PACSTX
Annual Conference

October 18, 2023

Topics Common Errors

Utilization Review

- Holly Lindsey will discuss data entry

IDD PES

- Fabian Aguirre will discuss tangled transfers

PCS

- Marie Redman will discuss claims and reconsiderations

PEMS

- Angie Hutchinson will discuss PEMS

Audience Q&A

Utilization Review

Holly Lindsey, *Manager*
HCS/TxHmL Waivers Utilization Review
Medicaid and CHIP Services

UR Common Errors and Misunderstandings – Asking for help

- Turnaround time
- Unlock form
- Adequate information
- Protected Health Information (PHI)

UR Common Errors and Misunderstandings – Requisition fee

Use the correct requisition fee on rates sheet

- Sends form to Pending DADS Review status
- Requires override even after correction

UR Common Errors and Misunderstandings – Req fees

Requisition Fees	Payment Rate
Adaptive Aids, Medical Supplies and Dental	
Under $500	10% of cost
$500 to $999.99	$54.03
$1,000 to $1,499.99	$92.85
$1,500 to $1,999.99	$105.66
$2,000 to $2,499.99	$118.86
$2,500 to $2,999.99	$134.21
$3,000 to $3,499.99	$140.81
$3,500 to $3,999.99	$147.02
$4,000 to $4,499.99	$153.62
$4,500 to $4,999.99	$160.22
$5,000 and over	$168.96

UR Common Errors and Misunderstandings - TP2

TP2 are timeliness holds

Meeting date after the effective date of renewal

- Hold meeting before the end of the previous IPC
- Enter signature date as date of meeting
- Hold meeting even if something else is tangled
- Document efforts

UR Common Errors and Misunderstandings - TP2

PROV/INDIVIDUAL INFO | IPC SERVICES/COST | NON WAIVER SERVICES | CERTIFICATIONS | ATTACHMENTS

HCS Program Provider Signature

Service Planning Team: By signing below, you indicate your agreement that the HCS services for this inc
institutionalization, assure health and safety, and are based on outcomes on the PDP.

46	Certification of the HCS Provider Representative Signature	☑
47	Provider Representative printed First Name	
47c	Provider Representative printed Last Name	
48	Provider Representative Signature Date	10/14/2022

Individual/Legally Authorized Representative (LAR) Signature

49	Certification of Individual/Legally Authorized Representative	☑
50	Individual/Legally Authorized Representative Signature Date	10/14/2022
51a	Individual/LAR participated by phone	☐
51b	Individual/LAR participated by phone on: (Date)	mm/dd/yyyy

PROV/INDIVIDUAL INFO

12a	Effective Date	11/29/2022

UR Common Errors and Misunderstandings – ISS Auto-authorizations

Not a "conversion" of dayhab to Individual Skills and Socialization

- IL 2023-03
- Needed a processed complete dayhab service authorization before 3/1/2023
- Enter a revision to add if no auto-authorization
- Request state action IPC to correct if revision not available

UR Common Errors and Misunderstandings - Revisions

- Out-of-order
  - Must be done by UR
  - Send signed "hardcopy"

- "Losing" the Revise button
  - 30 days before Renewal
  - After Renewal entry
  - During / post transfer

UR Common Errors and Misunderstandings - Form 8578

Purpose codes

Pending DADS Review

- Remands / timer ran out on LIDDA agreement
- LOC vs LON
- Boxes 35-38 and/or Box 40

LA/DADS Review Tab

UR Common Errors and Misunderstandings - "Identifying Information" error

Might be

- Mismatch of information
- Transfer related
  - 10C was not ended
  - Receiving provider did not enter an IMT

IDD PES (Transfers)

Fabian Aguirre, *Director*
Intellectual/Developmental Disabilities Program Eligibility and Support (IDD PES)
Medicaid and CHIP Services

Most Common Errors Transfers

- Information errors (e.g., location, county, and contract number)
- Incorrect calculation of days/units on Transfer IPC
- Location Availability (e.g., tangled transfer)
- Incorrect order of form entry preventing transfer submission
- Overbilled claims preventing transfer submission

