Texas Home Living

TxHmL

Provider User Guide

Department of Aging and Disability Services

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Texas Home Living (TxHmL)
Provider User Guide

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Introduction

Overview

About TxHmL

The Texas Home Living (TxHmL) program is a Medicaid waiver program that provides community-based services and supports to eligible individuals who live in their own homes or in their family homes.

In the TxHmL program, the local Mental Retardation Authority (MRA) provides the service coordination, and program providers are responsible for the delivery of services to individuals who are enrolled in the TxHmL program.

Consumer Directed Services Option

Consumer Directed Services is a service delivery option in which an individual or legally authorized representative (LAR) employs and retains service providers and directs the delivery of program services. An individual who chooses the CDS option is supported by a consumer directed services agency (CDSA) chosen by the individual to provide financial management services, and, at the individual's request, support consultation services if offered by the program in which the individual is enrolled.

Provider-managed Services Option

The traditional agency model (provider-managed) service delivery option is available to provide approved services that the individual/LAR elects not to self-direct. In the traditional agency option, the individual or his or her legally authorized representative (LAR) choose a certified and contracted HCS Program provider capable of delivering the full array of HCS Program service components. The program provider employs and retains service providers, and directs the delivery of program services.

System Functions

The TxHmL automated system contains the following on-line functions.

Function	Description
TxHmL Data Entry	Using the Provider Data Entry screens, the provider can: • enter service delivery (claims) • discharge an individual from the program (temporary and permanent) • enter critical incident data • enter provider staff information • update provider and contract information
TxHmL Inquiry	Using the Provider Inquiry screens, the provider can view: • consumer demographic data • Medicaid eligibility • consumer roster • service delivery by IPC • enrollment checklist information • payment eligibility verification • provider location • consumer IPC services holds • MR/RC assessment expiration • contract information • DSM/ICD code & text search • county/MRA • provider location list • reimbursement authorization • Permanency Plan Review approval status • an individual's IPC • consumer discharges • MR/RC assessments – summary • service delivery by provider • level of care information • MR/RC assessments • consumer assignments • IPC expiration information • provider information • current contract list • staff ID information • provider/contract roster • MRA contacts • claims inquiry • prior approval

In this Guide

The *TxHmL User Guide* consists of the *Introduction*, *Procedures*, *Inquiry*, *Accessing Reports*, *Screen Fields*, and *Glossary* sections and includes:

- an overview of the system
- how to access and exit the system
- work procedures
- how to use the **Inquiry** function
- accessing reports
- screen fields/descriptions table
- a glossary
- county codes/county names listing
- a quick reference

Setup, Access, and Support

Introduction

The Texas Department of Aging and Disability Services (DADS) currently operates an automated enrollment and billing system for the Texas Home Living (TxHmL) program. This system allows providers to electronically submit billing, make inquiries, and enter individual information.

To have access to this system, the provider must have a PC system. It is the provider's responsibility to have a licensed copy of Windows 3.1 or higher loaded on each machine *and* their modem fully functioning *before* requesting access.

Becoming a VPN or Dial-up User

To become a Virtual Private Network (VPN) or dial-up user, the user must be a contracted provider of TxHmL services and *be serving an individual*. Although both VPN and dial-up are available, **VPN is the preferred method** and is much faster and more reliable than dial-up. Also, the fees for VPN service are lower than the fees for dial-up.

A provider should contact their DADS Access & Intake, Program Enrollment contact person *as soon as they receive their first individual*. The necessary forms required for being set up to use VPN or dial-up and accessing the automated system will then be sent to the provider. The completed forms, and any required fees ***must* be returned to the provider's DADS contact person for approval before access to any systems will be granted.**

If a provider has CARE access and needs an additional account, the provider must contact the Central Help Desk at 1-888-952-HELP (4357) and tell them what is needed.

DADS provides one free dial-up account per component code. A VPN account or additional dial-up accounts may be obtained for a fee. Contact DADS Community Services Contracts for information on the cost of an additional account. *Fee payments must be sent to DADS, not to ESM.*

Network

After receiving a VPN or Dial-up User ID and Password from Enterprise Security Management (ESM) staff, the provider will need to establish a connection to the HHSC network (HHSCN).

The *VPN Installation Guide* can be obtained at http://vpn.tx.net/. The instructions contained in this guide *must* be completed *prior to* installing the QWS3270 emulation software. The user must log in to VPN before downloading and/or using QWS3270

Information about VPN or dial-up can be obtained by calling the Help Desk. The dial-up set up *must* be completed *prior to* installing the QWS3270 emulation software. The user must log in to dial-up before downloading and/or using QWS3270.

QW3270 Software	After completing the instructions and establishing a connection with the HHSCN, the QWS3270 emulation software can be installed. The QWS3270 installation software is available via download from the ESM Intranet site http://hhscx.hhsc.state.tx.us/tech/security/default.shtml by selecting the **Private Provider Setup and Information** link.
Windows Vista	**The version of QWS3270 that is supported by HHSC is not compatible with Windows Vista. HHSC does not support the version of QWS3270 that is Vista compatible.** Users with Windows Vista must purchase and download a compatible version of QWS3270, which can be found at www.jollygiant.com.
Forms	Once a VPN or dial-up account has been established with HHSCN, forms requesting access to systems and applications may be obtained at the ESM Intranet site by clicking on the **Enterprise Systems and Applications Security Access Forms** link. To request additional access to DADS automated systems, use the Waiver Programs Provider Access Request Form IS090. (Use IS090C for HCS/TxHmL Waiver Programs – CDS Agency) A Security and Privacy Agreement (SPA), EASM-SM-002 form must be submitted by ***all*** users of any DADS system or application.
Support	For questions about installing the QWS3270 emulation software, User ID and Password information, or accessing the mainframe (after a VPN or dial-up connection to HHSCN has been established), you may call the Central Help Desk at 1-888-952-HELP (4357).
Technical Support	To successfully access the dial-up system, you must follow your hardware/ software installation directions precisely and install each item according to the manufacturer's directions. To effectively use the dial-up access system, it is important to have the technical expertise required to install and maintain your hardware and software. DADS will not install and/or maintain the provider's hardware or software. DADS does not take responsibility for installation of your equipment. As there are many combinations of hardware and software that you could be using, DADS cannot resolve every problem you may encounter. You will need to rely on your technical expert for information concerning your hardware, software, and communications setup.

Provider Menus

The system provides menus for data entry/update and inquiry functions.

The **L00: Authority Data Entry Menu** displays action codes and data entry/update options. A sample menu is shown below.

If you use an Action Code that is *not* available to TxHmL providers, the message, *"Authority consumer in provider application"* is displayed and that data entry option cannot be accessed. The provider's MRA is responsible for the data entry of that action.

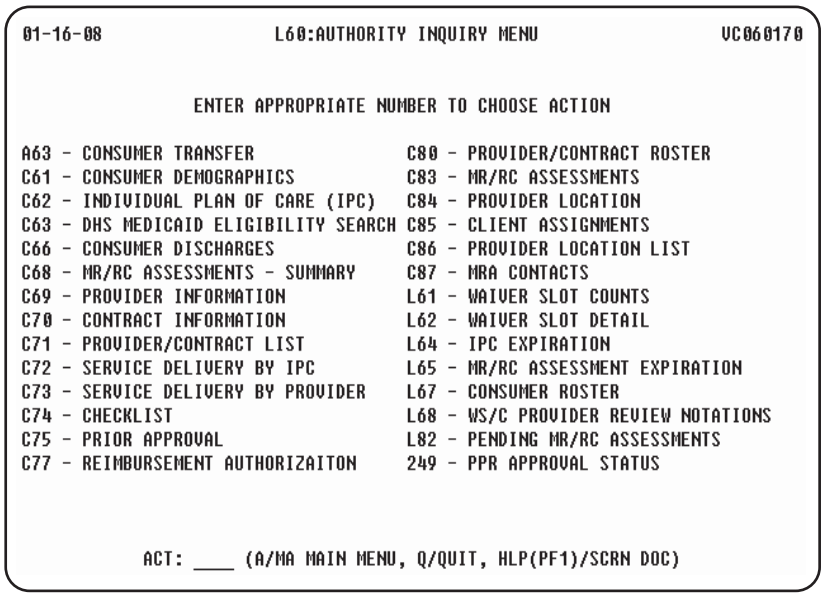
Data Entry Menu

The **L00: Authority Data Entry Menu** displays action codes and data entry/update options. A sample menu is shown below.

```
01-16-08              L00:AUTHORITY DATA ENTRY MENU                VC060

                ENTER APPROPRIATE NUMBER TO CHOOSE ACTION

L01 - CONSUMER ENROLLMENT              L02 - INDIVIDUAL PLAN OF CARE
L03 - ENROLLMENT PACKET CHECKLIST      L05 - PROVIDER CHOICE
L06 - CONSUMER TRANSFER (TXHML)        L09 - REGISTER CLIENT UPDATE
L10 - CLIENT CORRESPONDENT UPDATE      L11 - CLIENT NAME UPDATE
L12 - CLIENT ADDRESS UPDATE            L18 - CONSUMER DISCHARGE (TXHML)
L20 - GUARDIAN INFORMATION UPDATE      L23 - WAIVER MR/RC ASSESSMENT
L26 - CLIENT ASSIGNMENTS (TXHML)       L28 - MRA/MHA CONTACTS
L29 - ICF/MR MR/RC ASSESSMENT          L30 - MRA ASSIGNMENT NOTIFICATION
309 - PERMANENCY PLAN REVIEW - 9/1/05+       (TXHML)
339 - PERMANENCY PLAN REVIEW           490 - CASE MGMT ASSIGNMENT (TXHML)









          ACT: ___ (A/MA MAIN MENU, Q/QUIT, HLP(PF1)/SCRN DOC)
```

Inquiry Menu

The **L60: Provider Inquiry Menu** displays action codes and inquiry options. A sample menu is shown below.



```
01-16-08              L60:AUTHORITY INQUIRY MENU                VC060170

                ENTER APPROPRIATE NUMBER TO CHOOSE ACTION

A63 - CONSUMER TRANSFER               C80 - PROVIDER/CONTRACT ROSTER
C61 - CONSUMER DEMOGRAPHICS           C83 - MR/RC ASSESSMENTS
C62 - INDIVIDUAL PLAN OF CARE (IPC)   C84 - PROVIDER LOCATION
C63 - DHS MEDICAID ELIGIBILITY SEARCH C85 - CLIENT ASSIGNMENTS
C66 - CONSUMER DISCHARGES             C86 - PROVIDER LOCATION LIST
C68 - MR/RC ASSESSMENTS - SUMMARY     C87 - MRA CONTACTS
C69 - PROVIDER INFORMATION            L61 - WAIVER SLOT COUNTS
C70 - CONTRACT INFORMATION            L62 - WAIVER SLOT DETAIL
C71 - PROVIDER/CONTRACT LIST          L64 - IPC EXPIRATION
C72 - SERVICE DELIVERY BY IPC         L65 - MR/RC ASSESSMENT EXPIRATION
C73 - SERVICE DELIVERY BY PROVIDER    L67 - CONSUMER ROSTER
C74 - CHECKLIST                       L68 - WS/C PROVIDER REVIEW NOTATIONS
C75 - PRIOR APPROVAL                  L82 - PENDING MR/RC ASSESSMENTS
C77 - REIMBURSEMENT AUTHORIZAITON     249 - PPR APPROVAL STATUS



           ACT: ___ (A/MA MAIN MENU, Q/QUIT, HLP(PF1)/SCRN DOC)
```

Access an Option

To access an option, type its action code in the Action field (ACT:) at the bottom of the screen. For example, if you need to access the Consumer Discharge function, type action code **L18** in the Action field (ACT: **L18**) of any screen and press **Enter**.

Header Screens

When you access a data entry or data update option, the first screen displayed requests client-identifying information. This screen is referred to as the ***header screen***. Header screens may also include the Add/Change/Delete or Add/Correct/Delete direction in the title of the screen.

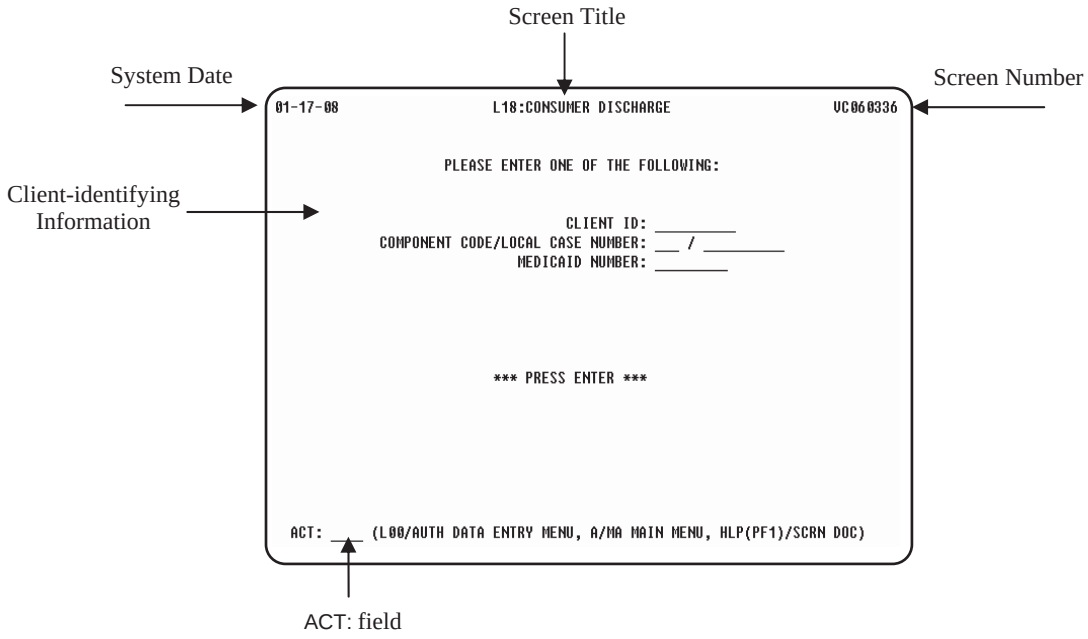
Add/Change/Delete

When using the data entry screens, you will add, change, and delete records.

Use	to…
Add	add a new record.
Change or **Correct**	change or correct incorrect information on a record.
Delete	delete a record entered in error.

Screen Structure

A sample header screen for the **L18: Consumer Discharge** option with its identified structure is shown below.



The above sample shows:

- System Date: **01/17/08**, the current date
- Screen Title: **L18: Consumer Discharge**
- Screen Number: **VC060336** - used to identify where you are in the system if you have problems.
- Client-identifying Information fields
- ACT: field - for Action Code entry

Web Addresses

Introduction

Access to Internet and Intranet web sites is available for information, reference, and downloading purposes. These web addresses are sited throughout the *TxHmL Provider User Guide.*

Web Addresses

The following web sites (and their corresponding web addresses) are available to providers:

- to access the Private Provider Set-up Information and the Access Request Forms links:
  Enterprise Security Management web site
  http://hhscx.hhsc.state.tx.us/tech/security/default.shtml

- to access the User Guides (HCS, TxHmL, MRA):
  HHSC IT Documentation for Legacy MHMR Applications web site
  http://www2.mhmr.state.tx.us/655/cis/training/download.html

- to access HCS forms:
  HCS Waiver forms web site
  http://www.dads.state.tx.us/providers/mra/handbooks.html

- to access the Minor Home Modification/Adaptive Aids/Dental Summary sheet (4116A):
  Medicaid Billing Protocol web site
  http://www.dads.state.tx.us/handbooks/txhml/forms/index.asp

- to access the HCS and TxHmL Bill Code Crosswalk for billing information:
  Bill Code Crosswalks website
  http://www.dads.state.tx.us/providers/hipaa/billcodes/index.html#hcs

- to access HIPPA Compliance information:
  Health Insurance Portability and Accountability Act web site
  http://www.dads.state.tx.us/providers/hipaa/index.html

Procedures

Introduction

The Mental Retardation Authority's Service Coordinator is responsible for the coordination and data entry of all TxHmL enrollments, revisions to the Individual Plan of Care (IPC), MR/RC Assessments, the transfer of a consumer to a different contract, permanent discharge acknowledgement, consumer assignment to location, and consumer demographic updates.

The TxHmL provider is responsible for the data entry of temporary and permanent discharge of consumers, staff entry, provider/contract update, critical incident reporting, and service delivery.

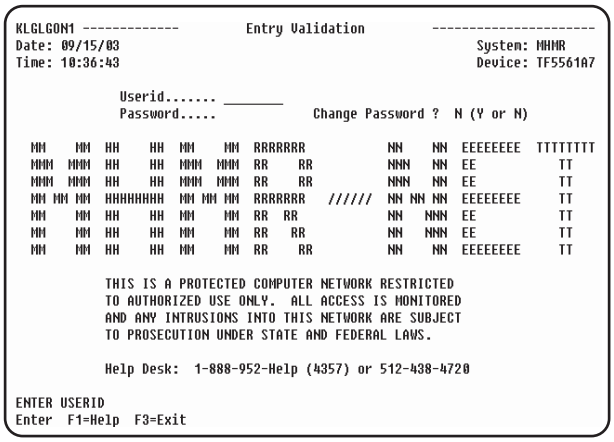
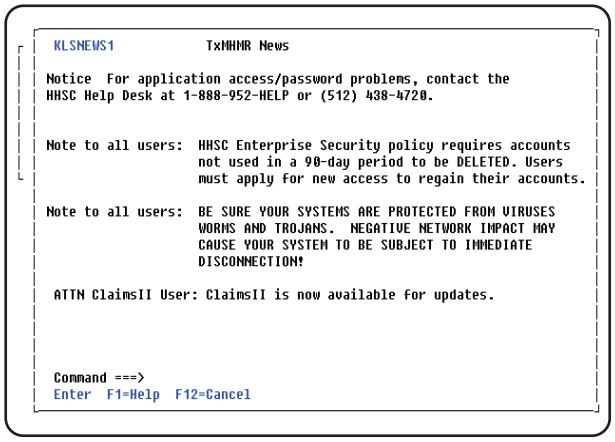
The *Procedures* section of the TxHmL Provider User Guide describes the general steps used for each process for which the provider is responsible. Sample screens in this documentation display fictitious consumer information to show the screens used in the procedures you perform.

In this Section

This section contains information on the following processes:

Logon Procedure

The following table describes the steps used to logon to CARE and access the TxHmL automated system. The procedure begins at the SuperSession **MHMR-NET** screen.

Step	View	Action
1	A sample SuperSession **MHMR-NET** screen is shown below. 	• Type your User ID in the USERID field. • Tab to the PASSWORD field and type your password. • Press **Enter**. Result: A broadcast message screen is displayed.
2	A sample broadcast message screen is shown below. 	A broadcast message screen is provided to display network information. • Read the screen for messages concerning system availability. • Press **Enter**. Result: The system displays the **CL/SUPERSESSION Main Menu** screen.

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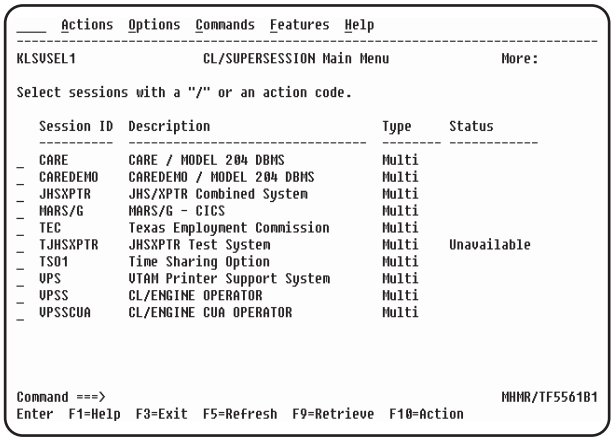
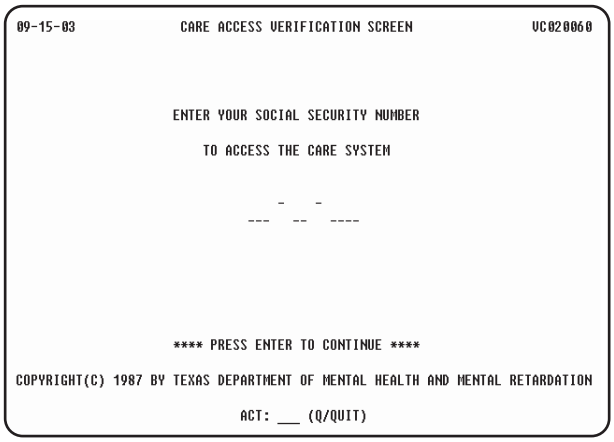
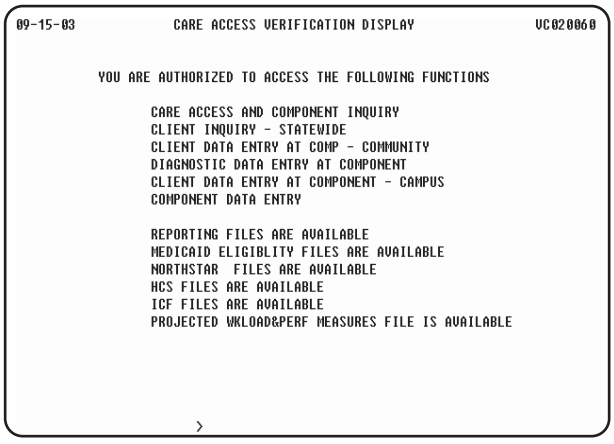
Logon Procedure, continued

Step	View	Action
3	A sample **CL/SUPERSESSION Main Menu** screen is shown below.  ___ Actions Options Commands Features Help KLSUSEL1 CL/SUPERSESSION Main Menu More: Select sessions with a "/" or an action code. Session ID Description Type Status _ CARE CARE / MODEL 204 DBMS Multi _ CAREDEMO CAREDEMO / MODEL 204 DBMS Multi _ JHSXPTR JHS/XPTR Combined System Multi _ MARS/G MARS/G - CICS Multi _ TEC Texas Employment Commission Multi _ TJHSXPTR JHSXPTR Test System Multi Unavailable _ TSO1 Time Sharing Option Multi _ VPS VTAM Printer Support System Multi _ VPSS CL/ENGINE OPERATOR Multi _ VPSSCUA CL/ENGINE CUA OPERATOR Multi Command ===> MHMR/TF5561B1 Enter F1=Help F3=Exit F5=Refresh F9=Retrieve F10=Action	The **CL/SUPERSESSION Main Menu** provides a listing of your menu applications and will vary according to the applications to which you have access. • Review the **CL/SUPERSESSION Main Menu**. • Type **S** (Select) in the field next to **CARE**. Result: The **CARE Access Verification Screen** is displayed.
4	A sample **CARE Access Verification Screen** is shown below.  09-15-03 CARE ACCESS VERIFICATION SCREEN VC020060 ENTER YOUR SOCIAL SECURITY NUMBER TO ACCESS THE CARE SYSTEM - - --- -- ---- **** PRESS ENTER TO CONTINUE **** COPYRIGHT(C) 1987 BY TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION ACT: __ (Q/QUIT)	The **CARE Access Verification Screen** allows you to enter your social security number, which is linked to your User ID number. • Type your social security number. • Press **Enter**. Result: The **CARE Access Verification Display** screen is displayed.
5	A sample **CARE Access Verification Display** screen is shown below.  09-15-03 CARE ACCESS VERIFICATION DISPLAY VC020060 YOU ARE AUTHORIZED TO ACCESS THE FOLLOWING FUNCTIONS CARE ACCESS AND COMPONENT INQUIRY CLIENT INQUIRY - STATEWIDE CLIENT DATA ENTRY AT COMP - COMMUNITY DIAGNOSTIC DATA ENTRY AT COMPONENT CLIENT DATA ENTRY AT COMPONENT - CAMPUS COMPONENT DATA ENTRY REPORTING FILES ARE AVAILABLE MEDICAID ELIGIBLITY FILES ARE AVAILABLE NORTHSTAR FILES ARE AVAILABLE HCS FILES ARE AVAILABLE ICF FILES ARE AVAILABLE PROJECTED WKLOAD&PERF MEASURES FILE IS AVAILABLE ›	The **CARE Access Verification Display** screen lists the functions you are authorized to access. • Press **Enter**. Result: A message screen is displayed.

