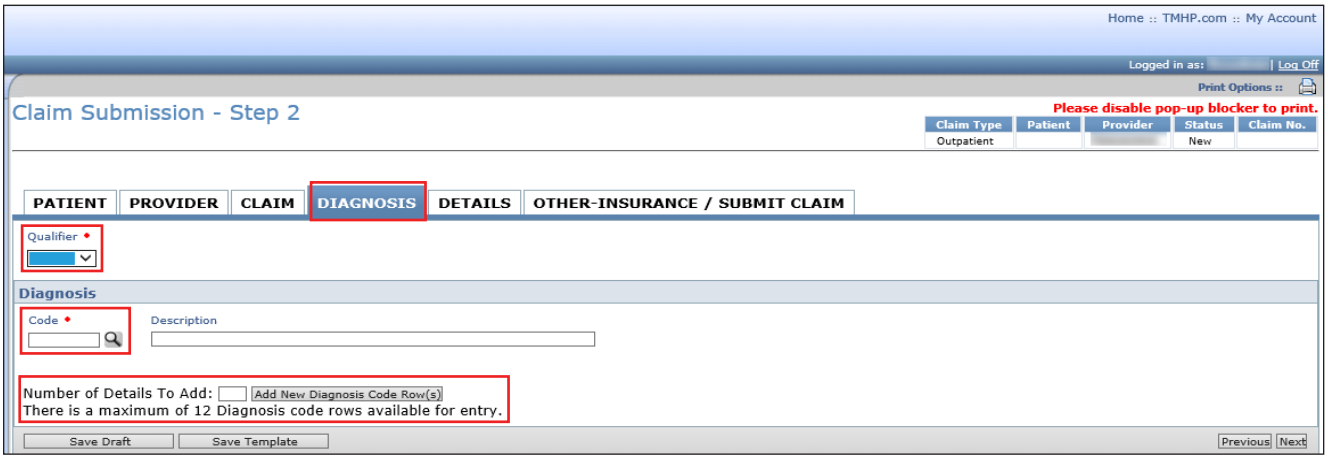
To add value code rows, click **Add New Value Code** (up to 24 rows) and click **Add New Diagnosis Code Row(s).**

To add condition codes, click **Add New Condition Code.**

To delete any added rows, click **Remove**.

Diagnosis Tab

On the Diagnosis tab, complete all required fields.



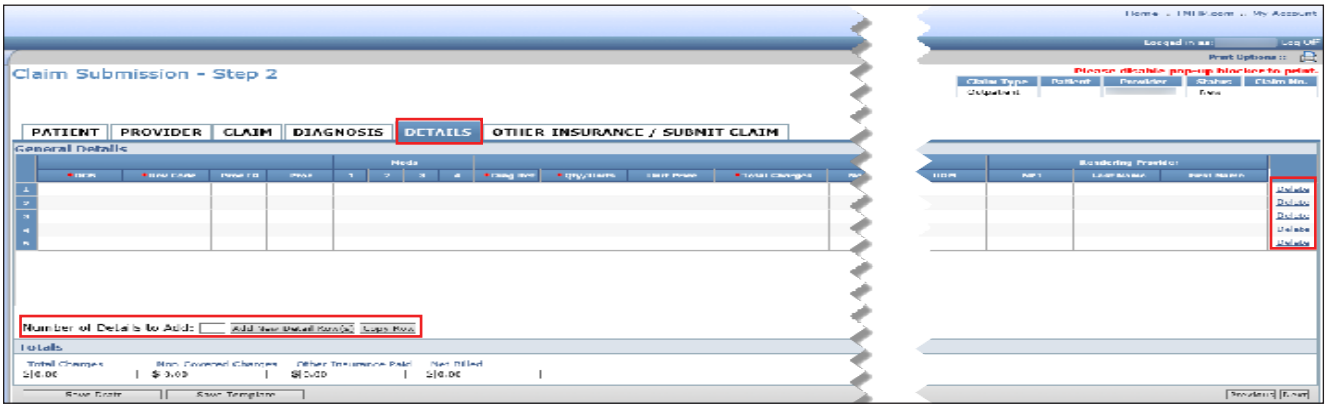
Use the Qualifier drop-down list to select ICD-9 or ICD-10 to ensure the correct ICD diagnosis code is found in the Code lookup field. The qualifier selected must be valid for the diagnosis code entered, based on the date of services.

Input the diagnosis code to the highest degree of specificity. Click the magnifying glass icon to look up the code description.

To add additional diagnosis code rows, enter the **Number of Details To Add** (up to 12) and click **Add New Diagnosis Code Row(s).**

Details Tab

On the Details tab, complete all required fields.



The Total Charges on each row are automatically calculated based on the Qty/Units x Unit Price. It's important to note that for EVV claims, the units on the EVV claim must match the units on the EVV transactions for the date of service, or the claim will be denied. Additionally, the Total Charges at the bottom of the screen is automatically calculated, based on the Total Charges for each row entered.

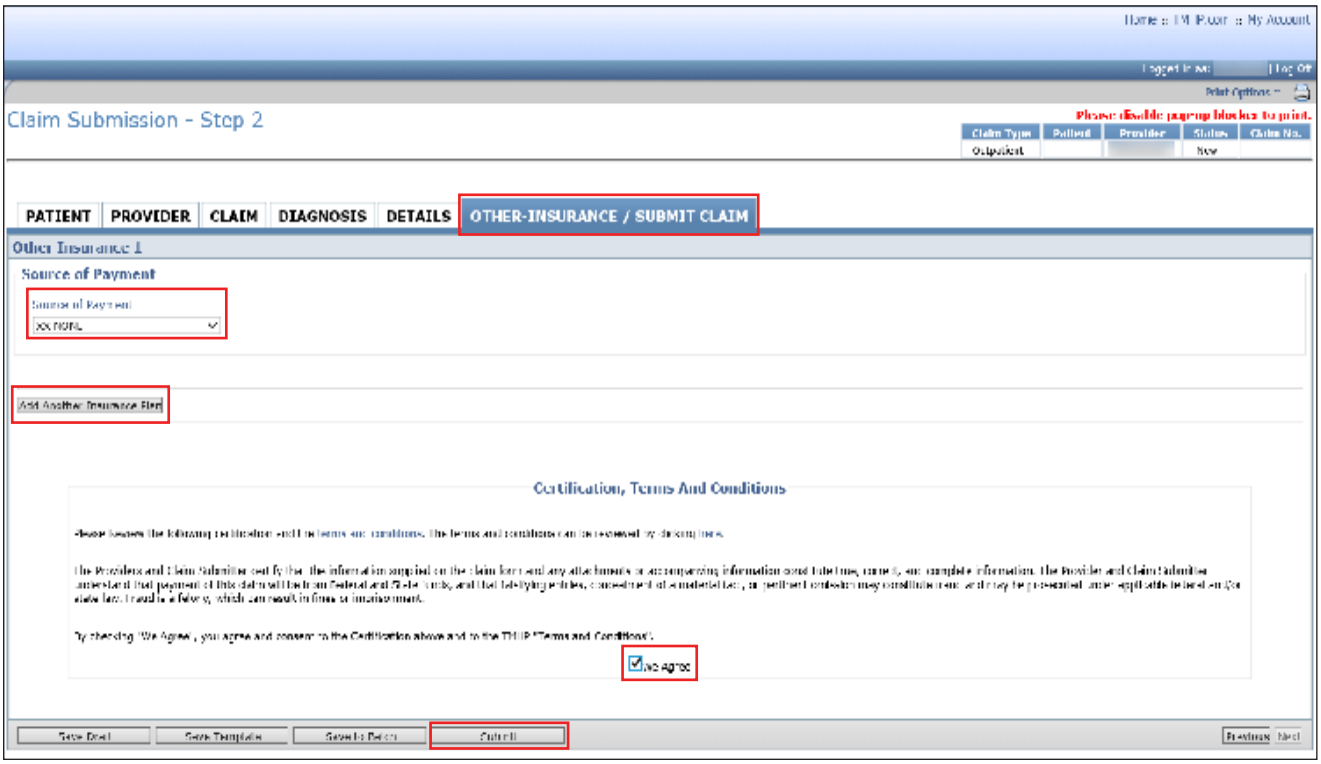
To add additional detail rows, enter the **Number of Details To Add** (up to 28) and click **Add New Detail Row(s).** To duplicate a detail row, click on the row number and click **Copy Row.**

To remove a row, click **Delete** in the far right column.