Preventing Processing Delays Transfers

Follow Best Practices from the October 2023 Town Hall

1915(c) Waiver Programs | TMHP

Helpful Links

To learn more about 1915(c) waiver programs, see the following websites and resources:

- Health and Human Services Commission (HHSC)
- Centers for Medicare & Medicaid Services (CMS)
- HHSC HCS and TxHmL past Webinars, Recordings and FAQs

Best Practice Highlights Transfers/Moves

Receiving Providers

- Confirm location availability (use requested began date)
- Ensure the location code is correct on all documentation.
- Not all moves are a transfer (e.g., moving Residential Type)
- Do not enter a Renewal if the "IMT - Individual Update" is not "Processed/Complete."
- For subsequent forms, ***always*** align the location code and address to the "IMT – Individual Update" (may require manual entry)

Transferring Providers

- Ensure the location is open
- Correct all overbilled claims
- Do not enter an IPC Renewal if the Transfer is not "Processed/Complete."

Troubleshooting Transfers

Follow Troubleshooting from the October 2023 Town Hall

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Troubleshooting Highlights Location Availability

"Location Availability" status on Transfer

First, use Appendix B (found in the Provider User Guide)

Appendix B list each status with a description and needed action

Next, check if the location code and date are correct

Last, use "Provider Location Search" to identify who is in that location

Location code/date is incorrect

Ensure there is availability, then contact the LIDDA for corrections

Location code/date is correct

Ensure there is availability, then contact IDD PES to reactive location availability

Troubleshooting Highlights
Tangled Transfer

If the last form is a movement form

Providers can troubleshoot and reactivate "location availability" without sending to State Staff.

If the last form is a transfer/termination

Please contact IDD PES. Use subject line "Tangled Transfer" and include:

- all individuals tangled,
- DLNs,
- Status,
- location codes, and
- applicable move/transfer/enrollment/termination dates.

Future Improvements Transfers

- Additional staff to process transfers
- Streamline assistance with tangled transfers
- System enhancements

Claims and Reconsiderations

Marie Redman, *Manager*
HHSC Provider Claims Services (PCS)
Medicaid and CHIP Services

Information for Reconsideration Requests

- A signed, written request sent to Provider Claims Services (PCS) that contains:
  - Client's name, Medicaid/CARE ID,
  - Dates of service(s) to be reconsidered,
  - Reason for the request for reconsideration,
  - Contact's name,
  - Contact's telephone and fax number , and
  - Provider's name, Contract Number and Component Code
- Copies of communications with any HHSC staff or Medicaid Specialist involved in the case and all supporting documentation.

Information for Reconsideration Requests (Continued)

- Must have rebilled and received the F0250 filing deadline denial code (Late billing - Claim must be filed 12 months from the end of the month of service or 12 months from the end of the eligibility add date)
- Fax the request to: 512-438-2301, ATTN: Marie Redman, PCS Manager
- Allow 30 business days for a decision on the reconsideration request. Providers are encouraged to monitor their R&S reports for adjusted claims. Adverse action letters will be mailed to the provider's address as documented in their HHSC Provider Contract.
- For more information, contact PCS at 512-438-2200, Option 1

Most Common EOBs for Claims Denials

- **EOB F0077:** Billing Code was not submitted or cannot be determined
- **EOB F0288:** Claim cannot be paid because consumer is on Client Hold for the given waiver program and Date(s) of Service
- **EOB F0041:** Service Group is missing, invalid, inactive, or cannot be determined
- **EOB F0281:** Contract Number for NPI cannot be determined
- **EOB F0155:** Unable to determine appropriate Fund Code for Service billed, verify Medicaid Eligibility
- **EOB F0138:** A valid Service Authorization for this client for this Service on these dates is not available