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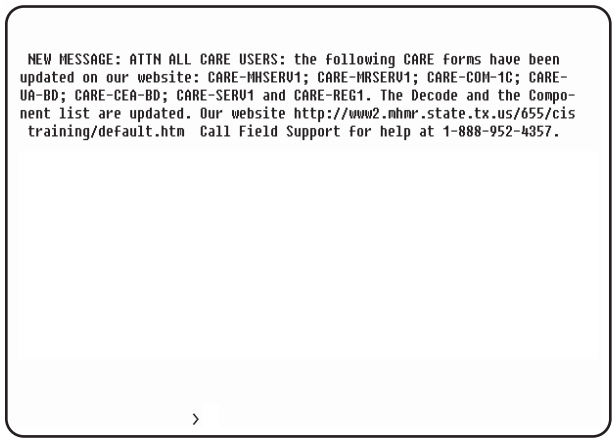
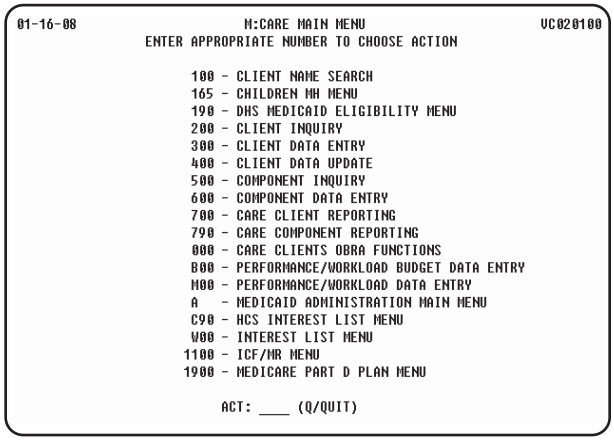
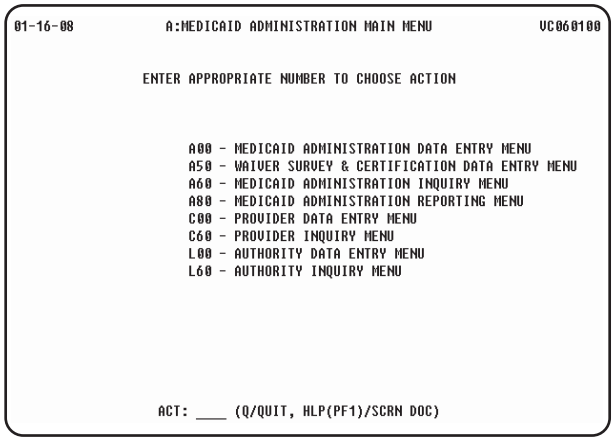
Logon Procedure, continued

Step	View	Action
6	A sample message screen is shown below.  NEW MESSAGE: ATTN ALL CARE USERS: the following CARE forms have been updated on our website: CARE-MHSERV1; CARE-MRSERV1; CARE-COM-1C; CARE-UA-BD; CARE-CEA-BD; CARE-SERV1 and CARE-REG1. The Decode and the Component list are updated. Our website http://www2.mhmr.state.tx.us/655/cistraining/default.htm Call Field Support for help at 1-888-952-4357. ›	• Read the screen for messages concerning system or application issues. • Press **Enter** to proceed. Result: The **M: CARE Main Menu** is displayed.
7	A sample **M: CARE Main Menu** is shown below.  01-16-08 M:CARE MAIN MENU VC020100 ENTER APPROPRIATE NUMBER TO CHOOSE ACTION 100 - CLIENT NAME SEARCH 165 - CHILDREN MH MENU 190 - DHS MEDICAID ELIGIBILITY MENU 200 - CLIENT INQUIRY 300 - CLIENT DATA ENTRY 400 - CLIENT DATA UPDATE 500 - COMPONENT INQUIRY 600 - COMPONENT DATA ENTRY 700 - CARE CLIENT REPORTING 790 - CARE COMPONENT REPORTING 800 - CARE CLIENTS OBRA FUNCTIONS B00 - PERFORMANCE/WORKLOAD BUDGET DATA ENTRY H00 - PERFORMANCE/WORKLOAD DATA ENTRY A - MEDICAID ADMINISTRATION MAIN MENU C90 - HCS INTEREST LIST MENU W00 - INTEREST LIST MENU 1100 - ICF/MR MENU 1900 - MEDICARE PART D PLAN MENU ACT: ___ (Q/QUIT)	The **M: CARE Main Menu** displays the action codes and descriptions of the CARE functions. To access the **A: Medicaid Administration Main Menu**: • Type **A** in the ACT: field. • Press **Enter**. Result: The **A: Medicaid Administration Main Menu** is displayed. Note: To select a function listed on this menu: • Type the action code in the ACT: field. • Press **Enter**. Result: The screen containing the menu for the selected function is displayed.
8	A sample **A: Medicaid Administration Main Menu** is shown below.  01-16-08 A:MEDICAID ADMINISTRATION MAIN MENU VC060100 ENTER APPROPRIATE NUMBER TO CHOOSE ACTION A00 - MEDICAID ADMINISTRATION DATA ENTRY MENU A50 - WAIVER SURVEY & CERTIFICATION DATA ENTRY MENU A60 - MEDICAID ADMINISTRATION INQUIRY MENU A80 - MEDICAID ADMINISTRATION REPORTING MENU C00 - PROVIDER DATA ENTRY MENU C60 - PROVIDER INQUIRY MENU L00 - AUTHORITY DATA ENTRY MENU L60 - AUTHORITY INQUIRY MENU ACT: ___ (Q/QUIT, HLP(PF1)/SCRN DOC)	To access the Provider Data Entry Menu: • Type **C00** in the ACT: field. • Press **Enter**. Result: The **C00: Provider Data Entry Menu** is displayed. ***or*** To access the Provider Inquiry Menu: • Type **C60** in the ACT: field. • Press **Enter**. Result: The **C60: Provider Inquiry Menu** is displayed.

Exiting the Automated System

Exit Procedure

You can exit the system from any screen. To exit the system:

- Type **Q** in the ACT: field.
- Press **Enter**.
- Type **logoff** at the prompt.
- Press **Enter**.

Result: The **CL/SUPERSESSION Main Menu** is displayed.

- Press **F3** to display the **Exit Menu**.
- Press **F3** to exit the system.

You must also disconnect your HHSCN connection to terminate your dial-up connection.

Changing Your Password

Change Password

You *must* change your *temporary* password. It is recommended that you change it to one that is meaningful to you.

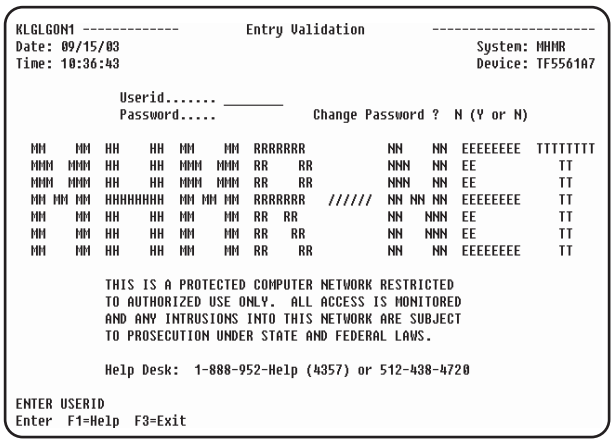
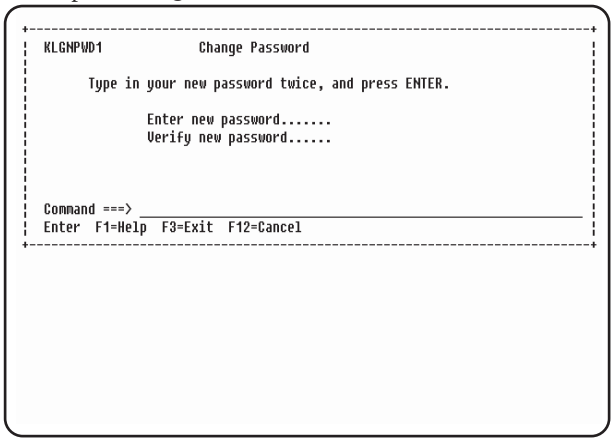
You can change your password as often as you like, but your password *must* be changed *every 90 days* (a prompt will occur).

Your password *must* contain:

- six to eight characters (letters or numbers),
- *no* spaces,
- *no* special characters (#, $, ;),
- *nothing* associated with your user number,
- *no* double characters, and
- passwords *cannot* be reused.

Change Password Procedure

The following table describes how to change your password. The procedure begins at the SuperSession **MHMR-NET** screen.

Step	View	Action
1	A sample SuperSession **MHMR-NET** screen is shown below. 	To change your password: • Type your User ID in the USERID field. • Tab to the PASSWORD field and type your password. • Tab to the CHANGE PASSWORD? field. • Type **Y** (Yes). • Press **Enter**. Result: The **Change Password** screen is displayed.
2	A sample **Change Password** screen is shown below. 	• Type your new password in the ENTER NEW PASSWORD field. • Type your password again in the VERIFY NEW PASSWORD field. • Press **Enter**. Result: A message stating that your password has changed is displayed.

Consumer Discharge (C18)

Introduction

The *Consumer Discharge* process allows a provider to add, change, or delete permanent and temporary discharges.

Permanent Discharge

A *permanent* discharge is the termination of services to the individual by the provider because the individual has voluntarily left the program or is found to be ineligible for the program.

For permanent discharges, **C18: Consumer Discharge** must be entered by the provider and **L18: Consumer Discharge** must be entered by the Mental Retardation Authority (MRA). The MRA's Service Coordinator is responsible for submitting the required documentation after the permanent discharge staffing occurs and the data entry has been completed by the provider and the MRA.

Temporary Discharge

A *temporary* discharge is the suspension of services to the individual by the provider while the individual is unable or unwilling to receive services. For temporary discharges, no documentation needs to be sent to DADS Access & Intake, Program Enrollment.

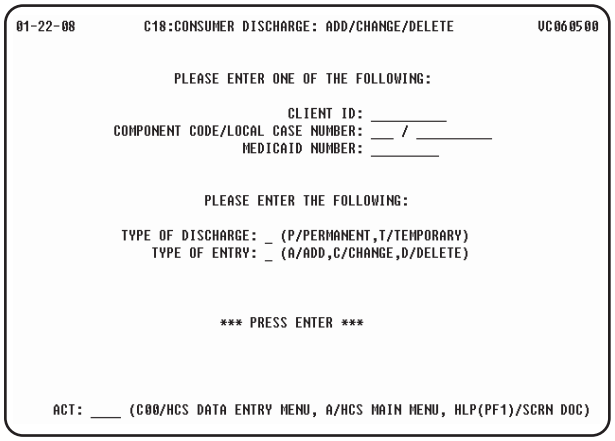
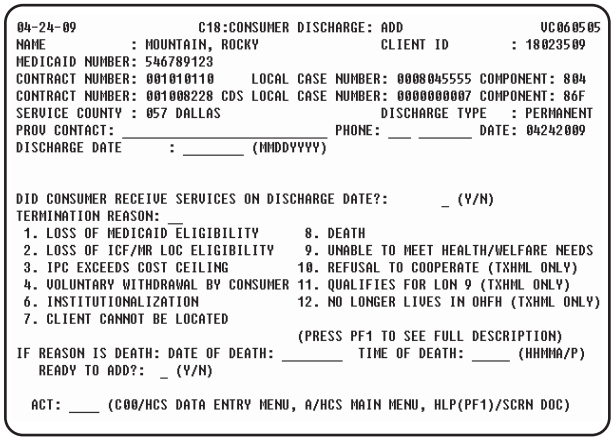
If a provider wants to continue a temporary discharge past 270 days, the extension must be approved by DADS Access & Intake, Program Enrollment.

If the discharge is temporary, do not type the discharge end date until the individual has returned. The discharge end date is the last full day the individual was absent from the program.

Do not end a temporary discharge for an individual who is transferring to another contract unless the individual returns prior to the transfer effective date.

Consumer Discharge (C18): Add (Permanent)

Procedure — The following table describes the steps a provider will use to enter an individual's permanent discharge.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/Delete** header screen is shown below.  01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: ___ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **P** (Permanent) in the TYPE OF DISCHARGE field. • Type **A** (Add) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Add** screen is displayed.
3	A sample **C18: Consumer Discharge: Add** screen is shown below.  04-24-09 C18:CONSUMER DISCHARGE: ADD VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 546789123 CONTRACT NUMBER: 001010110 LOCAL CASE NUMBER: 0008045555 COMPONENT: 804 CONTRACT NUMBER: 001008228 CDS LOCAL CASE NUMBER: 0000000007 COMPONENT: 86F SERVICE COUNTY : 057 DALLAS DISCHARGE TYPE : PERMANENT PROV CONTACT: _____ PHONE: ___ _____ DATE: 04242009 DISCHARGE DATE : _____ (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE?: _ (Y/N) TERMINATION REASON: __ 1. LOSS OF MEDICAID ELIGIBILITY 8. DEATH 2. LOSS OF ICF/MR LOC ELIGIBILITY 9. UNABLE TO MEET HEALTH/WELFARE NEEDS 3. IPC EXCEEDS COST CEILING 10. REFUSAL TO COOPERATE (TXHML ONLY) 4. VOLUNTARY WITHDRAWAL BY CONSUMER 11. QUALIFIES FOR LON 9 (TXHML ONLY) 6. INSTITUTIONALIZATION 12. NO LONGER LIVES IN OHFH (TXHML ONLY) 7. CLIENT CANNOT BE LOCATED (PRESS PF1 TO SEE FULL DESCRIPTION) IF REASON IS DEATH: DATE OF DEATH: _____ TIME OF DEATH: ____ (HHMMA/P) READY TO ADD?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the name of the provider contact in the PROV CONTACT field. • Type the phone number for the provider contact in the PHONE field. • Type the discharge date in the DISCHARGE DATE field. • Type **Y** (Yes) or **N** (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE? field. Note: 24-hour services *cannot* be billed on the Discharge Date. • Type the number representing the reason for termination in the TERMINATION REASON field. ***If the reason of discharge is death***: • Type the date of death in the DATE OF DEATH field. • Type the time of death in the TIME OF DEATH field. (HHMMA/P format) • Type **Y** in the READY TO ADD? field. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Added."*

Consumer Discharge (C18): Change (Permanent)

Procedure

The following table describes the steps a provider will use to change an individual's permanent discharge.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/Delete** header screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **P** (Permanent) in the TYPE OF DISCHARGE field. • Type **C** (Change) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Change** screen is displayed.
3	A sample **C18: Consumer Discharge: Change** screen is shown below. 04-24-09 C18:CONSUMER DISCHARGE: CHANGE VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 546789123 CONTRACT NUMBER: 001010110 LOCAL CASE NUMBER: 0008045555 COMPONENT: 804 CONTRACT NUMBER: 001008228 CDS LOCAL CASE NUMBER: 0000000007 COMPONENT: 86F SERVICE COUNTY : 057 DALLAS DISCHARGE TYPE : PERMANENT PROV CONTACT: JOHN GLENN_____ PHONE: 555 5555555 DATE: 04242009 DISCHARGE DATE : 04202009 (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE?: N (Y/N) TERMINATION REASON: 3_ 1. LOSS OF MEDICAID ELIGIBILITY 8. DEATH 2. LOSS OF ICF/MR LOC ELIGIBILITY 9. UNABLE TO MEET HEALTH/WELFARE NEEDS 3. IPC EXCEEDS COST CEILING 10. REFUSAL TO COOPERATE (TXHML ONLY) 4. VOLUNTARY WITHDRAWAL BY CONSUMER 11. QUALIFIES FOR LON 9 (TXHML ONLY) 6. INSTITUTIONALIZATION 12. NO LONGER LIVES IN OHFH (TXHML ONLY) 7. CLIENT CANNOT BE LOCATED (PRESS PF1 TO SEE FULL DESCRIPTION) IF REASON IS DEATH: DATE OF DEATH: _____ TIME OF DEATH: ____ (HHMMA/P) READY TO CHANGE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type changes to the discharge information in the appropriate fields. • Type **Y** in the READY TO CHANGE? field. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Changed."*

Consumer Discharge (C18): Delete (Permanent)

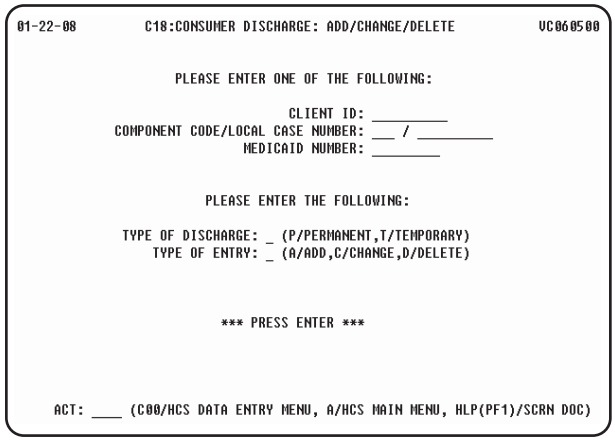
Procedure

The following table describes the steps a provider will use to delete an individual's permanent discharge.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/Delete** header screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **P** (Permanent) in the TYPE OF DISCHARGE field. • Type **D** (Delete) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Delete** screen is displayed.
3	A sample **C18: Consumer Discharge: Delete** screen is shown below. 04-24-09 C18:CONSUMER DISCHARGE: DELETE VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 546789123 CONTRACT NUMBER: 001010110 LOCAL CASE NUMBER: 0008045555 COMPONENT: 804 CONTRACT NUMBER: 001008228 CDS LOCAL CASE NUMBER: 0000000007 COMPONENT: 86F SERVICE COUNTY : 057 DALLAS DISCHARGE TYPE : PERMANENT PROV CONTACT: JOHN GLENN_____ PHONE: 555 5555555 DATE: 04242009 DISCHARGE DATE : 04202009 (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE?: N (Y/N) TERMINATION REASON: 3_ 1. LOSS OF MEDICAID ELIGIBILITY 8. DEATH 2. LOSS OF ICF/MR LOC ELIGIBILITY 9. UNABLE TO MEET HEALTH/WELFARE NEEDS 3. IPC EXCEEDS COST CEILING 10. REFUSAL TO COOPERATE (TXHML ONLY) 4. VOLUNTARY WITHDRAWAL BY CONSUMER 11. QUALIFIES FOR LON 9 (TXHML ONLY) 6. INSTITUTIONALIZATION 12. NO LONGER LIVES IN OHFH (TXHML ONLY) 7. CLIENT CANNOT BE LOCATED (PRESS PF1 TO SEE FULL DESCRIPTION) IF REASON IS DEATH: DATE OF DEATH: _____ TIME OF DEATH: ____ (HHMMA/P) READY TO DELETE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** in the READY TO DELETE? field. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Deleted."*

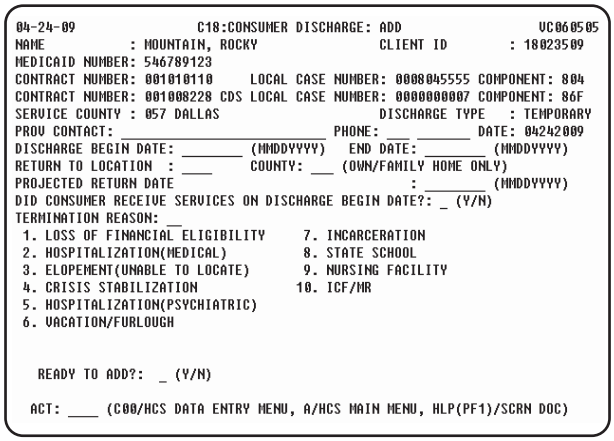
Consumer Discharge (C18): Add (Temporary)

Procedure — The following table describes the steps a provider will use to enter an individual's temporary discharge.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/ Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/ Delete** header screen is shown below. 	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **T** (Temporary) in the TYPE OF DISCHARGE field. • Type **A** (Add) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Add** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **C18: Consumer Discharge: Add** screen is shown below.  04-24-09 C18:CONSUMER DISCHARGE: ADD VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 546789123 CONTRACT NUMBER: 001010110 LOCAL CASE NUMBER: 0008045555 COMPONENT: 804 CONTRACT NUMBER: 001008228 CDS LOCAL CASE NUMBER: 0000000007 COMPONENT: 86F SERVICE COUNTY : 057 DALLAS DISCHARGE TYPE : TEMPORARY PROV CONTACT: _____ PHONE: ___ _____ DATE: 04242009 DISCHARGE BEGIN DATE: _____ (MMDDYYYY) END DATE: _____ (MMDDYYYY) RETURN TO LOCATION : ___ COUNTY: ___ (OWN/FAMILY HOME ONLY) PROJECTED RETURN DATE : _____ (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE?: _ (Y/N) TERMINATION REASON: __ 1. LOSS OF FINANCIAL ELIGIBILITY 7. INCARCERATION 2. HOSPITALIZATION(MEDICAL) 8. STATE SCHOOL 3. ELOPEMENT(UNABLE TO LOCATE) 9. NURSING FACILITY 4. CRISIS STABILIZATION 10. ICF/MR 5. HOSPITALIZATION(PSYCHIATRIC) 6. VACATION/FURLOUGH READY TO ADD?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the name of the provider contact in the PROV CONTACT field. • Type the phone number for the provider contact in the PHONE field. • Type the discharge begin date in the DISCHARGE BEGIN DATE field. • Type the projected return date in the PROJECTED RETURN DATE field. • Type **Y** (Yes) or **N** (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE? field. Note: 24-hour services *cannot* be billed on the Discharge Date. • Type the reason for temporary discharge in the TERMINATION REASON field. The following table lists the reasons and their descriptions. **Reason** / **Description** 1. Loss of Financial Eligibility — Individual has lost Medicaid eligibility 2. Hospitalization (Medical) — Individual is in a medical hospital. 3. Elopement (Unable to Locate) — Individual cannot be found or refuses to cooperate. 4. Crisis Stabilization — Individual is in a private psychiatric hospital or an acute behavioral treatment center. 5. Hospitalization (Psychiatric) — Individual is in a State Hospital. 6. Vacation/ Furlough — Individual is on vacation or not receiving waiver services. 7. Incarceration — Individual is in a city/town, county, state, or federal correction facility. 8. State School — Individual is in a State School. 9. Nursing Facility — Individual is in a nursing home or other type of nursing facility. 10. ICF/MR — Individual is in an intermediate care facility. • Type **Y** in the READY TO ADD? field. Note: If the discharge date is more than thirty days in the past a screen displays the message, *"The discharge effective date is 30+ days ago. Please notify the PE/ETD program specialist assigned to your Component code. If you do not know which program specialist is assigned to your component code, you may call (512) 438-5055 or send e-mail to enrollmenttransferdischargeinfo@dads.state.tx.us."* • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Added."*

Consumer Discharge (C18): Change (Temporary)

Procedure

The following table describes the steps a provider will use to change an individual's temporary discharge.

The provider will also use the change function to end a temporary discharge.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/Delete** header screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **T** (Temporary) in the TYPE OF DISCHARGE field. • Type **C** (Change) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Change** screen is displayed.
3	A sample **C18: Consumer Discharge: Change** screen is shown below. 04-24-09 C18:CONSUMER DISCHARGE: CHANGE VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 546789123 CONTRACT NUMBER: 001010110 LOCAL CASE NUMBER: 0008045555 COMPONENT: 804 CONTRACT NUMBER: 001008228 CDS LOCAL CASE NUMBER: 0000000007 COMPONENT: 86F SERVICE COUNTY : 057 DALLAS DISCHARGE TYPE : TEMPORARY PROV CONTACT: JOHN GLENN_____ PHONE: 555 5555555 DATE: 04242009 DISCHARGE BEGIN DATE: 04202009 (MMDDYYYY) END DATE: _____ (MMDDYYYY) RETURN TO LOCATION : ___ COUNTY: __ (OWN/FAMILY HOME ONLY) PROJECTED RETURN DATE : 06202009 (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE?: N (Y/N) TERMINATION REASON: 1_ 1. LOSS OF FINANCIAL ELIGIBILITY 7. INCARCERATION 2. HOSPITALIZATION(MEDICAL) 8. STATE SCHOOL 3. ELOPEMENT(UNABLE TO LOCATE) 9. NURSING FACILITY 4. CRISIS STABILIZATION 10. ICF/MR 5. HOSPITALIZATION(PSYCHIATRIC) 6. VACATION/FURLOUGH READY TO CHANGE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type changes to the discharge information in the appropriate fields. Note: If the individual is ending his/her temporary discharge, type the end date in the END DATE field. • Type **Y** in the READY TO CHANGE? field. Note: If the discharge date is more than thirty days in the past a screen displays the message, *"The discharge effective date is 30+ days ago. Please notify the PE/ETD program specialist assigned to your Component code. If you do not know which program specialist is assigned to your component code, you may call (512) 438-5055 or send e-mail to enrollmenttransferdischargeinfo@dads.state.tx.us."* • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Changed."*

Consumer Discharge (C18): Delete (Temporary)

Procedure — The following table describes the steps a provider will use to delete an individual's temporary discharge.

Step	View	Action
1	_ _	• Type **C18** in the ACT: field of any screen. • Press **Enter**. Result: The **C18: Consumer Discharge: Add/Change/Delete** header screen is displayed.
2	A sample **C18: Consumer Discharge: Add/Change/Delete** header screen is shown below. 01-22-08 C18:CONSUMER DISCHARGE: ADD/CHANGE/DELETE VC060500 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: ___ / _____ MEDICAID NUMBER: _____ PLEASE ENTER THE FOLLOWING: TYPE OF DISCHARGE: _ (P/PERMANENT,T/TEMPORARY) TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Type **T** (Temporary) in the TYPE OF DISCHARGE field. • Type **D** (Delete) in the TYPE OF ENTRY field • Press **Enter**. Result: The **C18: Consumer Discharge: Delete** screen is displayed.
3	A sample **C18: Consumer Discharge: Delete** screen is shown below. 04-24-09 C18:CONSUMER DISCHARGE: DELETE VC060505 NAME : MOUNTAIN, ROCKY CLIENT ID : 18023509 MEDICAID NUMBER: 546789123 CONTRACT NUMBER: 001010110 LOCAL CASE NUMBER: 0008045555 COMPONENT: 804 CONTRACT NUMBER: 001008228 CDS LOCAL CASE NUMBER: 0000000007 COMPONENT: 86F SERVICE COUNTY : 057 DALLAS DISCHARGE TYPE : TEMPORARY PROV CONTACT: JOHN GLENN_____ PHONE: 555 5555555 DATE: 04242009 DISCHARGE BEGIN DATE: 04202009 (MMDDYYYY) END DATE: _____ (MMDDYYYY) RETURN TO LOCATION : ___ COUNTY: ___ (OWN/FAMILY HOME ONLY) PROJECTED RETURN DATE : 06202009 (MMDDYYYY) DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE?: N (Y/N) TERMINATION REASON: 1_ 1. LOSS OF FINANCIAL ELIGIBILITY 7. INCARCERATION 2. HOSPITALIZATION(MEDICAL) 8. STATE SCHOOL 3. ELOPEMENT(UNABLE TO LOCATE) 9. NURSING FACILITY 4. CRISIS STABILIZATION 10. ICF/MR 5. HOSPITALIZATION(PSYCHIATRIC) 6. VACATION/FURLOUGH READY TO DELETE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **Y** in the READY TO DELETE? field. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The **C18: Consumer Discharge** header screen is displayed with the message, *"Previous Information Deleted."*

Critical Incident Data (686)

Introduction

The *Critical Incident Data* process allows a provider to add, change, or delete critical incident data.

The entry of critical incident data is required on a monthly basis for *all* of the contracts administered by a provider of MRA General Revenue, HCS, TxHmL, and ICF/MR services. Critical incident data must be entered *no later than* 30 days from the end of the month being reported. For example, the data reported in the month of September will reflect data that was entered in August.

When adding critical incident data, the fields on the **686: Critical Incident Data: Add** screen will clear to allow for multiple entries of the contracts for your component, and the number of contracts entered is displayed.

Reportable Data

The following information provides terms and definitions used on the Critical Incident Data screens.

Term	Definition
Medication Error	A medication error is reported when there is a discrepancy between what a physician prescribes and what an individual actually takes and the individual self-administers medication under supervision of the Program Provider or has medication administered by the Program Provider. A medication error occurs in one of three ways: • **Wrong medication** - an individual takes medication that is not prescribed for that individual. This includes taking medication after it has been discontinued or taking the incorrect medication because it was inappropriately labeled. • **Wrong dose** - an individual takes a dose of medication other than the dose prescribed. • **Omitted dose** - an individual does not take a prescribed dose of medication within one hour before or one hour after the prescribed time, except an omitted dose does not include an individual's refusal to take medication.
Serious Injury	A serious physical injury is reported, regardless of the cause or setting in which it occurred, when an individual sustains: • a fracture; • a dislocation of any joint; • an internal injury; • a contusion larger than 2½ inches in diameter; • a concussion; • a second or third degree burn; • a laceration requiring sutures; or • an injury determined serious by a physician, physician assistant, registered nurse, or a vocational nurse.

continued on next page

Reportable Data, continued

Term	Definition
Behavior Intervention Plan Authorizing Restraint	A behavior intervention plan is reported if it authorizes a personal, mechanical or psychoactive medication, as defined below, for an individual. • **Personal restraint** - the application of pressure, except physical guidance or prompting of brief duration that restricts the free movement of part or all of an individual's body. • **Mechanical restraint** - the use of a device that restricts the free movement of part or all of an individual's body. Such a device includes an anklet, a wristlet, a camisole, a helmet with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and a restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt, or one used for medical treatment, such as a helmet to prevent injury during a seizure. • **Psychoactive medication** - the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means, to control an individual's activity and which is not a standard treatment for the individual's medical or psychiatric condition.
Emergency Personal Restraint	An emergency personal restraint is reported when the Program Provider uses a personal restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Emergency Mechanical Restraint	An emergency mechanical restraint is reported when the Program Provider uses a mechanical restraint, as defined above, and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Emergency Psychoactive Medication	An emergency psychoactive medication is reported when the Program Provider uses a psychoactive medication, as defined above and such restraint is not authorized in a written behavior intervention plan approved by the individual's IDT.
Individual Requiring Emergency Restraint	An individual is reported as requiring emergency restraint if the individual is restrained (by either personal or mechanical restraint or psychoactive medication) at least once during a calendar month. If an individual is restrained more than once during a calendar month, the individual is reported only once for that month.
Restraint Related Injury	A restraint related injury is a serious injury sustained by an individual that is clearly related to the application of a personal restraint, an emergency mechanical restraint, or an emergency psychoactive medication administered to an individual. Reportable injuries in this category are not due to self-injury that occurred prior to the application of restraint. Serious injuries sustained during the application of a restraint that are investigated by DFPS as an allegation of abuse, neglect or exploitation must be included in CIRS reporting for this category.