Other-Insurance/Submit Claim Tab

On the Other-Insurance/Submit Claim tab, you can select an option from the **Source of Payment** drop-down list. Enter insurance information into all required fields. Click **Add Another Insurance Plan** to create new insurance

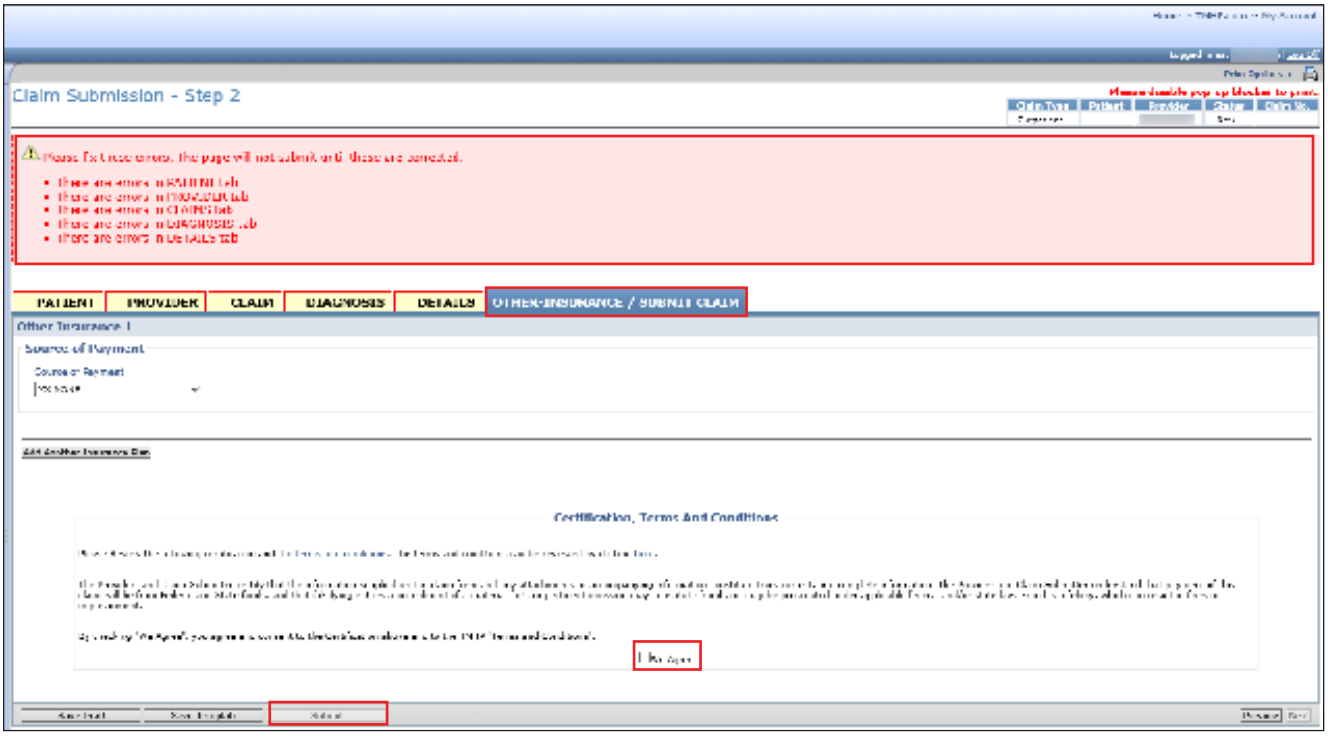
that is not on file.



After reviewing the Certification, Terms, and Conditions, check **We Agree** to enable the Submit button.

Click **Submit** for the claim information to be automatically verified by TexMedConnect.

If there is any missing or invalid information, an error message will display the location of the error. Click each tab to view the error message detailing fields that must be corrected. The claim will not submit until the errors are corrected.

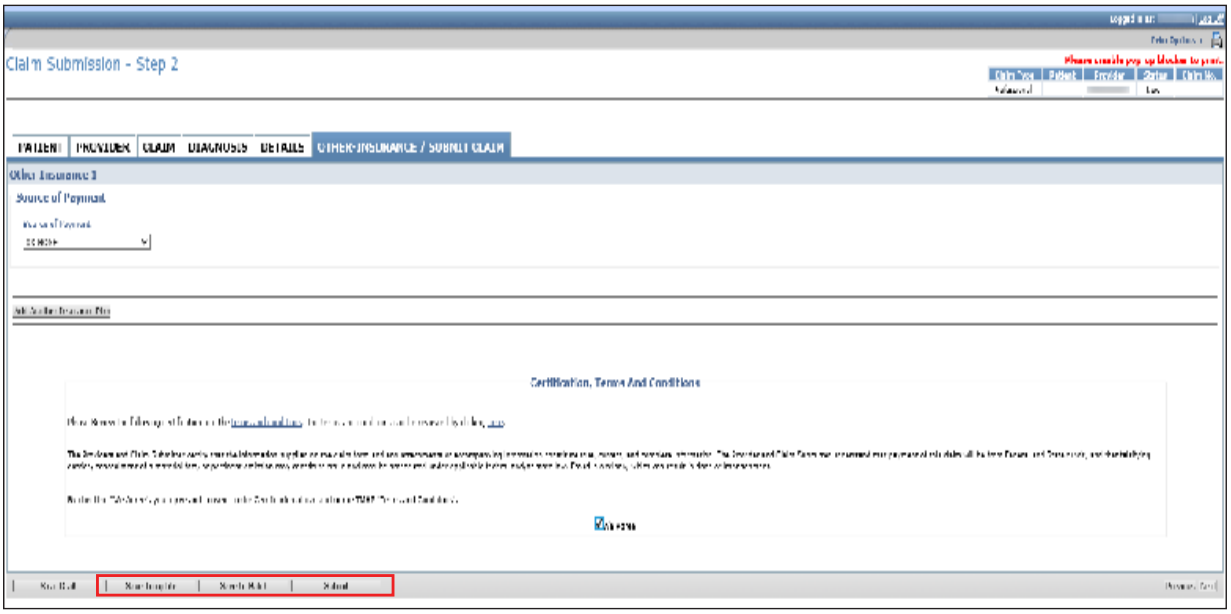


Once all errors are corrected, return to the Other-Insurance/Submit Claim tab. Read the Terms and Conditions, then check the **We Agree box**. Click **Submit** to submit the claim.

Once a claim is submitted successfully, you can view information about claim routing and a TMHP ETN. Click the ETN number to open the CSI screen to view claim routing information and the status of the claim, such as *Pending*, *Accepted*, or *Rejected*.

Saving a Claim

MCO LTSS provider claims can be saved as a draft or saved as a template.