Most Common EOBs for Claims Denials

- **EOB F0269:** Claim Detail is an Exact Duplicate of History Claim Detail
- **EOB F0250:** Late billing - Claim must be filed 12 months from the end of the month of service or 12 months from the end of the eligibility add date
- **EOB F0187:** No units available from client Service Authorization
- **EOB F0165:** This service has already been paid. Please do not file for duplicate services.
- **EOB EVV07:** Claim to visit match not performed per State direction
- **F0325:** Line Item Control Number-Required HHMM (military format)

PEMS

Angie Hutchison, *Manager,* **Provider Resolution and Administrative Appeals Operations Management Claims Administrator**
Medicaid and CHIP Services

Provider Enrollment Revalidations

- Texas Medicaid providers are required to revalidate their enrollment information every 5 years. Effective May 11, 2023, the federal flexibility to extend Medicaid provider revalidation dates that were due during the federal COVID-19 PHE ended.

  *In some situations, providers may have to revalidate enrollment on a more frequent basis in accordance with Texas Administrative Code (TAC) §371.1015.

- Notice of Required Revalidation: This is the notice that gets triggered 120/90/45 days prior to the revalidation due date. In February 2023, TMHP sent Post-PHE Revalidation Notifications via standard mail and email.

Provider Enrollment Revalidations

- Providers may submit their revalidation applications online in the Provider Enrollment and Management System (PEMS).
- PEMS allows providers to revalidate within 120 days from the scheduled due date.
- Providers should complete their revalidation before the end of their enrollment period to remain enrolled in all Texas state health care programs.

Application Fees

- An application fee will be required in the following instances:
    - Providers initially enrolling in Medicaid and the Children's Health Insurance Program (CHIP)
    - Providers revalidating their Medicaid or CHIP enrollment
    - Providers adding a new Medicare practice location

*Note: Providers that have already paid the application fee to Medicare or another state's CHIP or Medicaid program have fulfilled the requirement and do not have to pay the fee to Texas Medicaid or the Children with Special Health Care Needs (CSHCN) Services Program. Proof of payment must be submitted with the application.

Site Visits

- Site visits are required for providers falling under the moderate/high-screen risk category classification.

- Situations where a site visit can be leveraged:
  - TMHP can leverage a site visit if Medicare has conducted a site visit within the last 5 years.
  - A site visit may also be leveraged if TMHP has conducted a site visit within the last calendar year.

Provider Reminder

- Timely Enrollment Revalidation is required
- Know Your due date
- Watch for Enrollment Revalidations notices from TMHP

Don’t Wait, Revalidate!

Deficiency Type	Details/Resolution
Failure to Disclose Principals	Providers should disclose all indirect owners and employees that have control over day-to-day operations, should align with the submitted organizational structure chart.
Application Fee	An application fee is required for each unique service type and program.
Name Mismatches	Do not provide a DBA name unless it is a legal DBA name identified by the SoS with the Assumed Name Certificate. For corporations, the name must match the Articles of Incorporation & Article of Amendment. If it is not a legal DBA, the name should be entered as a location name. Location names do not have to match licensure or Medicare.

Deficiency Type	Details/Resolution
W9/Ownership Disclosure	Ensure all supporting documents are provided. Example: the provider selected "Partnership" for the Federal tax classification on the Substitute Form W-9. the provider must upload a copy of the partnership agreement or a written statement identifying no written partnership agreement exists on a company letterhead.
Authorized Signatory	Ensure that the electronic signature matches the name of the Authorized Representative on the agreements. Make sure that the Representative's Position/Title is completed.

Provider Enrollment Resources

How to get assistance:

- The Accenture contact center can help with enrollment applications and enrollment policy.
- Providers have two ways to get enrollment assistance from TMHP. Call our contact center at 800-925-9126 or by emailing provider.relations@tmhp.com directly.
- For account assistance, call the EDI Help Desk at 888-866-3638.

Additional resources:

- PEMS Instructional Site - https://www.tmhp.com/topics/provider-enrollment/pems/start-application
- Provider Enrollment Help | TMHP - https://www.tmhp.com/topics/provider-enrollment/provider-enrollment-help
- TMHP video tutorials and demonstrations - youtube.com/c/TexasMedicaidHealthcarePartnership

Thank You

Navigating PEMS & TMHP