Critical Incident Data (686): Add

Procedure

The following table describes the steps a provider will use to enter critical incident data for a specified reporting month.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/ Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/ Delete** header screen is shown below. 05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field. • Type the contract number in the CONTRACT NUMBER field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Add** screen is displayed.

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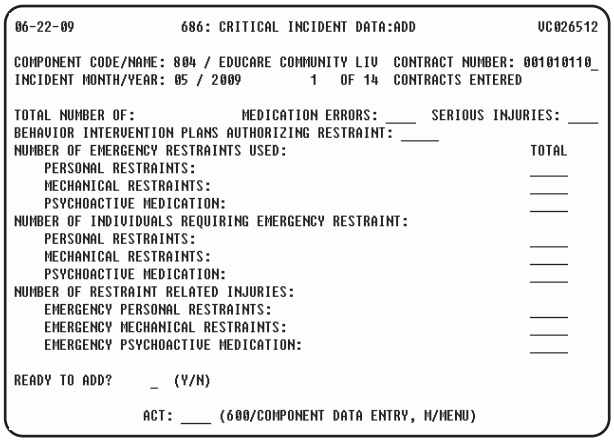
Procedure, continued

Step	View	Action
3	A sample **686: Critical Incident Data: Add** screen is shown below.  06-22-09 686: CRITICAL INCIDENT DATA:ADD VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001010110_ INCIDENT MONTH/YEAR: 05 / 2009 1 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: ___ SERIOUS INJURIES: ___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: ____ NUMBER OF EMERGENCY RESTRAINTS USED: TOTAL PERSONAL RESTRAINTS: ____ MECHANICAL RESTRAINTS: ____ PSYCHOACTIVE MEDICATION: ____ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: ____ MECHANICAL RESTRAINTS: ____ PSYCHOACTIVE MEDICATION: ____ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: ____ EMERGENCY MECHANICAL RESTRAINTS: ____ EMERGENCY PSYCHOACTIVE MEDICATION: ____ READY TO ADD? _ (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU) The top of the screen displays the component code and name, the contract number for which you are reporting incidents, and the incident month and year. In this example, *1 of 14 Contracts Entered* is displayed at the top of the screen. As data is entered for each contract, the screen displays the total number of contracts for the component and the number of that total that has been entered. The middle portion of the screen provides fields for you to enter the number of errors, injuries, restraint information, and TOTAL fields. You will enter the following information: **Number Of Emergency Restraints Used:** These fields include the total number of times a restraint was used in each category. **Number Of Individuals Requiring Emergency Restraint:** These fields include the total number of individuals who were restrained in each category. **Number Of Restraint Related Injuries:** These fields include the total number injuries that were related to a restraint incident in each category. **Note: Zeroes *must* be entered in the fields on this screen when there is no reportable data for that month. *Data must be entered monthly*.** *See the example on the following page.*	The contract number that was entered on the header screen is displayed but can be changed. • Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen. • Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field. • Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field. • Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field. **Number Of Emergency Restraints Used** • Type the total number of emergency restraints used by category during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields. **Number Of Individuals Requiring Emergency Restraint** • Type the total number of individuals requiring emergency restraint during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields. **Number Of Restraint Related Injuries** • Type the total number of restraint related injuries during the report month in the EMERGENCY PERSONAL RESTRAINTS, EMERGENCY MECHANICAL RESTRAINTS, and EMERGENCY PSYCHOACTIVE MEDICATION TOTAL fields. • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, *"Previous Information Added"* is displayed. • Repeat this step for all contracts. • When all contracts have been entered, type **N** in the READY TO ADD? field and press **Enter** to return to the header screen.

continued on next page

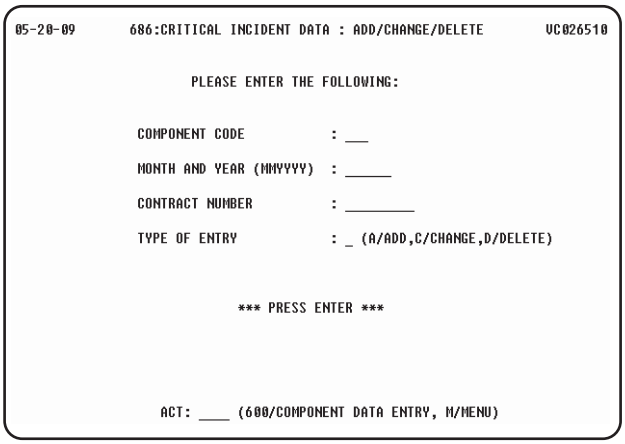
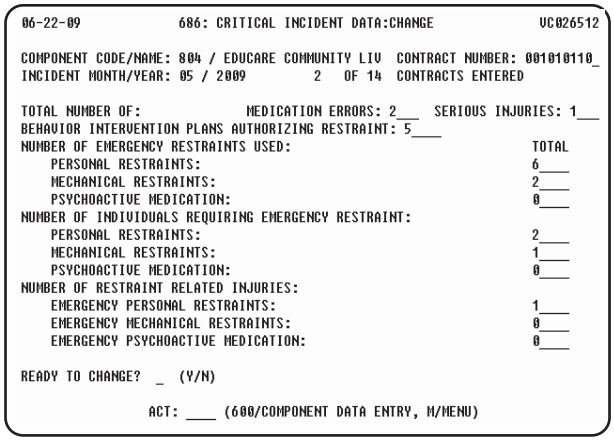
Procedure, continued

Step	View	Action
3 cont.	Example screen: 06-23-09 686: CRITICAL INCIDENT DATA:ADD VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001010110_ INCIDENT MONTH/YEAR: 05 / 2009 1 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: 2___ SERIOUS INJURIES: 1___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: 5___ NUMBER OF EMERGENCY RESTRAINTS USED: TOTAL PERSONAL RESTRAINTS: 6___ MECHANICAL RESTRAINTS: 2___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: 2___ MECHANICAL RESTRAINTS: 1___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: 1___ EMERGENCY MECHANICAL RESTRAINTS: 0___ EMERGENCY PSYCHOACTIVE MEDICATION: 0___ READY TO ADD? Y (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Example: The following describes the data displayed on the sample screen on the left side of the page. **Number of Emergency Restraints** section: • John has had four personal restraints in a month and Sally has had two personal restraints in a month, so you would type **6** in the TOTAL field. • Bob has had two mechanical restraints in a month, so you would type **2** in the TOTAL field. • There were no psychoactive medication restraints, so you would type **0** in the Total field. **Number of Individuals Requiring Emergency Restraint** section: • Even though John has had 4 and Sally has had 2 personal restraints, this field is counting individuals, so you would type **2** in the TOTAL field. Bob has had two mechanical restraints, but you would type **1** in the TOTAL field. There were no psychoactive medication restraints, so you would type **0** in the Total field. **Number of Restraint Related Injuries** section: • One of Bob's restraints resulted in a restraint related injury, so you would type **1** in the TOTAL field. You would type 0 in the EMERGENCY MECHANICAL RESTRAINT and EMERGENCY PSYCHOACTIVE MEDICATION TOTAL fields. ***Important: Remember that you must type zeroes in all fields that have no critical incident data to be reported.***

Critical Incident Data (686): Change

Procedure

The following table describes the steps a provider will use to change critical incident data that has been entered incorrectly.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/Delete** header screen is shown below.  05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field. • Type the contract number in the CONTRACT NUMBER field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Change** screen is displayed.
3	A sample **686: Critical Incident Data: Change** screen is shown below.  06-22-09 686: CRITICAL INCIDENT DATA:CHANGE VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001010110_ INCIDENT MONTH/YEAR: 05 / 2009 2 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: 2___ SERIOUS INJURIES: 1___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: 5___ NUMBER OF EMERGENCY RESTRAINTS USED: TOTAL PERSONAL RESTRAINTS: 6___ MECHANICAL RESTRAINTS: 2___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: 2___ MECHANICAL RESTRAINTS: 1___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: 1___ EMERGENCY MECHANICAL RESTRAINTS: 0___ EMERGENCY PSYCHOACTIVE MEDICATION: 0___ READY TO CHANGE? _ (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	• Type changes to the critical incident data in the appropriate fields. • Type **Y** in the READY TO CHANGE? field to submit the data to the system. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Critical Incident Data (686): Delete

Procedure

The following table describes the steps a provider will use to delete critical incident data that has been entered in error.

Step	View	Action
1	_ _	• Type **686** in the ACT: field of any screen. • Press **Enter**. Result: The **686: Critical Incident Data: Add/Change/Delete** header screen is displayed.
2	A sample **686: Critical Incident Data: Add/Change/Delete** header screen is shown below. 05-20-09 686:CRITICAL INCIDENT DATA : ADD/CHANGE/DELETE VC026510 PLEASE ENTER THE FOLLOWING: COMPONENT CODE : __ MONTH AND YEAR (MMYYYY) : _____ CONTRACT NUMBER : _____ TYPE OF ENTRY : _ (A/ADD,C/CHANGE,D/DELETE) *** PRESS ENTER *** ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	Your component code is displayed based on your logon account number. • Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field. • Type the contract number in the CONTRACT NUMBER field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **686: Critical Incident Data: Delete** screen is displayed.
3	A sample **686: Critical Incident Data: Delete** screen is shown below. 06-22-09 686: CRITICAL INCIDENT DATA:DELETE VC026512 COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIV CONTRACT NUMBER: 001010110_ INCIDENT MONTH/YEAR: 05 / 2009 2 OF 14 CONTRACTS ENTERED TOTAL NUMBER OF: MEDICATION ERRORS: 2___ SERIOUS INJURIES: 1___ BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT: 5___ NUMBER OF EMERGENCY RESTRAINTS USED: TOTAL PERSONAL RESTRAINTS: 6___ MECHANICAL RESTRAINTS: 2___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF INDIVIDUALS REQUIRING EMERGENCY RESTRAINT: PERSONAL RESTRAINTS: 2___ MECHANICAL RESTRAINTS: 1___ PSYCHOACTIVE MEDICATION: 0___ NUMBER OF RESTRAINT RELATED INJURIES: EMERGENCY PERSONAL RESTRAINTS: 1___ EMERGENCY MECHANICAL RESTRAINTS: 0___ EMERGENCY PSYCHOACTIVE MEDICATION: 0___ READY TO DELETE? _ (Y/N) ACT: ___ (600/COMPONENT DATA ENTRY, M/MENU)	• Type **Y** in the READY TO DELETE? field to submit the data to the system. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Deleted."*

Critical Incident Data: Inquiry (286)

Introduction

The **Critical Incident Data: Inquiry** option is used to view critical incident data based on the information reported on the **686: Critical Incident Data** screens.

The report can be displayed in one of three ways. You can:

- Request a complete report that includes both the summary of incidents reported for each contract and a list of contracts for which incidents were not reported.
- Request a report that includes only the summary.
- Request a report that includes a list of contracts for which incidents were not reported.

Requesting Reports

When you request a report and enter only the Component Code and Month and Year on the header screen:

- The first screen(s) will display critical incidents for each contract
- The second screen will display contracts that did not report
- The third screen will display the Total Number of Critical Incidents for all contracts that reported

If you enter the Component Code, Month and Year, and a specific Contract Number on the header screen and:

- If the contract ***reported*** incidents for the Component Code and Month and Year:
  - The first screen will display critical incidents for the contract
  - The second screen will display 0 number of contracts did not report
  - The third screen will display the **total number** of Critical Incidents for that contract
- If the contract ***did not report*** for the Component Code and Month and Year:
  - The first screen will not be displayed
  - The second screen will display that the contract did not report
  - The third screen will display the 0 totals for Critical Incidents for that contract

Procedure

The table below displays the steps taken to access the **286: Critical Incident Data: Inquiry** screen.

Step	View	Action
1	_ _	• Type **286** in the ACT: field of any screen. • Press **Enter**. Result: The **286: Critical Incident Data: Inquiry** header screen is displayed.
2	A sample **286: Critical Incident Data: Inquiry** header screen is shown below. 06-11-09 286:CRITICAL INCIDENT DATA: INQUIRY VC026530 PLEASE ENTER ONE OF THE FOLLOWING: COMPONENT CODE: 804 MONTH AND YEAR: 052009 (MMYYYY) ENTER IF DESIRED: CONTRACT NUMBER: _____ - OR - CONTRACT TYPE: X HCS _ TXHML _ ICF/MR _ GR OR (BLANK=ALL) SUMMARY ONLY?: N (Y/N) NOT REPORTED ONLY?: N (Y/N) PRINTER CODE: _____ (ENTER FOR HARD-COPY) *** PRESS ENTER *** ACT: ___ (C60/PROV INQUIRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type the month and year in the MONTH AND YEAR field. (MMYYYY format) • Type the contract number in the CONTRACT NUMBER field, or • Type an **X** beside the appropriate contract type. (HCS, TxHmL, ICF/MR, or GR) • Type **Y** in the SUMMARY ONLY field if you want a summary *only*. • Type **Y** in the NOT REPORTED ONLY field if you want a list of contracts for which incidents were not reported *only*. • Press **Enter**. Result: The **286: Critical Incident Data Inquiry** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **286: Critical Incident Data Inquiry** screen is shown below. The following sample screens display a complete report that includes a summary of total incidents reported, a list of contracts for which no incidents were reported, and a summary for the contract for which data was reported in our example. The system displays data entered for each contract.	The screen displays the data that was entered for each contract on the **686: Critical Incident Data** screens. This screen is accessed when you leave **N** (No) in the SUMMARY ONLY and the NOT REPORTED ONLY fields on the header screen.

```
06-23-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532

COMPONENT CODE/NAME: 804/EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009   DATE REPORTED: 06/23/2009   STATUS: ON TIME

       CONTRACT NUMBER: TXHML 001010110 EDUCARE COMMUNITY LIVING CORPORATION --
T

         BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT:               5
                       TOTAL NUMBER OF MEDICATION ERRORS:               2
                          TOTAL NUMBER OF SERIOUS INJURIES:             1
                                                                    TOTAL
NBR. EMER. RESTRAINTS USED:      PERS. RESTRAINTS:                       6
                                 MECH. RESTRAINTS:                       2
                                PSYCH. RESTRAINTS:                       0
NBR. INDIV. REQ. EMERG.RESTRNT:  PERS. RESTRAINTS:                       2
                                 MECH. RESTRAINTS:                       1
                                PSYCH. RESTRAINTS:                       0
NBR. SER. INJ. DUE TO:     EMER. PERS. RESTRAINTS:                       1
                           EMER. MECH. RESTRAINTS:                       0
                          EMER. PSYCH. RESTRAINTS:                       0


                      >
```

```
06-23-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532
                       CONTRACTS NOT REPORTED - TXHML ONLY

COMPONENT CODE/NAME: 804 / EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009

            001010462  TXHML   EDUCARE COMMUNITY LIVING CORPORATION - T

 TOTAL NUMBER OF CONTRACTS NOT REPORTED:   1

                      >
```

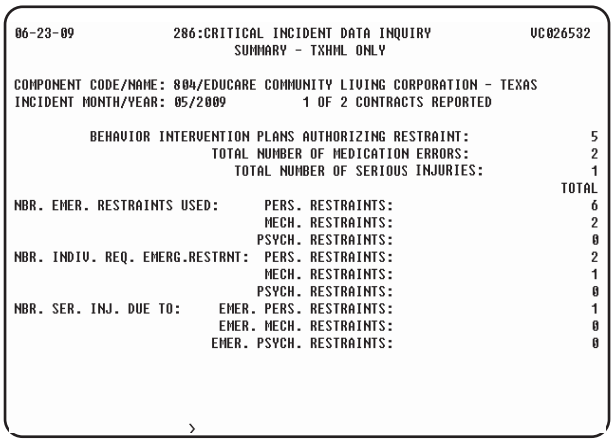
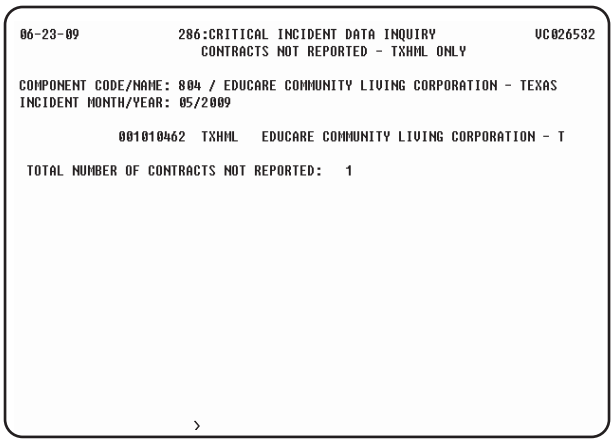
```
06-23-09            286:CRITICAL INCIDENT DATA INQUIRY            VC026532
                              SUMMARY - TXHML ONLY

COMPONENT CODE/NAME: 804/EDUCARE COMMUNITY LIVING CORPORATION - TEXAS
INCIDENT MONTH/YEAR: 05/2009          1 OF 2 CONTRACTS REPORTED

         BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT:               5
                       TOTAL NUMBER OF MEDICATION ERRORS:               2
                          TOTAL NUMBER OF SERIOUS INJURIES:             1
                                                                    TOTAL
NBR. EMER. RESTRAINTS USED:      PERS. RESTRAINTS:                       6
                                 MECH. RESTRAINTS:                       2
                                PSYCH. RESTRAINTS:                       0
NBR. INDIV. REQ. EMERG.RESTRNT:  PERS. RESTRAINTS:                       2
                                 MECH. RESTRAINTS:                       1
                                PSYCH. RESTRAINTS:                       0
NBR. SER. INJ. DUE TO:     EMER. PERS. RESTRAINTS:                       1
                           EMER. MECH. RESTRAINTS:                       0
                          EMER. PSYCH. RESTRAINTS:                       0


                      >
```

Procedure, continued

Step	View	Action
3, cont.	The following sample screen displays a report that includes only the summary. 	This screen is accessed when you type **Y** (Yes) in the SUMMARY ONLY field and **N** (No) in the NOT REPORTED ONLY fields on the header screen.
	The following sample screen displays a report that includes a list of contracts for which incidents were not reported. 	This screen is accessed when you type **N** (No) in the SUMMARY ONLY field and **Y** (Yes) in the NOT REPORTED ONLY fields on the header screen.

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Provider Staff Entry (C13)

Introduction

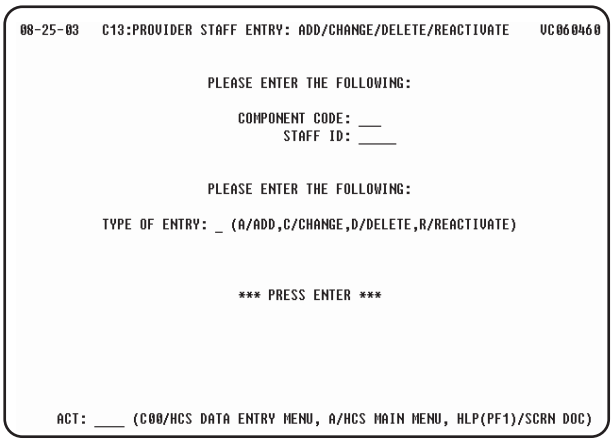
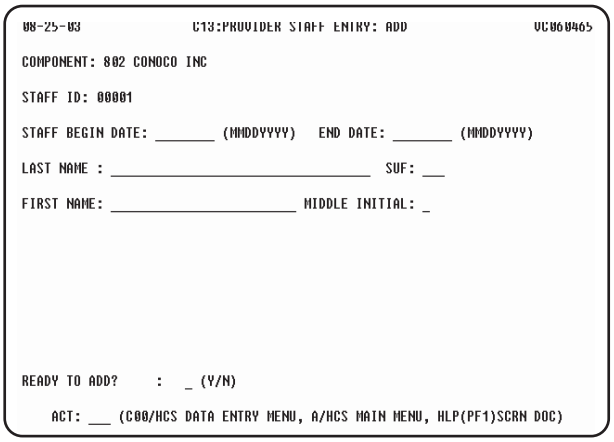
The *Provider Staff Entry* process allows a provider to add, change, delete, or reactivate information on staff members who provide services to consumers.

Provider Staff Entry (C13): Add

Procedure

The following table describes the steps a provider will use to add information on a staff member who provides services to consumers.

Note: Each provider defines their own staff ID numbers. The numbers can be alpha, numeric, or alphanumeric and up to five characters in length.

Step	View	Action
1	_ _	• Type **C13** in the ACT: field of any screen. • Press **Enter**. Result: The **C13: Provider Staff Entry: Add/ Change/Delete/Reactivate** header screen is displayed.
2	A sample **C13: Provider Staff Entry: Add/Change/ Delete/Reactivate** header screen is shown below. 	Your component code is displayed based on your logon account number. • Type the staff member's identification number in the STAFF ID field. • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **C13: Provider Staff Entry: Add** screen is displayed.
3	A sample **C13: Provider Staff Entry: Add** screen is shown below. 	• Type the date the staff member began providing services at your program in the STAFF BEGIN DATE field. • Type the date of the last day the staff member provided services in the END DATE field. This field can be left blank. • Type the last name of the service provider in the LAST NAME field. • Type the suffix, if any, of the service provider in the SUF field. • Type the first name of the service provider in the FIRST NAME field. • Type the middle initial of the service provider, if available, in the MIDDLE INITIAL field. • Type **Y** in the READY TO ADD? field to submit the data to the system. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Added."*

Provider Staff Entry (C13): Change

Procedure

The following table describes the steps a provider will use to change information about a staff member.

Note: If a staff member leaves employment in the program, this function is used to enter the staff member's last date of employment.

Step	View	Action
1	_ _	• Type **C13** in the ACT: field of any screen. • Press **Enter**. Result: The **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen is displayed.
2	A sample **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen is shown below. 08-25-03 C13:PROVIDER STAFF ENTRY: ADD/CHANGE/DELETE/REACTIVATE VC060460 PLEASE ENTER THE FOLLOWING: COMPONENT CODE: __ STAFF ID: ____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE,R/REACTIVATE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type the staff member's identification number in the STAFF ID field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **C13: Provider Staff Entry: Change** screen is displayed.
3	A sample **C13: Provider Staff Entry: Change** screen is shown below. 08-25-03 C13:PROVIDER STAFF ENTRY: CHANGE VC060465 COMPONENT: 802 CONOCO INC STAFF ID: 00001 STAFF BEGIN DATE: 08012003 (MMDDYYYY) END DATE: _____ (MMDDYYYY) LAST NAME : JAMES_____ SUF: __ FIRST NAME: JOHN_____ MIDDLE INITIAL: _ READY TO CHANGE? : _ (Y/N) ACT: __ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)SCRN DOC)	• Type the date the staff member began providing services at your program in the STAFF BEGIN DATE field. • Type the date of the last day the staff member provided services in the END DATE field. • Type the last name of the service provider in the LAST NAME field. • Type the suffix, if any, of the service provider in the SUF field. • Type the first name of the service provider in the FIRST NAME field. • Type the middle initial of the service provider, if available, in the MIDDLE INITIAL field. • Type **Y** in the READY TO CHANGE? field to submit the data to the system. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Provider Staff Entry (C13): Delete

Procedure

The following table describes the steps a provider will use to delete information about a staff member. This function is used if a staff member record was entered in error.

Note: A staff member record *cannot* be deleted if that staff member's ID was used on the Service Delivery screen (**C22**).

Step	View	Action
1	_ _	• Type **C13** in the ACT: field of any screen. • Press **Enter**. Result: The **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen is displayed.
2	A sample **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen is shown below. 08-25-03 C13:PROVIDER STAFF ENTRY: ADD/CHANGE/DELETE/REACTIVATE VC060460 PLEASE ENTER THE FOLLOWING: COMPONENT CODE: __ STAFF ID: ____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE,R/REACTIVATE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type the staff member's identification number in the STAFF ID field. • Type **D** (Delete) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **C13: Provider Staff Entry: Delete** screen is displayed.
3	A sample **C13: Provider Staff Entry: Delete** screen is shown below. 08-25-03 C13:PROVIDER STAFF ENTRY: DELETE VC060465 COMPONENT: 802 CONOCO INC STAFF ID: 00001 STAFF BEGIN DATE: 08012003 (MMDDYYYY) END DATE: _____ (MMDDYYYY) LAST NAME : JAMES_____ SUF: __ FIRST NAME: JOHN_____ MIDDLE INITIAL: _ READY TO DELETE? : _ (Y/N) ACT: __ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)SCRN DOC)	• Type **Y** in the READY TO DELETE? field to submit the data to the system. Note: You can type **N** in the READY TO DELETE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Deleted."*

Provider Staff Entry (C13): Reactivate

Procedure — The following table describes the steps a provider will use to reactivate a staff member record that was previously ended.

Step	View	Action
1	_ _	• Type **C13** in the ACT: field of any screen. • Press **Enter**. Result: The **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen is displayed.
2	A sample **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen is shown below. 08-25-03 C13:PROVIDER STAFF ENTRY: ADD/CHANGE/DELETE/REACTIVATE VC060460 PLEASE ENTER THE FOLLOWING: COMPONENT CODE: __ STAFF ID: ____ PLEASE ENTER THE FOLLOWING: TYPE OF ENTRY: _ (A/ADD,C/CHANGE,D/DELETE,R/REACTIVATE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type the staff member's identification number in the STAFF ID field. • Type **R** (Reactivate) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **C13: Provider Staff Entry: Reactivate** screen is displayed.
3	A sample **C13: Provider Staff Entry: Reactivate** screen is shown below. 08-25-03 C13:PROVIDER STAFF ENTRY: REACTIVATE VC060465 COMPONENT: 802 CONOCO INC STAFF ID: 00001 STAFF BEGIN DATE: 07012003 (MMDDYYYY) END DATE: 07312003 (MMDDYYYY) LAST NAME : JAMES_____ SUF: ___ FIRST NAME: JOHN_____ MIDDLE INITIAL: _ READY TO REACTIVATE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)SCRN DOC)	• Type the date the staff member began providing services at your program in the STAFF BEGIN DATE field. • Type the date of the last day the staff member provided services in the END DATE field. This field can be left blank. • Type the last name of the service provider in the LAST NAME field. • Type the suffix, if any, of the service provider in the SUF field. • Type the first name of the service provider in the FIRST NAME field. • Type the middle initial of the service provider, if available, in the MIDDLE INITIAL field. • Type **Y** in the READY TO REACTIVATE? field to submit the data to the system. Note: You can type **N** in the READY TO REACTIVATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Added."*

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Provider/Contract Update (C14)

Introduction

The *Provider/Contract Update* process allows a provider to add, change, or delete provider, contract, and applicant contact address information that includes:

- the provider's physical address*
- the provider's mailing address
- the provider's billing address
- the contract physical address**
- the contract mailing address
- the applicant contact's physical address
- the applicant contact's mailing address

* The provider's email address can be updated when updating the Provider's Physical Address.