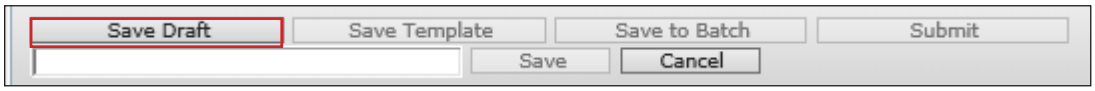
Click **Save Draft** to add the claim to the Draft list for completion at a later time.

Click **Save Template** to add claims to the Individual Template list for quicker claims creation in the future.

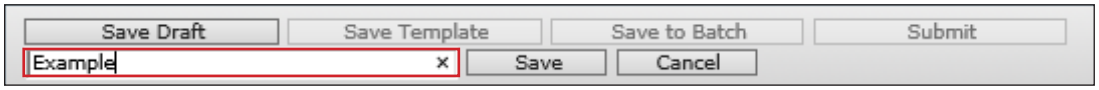
Saving as a Draft

You can save incomplete claims in a draft status for later submission. To save a claim as a draft, follow these steps:

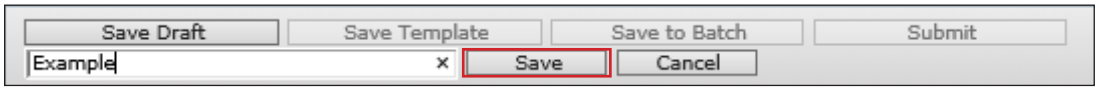
1) Click Save Draft.



2) Enter a draft name in the blank field that appears. The draft name can include both numbers and letters.



3) Click Save to save the draft. Click Cancel to close the draft name field.



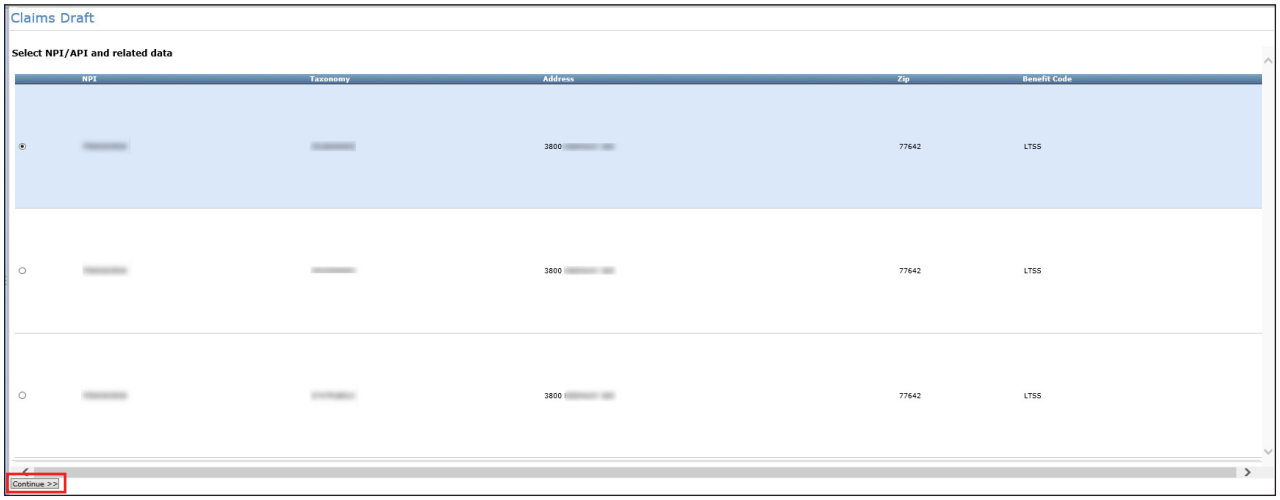
The claim is saved to the Draft screen for completion at a later time.

Viewing Draft Claims

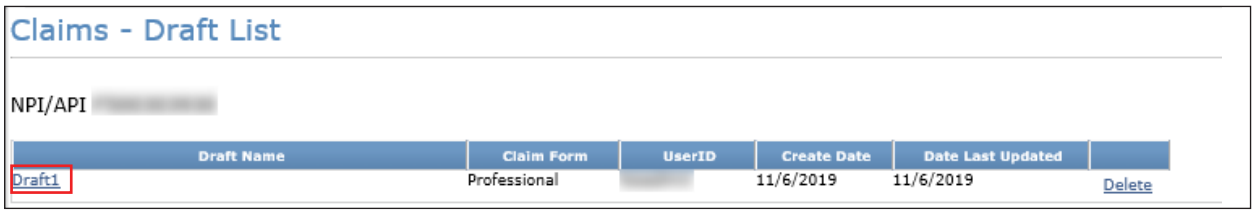
A list of NPIs and APIs and related data appear in the Claims Draft screen. Once a draft is submitted, it is removed from the draft list. Additionally, drafts are removed if they are not submitted within 45 days. A maximum of 50 drafts can be created for each NPI or API number. Drafts are displayed by NPI or API. To view a list of draft claims:

1) Click **Draft** in the left navigation panel.

2) Select the NPI or API on the Claims Draft screen. Click **Continue**.



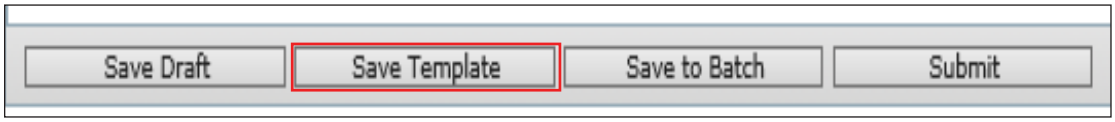
3) Click on a draft name to continue working on it. Drafts can be sorted by clicking column headers.



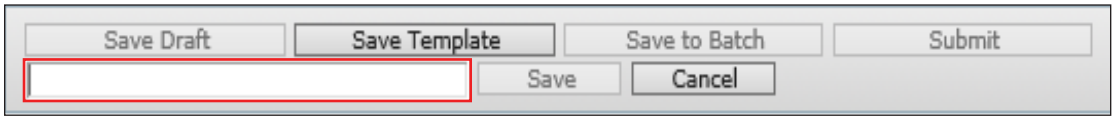
Saving Individual Claims as Templates

You can save individual claims as a template to save time submitting claims in the future. To save a claim as a template, follow these steps:

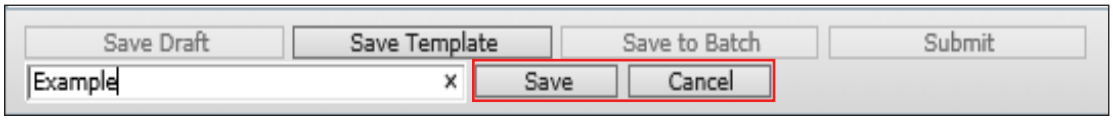
1) Click **Save Template**.



2) Enter a template name in the blank field that appears.



3) Click **Save** to save the template. Click **Cancel** to close the template name field.



