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October 9, 2003

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To: CBA/CCAD/CWP Adult Foster Care (AFC) Provider Agencies
CBA/CCAD/CWP Assisted Living/Residential Care Provider Agencies
CBA/CCAD/CWP Emergency Response Services (ERS) Providers
CBA/CCAD/CWP Home Delivered Meals Providers
CBA/CWP Home and Community Support Services Provider Agencies
CBA/CWP Out of Home Respite Providers
Community Living Assistance and Support Services (CLASS) Provider Agencies
Deaf-Blind with Multiple Disabilities (DB-MD) Provider Agencies
Medically Dependent Children Program (MDCP) Providers

Subject: Long Term Care (LTC)
Information Letter No. 03-26
Health Insurance Portability and Accountability Act (HIPAA) Changes

This letter is to inform providers of some recent changes that have been made to the Long Term Care (LTC) Bill Code Crosswalk that affect how you can submit a Health Insurance Portability and Accountability Act (HIPAA) compliant claim. These changes were made to give providers more options regarding the type of format to use when submitting a claim and to have more consistency across programs. This letter also explains how Medicaid waiver claims for dental services will be processed.

Please check the Texas Department of Human Services (DHS) HIPAA site at: http://www.dhs.state.tx.us/providers/hipaa/ltc_conference/index.html, after October 1, 2003 to make sure you have the most current version of the LTC Bill Code Crosswalk. The crosswalk will be updated on a quarterly basis after HIPAA implementation on October 16, 2003.

HIGHLIGHT OF RECENT CHANGES

1. DHS made changes to the LTC Bill Code Crosswalk, for some services, to allow TDHconnect and other electronic providers to submit claims using the Professional ("837P") claim format instead of the Institutional ("837I") claim format (i.e. for Community Care for the Aged and Disabled (CCAD), Community Based Alternatives (CBA), and Consolidated Waiver Program (CWP) Adult Foster Care (AFC).

2. HIPAA requires that all providers that transmit electronic claims include a valid ICD-9 (International Classification of Disease) diagnosis code for the client in order for the claim to process. Without a diagnosis code, the claim **may** reject. A diagnosis code is required for all claims **except the following**:
- Claims submitted for services to SG7 – CCAD clients,
 - Claims for meals regardless of service group,
 - Claims for Emergency Response Services (ERS) regardless of service group, and
 - Claims for “atypical” services (e.g. transportation, requisition fees, Program of All-Inclusive Care for the Elderly (PACE)).

Removal of the diagnosis code requirement for CCAD-Service Group 7 resulted in changes to the crosswalk. It was necessary to crosswalk all CCAD bill codes to national Health Care Common Procedural Coding System (HCPCS) or Physician Current Procedural Terminology (CPT) codes rather than use the revenue codes as originally done. This change may result in you having to use a different claim format.

HOW TO DETERMINE THE CORRECT CLAIM FORMAT

Remember to use the following steps to choose a claim format when billing electronically.

1. Go to the crosswalk and find the line that defines the services you are billing.
2. If the line shows a revenue code in the National Code fields, use the 837I – Institutional claim format, even if there is also a HCPCS or CPT code noted.
3. If there is no revenue code, look at the procedure code qualifier field. If the procedure code qualifier is:
 - AD, use the 837D – Dental format,
 - HC, use the 837P – Professional format, or
 - ZZ, use the 837P – Professional format.

Note: Paper submitters will use the Form 1290 (Long Term Care Claim) regardless of the type of claim or procedure code.

HOW TO OBTAIN THE ICD-9 CODE

The diagnosis code for CBA and CWP clients is found in the most recent Form 3652 Client Assessment, Review, and Evaluation (CARE), in items 16 – 20, that is completed by the Home and Community Support Services (HCSS) Registered Nurse (RN). Providers should use the primary diagnosis code found in item 16 when they complete the electronic claim. Providers of CWP clients whose level of care was determined using the Form 3650 Level of Care should use the diagnosis code on the Form 3650.

Effective upon receipt of this letter, case managers should send a copy of the Form 3652 or Form 3650, as appropriate, to the Assisted Living/Residential Care (AL/RC) providers, the AFC, and the out-of-home respite providers when (1) an applicant is approved for CBA or CWP services and (2) at the time the client's continued eligibility is approved at the annual reassessment.

Currently, some of the CBA and CWP providers that will be submitting electronic claims using the Institutional format do not have a copy of the Form 3652 or Form 3650 with the diagnosis code. These providers must contact either the client's case manager or the HCSS RN of the client to obtain the client's ICD-9 code.

HOW TO PROCESS WAIVER CLAIMS FOR DENTAL SERVICES

HIPAA requires all dental services to be submitted using the Dental (837D) claim format. DHS will continue to authorize dental services as an Adaptive Aid in those waiver programs that pay for dental services, except for CWP. Dental treatments for CWP clients will continue to be authorized through the waiver service of Dental Services.

DHS recommends that the licensed dentist complete the dental claim format with all the appropriate information, such as name of dentist, dental procedure code (D9999), tooth worked on, etc. The dental claim format must include the HCPCS code D9999 as the procedure code. The dentist will be considered the service provider and the waiver provider will be considered the billing provider. After the dentist completes the dental claim format and sends it to the waiver provider, the waiver provider will submit the claim electronically to the National Heritage Insurance Company. The dentist does not have to be a Medicaid enrolled dentist.

If you have any questions regarding this information letter, please contact your contract manager.

Sincerely,

Signature on file

Marilyn Eaton
Lead Director
Long Term Care Services

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