** The Program Contact name, telephone number, and fax number information can also be updated when updating the Contract Physical Address.

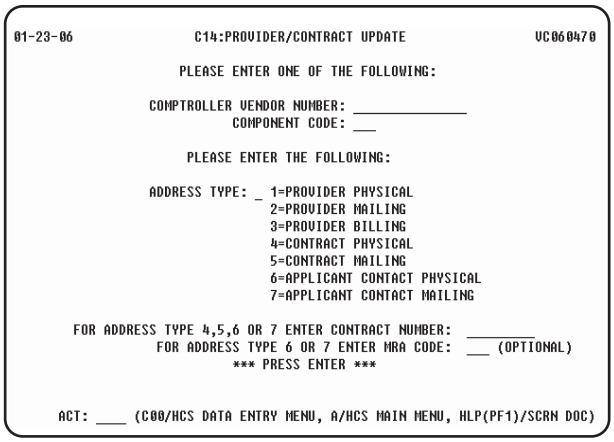
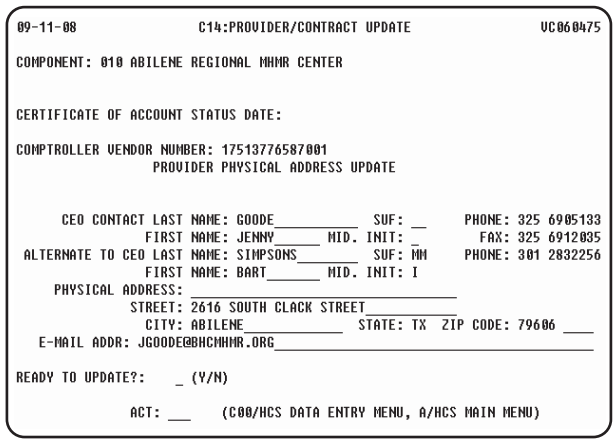
Important

It is vital that all provider and contract information be kept current. Failure to do so will delay the ability to get information to providers.

Provider and contract information that **C14: Provider/Contract Update** will not allow a provider to enter must be sent to the Community Services (CS), Contracts section of Provider Services for data entry.

Provider/Contract Update (C14): Provider Physical Address

Procedure — The following table describes the steps a provider will use to update the provider's physical address information.

Step	View	Action
1	_ _	• Type **C14** in the ACT: field of any screen. • Press **Enter**. Result: The **C14: Provider/Contract Update** header screen is displayed.
2	A sample **C14: Provider/Contract Update** header screen is shown below. 	Your component code is displayed based on your logon account number. • Type **1** (Provider Physical) in the ADDRESS TYPE field. • Press **Enter**. Result: The **C14: Provider/Contract Update** screen is displayed.
3	A sample **C14: Provider/Contract Update** screen is shown below. 	• Update information in the appropriate **Provider Physical Address Update** fields. Note 1: The alternate to CEO name and phone number, physical address, street, city, state, zip code, and email address information can be updated on this screen. Note 2: The ALTERNATE TO CEO field is the name of a contact other than the CEO. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

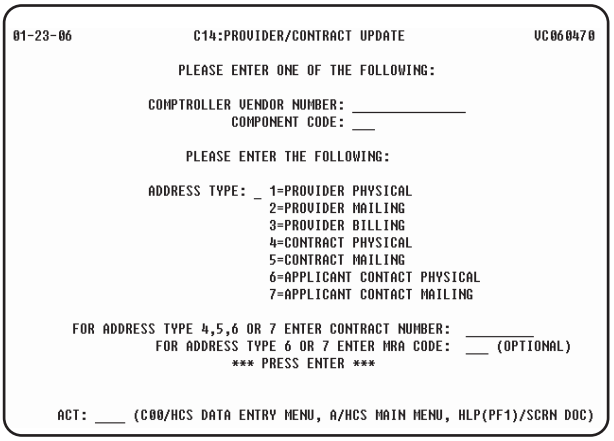
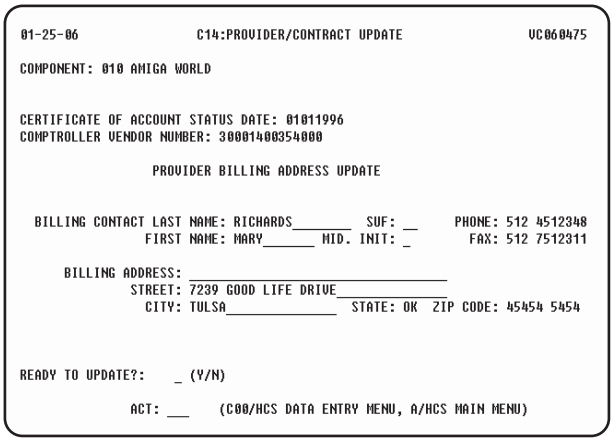
Provider/Contract Update (C14): Provider Mailing Address

Procedure — The following table describes the steps a provider will use to update the provider's mailing address information.

Step	View	Action
1	_ _	• Type **C14** in the ACT: field of any screen. • Press **Enter**. Result: The **C14: Provider/Contract Update** header screen is displayed.
2	A sample **C14: Provider/Contract Update** header screen is shown below. 01-23-06 C14:PROVIDER/CONTRACT UPDATE VC060470 PLEASE ENTER ONE OF THE FOLLOWING: COMPTROLLER VENDOR NUMBER: _____ COMPONENT CODE: __ PLEASE ENTER THE FOLLOWING: ADDRESS TYPE: _ 1=PROVIDER PHYSICAL 2=PROVIDER MAILING 3=PROVIDER BILLING 4=CONTRACT PHYSICAL 5=CONTRACT MAILING 6=APPLICANT CONTACT PHYSICAL 7=APPLICANT CONTACT MAILING FOR ADDRESS TYPE 4,5,6 OR 7 ENTER CONTRACT NUMBER: _____ FOR ADDRESS TYPE 6 OR 7 ENTER MRA CODE: __ (OPTIONAL) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type **2** (Provider Mailing) in the ADDRESS TYPE field. • Press **Enter**. Result: The **C14: Provider/Contract Update** screen is displayed.
3	A sample **C14: Provider/Contract Update** screen is shown below. 09-11-08 C14:PROVIDER/CONTRACT UPDATE VC060475 COMPONENT: 010 ABILENE REGIONAL MHMR CENTER CERTIFICATE OF ACCOUNT STATUS DATE: COMPTROLLER VENDOR NUMBER: 17513776587001 PROVIDER MAILING ADDRESS UPDATE CEO CONTACT LAST NAME: GOODE_____ SUF: __ PHONE: 325 6905133 FIRST NAME: JENNY_____ MID. INIT: _ FAX: 325 6912035 ALTERNATE TO CEO LAST NAME: SIMPSONS_____ SUF: MM PHONE: 301 2832256 FIRST NAME: BART_____ MID. INIT: I MAILING ADDRESS: _____ STREET: 2616 SOUTH CLACK STREET_____ CITY: ABILENE_____ STATE: TX ZIP CODE: 79606 ___ READY TO UPDATE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU)	• Update information in the appropriate **Provider Mailing Address Update** fields. Note 1: The alternate to CEO mailing address, street, city, state, and zip code information can be updated on this screen. Note 2: The ALTERNATE TO CEO field is the name of a contact other than the CEO. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Provider/Contract Update (C14): Provider Billing Address

Procedure — The following table describes the steps a provider will use to update the provider's billing address information.

Step	View	Action
1	_ _	• Type **C14** in the ACT: field of any screen. • Press **Enter**. Result: The **C14: Provider/Contract Update** header screen is displayed.
2	A sample **C14: Provider/Contract Update** header screen is shown below. 	Your component code is displayed based on your logon account number. • Type **3** (Provider Billing) in the ADDRESS TYPE field. • Press **Enter**. Result: The **C14: Provider/Contract Update** screen is displayed.
3	A sample **C14: Provider/Contract Update** screen is shown below. 	• Update information in the appropriate **Provider Billing Address Update** fields. Note: The billing address, street, city, state, and zip code information can be updated on this screen. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Provider/Contract Update (C14): Contract Physical Address

Procedure

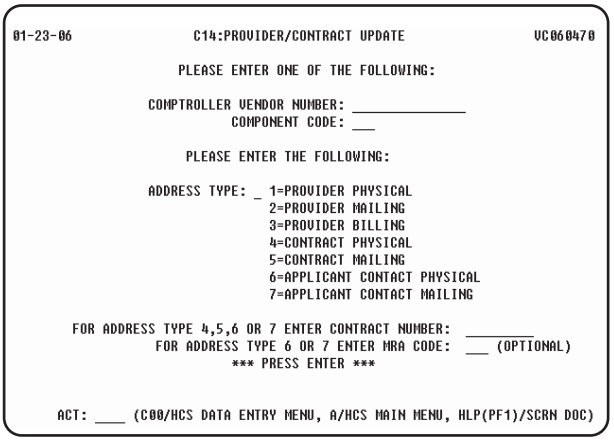
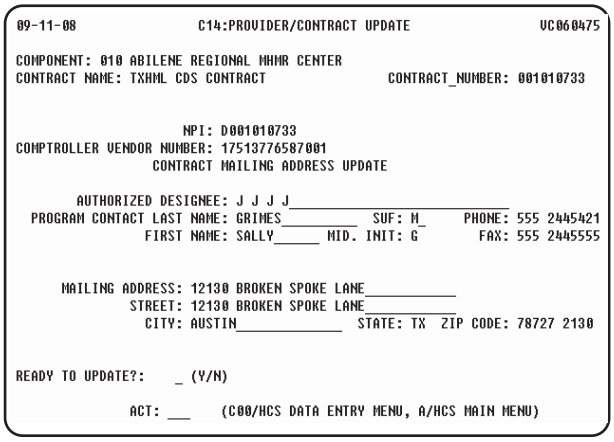
The following table describes the steps a provider will use to update contract physical address information.

Note: This procedure is also used to update Program Contact information.

Step	View	Action
1	_ _	• Type **C14** in the ACT: field of any screen. • Press **Enter**. Result: The **C14: Provider/Contract Update** header screen is displayed.
2	A sample **C14: Provider/Contract Update** header screen is shown below. 01-23-06 C14:PROVIDER/CONTRACT UPDATE VC060470 PLEASE ENTER ONE OF THE FOLLOWING: COMPTROLLER VENDOR NUMBER: _____ COMPONENT CODE: __ PLEASE ENTER THE FOLLOWING: ADDRESS TYPE: _ 1=PROVIDER PHYSICAL 2=PROVIDER MAILING 3=PROVIDER BILLING 4=CONTRACT PHYSICAL 5=CONTRACT MAILING 6=APPLICANT CONTACT PHYSICAL 7=APPLICANT CONTACT MAILING FOR ADDRESS TYPE 4,5,6 OR 7 ENTER CONTRACT NUMBER: _____ FOR ADDRESS TYPE 6 OR 7 ENTER MRA CODE: __ (OPTIONAL) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type **4** (Contract Physical) in the ADDRESS TYPE field. • Type the contract number in the FOR ADDRESS TYPE 4, 5, 6 OR 7 ENTER CONTRACT NUMBER field. • Press **Enter**. Result: The **C14: Provider/Contract Update** screen is displayed.
3	A sample **C14: Provider/Contract Update** screen is shown below. 09-11-08 C14:PROVIDER/CONTRACT UPDATE VC060475 COMPONENT: 010 ABILENE REGIONAL MHMR CENTER CONTRACT NAME: TXHML CDS CONTRACT CONTRACT_NUMBER: 001010733 NPI: D001010733 COMPTROLLER VENDOR NUMBER: 17513776587001 CONTRACT PHYSICAL ADDRESS UPDATE AUTHORIZED DESIGNEE: J J J J_____ PROGRAM CONTACT LAST NAME: GRIMES_____ SUF: M_ PHONE: 555 2445421 FIRST NAME: SALLY_____ MID. INIT: G FAX: 555 2445555 PHYSICAL ADDRESS: _____ STREET: 12130 BROKEN SPOKE LANE_____ CITY: AUSTIN_____ STATE: TX ZIP CODE: 78727 2130 READY TO UPDATE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU)	• Update information in the appropriate **Contract Physical Address Update** fields. Note: The program contact name, telephone, and fax number information as well as the physical address, street, city, state, and zip code information can be updated on this screen. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Provider/Contract Update (C14): Contract Mailing Address

Procedure — The following table describes the steps a provider will use to update the contract mailing address information.

Step	View	Action
1	_ _	• Type **C14** in the ACT: field of any screen. • Press **Enter**. Result: The **C14: Provider/Contract Update** header screen is displayed.
2	A sample **C14: Provider/Contract Update** header screen is shown below. 	Your component code is displayed based on your logon account number. • Type **5** (Contract Mailing) in the ADDRESS TYPE field. • Type the contract number in the FOR ADDRESS TYPE 4, 5, 6 OR 7 ENTER CONTRACT NUMBER field. • Press **Enter**. Result: The **C14: Provider/Contract Update** screen is displayed.
3	A sample **C14: Provider/Contract Update** screen is shown below. 	• Update information in the appropriate **Contract Mailing Address Update** fields. Note: The mailing address, street, city, state, and zip code information can be updated on this screen. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

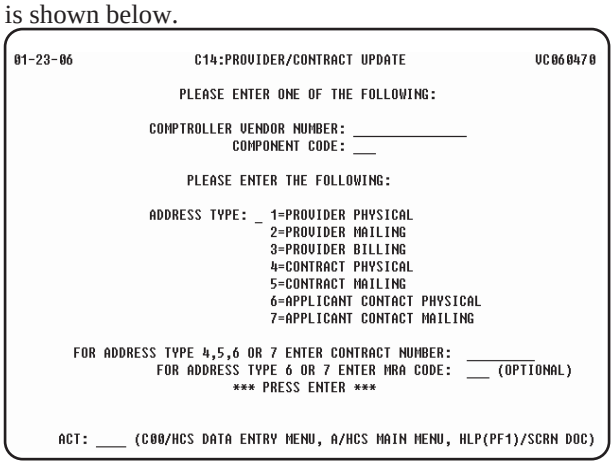
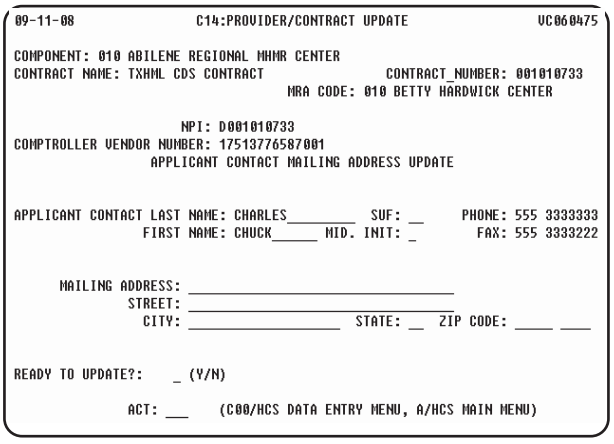
Provider/Contract Update (C14): Applicant Contact Physical Address

Procedure — The following table describes the steps a provider will use to update the applicant contact physical address information.

Step	View	Action
1	_ _	• Type **C14** in the ACT: field of any screen. • Press **Enter**. Result: The **C14: Provider/Contract Update** header screen is displayed.
2	A sample **C14: Provider/Contract Update** header screen is shown below. 01-23-06 C14:PROVIDER/CONTRACT UPDATE VC060470 PLEASE ENTER ONE OF THE FOLLOWING: COMPTROLLER VENDOR NUMBER: _____ COMPONENT CODE: __ PLEASE ENTER THE FOLLOWING: ADDRESS TYPE: _ 1=PROVIDER PHYSICAL 2=PROVIDER MAILING 3=PROVIDER BILLING 4=CONTRACT PHYSICAL 5=CONTRACT MAILING 6=APPLICANT CONTACT PHYSICAL 7=APPLICANT CONTACT MAILING FOR ADDRESS TYPE 4,5,6 OR 7 ENTER CONTRACT NUMBER: _____ FOR ADDRESS TYPE 6 OR 7 ENTER MRA CODE: __ (OPTIONAL) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	Your component code is displayed based on your logon account number. • Type **6** (Applicant Contact Physical) in the ADDRESS TYPE field. • Type the contract number in the FOR ADDRESS TYPE 4, 5, 6 OR 7 ENTER CONTRACT NUMBER field. • Type the MRA Code in the FOR ADDRESS TYPE 6 OR 7 ENTER MRA CODE field. Note: This field is *optional*. If you enter the MRA Code, the code must be valid and the correct MRA for the contract number entered. If you do *not* enter the MRA Code, an informational message is displayed that you are updating the default applicant contact for the contract and not an MRA-specific applicant contact. • Press **Enter**. Result: The **C14: Provider/Contract Update** screen is displayed.
3	A sample **C14: Provider/Contract Update** screen is shown below. 09-11-08 C14:PROVIDER/CONTRACT UPDATE VC060475 COMPONENT: 010 ABILENE REGIONAL MHMR CENTER CONTRACT NAME: TXHML CDS CONTRACT CONTRACT NUMBER: 001010733 MRA CODE: 010 BETTY HARDWICK CENTER NPI: D001010733 COMPTROLLER VENDOR NUMBER: 17513776587001 APPLICANT CONTACT PHYSICAL ADDRESS UPDATE APPLICANT CONTACT LAST NAME: _____ SUF: __ PHONE: ___ _____ FIRST NAME: _____ MID. INIT: _ FAX: ___ _____ PHYSICAL ADDRESS: _____ STREET: _____ CITY: _____ STATE: __ ZIP CODE: ____ ___ E-MAIL ADDR: _____ READY TO UPDATE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU)	• Type update information in the appropriate **Applicant Contact Physical Address Update** fields. Note: The applicant contact name, phone, fax, physical address, street, city, state, zip code, and e-mail address information can be updated on this screen. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Provider/Contract Update (C14): Applicant Contact Mailing Address

Procedure — The following table describes the steps a provider will use to update the applicant contact mailing address information.

Step	View	Action
1	_ _	• Type **C14** in the ACT: field of any screen. • Press **Enter**. Result: The **C14: Provider/Contract Update** header screen is displayed.
2	A sample **C14: Provider/Contract Update** header screen is shown below. 	Your component code is displayed based on your logon account number. • Type **7** (Applicant Contact Mailing) in the ADDRESS TYPE field. • Type the contract number in the FOR ADDRESS TYPE 4, 5, 6 OR 7 ENTER CONTRACT NUMBER field. • Type the MRA Code in the FOR ADDRESS TYPE 6 OR 7 ENTER MRA CODE field. Note: This field is *optional*. If you enter the MRA Code, the code must be valid and the correct MRA for the contract number entered. If you do *not* enter the MRA Code, an informational message is displayed that you are updating the default applicant contact for the contract and not an MRA-specific applicant contact. • Press **Enter**. Result: The **C14: Provider/Contract Update** screen is displayed.
3	A sample **C14: Provider/Contract Update** screen is shown below. 	• Update information in the appropriate **Applicant Contact Mailing Address Update** fields. Note: The mailing address, street, city, state, and zip code information can be updated on this screen. • Type **Y** in the READY TO UPDATE? field to submit the data to the system. Note: You can type **N** in the READY TO UPDATE? field to take no action and return to the header screen. • Press **Enter**. Result: The header screen is displayed with the message, *"Previous Information Changed."*

Service Delivery

Introduction

The TxHmL program's reimbursement methodology is based on fee for service, and payment is based on service entry. The *Service Delivery* process allows a provider to enter individual services provided to TxHmL consumers, as well as change or delete service delivery data. For all self-directed services other than Financial Management (FMSV) actual units of services must be entered into CARE. After adding claims for all self-directed services except Financial Management (FMSV) and Support Consultation (SCV) on the **C22** screen, the system will automatically branch to the **C28: Actual Units of Service** screen where actual units of services will be entered.

Documentation on two inquiry screens, **C89: Claims Inquiry** and **C77: Reimbursement Authorization Inquiry**, is included with this procedure as data from these screens is required for the provider to bill certain services or make changes to claims in **C22**. Documentation on a third inquiry screen, **C75: Prior Approval Inquiry**, is also included as data from this screen is required on the *Minor Home Modifications/Adaptive Aids/Dental Summary Sheet* (4116A).

Special Consideration

Special consideration must be given to minor home modifications (MHM), adaptive aids (AA), and dental (DE) services.

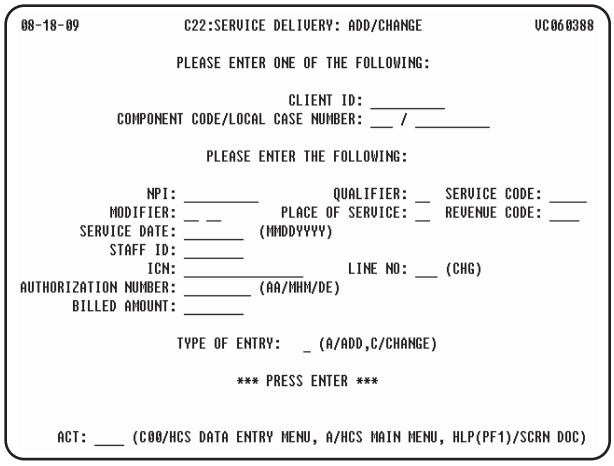
Prior Approval for AA/MHM services: Providers may obtain prior approval to determine how much DADS will pay for a particular AA or MHM. Providers submit the *AA/MHM Request for Prior Approval* form to DADS to request approval of an AA or MHM prior to its purchase. Submitted requests will be assigned a Prior Approval (PA) Tracking Number. Providers are responsible for accessing **C75: Prior Approval Inquiry** to look up the PA Tracking Number and status for a submitted request.

Note: AA/MHM/DE services must also be placed on the consumer's IPC by the service planning team prior to the service being provided in order to be reimbursed.

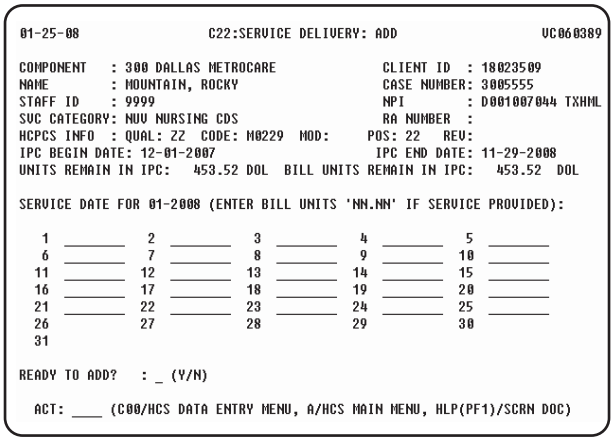
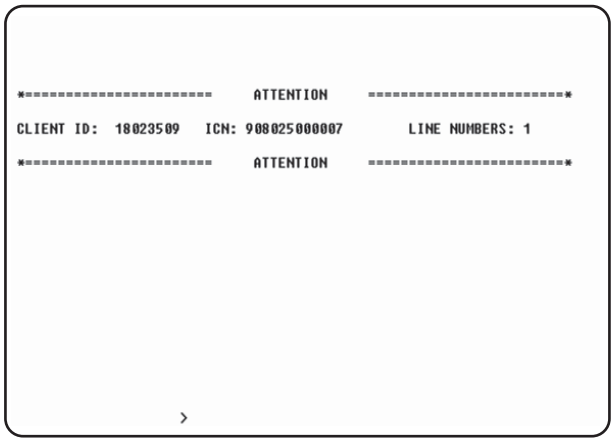
Reimbursement Authorization for MHM/AA/DE services: When providers submit a *Minor Home Modification/Adaptive Aids/Dental Summary Sheet* (4116A) with receipts and any other needed information, they are requesting Reimbursement Authorization (i.e., authorization for payment). Once Reimbursement Authorization has been given an "approved" status in **C77: Reimbursement Authorization Inquiry**, providers may bill for the AA, MHM, or DE service using **C22: Service Delivery**. The Reimbursement Authorization (RA) Tracking Number obtained from **C77** should be used as the authorization number in **C22**. Providers are responsible for reviewing **C77** to obtain the RA Tracking Number and status for a submitted request.

C22: Service Delivery: Add
C28: Actual Units of Service: Add

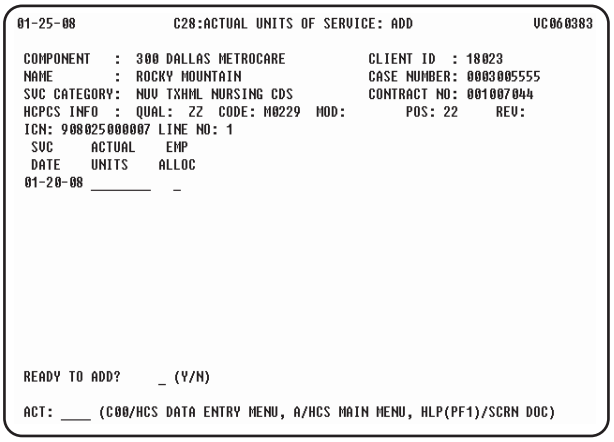
Procedure — The following table describes the steps a provider will use to add service delivery information.