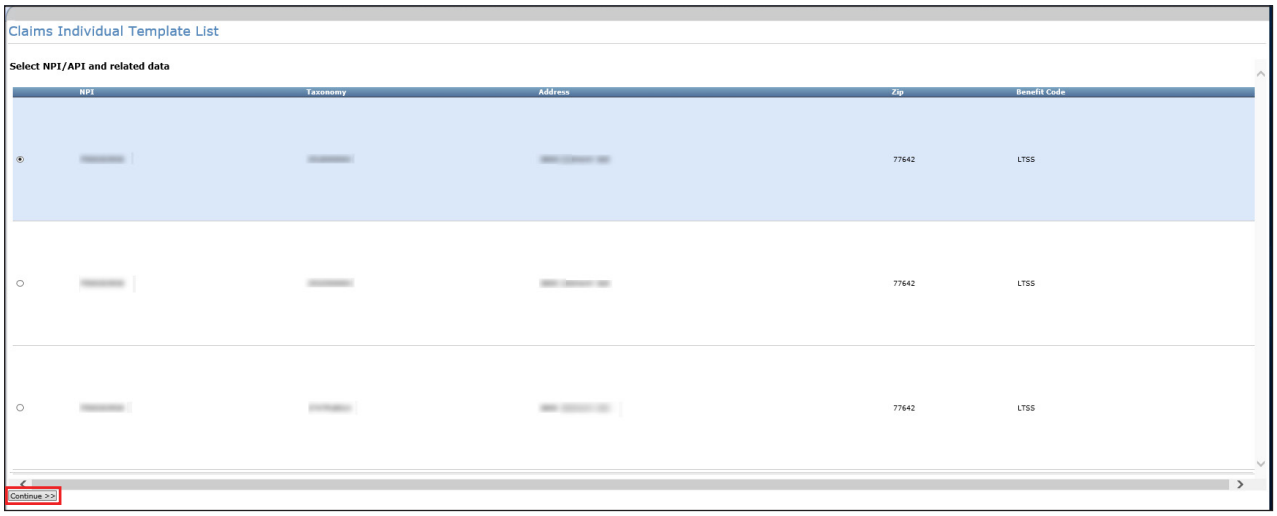
4) The claim is saved to the Individual Template screen for completion at a later time.

Viewing Individual Templates

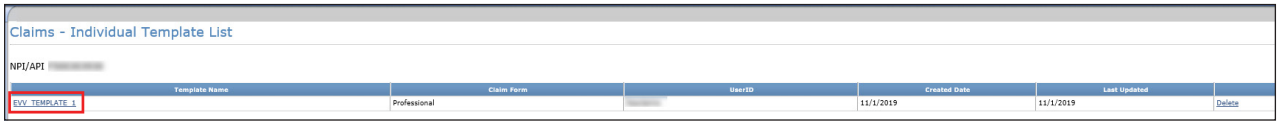
A list of NPIs and APIs and related data appear in the Claims Individual Template List screen. Templates are displayed by NPI or API. Templates do not disappear when used, but they are removed after 90 days of not being used. A maximum of 1000 individual claim templates can be created for each NPI or API number. To view a list of individual templates:

1) Click **Individual Template** in the left navigation panel.

2) Select the NPI or API on the Claims Individual Template List screen. Click **Continue**.



3) Click on a template name to continue working on a claim. Templates can be sorted by clicking column headers.



Saving as Batch

You can save a claim to batch, which creates a pending batch list that is maintained until you submit the batch. One batch can contain up to 250 claims. Claims from Draft, Templates, or claims currently being created can be saved to a pending batch. Pending batches not submitted after 45 days are deleted. To save a claim to batch, follow these steps:

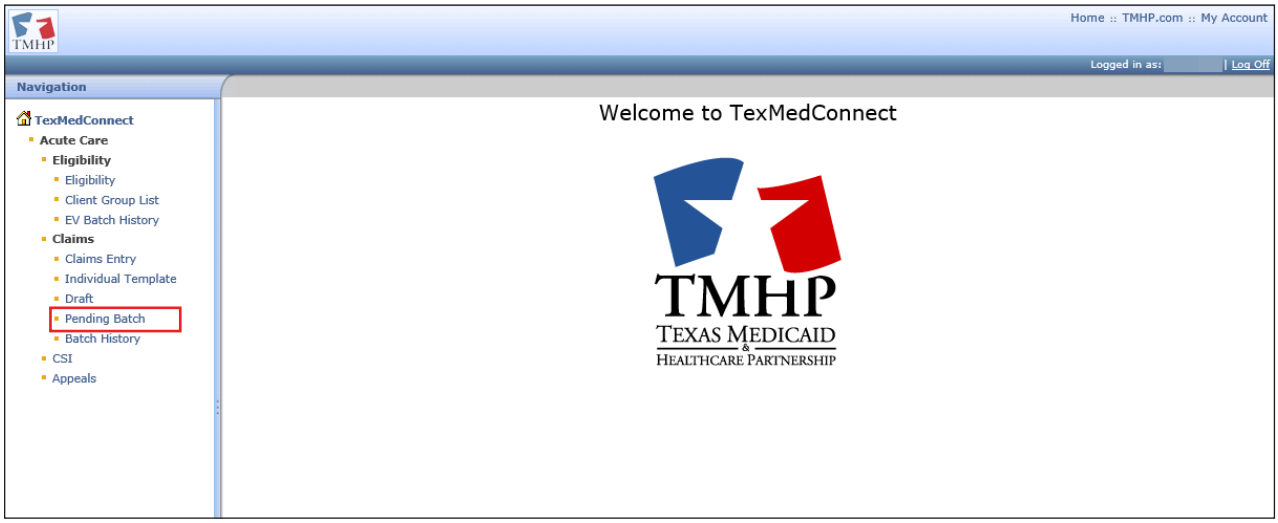
1) Click **Save to Batch**.

2) After you click **Save to Batch**, the system will take you back to the claims entry screen.

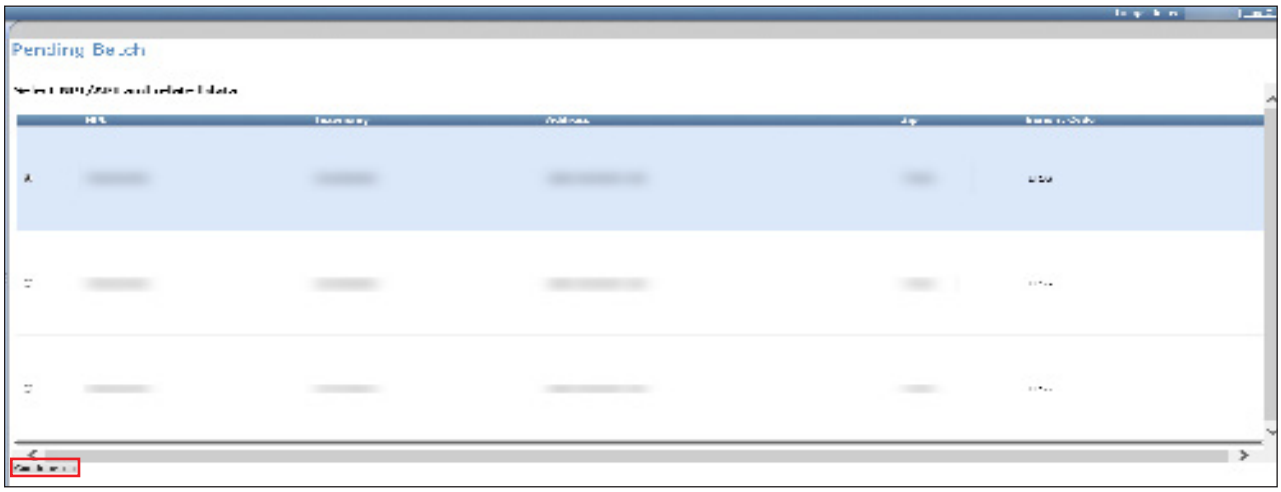
Pending Batch

The pending batch list displays claims that are ready to be submitted. To submit a batch of pending claims, follow these steps:

1) Click **Pending Batch** in the left navigation panel.