Step	View	Action
1	_ _	• Type **C22** in the ACT: field of any screen. • Press **Enter**. Result: The **C22: Service Delivery: Add/Change** header screen is displayed.
2	A sample **C22: Service Delivery: Add/Change** header screen is shown below.  08-18-09 C22:SERVICE DELIVERY: ADD/CHANGE VC060388 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: NPI: _____ QUALIFIER: __ SERVICE CODE: ____ MODIFIER: _ _ PLACE OF SERVICE: __ REVENUE CODE: ___ SERVICE DATE: _____ (MMDDYYYY) STAFF ID: _____ ICN: _____ LINE NO: __ (CHG) AUTHORIZATION NUMBER: _____ (AA/MHM/DE) BILLED AMOUNT: _____ TYPE OF ENTRY: _ (A/ADD,C/CHANGE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC) This screen allows you to set the criteria for the **C22: Service Delivery: Add** screen where you will enter units of time that services were provided to an individual. Refer to the Bill Code Crosswalk document at **http://www.dads.state.tx.us/providers/hipaa/billcodes/index.html** or the list of codes to use in the QUALIFIER, SERVICE CODE, MODIFIER, PLACE OF SERVICE, and REVENUE CODE fields as well as to determine the services that require a Staff ID in the STAFF ID field.	• Type the client ID in the CLIENT ID field, *or* • Type the local case number in the LOCAL CASE NUMBER field. Note: Your component code is displayed based on your logon account number. *For all services **except** AA (Adaptive Aids), MHM (Minor Home Modifications), and DE (Dental)*: • Type the national provider ID in the NPI field. • Type the Procedure Code Qualifier code in the QUALIFIER (**Claims Cd Ql**) field. • Type the HCPCS/CPT® code in the SERVICE CODE (**Claims Procedure Code**) field. • Type the modifier (if required) in the MODIFIER (**Claims Mod**) field. Note: The MODIFIER field has been changed to allow entry for the modifier code for TxHmL CDS Nursing Services Specialized – LVN and TxHmL CDS Nursing Services Specialized – RN. The modifier codes for these services are TG/UC and they **must be entered in that order**. The system will reject any other combination. If a modifier is used for any other category, you must type the modifier in the first field and leave the second field blank. • Type the place where the service was provided in the PLACE OF SERVICE (**Claims Place of Service**) field. • Type the revenue code in the REVENUE CODE (**Claims Rev Code**) field. • Type the date services were provided in the SERVICE DATE field. • Type the staff ID (if required) in the STAFF ID field. *For AA/MHM/DE service entry*: • Type the authorization number in the AUTHORIZATION NUMBER field. Note: Use **C77: Reimbursement Authorization Inquiry** to verify status and obtain a Reimbursement Authorization Tracking Number (*see page 107*). Only Reimbursement Authorization Tracking Numbers with *approved* status can be used as an authorization number on this screen. *For **all** services*: • Type **A** (Add) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **C22: Service Delivery: Add** screen is displayed.

Procedure, continued

Step	View	Action
3	A sample **C22: Service Delivery: Add** screen is shown below.  01-25-08 C22:SERVICE DELIVERY: ADD VC060389 COMPONENT : 300 DALLAS METROCARE CLIENT ID : 18023509 NAME : MOUNTAIN, ROCKY CASE NUMBER: 3005555 STAFF ID : 9999 NPI : D001007044 TXHML SVC CATEGORY: NUV NURSING CDS RA NUMBER : HCPCS INFO : QUAL: ZZ CODE: M0229 MOD: POS: 22 REV: IPC BEGIN DATE: 12-01-2007 IPC END DATE: 11-29-2008 UNITS REMAIN IN IPC: 453.52 DOL BILL UNITS REMAIN IN IPC: 453.52 DOL SERVICE DATE FOR 01-2008 (ENTER BILL UNITS 'NN.NN' IF SERVICE PROVIDED): 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____ 11 _____ 12 _____ 13 _____ 14 _____ 15 _____ 16 _____ 17 _____ 18 _____ 19 _____ 20 _____ 21 _____ 22 _____ 23 _____ 24 _____ 25 _____ 26 27 28 29 30 31 READY TO ADD? : _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC) If you requested a date in the current month, the days of the month are displayed with the cursor in the field for the date specified. You can enter data for days prior to and including the current date. You ***cannot*** enter data for future dates. If you requested a date in the previous month, the days for the month are displayed with the cursor in the date you specified. You can enter data for any day of the month.	• Type information in the appropriate fields. The BILL UNITS fields allow you to enter the units of service provided. • Type **Y** in the READY TO ADD? field. Note: You can type **N** in the READY TO ADD? field to take no action and return to the header screen. • Press **Enter**. Result: A message screen displays the **Client ID**, **ICN**, and **Line Numbers**.
4	A sample message screen is shown below.  *---------- ATTENTION ----------* CLIENT ID: 18023509 ICN: 908025000007 LINE NUMBERS: 1 *---------- ATTENTION ----------* >	• Press **Enter**. Result: **If…** / **Then…** the service is ***not*** self-directed → The **C22: Service Delivery** header screen is displayed with the message, *"Previous Information Added."* the service ***is self-directed and not Financial Management (FMSV)*** → The **C28: Actual Units of Service: Add** screen is displayed. *Continue with Step 5.*

Procedure, continued

Step	View	Action
5	A sample **C28: Actual Units of Service: Add** screen is shown below.  01-25-08 C28:ACTUAL UNITS OF SERVICE: ADD VC060383 COMPONENT : 300 DALLAS METROCARE CLIENT ID : 18023 NAME : ROCKY MOUNTAIN CASE NUMBER: 0003005555 SVC CATEGORY: NUV TXHML NURSING CDS CONTRACT NO: 001007044 HCPCS INFO : QUAL: ZZ CODE: M0229 MOD: POS: 22 REV: ICN: 908025000007 LINE NO: 1 SVC ACTUAL EMP DATE UNITS ALLOC 01-20-08 _____ _ READY TO ADD? _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the actual units of service provided in the ACTUAL UNITS field. • Type the employer cost allocation units in the EMP ALLOC field. Note: The employer cost allocation codes are: 1 = Indirect cost only (one actual unit must equal 0) 2 = Indirect + direct cost (actual units must be greater than 0) 3 = Direct cost only (actual units must be greater than 0) • Type **Y** in the READY TO ADD? field. • Press **Enter**. Result: The **C22: Service Delivery: Add/Change** header screen is displayed with the message, *"Previous Information Added."*

Note: The provider has 95 days from the end of the month of service to enter claims information into **C22**.

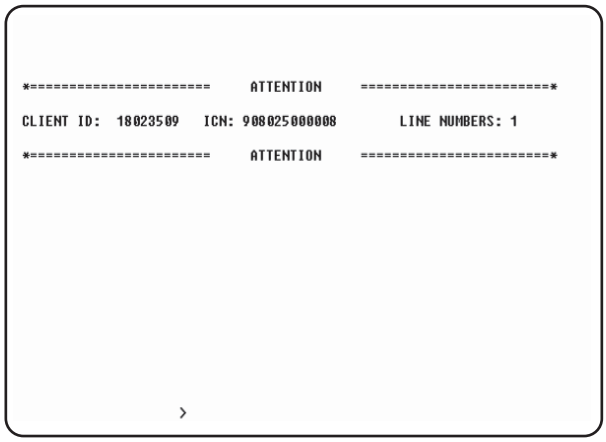
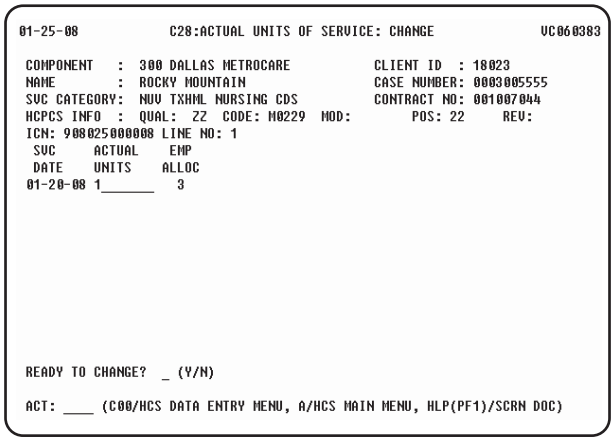
C22: Service Delivery: Change
C28: Actual Units of Service: Change

Procedure

The following table describes the steps a provider will use to change service delivery information.

Step	View	Action
1	_ _	• Access **C89: Claims Inquiry** to obtain the ICN and Line Number. *See procedure on page 47.*
2	_ _	• Type **C22** in the ACT: field of any screen. • Press **Enter**. Result: The **C22: Service Delivery: Add/Change** header screen is displayed.
3	A sample **C22: Service Delivery: Add/Change** header screen is shown below. 08-18-09 C22:SERVICE DELIVERY: ADD/CHANGE VC060388 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: NPI: _____ QUALIFIER: __ SERVICE CODE: ____ MODIFIER: __ __ PLACE OF SERVICE: __ REVENUE CODE: ___ SERVICE DATE: _____ (MMDDYYYY) STAFF ID: _____ ICN: _____ LINE NO: __ (CHG) AUTHORIZATION NUMBER: _____ (AA/MHM/DE) BILLED AMOUNT: _____ TYPE OF ENTRY: _ (A/ADD,C/CHANGE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC) This screen allows you to set the criteria for the **C22: Service Delivery: Change** screen where you will enter or change the units of time entered for a particular service.	*For all services*: • Type the client ID in the CLIENT ID field, *or* • Type the local case number in the LOCAL CASE NUMBER field. Note: Your component code is displayed based on your logon account number. • Type the internal control number in the ICN field. • Type the line number in the LINE NO field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **C22: Service Delivery: Change** screen is displayed.
4	A sample **C22: Service Delivery: Change** screen is shown below. 01-25-08 C22:SERVICE DELIVERY: CHANGE VC060389 COMPONENT : 300 DALLAS METROCARE CLIENT ID : 18023509 NAME : MOUNTAIN, ROCKY CASE NUMBER: 3005555 STAFF ID : 9999 NPI : D0010070044 TXHML SVC CATEGORY: NUV NURSING CDS RA NUMBER : HCPCS INFO : QUAL: ZZ CODE: H0229 MOD: POS: 22 REV: IPC BEGIN DATE: 12-01-2007 IPC END DATE: 11-29-2008 UNITS REMAIN IN IPC: 401.52 DOL BILL UNITS REMAIN IN IPC: 401.52 DOL ICN: 908025000007 LINE NO: 1 SERVICE DATE : 01-20-2008 UNITS: 52.00 (NN.NN) READY TO CHANGE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type corrections for units of service errors. • Type **Y** in the READY TO CHANGE? field. Note: You can type **N** in the READY TO CHANGE? field to take no action and return to the header screen. • Press **Enter**. Result: A message screen displays the **Client ID**, **ICN**, and **Line Numbers**. Note: For corrections to POS (Place of Service) errors, units must be changed to **00.00** and services re-entered using the correct POS code.

Procedure, continued

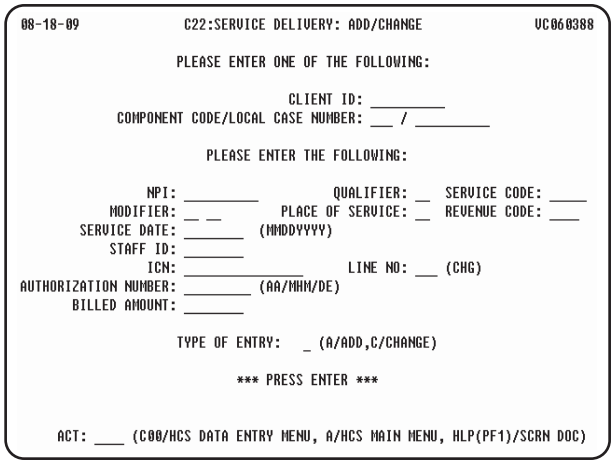
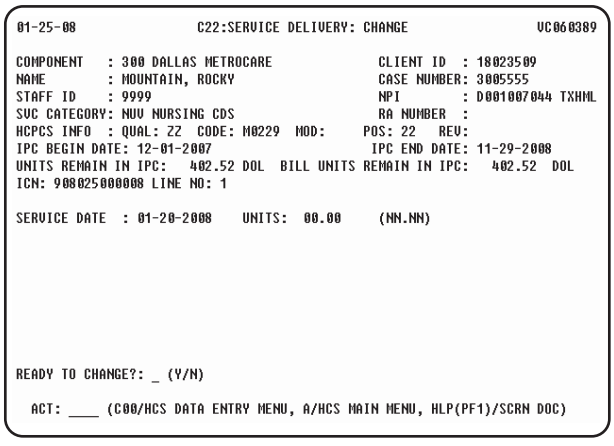
<table>
<tr><th>Step</th><th>View</th><th>Action</th></tr>
<tr><td>5</td><td>A sample screen is shown below.
 
</td><td>• Press Enter
Result:
<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>the service is not self-directed</td><td>The C22: Service Delivery header screen is displayed with the message, “Previous Information Changed.”</td></tr>
<tr><td>the service is self-directed</td><td>The C28: Actual Units of Service: Change screen is displayed. Continue with Step 6.</td></tr>
</table></td></tr>
<tr><td>6</td><td>A sample C28: Actual Units of Service: Change screen is shown below.
 
</td><td>• Type corrections to the actual units of service provided in the ACTUAL UNITS field.
• Type corrections to the employer cost allocation units in the EMP ALLOC field.
• Type Y in the READY TO CHANGE? field.
• Press Enter.
Result: The C22: Service Delivery: Add/Change header screen is displayed with the message, “Previous Information Changed.”</td></tr>
</table>

Service Delivery (C22/C28) – How to Delete

Procedure

The following table describes the steps a provider will use to delete service delivery information.

Note: This procedure is used if the service delivery entered was entered in error and the service was not actually delivered.

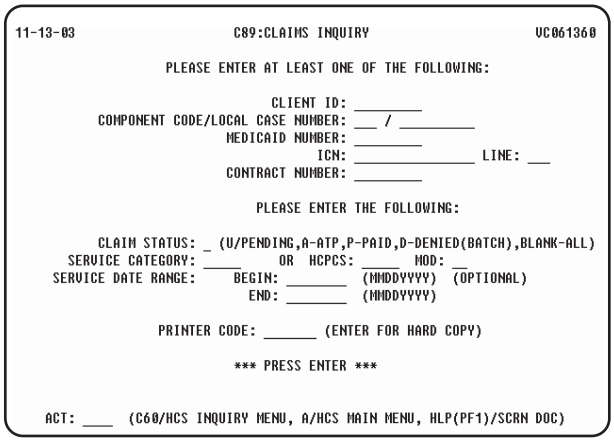
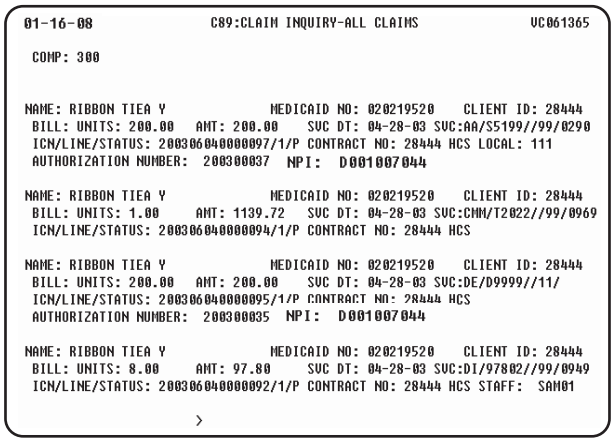
Step	View	Action
1	_ _	• Access **C89: Claims Inquiry** to obtain the ICN and Line Number. *See procedure on page 47.*
2	_ _	• Type **C22** in the ACT: field of any screen. • Press **Enter**. Result: The **C22: Service Delivery: Add/Change** header screen is displayed.
3	A sample **C22: Service Delivery: Add/Change** header screen is shown below.  08-18-09 C22:SERVICE DELIVERY: ADD/CHANGE VC060388 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ PLEASE ENTER THE FOLLOWING: NPI: _____ QUALIFIER: __ SERVICE CODE: ____ MODIFIER: __ __ PLACE OF SERVICE: __ REVENUE CODE: ___ SERVICE DATE: _____ (MMDDYYYY) STAFF ID: _____ ICN: _____ LINE NO: __ (CHG) AUTHORIZATION NUMBER: _____ (AA/MMM/DE) BILLED AMOUNT: _____ TYPE OF ENTRY: _ (A/ADD,C/CHANGE) *** PRESS ENTER *** ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type the client ID in the CLIENT ID field, *or* • Type the local case number in the LOCAL CASE NUMBER field. Note: Your component code is displayed based on your logon account number. • Type the internal control number in the ICN field. • Type the line number in the LINE NO field. • Type **C** (Change) in the TYPE OF ENTRY field. • Press **Enter**. Result: The **C22: Service Delivery: Change** screen is displayed.
4	A sample **C22: Service Delivery: Change** screen is shown below.  01-25-08 C22:SERVICE DELIVERY: CHANGE VC060389 COMPONENT : 300 DALLAS METROCARE CLIENT ID : 18023509 NAME : MOUNTAIN, ROCKY CASE NUMBER: 3005555 STAFF ID : 9999 NPI : D001007044 TXHML SVC CATEGORY: NUV NURSING CDS RA NUMBER : HCPCS INFO : QUAL: ZZ CODE: M0229 MOD: POS: 22 REV: IPC BEGIN DATE: 12-01-2007 IPC END DATE: 11-29-2008 UNITS REMAIN IN IPC: 402.52 DOL BILL UNITS REMAIN IN IPC: 402.52 DOL ICN: 908025000008 LINE NO: 1 SERVICE DATE : 01-20-2008 UNITS: 00.00 (NN.NN) READY TO CHANGE?: _ (Y/N) ACT: ___ (C00/HCS DATA ENTRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Type **00.00** in the UNITS field. • Type **Y** in the READY TO CHANGE? field. • Press **Enter**. Result: The **C22: Service Delivery** header screen is displayed with the message, *"Previous Information Changed."* Note: When the **C22: Service Delivery** screen is used to add units for a service that is self-directed, the system will automatically branch to the **C28: Actual Units of Service** screen where actual units of service are entered. When the self-directed service units are deleted on the **C22: Service Delivery** screen, the screen will not branch to **C28** but the system will also delete the units that were added on the **C28** screen.
5	_ _	Repeat the steps in this procedure for each day of services that you want to delete.

C89: Claims Inquiry

Procedure

Using **C89: Claims Inquiry** allows the provider to view service dates billed and obtain the ICN and Line Number, which are required to make changes to claims in **C22: Service Delivery**.

The following table describes the steps a provider will use to access the claims inquiry screen and display the inquiry results.

Step	View	Action
1	_ _	• Type **C89** in the ACT: field of any screen. • Press **Enter**. Result: The **C89: Claims Inquiry** header screen is displayed.
2	A sample **C89: Claims Inquiry** header screen is shown below.  11-13-03 C89:CLAIMS INQUIRY VC061360 PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ ICN: _____ LINE: __ CONTRACT NUMBER: _____ PLEASE ENTER THE FOLLOWING: CLAIM STATUS: _ (U/PENDING,A-ATP,P-PAID,D-DENIED(BATCH),BLANK-ALL) SERVICE CATEGORY: _____ OR HCPCS: _____ MOD: __ SERVICE DATE RANGE: BEGIN: _____ (MMDDYYYY) (OPTIONAL) END: _____ (MMDDYYYY) PRINTER CODE: _____ (ENTER FOR HARD COPY) *** PRESS ENTER *** ACT: ___ (C60/HCS INQUIRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Your component code is displayed based on your logon account number. • If you want to limit the results of your inquiry, type the requested information in the appropriate fields. Note: The MODIFIER field has been changed to allow entry for the modifier code for TxHmL CDS Nursing Services Specialized – LVN and TxHmL CDS Nursing Services Specialized – RN. The modifier codes for these services are TG/UC and they **must be entered in that order**. The system will reject any other combination. If a modifier is used for any other category, you must type the modifier in the first field and leave the second field blank. • If you want a hard copy of the inquiry results, type your printer code in the PRINTER CODE field. • Press **Enter**. Result: The **C89: Claim Inquiry** screen is displayed.
3	A sample **C89: Claim Inquiry-All Claims** screen is shown below.  01-16-08 C89:CLAIM INQUIRY-ALL CLAIMS VC061365 COMP: 300 NAME: RIBBON TIEA Y MEDICAID NO: 020219520 CLIENT ID: 28444 BILL: UNITS: 200.00 AMT: 200.00 SVC DT: 04-28-03 SVC:AA/S5199//99/0290 ICN/LINE/STATUS: 20030604000097/1/P CONTRACT NO: 28444 HCS LOCAL: 111 AUTHORIZATION NUMBER: 200300037 NPI: D00100744 NAME: RIBBON TIEA Y MEDICAID NO: 020219520 CLIENT ID: 28444 BILL: UNITS: 1.00 AMT: 1139.72 SVC DT: 04-28-03 SVC:CHM/T2022//99/0969 ICN/LINE/STATUS: 20030604000094/1/P CONTRACT NO: 28444 HCS NAME: RIBBON TIEA Y MEDICAID NO: 020219520 CLIENT ID: 28444 BILL: UNITS: 200.00 AMT: 200.00 SVC DT: 04-28-03 SVC:DE/D9999//11/ ICN/LINE/STATUS: 20030604000095/1/P CONTRACT NO: 28444 HCS AUTHORIZATION NUMBER: 200300035 NPI: D00100744 NAME: RIBBON TIEA Y MEDICAID NO: 020219520 CLIENT ID: 28444 BILL: UNITS: 8.00 AMT: 97.80 SVC DT: 04-28-03 SVC:DI/97802//99/0949 ICN/LINE/STATUS: 20030604000092/1/P CONTRACT NO: 28444 HCS STAFF: SAM01 > The claim inquiry will display *all claims* when the CLAIM STATUS field on the header screen is left blank.	View the inquiry results. Data displayed for each claim includes: • Name • Medicaid Number • Billable Units • Billable Amount • Service Date • Service Category/HCPCS/CPT Code/POS Code • **ICN/Line Number**/Status Note 1: The sample displays the ICN/LINE/STATUS field as 200306040000097/1/P. This indicates **200306040000097** as the ICN, **1** as the Line Number, and **P** as the Status. Possible **Status** values are **U** (Pending), **P** (Paid), **A** (Approved to Pay), or **D** (Denied - Batch). Note 2: Screen print or record the ICN and Line Number for the service date you want to change. • Contract Number • Staff ID (if used) • Authorization Number (for AA, MHM, and DE only)

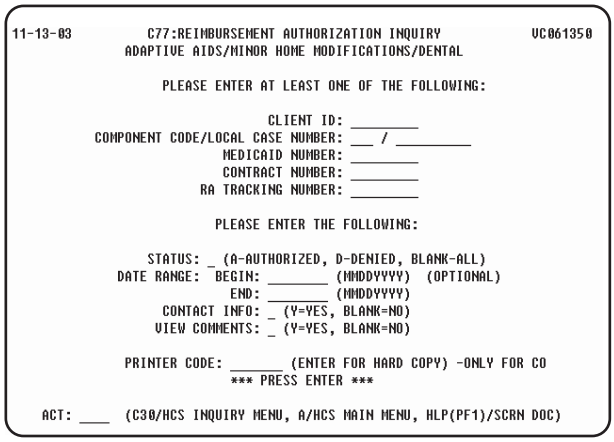
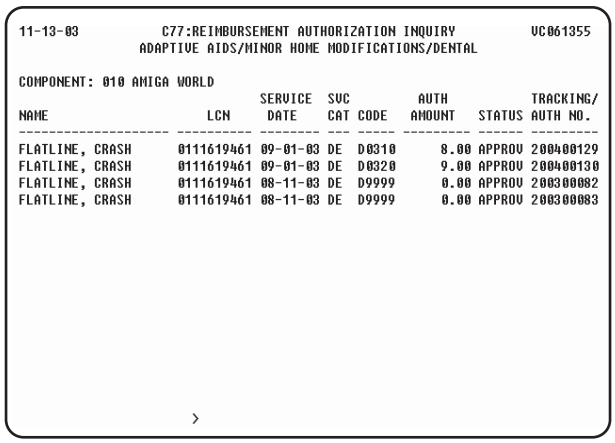
C77: Reimbursement Authorization Inquiry
Adaptive Aids/Minor Home Modifications/Dental

Procedure

Using **C77: Reimbursement Authorization Inquiry** allows the provider to:

- view/verify the status of a reimbursement authorization request for Adaptive Aids, Minor Home Modifications, and Dental services *and*
- obtain the Reimbursement Authorization Tracking Number necessary for entry of Adaptive Aids (AA), Minor Home Modifications (MHM), and Dental services (DE) billing on the **C22**: **Service Delivery** screen.

The following table describes the steps a provider will use to access the reimbursement authorization inquiry screen and display the inquiry results.

Step	View	Action
1	_ _	• Type **C77** in the ACT: field of any screen. • Press **Enter**. Result: The **C77: Reimbursement Authorization Inquiry** header screen is displayed.
2	A sample **C77: Reimbursement Authorization Inquiry** header screen is shown below.  11-13-03 C77:REIMBURSEMENT AUTHORIZATION INQUIRY VC061350 ADAPTIVE AIDS/MINOR HOME MODIFICATIONS/DENTAL PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ CONTRACT NUMBER: _____ RA TRACKING NUMBER: _____ PLEASE ENTER THE FOLLOWING: STATUS: _ (A-AUTHORIZED, D-DENIED, BLANK-ALL) DATE RANGE: BEGIN: _____ (MMDDYYYY) (OPTIONAL) END: _____ (MMDDYYYY) CONTACT INFO: _ (Y=YES, BLANK=NO) VIEW COMMENTS: _ (Y=YES, BLANK=NO) PRINTER CODE: _____ (ENTER FOR HARD COPY) -ONLY FOR CO *** PRESS ENTER *** ACT: ___ (C30/HCS INQUIRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Your component code is displayed based on your logon account number. • If you want to limit the results of your inquiry, type the requested information in the appropriate fields. • If you want to view contact information for Central Office staff who reviewed your 4116A, type **Y** (Yes) in the CONTACT INFO field. • If you want to view comments made by your reviewer concerning your 4116A, type **Y** (Yes) in the VIEW COMMENTS field. • If you want a hard copy of the inquiry results, type your printer code in the PRINTER CODE field. • Press **Enter**. Result: The **C77: Reimbursement Authorization Inquiry** screen is displayed.
3	A sample **C77: Reimbursement Authorization Inquiry** screen is shown below.  11-13-03 C77:REIMBURSEMENT AUTHORIZATION INQUIRY VC061355 ADAPTIVE AIDS/MINOR HOME MODIFICATIONS/DENTAL COMPONENT: 010 AMIGA WORLD NAME LCN SERVICE DATE SVC CAT CODE AUTH AMOUNT STATUS TRACKING/ AUTH NO. FLATLINE, CRASH 0111619461 09-01-03 DE D0310 8.00 APPROV 200400129 FLATLINE, CRASH 0111619461 09-01-03 DE D0320 9.00 APPROV 200400130 FLATLINE, CRASH 0111619461 08-11-03 DE D9999 0.00 APPROV 200300082 FLATLINE, CRASH 0111619461 08-11-03 DE D9999 0.00 APPROV 200300083 ›	View the inquiry results. Data displayed for each claim includes: • Name • Local Case Number • Service Date • Service Category • Service Code (Local) • Authorization Amount • Status Note: A status of **Approved** on this screen means that you can take the Tracking/Authorization Number to the **C22: Service Delivery** screen and file the claim for payment. • Tracking/Authorization Number • Denial Messages (if STATUS is Denied) • Contact Information (if requested) • Comments (if requested)

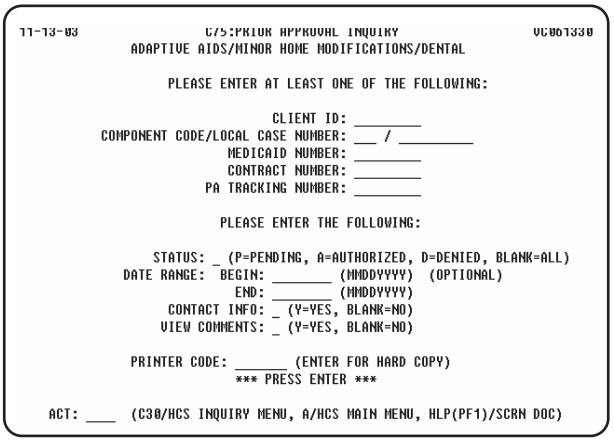
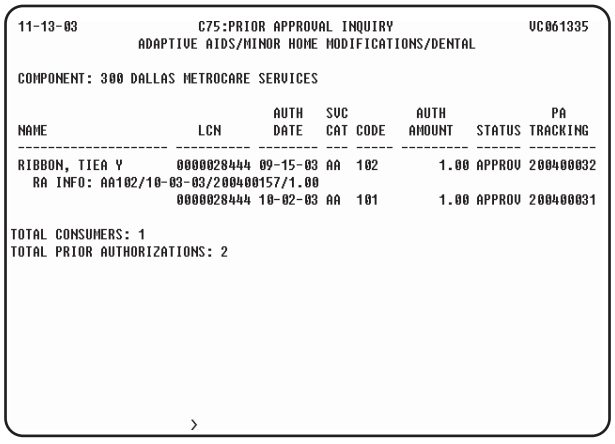
C75: Prior Approval Inquiry
Adaptive Aids/Minor Home Modifications/Dental

Procedure

Using **C75: Prior Approval Inquiry** allows the provider to:

- view/verify the status of a prior approval submission for Adaptive Aids and Minor Home Modifications, *and*
- obtain the PA (prior approval) Tracking Number necessary for submission on the *MHM/AA/DE Summary Sheet* (4116A) to request reimbursement authorization.

The following table describes the steps a provider will use to access the prior approval inquiry screen and display the inquiry results.

Step	View	Action
1	_ _	• Type **C75** in the ACT: field of any screen. • Press **Enter**. Result: The **C75: Prior Approval Inquiry** header screen is displayed.
2	A sample **C75: Prior Approval Inquiry** header screen is shown below.  11-13-03 C75:PRIOR APPROVAL INQUIRY VC061330 ADAPTIVE AIDS/MINOR HOME MODIFICATIONS/DENTAL PLEASE ENTER AT LEAST ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ CONTRACT NUMBER: _____ PA TRACKING NUMBER: _____ PLEASE ENTER THE FOLLOWING: STATUS: _ (P=PENDING, A=AUTHORIZED, D=DENIED, BLANK=ALL) DATE RANGE: BEGIN: _____ (MMDDYYYY) (OPTIONAL) END: _____ (MMDDYYYY) CONTACT INFO: _ (Y=YES, BLANK=NO) VIEW COMMENTS: _ (Y=YES, BLANK=NO) PRINTER CODE: _____ (ENTER FOR HARD COPY) *** PRESS ENTER *** ACT: ___ (C30/HCS INQUIRY MENU, A/HCS MAIN MENU, HLP(PF1)/SCRN DOC)	• Your component code is displayed based on your logon account number. • If you want to limit the results of your inquiry, type the requested information in the appropriate fields. • If you want to view contact information for Central Office staff who reviewed your PA packet, type **Y** (Yes) in the CONTACT INFO field. • If you want to view comments made by your reviewer concerning your packet, type **Y** (Yes) in the VIEW COMMENTS field. • If you want a hard copy of the inquiry results, type your printer code in the PRINTER CODE field. • Press **Enter**. Result: The **C75: Prior Approval Inquiry** screen is displayed.
3	A sample **C75: Prior Approval Inquiry** screen is shown below.  11-13-03 C75:PRIOR APPROVAL INQUIRY VC061335 ADAPTIVE AIDS/MINOR HOME MODIFICATIONS/DENTAL COMPONENT: 300 DALLAS METROCARE SERVICES NAME LCN AUTH DATE SVC CAT CODE AUTH AMOUNT STATUS PA TRACKING RIBBON, TIEA Y 0000028444 09-15-03 AA 102 1.00 APPROV 200400032 RA INFO: AA102/10-03-03/200400157/1.00 0000028444 10-02-03 AA 101 1.00 APPROV 200400031 TOTAL CONSUMERS: 1 TOTAL PRIOR AUTHORIZATIONS: 2 >	View the inquiry results. Data displayed for each claim includes: • Name • Local Case Number • Authorization Date • Service Category • Service Code (Local) • Authorization Amount • Status • PA Tracking Number • Denied/Pending Messages • Contact Information (if requested) • Comments (if requested) • Reimbursement Authorization information (if available) Note: Use PA Tracking Numbers with an "approved" status to submit for reimbursement authorization on the 4116A form.

Inquiry

Introduction

The inquiry screens offer a variety of online reports that provide quick response and are useful for data entry reference and for listing readily available information.

The *Inquiry* section provides general instructions on how to access and display information for the options on the **C60: Provider Inquiry Menu**. It does not include an example of how to access *each* inquiry option.

Inquiry Screens

The inquiry screens allow you to access and view individual, service, and billing information. The following table provides a listing of the inquiry screens and descriptions of inquiry results.

Inquiry Screen	Description
C61: Consumer Demographics	An individual's demographic information, including name, client ID, local case number, address, birthdate, SSN, contract number, service county, location, and dates for IPC, Level of Care/Need, and Medicaid program.
C62: Individual Plan of Care (IPC)	An individual's IPCs including revisions are displayed. Data displayed includes IPC dates, service units, annual cost, authorized amount, and signature information.
C63: DHS Medicaid Eligibility Search	Medicaid recipient information, including certification date, eligibility date, and other Medicaid eligibility information.
C64: IPC Expiration	Lists individuals at your component with IPCs due to expire by a specified date.
C65: MR/RC Assessment Expiration	Lists individuals at your component with MR/RC Assessments due to expire by a specified date.
C66: Consumer Discharges	Lists individuals at your component who have been discharged with discharge begin/end dates. May be limited to display temporary, permanent, or all discharges and by specific date ranges.
C67: Consumer Roster	Complete consumer roster for your component, including name, Client ID, local case number, Medicaid number, enrollment status, and contract number and name.
C68: MR/RC Assessments - Summary	An individual's MR/RC Assessment information, including dates, level of care (LOC), level of need (LON), effective dates, and purpose code.
C69: Provider Information	Information on providers, including legal name, CEO contact name, address/telephone information, and corresponding contract number, name, and status information.
C70: Contract Information	Information on contracts at your component, including dates, authorized designee, program contact, address/telephone information, and contract service areas.
C71: Current Contract List	Current contract list with contract name/number in component code or component name order.
C72: Service Delivery by IPC	Includes billing information by IPC (paid, not paid, amount remaining on IPC) in program units or dollars by selected individual. Shows category totals for TxHmL plans.
C73: Service Delivery by Provider	Service delivery for your component using service begin/end dates and services paid, approved to pay, and not paid for each individual served.

continued on next page

Inquiry Screens, continued

Inquiry Screen	Description
C74: Checklist	Enrollment checklist by individual.
C75: Prior Approval	Listing of individuals at your component for whom you have requested prior approval for adaptive aides/minor home modifications/dental services. Screen displays approval status and tracking number.
C77: Reimbursement Authorization	Listing of individuals at your component for whom you have requested a reimbursement authorization for adaptive aids/minor home modifications/ dental services. Screen displays approval status and tracking/authorization number.
C78: Staff ID	Listing of staff persons at your component with begin dates and assigned staff IDs.
C79: County/MRA	Listing of county codes and names with their corresponding MRA code and name and their waiver contract area.
C80: Provider/Contract Roster	Listing of providers and contract information, including CEO contact name and telephone number, provider physical/mailing address, billing contact person, and contract information.
C81: Payment Eligibility Verification	Payment eligibility verification by selected individual.
C82: Pending MR/RC Assessments	Listing of individuals at your component with MR/RC Assessments for whom a final decision has not been made. The pending status of the assessment is displayed.
C83: MR/RC Assessments	Displays the completed MR/RC Assessment by selected individual.
C84: Provider Location	Lists detailed information about a provider's residential locations, including address, dates, and contact information. Option to view clients assigned to residential location.
C85: Consumer Assignments	Displays assignment information for a selected individual, including assignment effective date, end date (if applicable), service county, and location.
C86: Provider Location List	Listing of provider residential locations at your component with location codes, names, status, and location type.
C87: MRA Contacts	Listing of Mental Retardation Authority (MRA) contacts, including contact name, address, telephone number, and email address.
C88: Consumer Holds	Listing by selected individual of hold begin/end dates and reason for the billing hold. Includes both permanent and temporary billing holds.
C89: Claims Inquiry	Listing of claims information by individual within component, including the bill units and amount for each service. Inquiry can be limited by claim status, service category, or date range. Use this screen to obtain the ICN and Line Number for billing.
C97: WS/C TXHML Prov Notations/Authority Reviews Inquiry	Providers can review this screen after a TxHmL Authority review to see if there were any concerns noted about the providers' programs during the Authority review.
249: PPR Approval Status	Displays the DADS approval status and date of the Permanency Planning Review.
771: DSM/ICD Code & Text Search	Displays a set of DSM or ICD codes based on a pattern search either for the diagnosis code or the text (diagnosis description).

Accessing an Inquiry Screen

Introduction

Accessing an Inquiry Screen provides general instructions on the steps involved in accessing an Inquiry screen. The procedure is the same for accessing all Inquiry screens, although the criteria you enter on the header screen may be different for each option.

Basic Steps

The basic steps for accessing and viewing all Inquiry options are:

- Key the Inquiry option action code in the ACT: field of any screen.
- Enter the key fields used to access the information.
- View the online Inquiry information.

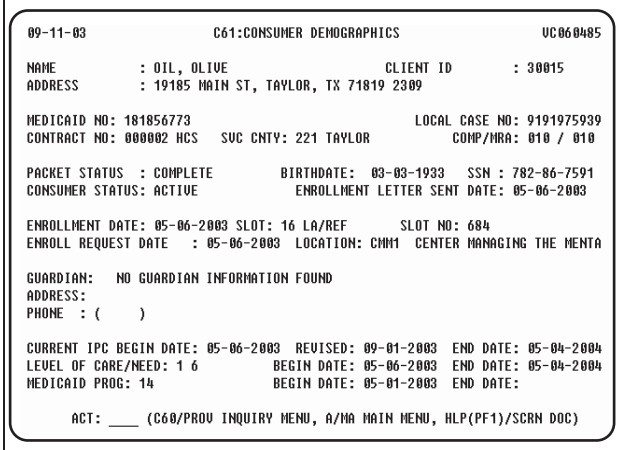
Procedure

The table below displays the steps taken to access an Inquiry screen. For this example, the **C61: Consumer Demographics** option is used.

Step	View	Action
1	_ _	• Key **C61** in the ACT: field of any screen. • Press **Enter**. Result: The **C61: Consumer Demographics: Inquiry** header screen is displayed.
2	A sample **C61: Consumer Demographics: Inquiry** header screen is shown below. 09-11-03 C61:CONSUMER DEMOGRAPHICS: INQUIRY VC060480 PLEASE ENTER ONE OF THE FOLLOWING: CLIENT ID: _____ COMPONENT CODE/LOCAL CASE NUMBER: __ / _____ MEDICAID NUMBER: _____ *** PRESS ENTER *** ACT: ___ (C60/PROV INQUIRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	• Key the requested identifying information in the appropriate fields. Rule: You must enter the Client ID, the local case number, *or* the Medicaid number. Note: Your component code is displayed based on your logon account number. • Press **Enter**. Result: The **C61: Consumer Demographics** screen is displayed.

continued on next page

Procedure, continued

Step	View	Action
3	A sample **C61: Consumer Demographics** screen is shown below.  09-11-03 C61:CONSUMER DEMOGRAPHICS VC060485 NAME : OIL, OLIVE CLIENT ID : 30015 ADDRESS : 19185 MAIN ST, TAYLOR, TX 71819 2309 MEDICAID NO: 181856773 LOCAL CASE NO: 9191975939 CONTRACT NO: 000002 HCS SVC CNTY: 221 TAYLOR COMP/MRA: 010 / 010 PACKET STATUS : COMPLETE BIRTHDATE: 03-03-1933 SSN : 782-86-7591 CONSUMER STATUS: ACTIVE ENROLLMENT LETTER SENT DATE: 05-06-2003 ENROLLMENT DATE: 05-06-2003 SLOT: 16 LA/REF SLOT NO: 684 ENROLL REQUEST DATE : 05-06-2003 LOCATION: CMM1 CENTER MANAGING THE MENTA GUARDIAN: NO GUARDIAN INFORMATION FOUND ADDRESS: PHONE : ( ) CURRENT IPC BEGIN DATE: 05-06-2003 REVISED: 09-01-2003 END DATE: 05-04-2004 LEVEL OF CARE/NEED: 1 6 BEGIN DATE: 05-06-2003 END DATE: 05-04-2004 MEDICAID PROG: 14 BEGIN DATE: 05-01-2003 END DATE: ACT: ___ (C60/PROV INQUIRY MENU, A/MA MAIN MENU, HLP(PF1)/SCRN DOC)	View the data. The sample screen displays the following information about the individual: • name • Client ID • address • Medicaid number • local case number • contract number • service county • component/MRA • packet status • birthdate • SSN • consumer status • Temporary Discharge, if the individual is currently on Temporary Discharge. • enrollment letter sent date • enrollment date • slot and slot number • enroll request date • location • guardian information (if applicable) • current IPC begin date, revised date, end date • Level of Care/Need, begin date, end date • Medicaid program, begin date, end date

Accessing Reports

Overview

Introduction

Reports have been developed to give MRAs and program providers cost, claim, billing, and information about individuals. A provider will receive, via the internet, Waiver reports, such as the consumer billing report, client profile report, etc., which will assist the provider in managing the program.

Providers will continue to be able to view reports using XPTR. However, since most providers have been unable to print reports from XPTR, the EDTS server has been established. Providers will be able to access this server to obtain certain reports.

EDTS Server

The DADS HCS/TXHML EDTS server was purchased solely for DADS HCS/TXHML to send reports to the provider and to send/receive X12 transaction files from/to the provider. No extraneous space was purchased, nor is any space available for providers to store copies of reports or uploads of any other miscellaneous data. Monthly scans are performed to clean out report files older than 16 days. In addition, random scans are performed and unauthorized data (i.e., files and folders) will be removed without notification to the provider.

Obtain Access

For a Waiver provider to establish a connection with DADS HCS/TXHML to retrieve Waiver reports, the following steps must be completed.

To obtain access to the EDTS server:

1. A provider must submit an Electronic Transmission Agreement (ETA) form fax to HHS Enterprise Security Management (ESM), using the fax number provided in the **Forward Completed Form To:** section of the form. The ETA form is, in part, a request for a user ID and password to have access to retrieve the Waiver reports. The user ID and password created by the ETA form are **separate** from the CARE user ID and password and the retrieval of the Waiver reports uses a process that is also completely separate from CARE. ***DO NOT*** confuse the ETA and CARE user IDs and passwords.
2. While ESM is processing the ETA form, the provider must determine which software to use and download it. Because of HIPAA Privacy rules, providers must use encryption software to retrieve Waiver reports. See the options in the *Recommended Client Software* section (most options can be downloaded from the Internet).

Obtain Access, continued	3. After the ETA form is processed, HHS Enterprise Security Management (ESM) will telephone the provider with a user ID and password. This process should take about two weeks.
Retrieve Reports in a Timely Manner	It is the provider's responsibility to retrieve the reports from their respective EDTS server folder. Providers should be aware that their reports are overwritten each time new reports are loaded. Several of these reports are loaded weekly. Therefore, providers must access the EDTS server on a weekly basis to avoid missing reports.
Backup Files	Backup files are kept in the event that previous reports must be recovered. These files, however, are not kept indefinitely, and reports can only be recovered for a limited period of time. Reports will be limited only to recovery for the most recent three months including the current month. Reports requested for recovery will be loaded to the provider's EDTS server folder. They will not be mailed.

Recommended Client Software

Introduction

The following table lists the recommended client software and their Internet addresses.

Note: Questions regarding specific software should be directed to the respective product vendor.

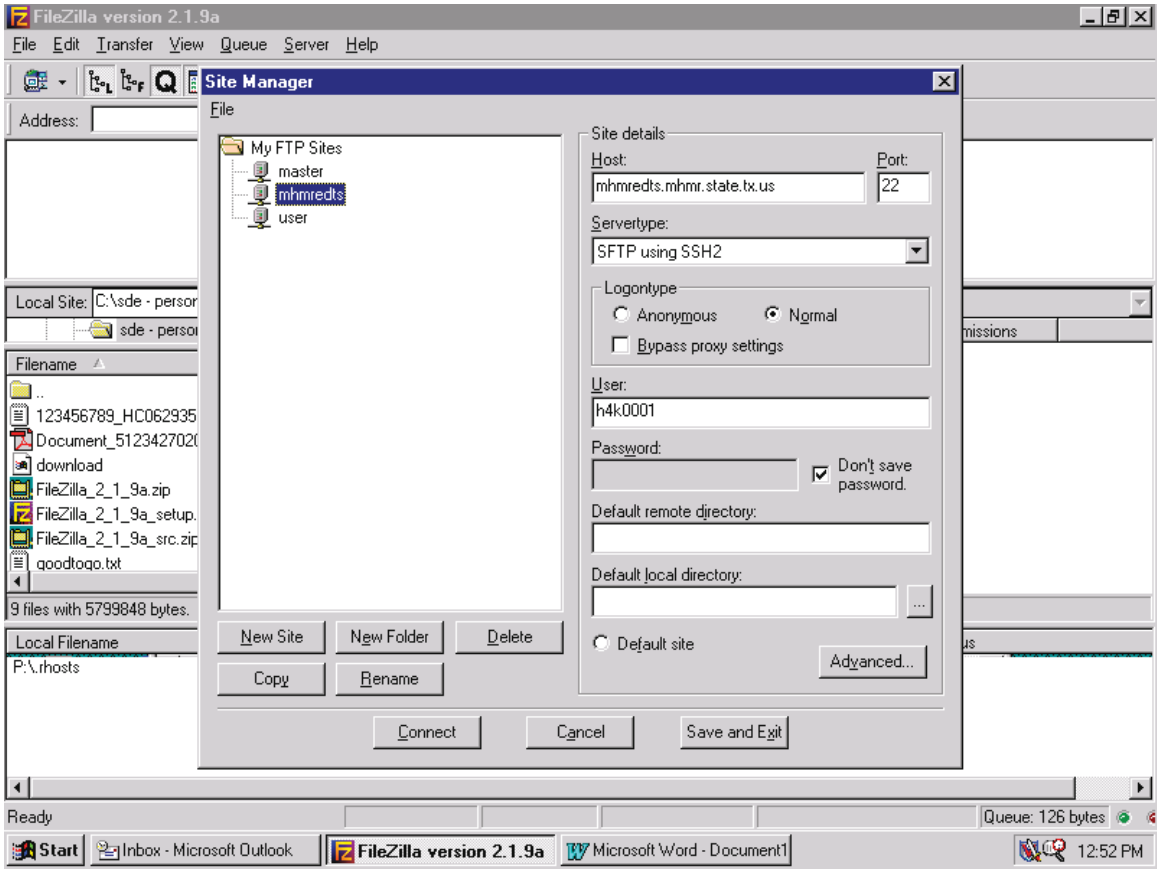
Type	Windows	Unix (and Variants)
Free	PuTTY (PSFTP command line client. Binary only transfers.) http://www.chiark.greenend.org.uk/~sgtatham/putty/download.html Note: It is suggested that you download the user manual and review the manual before downloading PSFTP.Exe. This is a DOS-based command requiring the EDTS server name (domain name) and your ETA Logon/password issued by IASS.	OpenSSH http://www.openssh.org/ Note: Only SFTP is supported for connections from OpenSSH clients.
	FileZilla (GUI client, based on PuTTY PSFTP code for SFTP connections) http://sourceforge.net/projects/filezilla Note 1: Select the latest version and download the highlighted items. This is a Windows-based command requiring the EDTS server name (domain name) and your ETA Logon/password issued by IASS. Note 2: Because DADS HCS/TXHML requires providers to have Windows-based systems for QWS3270 software for use with DADS HCS/TXHML's Automated System, it is thought that most Waiver providers will use the FileZilla software.	
Commercial	SSH Secure Shell for Workstations http://www.ssh.com/products/security/secureshellwks/	SSH Secure Shell for Servers http://www.ssh.com/products/security/secureshellserver/

FileZilla

FileZilla

The majority of providers are selecting the Windows-based free encryption software FileZilla.

The site manager function of FileZilla should be set up as shown below.



FileZilla allows you to highlight (click) the file inside the **Rpt/Waivers** folder, then drag the folder to your "C" drive displayed on the left center side of the FileZilla screen.

Zip/Unzip Software

Introduction	Starting July 1, 2004, DADS HCS/TXHML began compressing or 'Zipping' all reports loaded to the EDTS server. Therefore, providers will be required to use zip software to open their report files. This is being done in anticipation in years to come of an increased number of providers needing access to the EDTS server, as well as additional reports becoming available.
Zip Software	DADS HCS/TXHML plans to use the WINZIP software, which does have a minor cost associated with it. Providers may use any ZIP software to Unzip a file, regardless of the software that DADS HCS/TXHML uses to Zip the file. A comprehensive list of ZIP software products can be found at http://www.tucows.com/comp95_default.html.
Freeware	Some of the ZIP software products available at the above link are available at no cost to the user. They are listed as 'Freeware.' DADS HCS/TXHML reviewed four of the nine listed Freeware products for ease of understanding and usability. The IZArc software screen was found to be the easiest to understand; however, users had to reference the help section to fully understand how to utilize the screen's capability. It is at the provider's discretion which ZIP software is downloaded and used to UnZIP files.
Support	DADS HCS/TXHML will not provide support for any non-DADS HCS/TXHML software downloaded by the provider. It will be the provider's responsibility to contact the software company or vendor if problems are encountered during downloading or usage of ZIP software.

Access Server Connection/Load Reports/Retrieve Waiver Reports

Access the EDTS Server Connection

After the software has been downloaded, the provider must access the EDTS server to retrieve the Waiver reports. This server is accessible from any internet provider. Connections to the server must use the Secure Shell (SSH) version 2 protocol via an SFTP server. The EDTS server name (domain name) that must be used with the software is **mhmredts.mhmr.state.tx.us**

The contact name from ETA form will be considered the primary user and will have access to a folder named **Rpt** Folders named **X12in** and **X12out** will be visible on the screen, but will not be able to be accessed unless the provider is billing via X12 transactions (batch billing).

Additional provider staff who have access will be considered secondary users and will only see and have access to the **Rpt** folder (the **X12in** and **X12out** folders will not be visible to secondary users). Request for additional access may be obtained by completing the IS090 form and faxing it to the appropriate party.

Reports Loaded

By obtaining access, a folder unique to the provider will be created. As reports are prepared, they will be loaded to the folder according to the report time schedule.

The following reports will be loaded to the **Rpt** folder:

- **HC062460 – MRA Service Utilization Report *** (Portrait) Tuesday after the last Friday of the month/Monthly
  The Texas Home Living Utilization Report.
- **HC062942 – Remittance & Status Report** (Landscape) Friday/Weekly
  The Remittance & Status Report reconciles the warrant (actual paid claims from the Comptroller) to claims submitted, minus any additional credits from the Comptroller.
- **HC062962 – HCS Accumulated Approved to Pay Report** (Landscape) Friday/Weekly
  The Accumulated Approved to Pay report contains information on all claims submitted and sent for payment at the comptroller, it does not indicate payment from the comptroller.
- **HC062017 – Approved to Pay Report *** (Landscape) Tuesday/Weekly
  Formerly known as the Billing Report. The information on this report now includes ICN & Line numbers. This report has the same information as the Paid Claim File (GC062040), except that it is in a report format.
- **HC062310 – Service Utilization Report *** (Portrait) Tuesday after the last Friday of the month/Monthly
  The Utilization Report has not changed.

continued on next page

Reports Loaded, continued

- **HC062015 – Denied Claims Report *** (Landscape) Tuesday/Weekly
  Formerly known as the Exceptions Report. The information on this report now includes ICN & Line numbers.
- **GC062040 – Paid Claim File** * (File, semi-colon delimited) Tuesday/Weekly
  The Paid Claims File is new and contains data on claims DADS HCS & TXHML Waiver Programs have sent to the Comptroller to be paid. The data in this file is in semi-colon delimited format, which can be downloaded directly into the provider's local billing program.
- **HC062020 – Client Profile Report** * (Landscape) Tuesday after the last Friday of the month/Monthly
- **HC062746 – Waiver Local Authority Refinance by MRA Report** * (Landscape)
- **HC062835 – HHSC Cost Report** (Portrait) Annually after 1st billing run in September.
  Contains information that will assist with Annual Cost Reports.

*All billing reports will be available once Medicaid Administration approves billing.
Note: See *Format Report* for assistance on formatting the reports.

Retrieve Reports

The reports that are in the **Rpt** subfolder use the following naming convention: nnnnnnnnn_rrrrrrrr.txt. The nnnnnnnnn represents the provider's Electronic Transmission Interface Number (ETIN) and rrrrrrrr is the report number. Example: 123456789_HC062020

Note: The ETIN is a unique number assigned to each provider to ensure the provider receives the correct reports and is the same as the provider's Federal Tax Identification Number or Social Security Number.

Report files will be available for download into the provider's system from the **Rpt** sub-folder. See the *Formatting Report* section for formatting assistance.

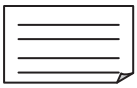
The reports in the **Rpt** folder will be overwritten each week, so the provider must save them to the **C:** drive if the reports are to be saved. To copy a report from the EDTS Server to your **C** drive:

- Click **Rpt**.
- Click **Waiver**.
- Locate the report you want to copy.
- Click and hold down the button to select the report.
- Drag and drop the document in the **Rpt/Waiver** section on the left side of the screen.
- Replace each saved file name with a unique name so the report will not be overwritten the next time the report is retrieved.

Format Report

Format Report

Any word-processing software can be used to view reports and report files opened as text. The following page setup instructions are based on the use of **Microsoft Word**.

Page Orientation	Format
Landscape 	Use these instructions to format the following reports. HC062015 – Denied Claims Report HC062017 – Approved To Pay Report HC062020 – Client Profile Report HC062942 – Remittance & Status HC062962 – HCS Accumulated Approved to Pay Report HC062962 – Waiver Local Authority Refinance by MRA Report To format the font: • Click **Format**. • Click **Font**. • Select **Courier New** in the **Font** section. • Select **Regular** in the **Font style** section. • Type **8.5** in the **Size** section. • Click **OK**. To format the page: • Click **File**. • Click **Page Setup**. • Click **Landscape** in the **Orientation** section. • Type the following settings in the **Margins** section. - Top: 0.2" - Bottom: 0.2" - Right: 0.17" - Left: 0.5"
Portrait 	Use these instructions to format the following reports. HC062460 – MRA Service Utilization Report HC062310 – Service Utilization Report To format the font: • Click **Format**. • Click **Font**. • Select **Courier New** in the **Font** section. • Select **Regular** in the **Font style** section. • Select **10** in the **Size** section. • Click **OK**. To format the page: • Click **File**. • Click **Page Setup**. • Click **Portrait** in the **Orientation** section. • Type the following settings in the **Margins** section. - Top: 0.8" - Bottom: 0.7" - Right: 1.0" - Left: 1.0"

Paid Claims Files

Format Paid Claim File

Paid Claims files will be available on request for those providers who want to receive a semi-colon delimited file (information that is not in any particular format.)