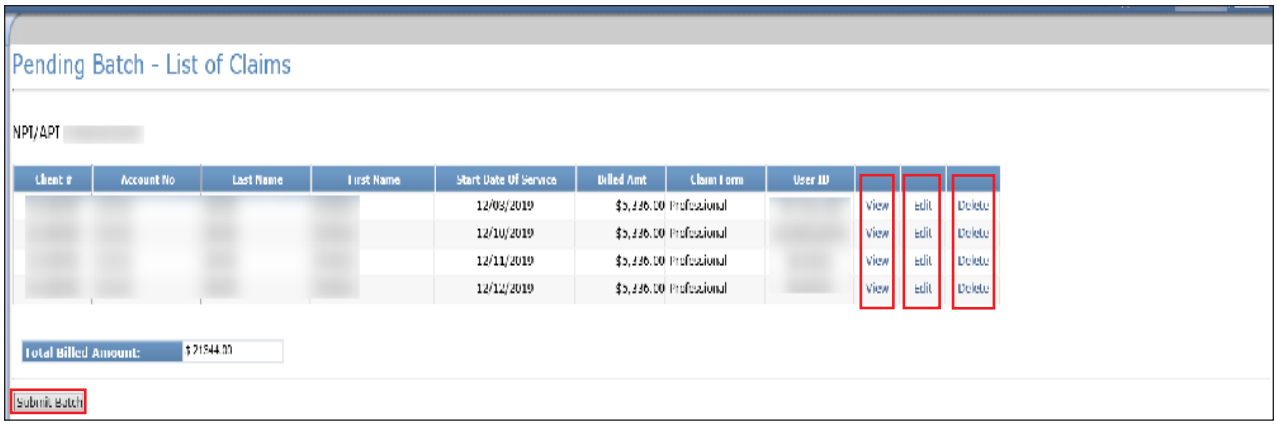


2) Select the NPI or API in the Select NPI/API and related data list, then click **Continue**.

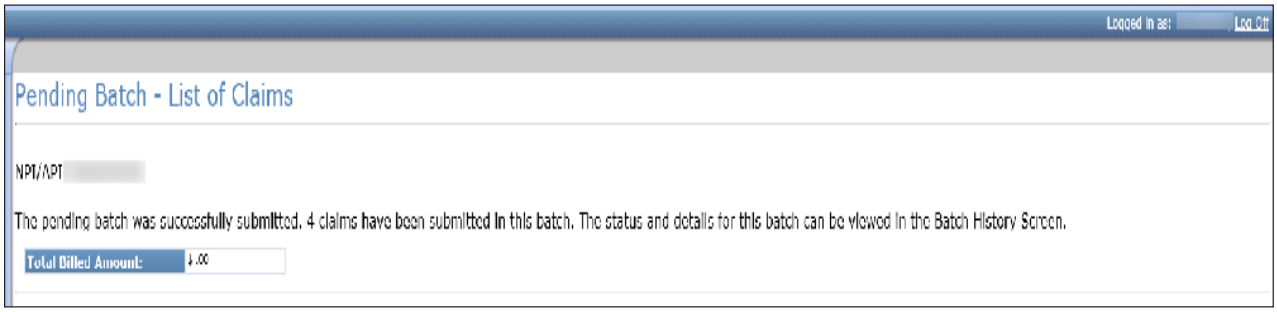


3) Click **View** to view pending claim detail. Click **Edit** to make changes to the pending claim. Click **Delete** to delete the pending claim.

   Click **Submit Batch** when all pending claims displayed are ready to be submitted. All claims in the batch will be submitted, even if they were created by other users under the same NPI.



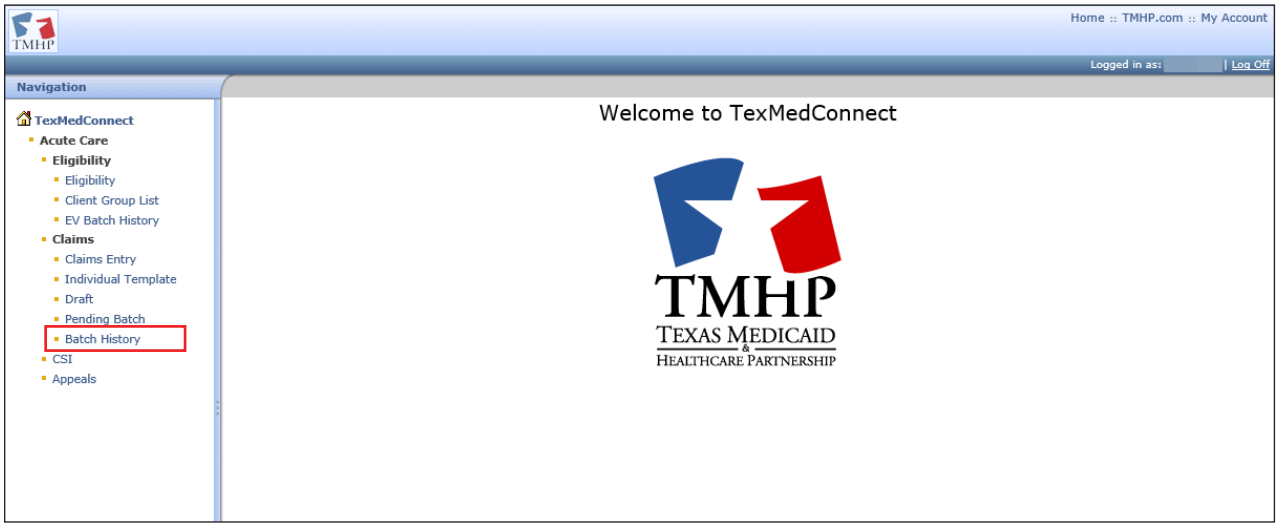
4) A confirmation appears when the batch is submitted.



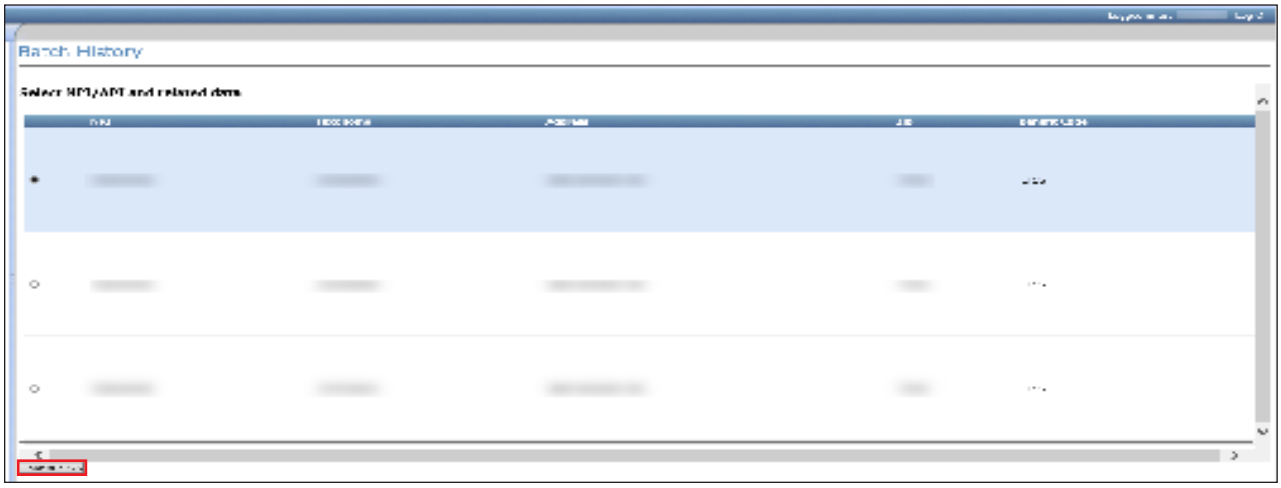
Batch History

You can view the history of previously submitted claim batches for the previous 120 days. Batches that are more than 120 days old are automatically deleted from the history. To view a batch history, follow these steps:

1) Click **Batch History** in the left navigation panel.