- **Spreadsheet Software -** Any spreadsheet software capable of importing delimited files can be used.
- **Semi-Colon Delimited Files -** Open the file in Excel, then follow the **Text Import Wizard** pop-up screens.
  - For **Original Data Type** select **Delimited** (instead of **Fixed-width**).
  - Click on **Next** to go to the next window.
  - In **Delimiters** check **Semicolon** and uncheck all others.
  - Click on **Next**.

  Note: Providers will need to adjust column formats in this third window.
  - Click on the columns that contain numbers (especially those with large numbers) in **Data Preview**
  - Select **Text** (instead of **General**) in **Column Data Format**.
  - Click **Finish**.

Passwords/Contacts

Passwords

DADS HCS/TXHML guidelines require passwords to be changed every 90 days. This includes those logon passwords issued for the mhmredts.mhmr.state.tx.us secure server. Users will be notified, via an email, that a message containing the user's new password has been placed in their EDTS server primary folder. This message will be placed in the primary folder seven (7) days prior to the old password expiration date. It will be the user's responsibility to read this message and note the new password. Should the message not be read in time, the user will be able to have a new password set by calling the Help Desk. The Help Desk will route the call to the appropriate office, which in turn will call the user with the new password.

Contacts

Use the following guidelines when you encounter problems or have questions:

For **Rpt** folder questions:

- HHSC Help Desk, 512-438-4720 or 1-888-952-4357 Monday through Friday between the hours of 7:00 a.m. – 6:00 p.m.

For HIPAA inquiries:

- DADS HCS/TXHML website: www.Dads.state.tx.us
- CMS (Centers for Medicare & Medicaid Services) ask for HIPAA.com (www.cms.hhs.gov/hipaa/hipaa2)

For questions regarding DADS HCS/TXHML forms, contact:

- HHSC Help Desk, Field Support, 1-512-438-4720 or 1-888-952-4357

For questions regarding software, contact:

- the software vendor.

Screen Fields

Screen Field Table

The following table describes fields displayed on various data entry and inquiry screens used for the waiver programs.

Field	Description
AA	Local code for Adaptive Aids. AA is one of the services provided by the HCS and/or TxHmL programs.
ABL	Code indicating the individual's adaptive behavior level. 1 = Mild ABL deficit 2 = Moderate ABL deficit 3 = Severe ABL deficit 4 = Profound ABL deficit
ADAPTIVE AIDS	The amount to be spent on adaptive aids. (Do not use commas - $$$$$ format.)
ADAPTIVE AIDS ASSESSMENT/BID	An assessment allowing the provider (HCS) or MRA (TxHmL) to seek a bid for the Adaptive Aids.
ADD TO HCS LIST?	Indicate whether individual is to be added to the Interest List.
ADDING A PROGRAM PROVIDER OR CDS AGENCY?	When transferring an individual, indicates whether a Program Provider or CDSA will be added when an SDO will be added where it does not exist.
ADDRESS DATE	Date the individual's address record is being updated.
ADDRESS TYPE	Type of address being updated on the Provider/Contract Update screen. 1 = Provider Physical 2 = Provider Mailing 3 = Provider Billing 4 = Contract Physical 5 = Contract Mailing
ADMIT FROM	The living arrangement in which the individual is currently residing. 1=Community 2=ICF-MR 3=State School 4=Refinance 5=State Hospital
AGE OF MAIN CAREGIVER	The age of the person who is the main caregiver of the individual.
AGGRESSIVE BEHAVIOR	Behavior intended to cause harm or injury to others.
AMBULATION	An individual's ability to walk or move about reflecting the amount of assistance required
ANNUAL COST	Total annual cost of the IPC.

Field	Description
ARE ANY SERVICES STAFFED BY A RELATIVE/GUARDIAN?	On the IPC, indicates whether any services are provided by a relative or guardian.
ASSIGNMENT BEGIN DATE	The date the IPC begins.
ASSIGNMENT END DATE	The date the individual is permanently discharged or transferred to a different MRA.
AUTHORIZATION NUMBER	For **C22: Service Delivery**, the Reimbursement Authorization Tracking Number obtained from the **C77: Reimbursement Authorization Inquiry** screen for Adaptive Aids/Minor Home Modifications/Dental services. Only Reimbursement Authorization Tracking Numbers with approved status can be used in this field.
AUTHORIZED DESIGNEE	Full name of the person authorized to respond to contract related issues.
BEG DT	Begin date of the IPC. Note: If this date is incorrect, contact Medicaid Administration.
BEHAVIOR PROGRAM	**Y** (Yes) or **N** (No) to indicate whether or not a behavior program is in place for the person.
BILLABLE UNITS	Term used by DADS to describe one (1) unit of a HIPAA Standard Procedure Code (e.g., HCPCS, Dental, or CPT code). Depending on the procedure code, one (1) unit may be equal to either 15 minutes or 1 day of service.
BILLED AMOUNT	For **C22: Service Delivery**, this field allows the provider to indicate the cost of providing the specific service. If left blank, the standard rate is applied.
BILLING ADDRESS	The billing contact's billing address.
BILLING CONTACT LAST NAME	The last name of the billing contact's name.
BROAD INDEPENDENCE	A number from the 3rd page of the ICAP Computer Report that reflects an individual's ability to independently perform activities of daily living
C.O. AUTHORIZE TRANSFER?	Field for DADS Access & Intake, Program Enrollment to authorize the transfer after the transfer has been accepted by the receiving provider.
C/O	Field that can be used as an extra address line.
CALCULATE?	Calculate the total annual cost of the IPC.
CARE ID	*Same as Client ID*. Individual's unique statewide identification number generated by the CARE system when each person is registered.
CASE COORDINATOR	Case coordinator's name. The signature must be on the IPC in the individual's chart.
CASE MANAGER POSITION	A code assigned to an MRA employee, usually an MRA service coordinator.

Field	Description
CASE MANAGEMENT UNIT	A code assigned to an MRA service coordination unit.
CASE NUMBER	Individual's local case number issued by your component.
CEO CONTACT LAST NAME	Last name of the Chief Executive Officer (CEO) contact.
CHANGING A PROGRAM PROVIDER OR CDS AGENCY?	When transferring an individual, indicates whether a Program Provider or CDSA is being changed when the SDO currently exists.
CHANGING SERVICE DELIVERY OPTIONS?	When transferring an individual, indicates whether an SDO is being changed when an existing service(s) is moved from one SDO to another SDO (contract numbers do not change).
CITY	Depending on the screen, indicates the city of residence of the individual/CEO contact/provider/billing contact/guardian, or the city of the contract
CLAIM STATUS	For **C89: Claims Inquiry** indicates a particular status for a specified claim. Possible values are: U = Pending P = Paid A = Approved to Pay D = Denied (Batch) Blank = All claims
CLIENT BIRTHDATE	Individual's date of birth.
CLIENT FIRST NAME	Individual's first name.
CLIENT ID	Individual's unique statewide identification number generated by the CARE system when each person is registered.
CLIENT LAST NAME	Individual's last name.
CLIENT LAST NAME/SUF	Individual's last name and suffix, if any.
CLIENT MIDDLE NAME	Individual's middle name.
CLOSE DATE	Date the location closed.
COMPLETED DATE (MR/RC ASSESSMENT)	Date the MR/RC assessment was completed.
COMPONENT	Three-digit unique code that identifies a state hospital, state school, state center, community center, or private provider.
COMPONENT CODE	Three-digit unique code that identifies a state hospital, state school, state center, community center, or private provider.
COMPTROLLER VENDOR NUMBER	Fourteen-digit number by which the State of Texas Comptroller's Office identifies the provider.
CONSUMER CONSENT DATE	Date the individual consented to the transfer.

Field	Description
CONSUMER/LEGAL REPRESENTATIVE	Name of the individual or legal representative. The signature must be on the IPC in the individual's chart.
CONSUMER STATUS	Individual's enrollment status. (Pre-enroll, Active, Enrollment Denied, Enrollment Terminated, Hold, Transferred)
CONTACT FREQ (Permanency Planning)	Code indicating the frequency of parent/guardian contact with the individual during the last six months. 1 = New Admission 2 = Daily 3 = Weekly 4 = Monthly 5 = 1-3 Times 6 = None
CONTACT INFO	**Y** (Yes) or **Blank** (No) to indicate whether you want to view contact information for Central Office staff who reviewed your Prior Approval packet/4116A.
CONTACT NAME (Permanency Planning)	The name of the permanency planning staff contact.
CONTACT PHONE (Permanency Planning)	The telephone number of the permanency planning staff contact.
CONTACT TYPE	Indicates **MHA** (Mental Health Authority) or **MRA** (Mental Retardation Authority) for adding contact information.
CONTRACT NAME	Name of the contract.
CONTRACT NUMBER	Nine-digit number that identifies the contract under which an individual is receiving services.
CONTRACTED PROVIDER NAME	Name of the provider representative. The signature must be on the IPC in the individual's chart and should be the name of the individual who signed the IPC.
CORRES. CITY	The primary/secondary correspondent's city of residence.
CORRES. NAME	The primary/secondary correspondent's name. The primary correspondent is the first person to contact on behalf of an individual in case of an emergency. The secondary correspondent is the person to contact on behalf of an individual if the primary correspondent cannot be reached.

Field	Description
CORRES. RELATIONSHIP	Code that represents the primary correspondent's relationship to the individual. 01 = Parent 02 = Child 03 = Spouse/Posslq 04 = Sibling 05 = Grandparent 06 = Step-child 07 = Step-parent 08 = Step-sibling 09 = Child-in-law 10 = Sibling-in-law 11 = Foster Parent 12 = Aunt/uncle 13 = Niece/nephew 14 = Cousin 15 = Guardian 16 = Trustee 17 = Executor 18 = Attorney 19 = Legal representative 20 = Sponsor 21 = Friend 22 = Parent-in-law 23 = Other relation 24 = This component 25 = Case manager 26 = Unknown 27 = Self
CORRES. STREET	The primary/secondary correspondent's street address.
CORRES. TELEPHONE	The primary/secondary correspondent's area code and telephone number.
COST CEILING	Total $ amounts currently allowed on an individual's IPC. Exceeding this amount requires a review by Utilization Review/Utilization Control section of Medicaid Administration.
COUNTY OF SERVICE	The county where the individual lives.
CURRENT LIVING ARRANGEMENT	Where the individual is currently living.
CURRENT MED. DIAG	Any other current medical diagnoses that the individual may have as determined by a physician.
DATE BEGIN	The date the individual requested the service type.
DENTAL	The amount to be spent on dental services. (Do not use commas - $$$$$ format.)
DE	Local code for Dental Services. DE is one of the services provided by the HCS program.
DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE? (Y/N)	**Y** (Yes) or **N** (No) to indicate whether the individual received services on the discharge date. Note: Payment for residential support and foster care services cannot be billed on the date of discharge.
DISCHARGE DATE	Date of the person's discharge.
DISCHARGE TYPE	Type of discharge (Permanent, Temporary). Permanent discharge is the termination of services to the individual by DADS because the individual has voluntarily left the program or is found to be ineligible for the program. Temporary discharge is the suspension of services to the individual by the provider while the individual is unable or unwilling to receive services.

Field	Description
DOES FAMILY/LAR SUPPORT GOAL?	Does the family/LAR support the goal?
EFFECTIVE DATE	Effective date of the particular status or determination, including Level of Care, Medicaid eligibility.
END DATE	Last day of a particular status or determination, including the current IPC, Level of Care, Medicaid eligibility, the last day the staff member provided services, date the temporary discharge ends, end date of the IPC.
ENROLLED, IS ENROLLING, OR IS ELIGIBLE FOR MFP IN A MEDICAID WAIVER	Indicate whether the individual is enrolled or enrolling in any Medicaid Waiver or is currently living in a nursing home and has access to a Medicaid waiver via the Money Follows the Person Program.
ENROLLMENT DATE	Date the individual was enrolled in the HCS and/or TxHmL program.
ENROLLMENT REQUEST DATE	The date the individual begins to receive services. Note: If the Enrollment Request date needs to be changed, the L01 screen must be completed and the date can be changed by re-entering the screen as a Change.
ENROLLMENT STATUS (or Consumer Status)	Individual's enrollment status in the HCS and/or TxHmL program. (Pre-enroll, Active, Enrollment Denied, Enrollment Terminated, Hold, Transferred)
ENTER BEGIN DATE FOR INITIAL ONLY (MMDDYYYY)	IPC begin date when entering an Initial IPC *only*. This date cannot be prior to the enrollment request date.
ENTERED BUT NOT PAID	Dollars entered but not paid for all services by service category.
ESTIMATED ANNUAL GROSS FAMILY INCOME	Total annual gross income of all family members living with the person, rounded to the nearest thousand. Note: Do not enter commas or decimal points.
ETHNICITY	The individual's ethnicity. B = Black H = Hispanic W = White A = Asian I = American Indian O = Other
ETHNIC/NEW FED RACE	**H** for Hispanic or Latino or **N** for not Hispanic or Latino.
FAMILY AND COMMUNITY SUPPORTS TO ACHIEVE GOAL	Indicate Y (Yes), N (No), or leave blank for each Family and Community Support option. Note: These are not required entry fields for individuals 18 to 21 years of age with a Permanency Plan Goal of 4.
FAMILY PARTICIPATED/POC	Indicate whether the family/LAR participated in the initial or annual meeting to discuss the Plan of Care.
FAMILY PARTICIPATED/PP	Indicate whether the family/LAR participated in the initial or review of the permanency plan.

Field	Description
FAMILY RESPONDED	Indicate whether the family/LAR responded to requests to participate in permanency planning meetings within the last six months.
FAMILY SIZE	Number of persons supported on the person's estimated annual gross family income including: • the number of parents living in the household, • the number of dependent children, • the person, and • any other persons dependent on the family for support.
FAX	The CEO/program contact's Fax number.
FIRST NAME	Depending on the screen, the first name of the individual, service provider, CEO contact, billing contact, program contact, or guardian.
FOR ADDRESS TYPE 4 OR 5 ENTER CONTRACT NUMBER	You *must* type the contract number if you typed **4** or **5** in the ADDRESS TYPE field to update a contract's physical or mailing address.
FOSTER COMPANION CARE	A person with whom the individual lives and that person provides assistance with a wide variety of daily living activities.
FREEDOM OF CHOICE FORM	The form the individual/LAR must sign indicating that he/she wants to participate in the HCS or TxHmL waiver.
FREQUENCY CODE (Waiver MR/RC Assessment)	(Nursing, Non-Vocational, and Vocational Settings) The code reflecting the amount of time a service is provided
FUNDING CODE	The code reflecting the source of funding for the service
GEN. MALADAPTIVE	A number from the 3rd page of the ICAP Computer Report that reflects the degree of behavioral problems the individual exhibits Note: If the number is negative, you *must* use the - (minus) sign just above the alpha section of the keyboard, **not** the **–** sign on the 10-key pad.
GUARDIAN	A person appointed by the Court to act on behalf of an individual who has been deemed incompetent to manage his/her affairs.
GUARDIAN'S CURRENT ADDRESS	Guardian's current address. A guardian is a person appointed by law to represent and make appropriate decisions for an individual.
HCS GROUP HOME (Y/N)	A home where three or four individuals reside in which supervised living service and/or residential support services is provided.
ICAP SERVICE LEVEL	Identifies the level of assistance required by an individual as determined by the Inventory for Client and Agency Planning (ICAP) assessment instrument.
IF REASON IS DEATH: DATE OF DEATH	If the Termination Reason is **8** (Death), the date of the death.

Field	Description
INTERNAL CONTROL NUMBER or ICN	Number used to uniquely identify a single claim. An ICN will be assigned to a claim when at least 1 line item for that claim has passed the Phase 1 edits (i.e., has been accepted into the system).
INTEREST COUNTY	The county of residence of the individual or LAR.
IPC BEGIN DATE	Date the Individual Plan of Care (IPC) began.
IPC END DATE	Date the Individual Plan of Care (IPC) ends.
IPC NON WAIVER SERVICES	Services that will be provided to the individual that are not HCS or TxHmL waiver services.
IPC REMAINING - AMTS TO BE PROVIDED	Total dollars for all services minus the amounts the transferring provider will be paid for services provided prior to the transfer effective date.
IQ	Actual IQ score, if obtainable. IF IQ cannot be ascertained for a person because of the severity of the disability (such as profound mental retardation), 19 should be entered as the score.
LAST NAME	Last name of the service provider.
LAST NAME/SUF	Individual's last name and suffix, if any.
LAST REVISION DATE	Date of the last revision.
LEGAL GUARDIANSHIP	Code that represents the individual's legal guardianship status. 1 = Minor 2 = Minor w/Conservator 3 = Adult w/Guardian of Estate and Person 4 = Adult w/ Guardian of Estate 5 = Adult w/Guardian of Person 6 = Adult w/Limited Guardian 7 = Adult w/Temporary Guardian 8 = Adult, No Guardian
LEGAL STATUS	Code to indicate the person's legal status. 0 = Minor – less than 18 years of age (with parent/guardian) 1 = Minor (ward of the state) 2 = Minor w/conservator 3 = Adult w/guardian of estate and person 4 = Adult w/guardian of estate 5 = Adult w/guardian of person 6 = Adult w/limited guardianship 7 = Adult w/temporary guardian 8 = Adult, no guardian
LEVEL OF CARE (LOC)	A determination of eligibility of an individual for the HCS and/or TxHmL programs. Assignment of the LOC is based on medical and intellectual diagnosis and professional evaluation of the person's needs.

Field	Description
LEVEL OF NEED (LON)	An assignment given to an individual enrolled in the HCS and/or TxHmL programs upon which reimbursement for services is based. The Level of Need determines the payment rate for Day Habilitation, Supervised Living, Residential Support Service, and Foster Care.
LINE ITEM	A single service or item submitted by the provider for payment. The line item contains information such as the billing procedure code, Staff ID, and date of service, or date range (for per diem services only). Claims are made up of one or more line items.
LINE NUMBER	Number used to uniquely identify a single line item within a claim. It is always used in conjunction with the ICN. Both the ICN and Line Number will be assigned to a line item when at least 1 line item on a claim has passed the Phase 1 edits (i.e., has been accepted into the system).
LOCAL CASE NUMBER	Number assigned to the individual by the provider. The number can be 1-10 characters with any combination of letters and numbers.
LOCATED FAMILY	Indicate whether the family could be located when needed within the last six months.
MAILING ADDRESS	The mailing address of the contract/provider.
MARITAL STATUS	Code that represents the individual's marital status. 1 = Married 2 = Widowed 3 = Divorced 4 = Separated 5 = Never Married 6 = Unknown/NA
MEDICAID NUMBER	The number assigned by HHSC to an individual who receives Medicaid. Note: The provider *cannot* change the Medicaid number of a currently enrolled HCS individual. Call DADS Access & Intake, Program Enrollment if you feel the number is incorrect and needs to be changed.
MEDICAID RECIPIENT NUMBER	Number that uniquely identifies an individual in the Medicaid Eligibility file.
MEDICARE NUMBER	The number assigned by the SSA to an individual who receives Medicare. Note: The provider *cannot* change the Medicare number of a currently enrolled HCS individual. Call DADS Access & Intake, Program Enrollment if you feel the number is incorrect and needs to be changed.
MFP DEMO	Indicate whether the person is participating in the Money Follows the Person Demonstration Grant.
MHM	Local code for Minor Home Modifications. MHM is one of the services provided by the HCS and/or TxHmL programs.

Field	Description
MID INIT	Depending on the screen, the middle initial of the individual/ CEO contact/program contact/guardian.
MIDDLE INITIAL	Middle initial of the service provider.
MIDDLE NAME	Individual's middle name.
MINOR HOME MOD	The amount to be spent on minor home modifications. (Do not use commas - $$$$$ format.)
MINOR HOME MODS ASSESSMENT/BID	An assessment allowing the provider (HCS) or MRA (TxHmL) to seek a bid for the Minor Home Modifications.
MODIFIER	*See Procedure Code Modifier*.
MOVE DATE (MRA Assignment Notification)	The date the individual moves to the new location (address).
MRA	Mental Retardation Authority.
NAME	The individual's name.
NEW FED ETHNICITY	**H** for Hispanic or Latino or **N** for not Hispanic or Latino.
NEW SDO	The Service Delivery Option for the existing services the receiving or current program provider enters.
NURSE	Name of the nurse on the interdisciplinary team. The signature must be on the IPC in the individual's chart.
ONSET	The month and year that the individual's condition was diagnosed.
OPEN DATE	Date the location type opened.
PACKET STATUS	The latest enrollment/renewal packet status. Enrollment packet = Pre-enroll, In-progress, Complete, Hold Renewal packet = Pre-renew, Complete, Hold
PERMANENCY PLAN GOAL	Code indicating the permanency plan goal. 1 = Return to family 2 = Move to family-based alternative (e.g., foster, extended family care, open adoption) 3 = Alternative living arrangement determined by individual and Legally Authorized Representative (LAR) (for individuals 18 through 21 only) 4 = Remain in current residence as determined by individual and LAR (for individuals 18 through 21 only).
PERSON DIRECTED PLANS/SMRF COMMUNITY LIVING PLAN	A Person Directed Plan is completed by the MRA and a SMRF Community Living Plan is completed by the State School.
PHONE	Depending on the screen, the phone number of the CEO/ billing/program contact.

Field	Description
PHYS EXAM DATE	Date of the individual's physical examination.
PHYSICAL ADDRESS	CEO contact's physical address.
PHYSICIANS EVALUATION AND RECOMMENDATIOIN	Physician's assessment of the individual. Note: Fields in this section are **not** required for waiver programs. Note: If this screen is used, **all** entries must be completed.
PLACE OF SERVICE or POS	One of five code sets providers use in **C22: Service Delivery** to bill for services. POS codes are used to identify the physical location where services were provided.
PRESENTING PROBLEM	Code representing the individual's presenting problem. 1 = MH (Mental Health) 2 = MR (Mental Retardation) 3 = ECI/DD (Early Childhood Intervention/Developmentally Delayed 4 = SA (Substance Abuse) 5 = Related Condition - MR
PREV. RES.	Code to indicate the individual's previous residence location (program) immediately before the current enrollment. 1 = Home (not enrolled in any program) 2 = Hospital 3 = Another ICF/MR community-based facility 4 = HCS provider services 5 = State hospital or state school 6 = Nursing facility 7 = Other 8 = Cannot determine
PRIMARY CORRESPONDENT	Name of the individual's primary correspondent.
PRIMARY DIAG	Individual's current primary diagnosis (not symptoms) as determined by a physician.
PROCEDURE CODE MODIFIER	One of five code sets providers use in **C22: Service Delivery** to bill for services. A Procedure Code Modifier is a two-digit code that further defines the services described by a HCPCS, CPT® or Dental procedure code. DADS uses modifiers to distinguish between services that are billed using the same HCPCS or CPT® code (e.g., SL and RSS, OT and PT).
PROCEDURE CODE QUALIFIER	One of five code sets providers use in **C22: Service Delivery** to bill for services. Procedure Code Qualifier **HC** indicates that HCPCS or CPT® procedure codes are being used to bill for services. Procedure Code Qualifier **AD** indicates that Dental procedure codes are being used to bill for services.
PROGRAM CONTACT LAST NAME	The program contact's last name.
PROJECTED RETURN DATE	Individual's projected return date.

Field	Description
PROVIDER COMMENTS	The MRA may enter comments for DADS review.
PROVIDER COMPONENT	Component code of the program provider chosen by the individual for **L05: Provider Choice**.
PROVIDER CONTRACT NUMBER	Contract number of the program provider chosen by the individual for **L05: Provider Choice**.
PROVIDER LOCAL CASE NUMBER	Local case number that the program provider assigned the individual for **L05: Provider Choice**.
PROVIDER REPRESENTATIVE NAME	Name of the provider representative.
PSYCHIATRIC DIAG	Diagnosis of an individual's current mental disorder(s), if applicable, as defined in the DSM.
PURPOSE CODE	Code to indicate the purpose of the MR/RC Assessment. 2 = No Current Assessment 3 = Continued Stay Assessment 4 = Change LON on Existing Assessment E = Gaps in Assessment
QUALIFIER	*See Procedure Code Qualifier.*
READY TO ADD?	Determine the action you want to take to submit the data to the system or cancel your request to add data.
READY TO CHANGE?	Determine the action you want to take to submit the data to the system or cancel your request to change data.
READY TO CORRECT?	Determine the action you want to take to submit the data to the system or cancel your request to correct data.
READY TO REACTIVATE?	Determine the action you want to take to submit the data to the system or cancel your request to reactivate.
READY TO RENEW?	Determine the action you want to take to submit the data to the system or cancel your request to renew the IPC.
READY TO REVISE?	Determine the action you want to take to submit the data to the system or cancel your request to revise data.
READY TO SEND FOR AUTHORIZATION?	Determine whether you want to submit the MR/RC Assessment to Utilization Review (UR).
READY TO TRANSFER?	Determine the action you want to take to submit the data to the system or cancel your request to transfer.
REC. LOC	Code identifying the recommended level of care for the individual. 0 = Denial of LOC (only entered by DADS) 1 = Mild to Profoundly Mentally Retarded or Related Conditions with an IQ of 75 or below 8 = Primary Diagnosis is a Related Condition with an IQ of 76 and above
REC. LON	Code identifying the recommended level of need for the individual.

Field	Description
RECEIVING AUTHORITY ACCEPTED BY (MRA Assignment Notification)	The name of the receiving MRA contact person.
RECEIVING AUTHORITY DATE (MRA Assignment Notification)	The date the MRA entered the data.
REGISTRATION EFFECTIVE DATE (MMDDYY)	Effective date of the individual's registration, the formal enrollment into the CARE system which establishes that an individual is registered to receive services from the system. Registration is done by the MRA only.
REGISTRATION EFFECTIVE TIME (HHMM A/P)	Effective time of the individual's registration.
RESIDENTIAL TYPE (ENTERED ON IPC)	Individual's residence type. 2 = Foster/companion care 3 = Own home/family home (OHFH) 4 = Supervised Living 5 = Residential Support
REV DT	Effective date of revisions made to the IPC. This field is required if the TYPE OF ENTRY is **R** (Revision).
REVENUE CODE	One of five code sets providers use in **C22: Service Delivery** to bill for services. A Revenue Code groups services into distinct cost centers. Revenue codes are required on the **C22: Service Delivery** screen when billing for services other than adaptive aids, minor home modifications, and dental.
REVIEW DATE	Date of the permanency planning review.
REVISION DATE	Effective date of revisions made to the IPC. This field is required if the TYPE OF ENTRY is **R** (Revision).
SELF-INJURY BEHAVIOR	Behavior which may result in physical injury to one's self.
SECONDARY CORRESPONDENT	Name of the individual's secondary correspondent.
SENDING AUTHORITY DATE (MRA Assignment Notification)	The date the Sending Authority entered the data.
SENDING AUTHORITY CONTACT NAME (MRA Assignment Notification)	The name of the Sending Authority MRA contact person.
SENDING AUTHORITY PHONE (MRA Assignment Notification)	The area code and telephone number of the Sending Authority MRA contact person.
SERIOUS DISRUP BEH	Behavior that seriously disrupts social activities or results in property damage.