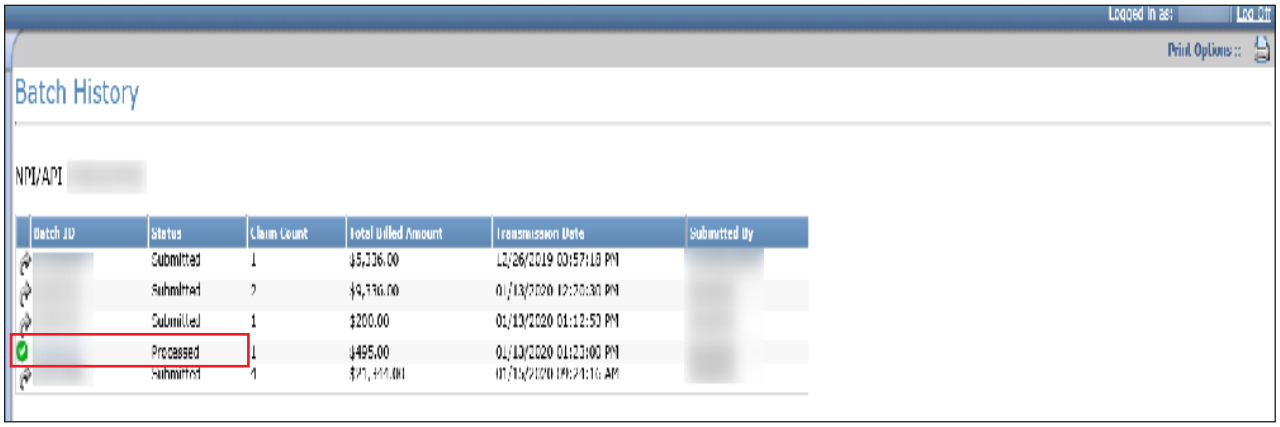
2) Select the NPI or API in the Select NPI/API and related data list, then click **Continue**.



3) A Batch History list appears. Batch IDs are assigned a *Submitted* status or a *Processed* status.

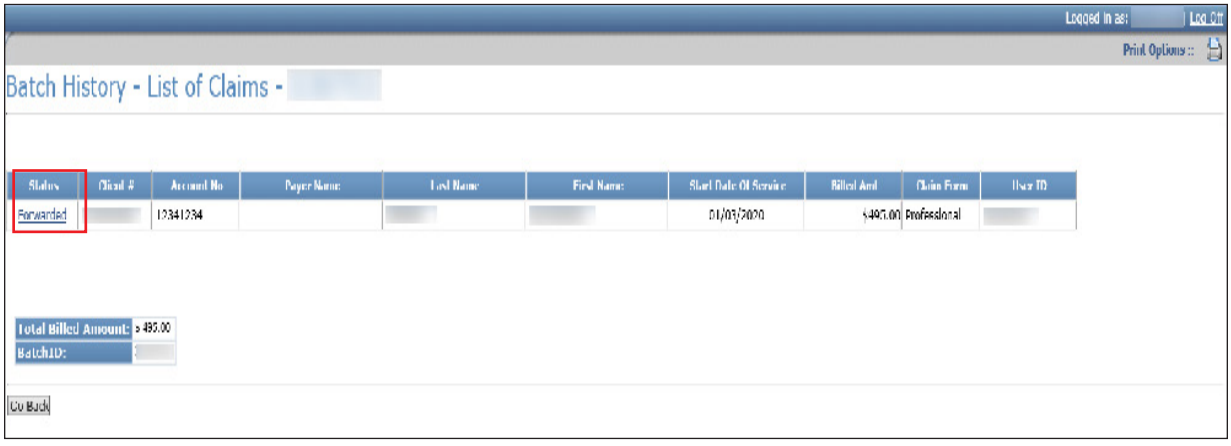
   A *Submitted* status indicates the user has submitted the batch, but it has not been forwarded to the payer. A *Processed* status indicates the batch has been processed by the system and forwarded to the payer. A *Submitted* status will change to a *Processed* status within 24 hours. Contact the EDI Help Desk a 888-863-3638, Option 4, if the batch remains in a *Submitted* status for over 24 hours.

   Click a **Batch ID** in *Processed* status to view the list of claims in that batch.

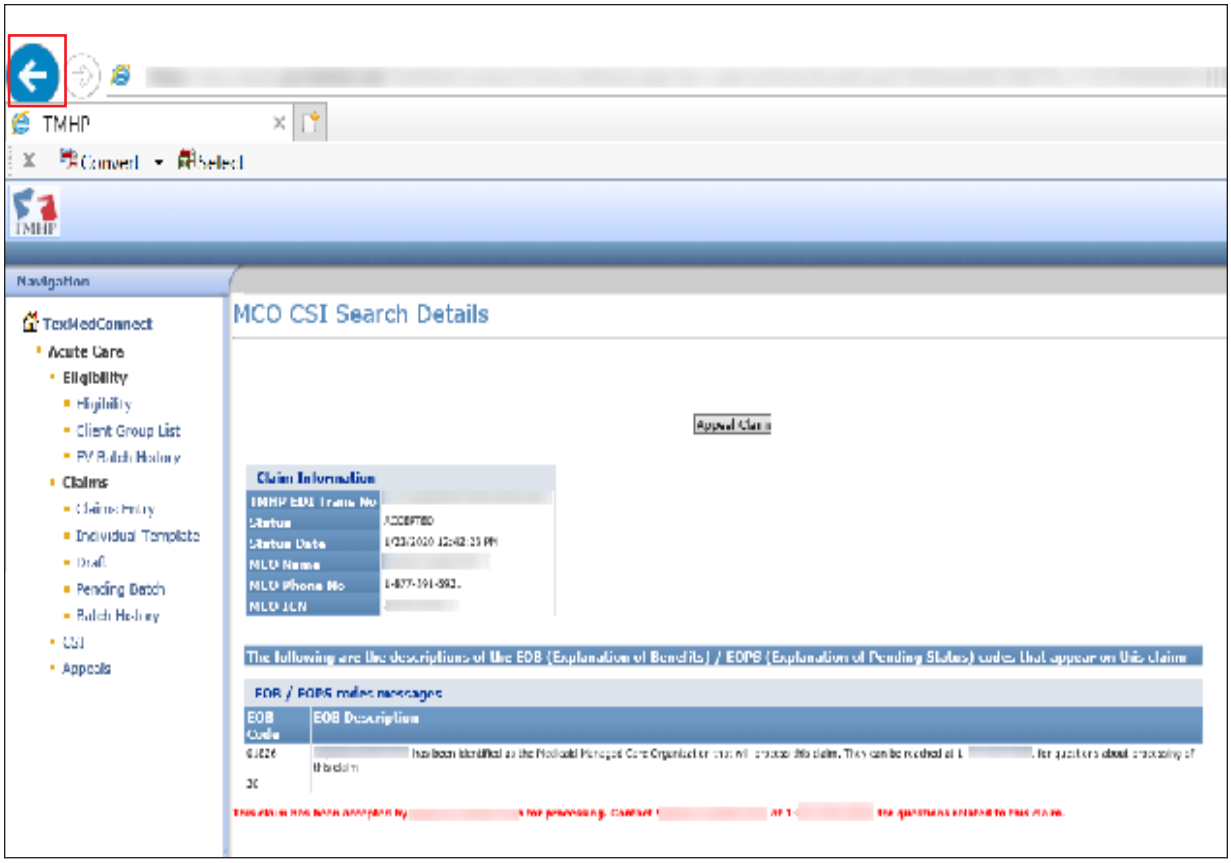


4) A list of claims for the Batch ID appears. Claims are in a *Forwarded*, *Accepted*, or *Rejected* status. *Forwarded* claims have been sent to the payer, but have not been accepted or rejected. *Accepted* claims have been accepted by the payer. *Rejected* claims have been rejected by the payer.

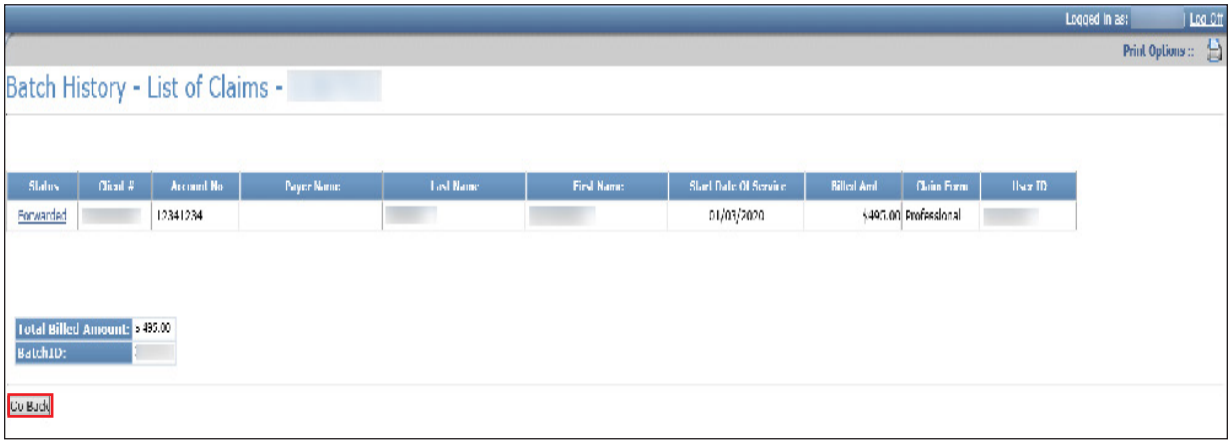
5) Clicking the **Status** link will take you to additional details on the MCO CSI Search Details screen.



6) The MCO CSI Search Details screen appears. Use the internet browser back button to return to the previous screen.



7) Click **Go Back** to return to the list of claims.



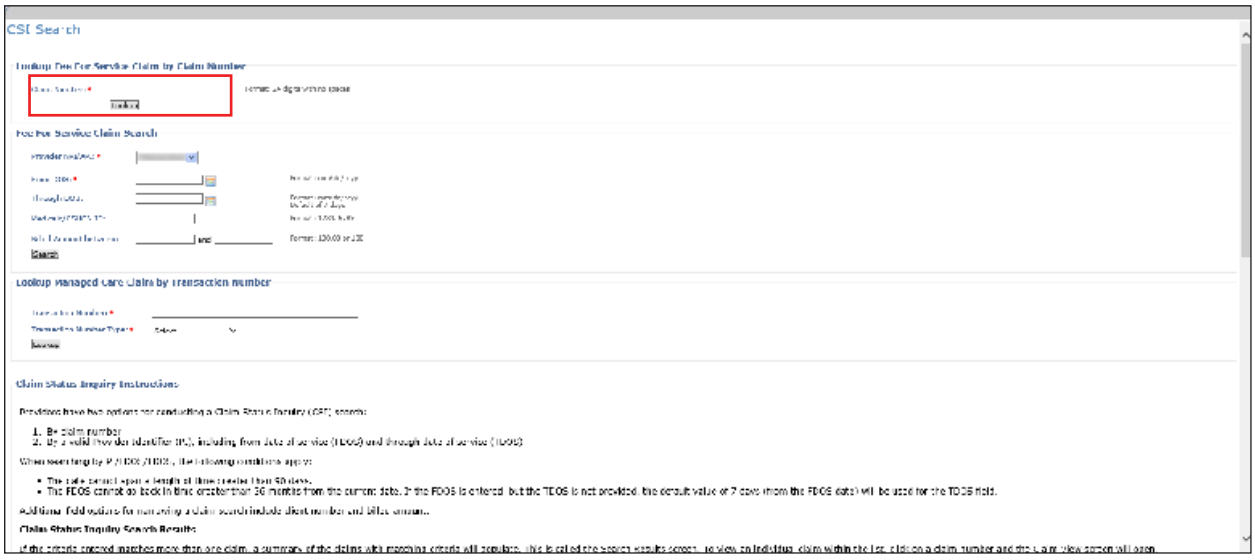
Claim Status Inquiry (CSI)

CSI allows you to determine the status of processed claims. The search can be performed using a claim number or a combination of other fields. A summary of claims within the past three years that matches the search criteria appears, and claim detail can be accessed. A maximum of 250 results are returned. To perform a CSI search:

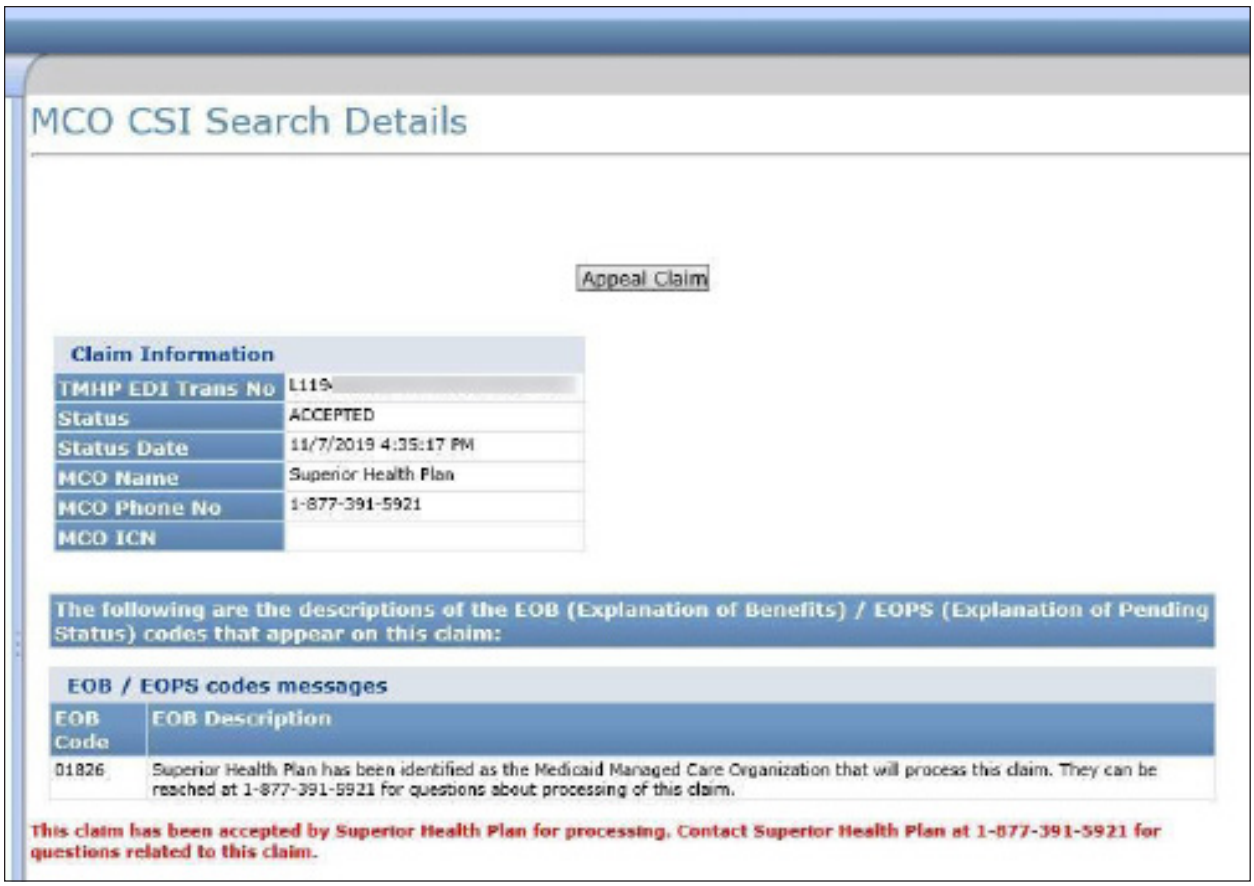
1) Click **CSI** in the left navigation panel.

2) Enter a claim number. Click **Lookup**. If you do not know the claim number, enter other claim information and click **Search**.

   It is important to note that a date range cannot be longer than 30 days, and the From date of service (DOS) field cannot have a date more than 36 months prior to today's date.



3) CSI search details appear if a match is found. If the search does not locate the desired claim, narrow the search criteria to produce a more specific match.



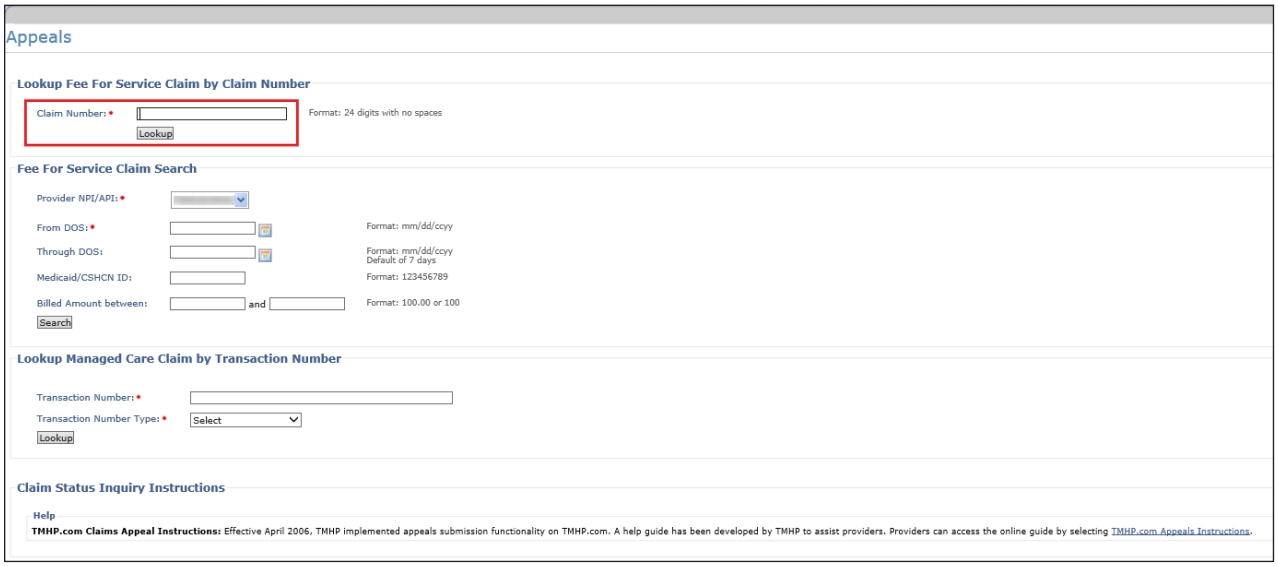
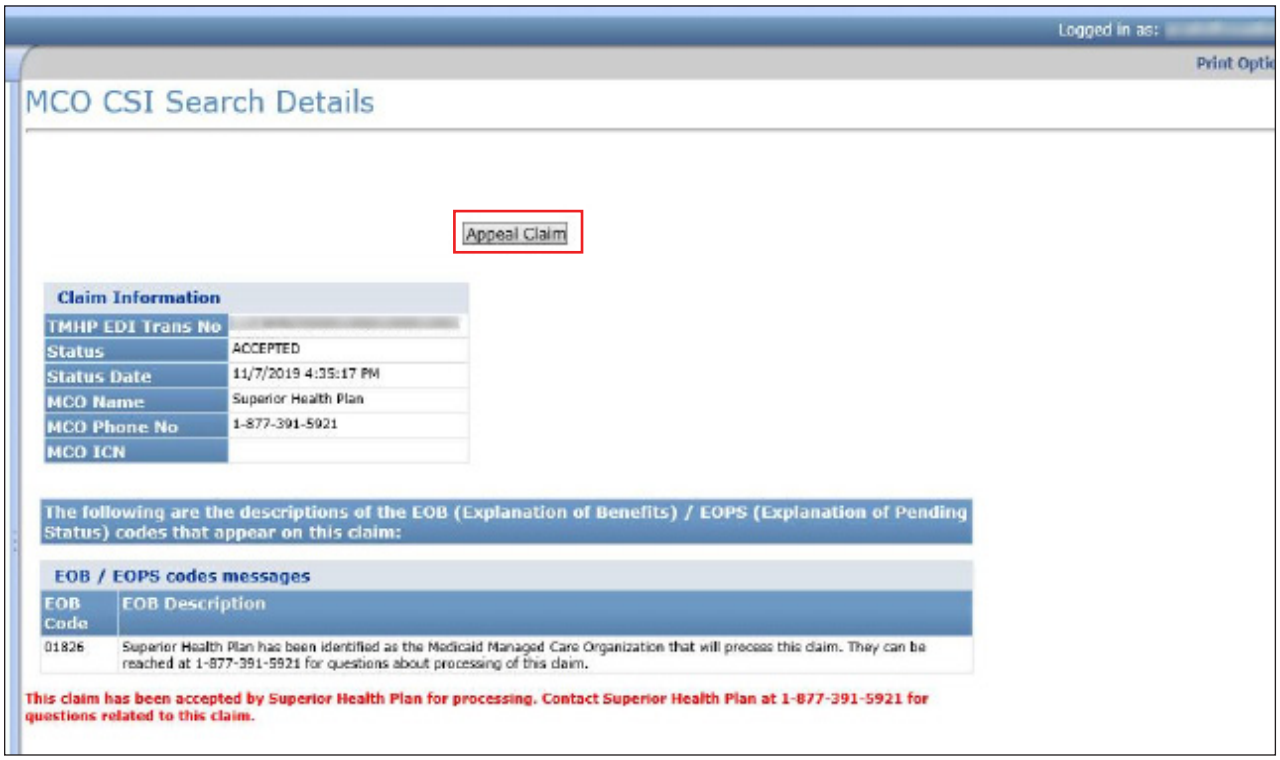
Claims Appeals

Institutional outpatient claims with a finalized status, such as *Denied* or *Paid*, must be appealed directly with the MCO using the existing appeal process.

Professional claims with a finalized status, such as *Denied* or *Paid*, can be appealed directly from TexMedConnect. You can only appeal finalized claims. **NOTE:** Your MCO may refer to "Appeals" as "Corrections," "Adjustments," or "Updates." To appeal a claim, follow these steps:

1) Click **Appeals** in the left navigation panel.

2) Enter the claim number. Click **Lookup**. If you do not know the claim number, enter other claim information and click **Search**.



3) CSI search details appear if a match is found. Click **Appeal Claim** to begin the appeal process.