Field	Description
SERVICE (Waiver MR/RC Assessment)	(Non -Vocational or Vocational) Whether and what kind of day services in which the individual participates.
SERVICE CATEGORY *or* SVC CATEGORY *or* SVC CAT	For **C89: Claims Inquiry**, this field indicates the formerly used bill code. You may enter this service category code *or* the HCPCS procedure code and modifier.
SERVICE CODE	One of five code sets providers use in **C22: Service Delivery** to bill for services. HCPCS and CPT® procedure codes are used in this field.
SERVICE COUNTY *or* SVC CNTY	Code for the county in which an individual is receiving services.
SERVICE DATE	Date services were provided.
SERVICE DATE FOR MM-YYYY	The month and year of the requested service date. If you requested a date in the current month, the days of the month are displayed with the cursor in the field for the date specified. You can enter data for days prior to and including the current date. You ***cannot*** enter data for future dates. If you requested a date in the previous month, the days for the month are displayed with the cursor in the date you specified. You can enter data for any day of the month.
SERVICE PROVIDER	Code to indicate if nursing services are provided by an LVN or RN.
SERVICE TYPE	Type of service based on the code entered on the request screen.
SERVICES BEGIN DATE	The date the waiver services will begin.
SERVICES PAID	Dollars for all services by service category.
SEX	Code indicating the individual's sex. (M = Male, F = Female)
SEXUAL AGGRESSIVE BEHAVIOR	Trying to impose one's sexual desires on another individual who is unwilling or unable to consent to such activities
SLOT TRACKING NUMBER	The number assigned to a specific type of slot. Note: the MRA can only enter the Slot Tracking Number **or** the Slot Type field.
SLOT TYPE	Refers to HCS waiver category offered to the individual.
SOCIAL SECURITY NUMBER	Individual's social security number. (N=None, U=Unknown)
STAFF BEGIN DATE	Date the staff member began providing services at your program.
STAFF ID	Staff member's identification number. Note: Providers define their own staff ID numbers. The numbers can be alpha or numeric or alphanumeric and up to five characters in length.

Field	Description
STATE	Depending on the screen, the state of residence of the primary/secondary correspondent, individual, CEO contact, provider, billing contact, guardian, or the contract.
STAT	The individual's current status relative to the service type.
STATUS	• For **C89: Claims Inquiry**, displays the status for a specified claim. Possible values are: U =Pending P =Paid A =Approved to Pay D =Denied (Batch) Blank = All Claims • For **C77: Reimbursement Authorization Inquiry**, indicate the status of the AA/MHM/DE claim. Possible values are: A =Authorized D =Denied Blank = All Claims • For **C75: Prior Approval Inquiry**, indicate the status of the AA/MHM claim. Possible values are: P =Pending A =Authorized D =Denied Blank = All Claims
STATUS DATE	The date the current status was changed. Note: The Status Date cannot be changed without changing the Status Field.
STREET	Depending on the screen, the street address of the contract, individual, CEO contact, provider, billing contact, or guardian.
SUF	Depending on the screen, the suffix (if any) of the service provider, CEO contact, billing contact, or program contact.
TERMINATION REASON (PERMANENT DISCHARGE)	Code that indicates the reason the individual is being *permanently* discharged. 1 = Loss of Medicaid Eligibility 2 = Loss of ICF/MR LOC Eligibility 3 = IPC Exceeds Cost Ceiling 4 = Voluntary Withdrawal by Consumer 6 = Institutionalization (Hospital, NF, ICFMR) 7 = Client Cannot Be Located 8 = Death 9 = Unable to Meet Health and Welfare Needs
TERMINATION REASON (TEMPORARY DISCHARGE)	Code that indicates the reason the individual is being *temporarily* discharged. 1 = Loss of Financial Eligibility 2 = Hospitalization 3 = Elopement 4 = Crisis Stabilization

Field	Description
TERMINATION REVIEWED BY: DATE:	The name of the MRA Representative who reviewed the termination request and the date the request was reviewed. Note: the date entered should be the same as the **Effective Date of Discharge** located under the signature line.
TIME (HHMM A/P)	The registration effective time.
TIME OF DEATH	If the TERMINATION REASON is **Death**, indicates the time of the death.
TO BE PROVIDED NOW TO TRANSFER DT	Dollars to be provided between today and the transfer effective date for all services that have not been entered. Note: If no amount is entered, the transferring provider will not be able to enter any additional services for that individual.
TO USE	The number of units to be used from now to transfer effective date (units that have not been claimed) for the transferring program and/or the transferring CDSA. The entry must be a valid number or "NA." The field will allow decimal fraction of units up to two decimal places (dollars for CDS services).
TOTAL ANNUAL COST	Total annual cost of the IPC.
TRANSFER ACCEPTED?	Indicates whether the provider receiving the individual accepts the transfer. The receiving provider completes this field ***after*** the transfer IPC has been entered.
TRANSFER EFFECTIVE DATE	Effective date of the individual's transfer.
TRANSFER TO COMPONENT	Three-digit code of the component to which the individual is transferring. Note: The provider transferring the individual completes this field. When the receiving provider accesses this screen, this field is displayed.
TRANSFER TO CONTRACT NUMBER	Contract number to which the individual is transferring.
TRANSFER TO SERVICE COUNTY	Service county to which the individual is transferring. See the *County Codes* section for a list of county codes and names.
TRAUMATIC BRAIN INJURY	Indicate whether the person has a history of traumatic brain injury.
TXHML STATUS	The status of the individual's TxHmL offer.
TYPE OF DISCHARGE	Type of discharge (P=Permanent, T=Temporary).
TYPE OF ENTRY	Determine the action you want to take. (A=Add, C=Change/Correct, D=Delete).

Field	Description
TYPE OF ENTRY (Individual Plan of Care)	Type of IPC (Individual Plan of Care) being entered. I = Initial E = Error Correction R = Revision N = Renewal T = Transfer D = Delete
TYPE OF LOCATION (entered on **C:24 Location** and **C25: Location Type Modification** screens)	Code to indicate the type of location. 2 = Foster/Companion Care 3 = 3-bed facility 4 = 4-bed facility
UNITS	Units (hours, days, or months) the service was provided.
UNITS REMAIN IN IPC	The remaining units in the IPC for the type of service requested. Indicates whether the units are by hours, days, or months.
VIEW COMMENTS	**Y** (Yes) or **Blank** (No) to indicate whether you want to view comments made by your reviewer concerning your Prior Approval packet/4116A.
ZIP CODE	Depending on the screen, the zip code of the individual/primary correspondent/secondary correspondent/CEO contact/provider/ billing contact/contract.
ZIP CODE/SUFFIX	Individual's zip code and suffix.
# VISITS BY FAM	Number of visits to the facility by the parent/guardian.
# VISITS TO FAM	Number of the resident's visits to the home.
WAIVER TYPE	The waiver type in which the individual is to be enrolled. (1=HCS, 4=TxHmL)

Glossary

Introduction

The following terms and definitions are used in the automated systems for the Home and Community-Based Services (HCS) and Texas Home Living (TxHmL) programs.

Forms identified in the *Glossary* are located on the Department of Aging and Disability Services (DADS) website. For a listing of web sites and their corresponding web addresses, refer to the *Web Addresses* section of the *Introduction.*

Adult

A person who is 18 years of age or older.

Actively involved

Involvement with an individual that the individual's service planning team deems to be of a quality nature based on the following:

- observed interactions of the person with the individual;
- a history of advocating for the best interests of the individual;
- knowledge and sensitivity to the individual's preferences, values, and beliefs;
- ability to communicate with the individual; and
- availability to the individual for assistance or support when needed.

Allowable Cost

A billable service or item that is within the rate and spending limits of the rate established by the Health and Human Services Commission and that meets the requirements of an individual's program.

Applicant

Depending on the context, an applicant is:

- a person applying for employment with an employer;
- a person or legal entity applying for a contract with an employer to deliver services to an individual; or
- a person applying for services through a DADS program.

Assignment (to Location Code)

Identifies the location and residential type of an individual's residence.

Authorized Amount

Total dollar amounts currently allowed on an individual's IPC (Individual Plan of Care). Exceeding this amount requires a review by the Program Enrollment/Utilization Review (PE/UR) unit of Mental Retardation Authorities.

Billable Unit

A term used by DADS to describe one (1) unit of a HIPAA standard procedure code. Depending on the procedure code, one (1) Billable Unit may be equal to 15 minutes, 1 day of service, or 1 month of service.

Budget	A written projection of expenditures for each program service delivered through the CDS option.
Budgeted Unit Rate	The unit rate calculated for employee compensation (wages and benefits) in the budgeting process for services delivered through the CDS option. The rate is calculated after employer support services have been budgeted.
CARE (Client Assignment and REgistration) System	Centralized, confidential client database, in which service recipients are registered and tracked.
CARE CDS Service Codes	In the CARE system, all services being self-directed have acronyms that end in "V." For example, in HCS with Supported Home Living (SHL), this service will appear as "SHLV."
Case Manager	A person who provides case management services to an individual. The case manager assists an individual who receives program services in gaining access to needed services, regardless of the funding source for the services, and assists with other duties as required by the individual's program. In the HCS Program, an individual is assigned a case manager.
CDS Option (Consumer Directed Services)	A service delivery option that allows individuals or their legally authorized representatives to be the employer of their direct service providers by recruiting, hiring, training, supervising, and terminating their service providers. Services that can be self-directed vary depending on the DADS program.
Certified HCS Provider	A contracted HCS program provider, serving enrolled individuals, that has received an on-sight survey by DADS and has demonstrated compliance with the HCS Principles.
Certified TxHmL Provider	A contracted TxHmL program provider, serving enrolled individuals, that has received an on-sight survey by DADS and has demonstrated compliance with TxHmL standards.
Claim	A service that is submitted by the provider for payment. Each claim must be for one individual, one contract, one service type, one month, one place of service, and one level of need. A single claim may include multiple dates of service within the month.
Client Identification Number (Client ID)	Unique statewide identifier generated by the CARE system when each person is registered by the Mental Retardation Authority. Also referred to as the CARE ID.

Client/Consumer	A person enrolled in the HCS and/or TxHmL program.
Community-Based Services	Services provided within the community by community centers or private providers. Includes the array of services reflected on the IPC.
Component Code	Three-digit unique code that identifies a state hospital, state school, state center, community center, or private provider. You must provide this three-digit code each time you contact DADS.
Comptroller Vendor Number	Fourteen-digit number by which the State of Texas Comptroller's office identifies the provider.
Consumer Directed Services Agency (CDSA)	An agency that contracts with DADS to provide financial management services (FMS) to individuals who choose to use the consumer directed services option.
Consumer Enrollment	Process of enrolling an individual into HCS and/or TxHmL in which the local Mental Retardation Authority has the responsibility of completing all steps in the enrollment process, including developing the PDP, MRRC, and IPC, monitoring the financial eligibility determination process, and electronically submitting information to the DADS, Program Enrollment/Utilization Review unit for review. The Program Enrollment unit approves all enrollments into the HCS or TxHmL program.
Consumer Hold	Consumer hold may be temporary hold or permanent hold and results in withholding of payment after claims have been submitted. Reasons for consumer hold are listed on the Consumer Hold Report (HC062270).
Contract Number	Nine-digit number that identifies the contract under which an individual is receiving services.
Contractor	A person, such as a licensed or certified therapist, a licensed or registered nurse, or other professional, who has a service agreement with an employer to perform one or more program services as an independent contractor, rather than an employee of the employer or of an entity. A contractor may be a sole proprietor.
Correspondent	In case of an emergency, the primary correspondent is the first person to contact on behalf of an individual. This person is not necessarily a relative or financially responsible for the care of the individual being served. The secondary correspondent is the person to contact on behalf of an individual if the primary correspondent cannot be reached.

Cost Ceiling	See *Authorized Amount*.
CPT®Code	Current Procedural Terminology (CPT®) is a set of procedure codes providers use to bill for services in **C22: Service Delivery**. CPT® Codes are used in the SERVICE CODE field.
DADS	The Department of Aging and Disability Services.
Designated Representative (DR)	An adult who is chosen by the employer (individual or LAR) to assist or to perform employer responsibilities in the CDS option. This individual must be willing to perform these duties on a volunteer basis, must be age 18 years or older, must pass a criminal background check and must not be listed on either the Employee Misconduct Registry or the Nurse Aid Registry.
Discharge	**Permanent Discharge (PD)**: the termination of services to the individual by DADS because the individual has voluntarily left the program or is found to be ineligible for the program. **Temporary Discharge (TD)**: the suspension of services to the individual by the provider while the individual is unable, ineligible, or unwilling to receive services.
Electronic Transmission Agreement (ETA)	A DADS form that providers use to request access to a secure server. Access may be for the provider, a clearinghouse that the provider has designated to transmit X12 transactions on its behalf, *or* any provider to retrieve reports from the EDTS server.
Employee	A person employed by an employer through a service agreement to deliver program services and is paid an hourly wage for those services.
Employer	An individual or LAR who chooses to participate in the CDS option, and, therefore, is responsible for hiring and retaining service providers to deliver program services. In the CDS option the employer must be either the individual receiving services (who is at least 18 years of age and does not have a legal guardian), a parent, or legal representative of a minor-aged individual, or the legal guardian, regardless of the age of the individual receiving services.
Employer-Agent	The Internal Revenue Service (IRS) designation of a CDSA as the entity responsible for specific activities and responsibilities required by the IRS on behalf of an employer in the CDS option.

Employer Support Services	Services and items the employer needs to perform employer and employment responsibilities, such as office equipment and supplies, recruitment, and payment of Hepatitis B vaccinations for employees and support consultation.
Entity	An organization that has a legal identity such as a corporation, limited partnership, limited liability company, professional association, or cooperative.
Financial Eligibility	To be served in the HCS or TxHmL program, an individual must receive Medicaid benefits. An individual is financially eligible if he/she is receiving Supplemental Security Income (SSI) benefits through the Social Security Administration *or* is receiving Medicaid Assistance Only (MAO) through the Texas Health and Human Services Commission.
Financial Management Services (FMS)	A service provided to the employer (individual or LAR) by a CDSA. This service consists of registration as the individual's employer-agent, assistance as necessary with the individual's service budget, approval of the service budget, performance of criminal background and registry checks upon request, verification of direct service provider credentials, processing direct service provider timesheets, computing and paying all federal and state taxes, distributing payroll, processing invoices and receipts for payment, maintenance of records for all expenses and reimbursements, monitoring of budgets, preparation of at least quarterly reports regarding the CDS budget for the employer and CM or SC.
Guardian	A person appointed by law to represent and make appropriate decisions for an individual because of a physical, mental, psychological, or intellectual condition that prevents the individual from making reasonable decisions or doing what is necessary for his or her health or welfare.
HCPCS	Healthcare Common Procedure Coding System. HCPCS (pronounced **hick′ • picks**) is a set of procedure codes providers use to bill for services in **C22: Service Delivery**. HCPCS Codes are used in the SERVICE CODE field.
Home and Community-Based Services (HCS) Waiver Program	A waiver of the Medicaid state plan granted under Section 1915 (c) of the Social Security Act which provides community-based services to certain people with mental retardation as an alternative to institutional care.
ICAP Service Level	The ICAP service level identifies the level of service as determined by the Inventory for Client and Agency Planning (ICAP) assessment instrument.
ICF/MR	An intermediate care facility for persons with mental retardation or a related condition.

Individual	A person enrolled in a program.
Individual Plan of Care (IPC)	A format for documentation of services needed by a person receiving services in the HCS or TxHmL program. The IPC is based on an assessment of the individual's needs and personal goals and is developed by qualified individuals. The IPC contains the specific types of services required to support an individual in the community, the units of services, and the estimated annual cost.
Individual Service Plan (ISP)	A written plan developed by the Interdisciplinary Team that describes the individual's characteristics, desires, needs, and personal outcomes, the waiver and non-waiver services necessary to achieve the individual's outcomes, the objectives and methodologies related to each service, and the justification for each service. The ISP must be reviewed and updated at least annually and as the individual's circumstances change. The ISP describes the services to be included in the IPC.
Interdisciplinary Team (IDT)	A planning team constituted by the provider consisting of the individual and Legally Authorized Representative (LAR), a case manager, a nurse, other persons chosen by the individual/LAR, and professional or direct care staff necessary to address the needs and desires of the individual.
Internal Control Number *or* **ICN**	An ICN is used to uniquely identify a single claim. An ICN will be assigned to a claim when at least 1 line item for that claim has passed the Phase 1 edits (i.e., has been accepted into the system).
Inventory for Client and Agency Planning (ICAP)	A validated, standardized assessment that measures the level of assistance and supervision an individual requires and, thus, the amount and intensity of services and supports an individual needs.
Legally Authorized Representative (LAR)	A person authorized or required by law to act on behalf of an individual with regard to a matter described in this chapter, including a parent, guardian, managing conservator of a minor, or the guardian of an adult.
Level of Care (LOC)	A determination of eligibility of an individual for the ICF/MR, HCS, or TxHmL programs. Assignment of the LOC is based on medical and intellectual diagnosis and professional evaluation of the person's needs.
Level of Need (LON)	An assignment given to an individual enrolled in the ICF/MR, HCS, or TxHmL programs upon which reimbursement for services is based. The Level of Need determines the payment rate for Day Habilitation, Supervised Living, Residential Support Service, and Foster Care in HCS and the daily rate in community ICF/MRs.

Line Item	The part of the claim that specifies the date of service. Multiple line items can be included as part of one claim.
Line Number	Number used to uniquely identify a single line item within a claim. It is always used in conjunction with the ICN. Both the ICN and Line Number will be assigned to a line item when at least 1 line item on a claim has passed the Phase 1 edits (i.e., has been accepted into the system).
Local Case Number	Number assigned to the individual by the provider. The local case number can be 1-10 characters with any combination of letters and numbers. When an individual moves from one provider to another, the new provider must assign a local case number.
Location Code	Code used to identify a home in which residential services are provided. The Location Code can be 1-4 characters with any combination of letters and numbers.
Logon Account Number (User ID Number)	Number assigned to each user by DADS that identifies the user and allows that user to access the network.
Mental Retardation Authority (MRA)	An entity to which the Texas Health and Human Services Commission's authority and responsibility described in THSC, §531.002(11) has been delegated.
Minor	A person who is 17 years of age or younger.
Minor Home Modification/ Adaptive Aids/ Dental Summary Sheet (4116A)	A form that is used to request Reimbursement Authorization for adaptive aids, minor home modifications, or dental services.
Modifier	See *Procedure Code Modifier*.
MR/RC Assessment	A form utilized by DADS for eligibility determination, LOC determination, and LON assignment. Refer to the MR/RC Assessment instructions at http://www.dads.state.tx.us/handbooks/instr/8000/F8578-HCS/ for definitions of the terms used on the MR/RC.
Non-Program Resource	A resource other than an individual's program that provides one or more support services or items.

Parent	A natural, legal, foster, or adoptive parent of a minor.

Permanency Planning	A philosophy and planning process that focuses on the outcome of family support for an individual under 22 years of age by facilitating a permanent living arrangement in which the primary feature is an enduring and nurturing parental relationship.
Person-Directed Plan (PDP)	The service plan for individuals in the TxHmL program that describes the supports and services necessary to achieve the desired outcomes identified by the individual, or the LAR on behalf of the individual. This document identifies the program services to be provided to the individual, the number of units of each service to be provided, and the projected cost of each service.
Place of Service *or* POS	One of five code sets providers use in **C22: Service Delivery** to bill for services. POS codes are used to identify the physical location where services were provided.
Prior Approval	Approval for those adaptive aids (AA) and minor home modifications (MHM) that have not been purchased. Providers may obtain prior approval to determine how much DADS will pay for a particular AA or MHM. Providers submit the *AA/MHM Request for Prior Approval* form to DADS, Provider Services, Billing and Payment unit to request approval of an AA or MHM prior to its purchase. Submitted requests will be assigned a Prior Approval (PA) Tracking Number. Providers are responsible for accessing **C75: Prior Approval Inquiry** to look up the PA Tracking Number and status for a submitted request.
Prior Authorization	A general term used in the healthcare industry to describe a process in which providers are responsible for getting services authorized, usually before the services have been provided, but in some cases afterward. Both Prior Approval and Reimbursement Authorization are types of prior authorization.
Procedure Code Modifier	One of five code sets providers use in **C22: Service Delivery** to bill for services. A Procedure Code Modifier is a two-digit code that further defines the services described by a HCPCS, CPT®, or Dental procedure code. DADS uses modifiers to distinguish between services that are billed using the same HCPCS or CPT® code (e.g., SL and RSS, OT and PT).
Procedure Code Qualifier	One of five code sets providers use in **C22: Service Delivery** to bill for services. Procedure Code Qualifier **HC** indicates that HCPCS or CPT® procedure codes are being used to bill for services. Procedure Code Qualifier **AD** indicates that Dental procedure codes are being used to bill for services.

Program	A community services program administered by DADS.
Program Unit	A term used by DADS to describe one (1) unit of service as it appears on the IPC. Depending on the service type, one (1) unit may be equal to 1 hour, 1 day, or 1 month of service.
Provider	A service provider with whom the department contracts for the delivery of community-based mental retardation services in a specified local service area (*contract area*) of the state.
Program Provider (PRGP)	In the CDS option, this term refers to the individual's comprehensive program provider agency.
Provisionally Certified HCS Provider	A legal entity that has completed the application process to become an HCS program provider, including submission of required contract information and an HCS Self-Assessment, attendance at the Pre-Application Orientation and New Provider Orientation, and demonstration of an HCS Self-Assessment that is in 100% compliance with the HCS Principles. Provisional certification must be obtained prior to the legal entity contracting with DADS as an HCS program provider.
Provisionally Certified TxHmL Provider	A legal entity that has completed the application process to become a TxHmL program provider. Provisional certification must be obtained prior to the legal entity contracting with DADS as a TxHmL program provider.
Qualifier	See *Procedure Code Qualifier*.
Registration	Formal enrollment into the CARE system which establishes that an individual is registered to receive services. Registration is done by the MRA only.
Reimbursement Authorization	Authorization that providers request from DADS to bill for adaptive aids (AA), minor home modifications (MHM), or dental (DE) services that have already been purchased and which may or may not have gone through the Prior Approval process. When providers submit a *Minor Home Modification/Adaptive Aids/Dental Summary Sheet* (4116A) with receipts and any other needed information, they are requesting Reimbursement Authorization (i.e., authorization for payment). Once Reimbursement Authorization has been given an "approved" status in **C77: Reimbursement Authorization Inquiry**, providers may bill for the AA, MHM, or DE service using **C22: Service Delivery**. The Reimbursement Authorization (RA) Tracking Number obtained from **C77** should be used as the authorization number in **C22**. Providers are responsible for reviewing **C77** to obtain the RA Tracking Number and status for a submitted request.

Related Condition

A severe, chronic disability that meets all of the following conditions:

(A) a condition attributable to:
  (i) cerebral palsy or epilepsy; or
  (ii) any other condition including autism, but excluding mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons;

(B) a condition manifested before the person reaches age 22 years;

(C) a condition likely to continue indefinitely; and

(D) a condition that results in substantial functional limitations in three or more of the following areas of major life activity:
  (i) self-care;
  (ii) understanding and use of language;
  (iii) learning;
  (iv) mobility;
  (v) self-direction; and
  (vi) capacity for independent living.

Residential Type *(for IPC entry)*

Code for the type of residential services the individual is receiving.

See the *Screen Fields* section of this User Guide for the complete list of Residential Type codes.

Revenue Code

One of five code sets providers use in **C22: Service Delivery** to bill for services. Revenue codes group services into distinct cost centers. Revenue codes are required on the **C22: Service Delivery** screen when billing for services other than adaptive aids, minor home modifications, and dental.

SDO

See *Service Delivery Option*

Service Agreement

A written agreement or acknowledgment between two parties that defines the relationship and lists respective roles and responsibilities.

Service Area

A geographic area served by a program or specified in a contract with DADS.

Service Back-Up Plan

A documented plan to ensure that critical program services delivered through the CDS option are provided to an individual when normal service delivery is interrupted or there is an emergency.

Service Code	One of five code sets providers use in C22: Service Delivery to bill for services. HCPCS and CPT® procedure codes are used in the Service Code field.
Service Coordinator	An employee of a mental retardation authority who is responsible for assisting an applicant, individual, or LAR to access needed medical, social, educational, and other appropriate services, including DADS program services. A service coordinator provides case management services to an individual in the TxHmL program.
Service County	County in which an individual is receiving services.
Service Delivery Option (SDO)	The manner in which individuals choose to receive their program services. In HCS, an individual can choose to self-direct supported home living and respite while having the remainder of their services provided by their program provider. An individual may also choose to have all of their services delivered by their program provider with the agency option. In TxHmL, and individual may choose to use CDS with ALL of their services. An individual may also choose to have a program provider agency provide all of their services, or may choose to self-direct some services while having a program provider deliver others.
Service Plan	A document developed in accordance with rules governing an individual's program that identifies the program services to be provided to the individual, the number of units of each service to be provided, and the projected cost of each service.
Service Planning Team	A group of people convened to plan services and supports with an individual receiving services, determined based on the requirements of an individual's program. Some DADS programs refer to the service planning team as an interdisciplinary team.
Service Provider	An employee, contractor, or vendor.
Service Type (for Waiting List entry)	Code for the type of service the individual is waiting to receive.

Slot Tracking Number	When an individual is enrolled in the waiver program, a Slot Tracking Number is assigned to the individual if the slot is classified as new allocation. When an individual is permanently discharged from the waiver program, the status of the Slot Tracking Number is automatically changed to unavailable. When a slot is released for use, the slot is assigned to a particular slot type and the status is changed to available. When an MRA enters the L01 screen and the individual has an assigned Slot Tracking Number, the slot type is omitted and the Slot Tracking Number is entered.
Slot Type	The slot type is determined by the specific funding allocation from the Texas Legislature.
Support Advisor	A person who provides support consultation to an employer, or a DR, or an individual receiving services through the CDS option. This person must have been certified through DADS to provide the service.
Support Consultation	An optional service that is provided by a support advisor and provides a level of assistance and training beyond that provided by the CDSA through FMS. Support consultation helps an employer to meet the required employer responsibilities of the CDS option and to successfully deliver program services.
Texas Home Living (TxHmL) Waiver Program	A Medicaid waiver program which provides community-based services and supports to eligible individuals who live in their own homes or in their family homes.
Transfer	The movement of an individual from one provider to a different provider or from one contract to another contract. All transfers *must be approved* by Program Enrollment staff of DADS, Access and Intake, Mental Retardation Authorities.
Vendor	A person selected by an employer or DR to deliver services, goods, or items, other than a direct service to an individual. Examples of vendors include a building contractor, electrician, durable medical equipment provider, pharmacy, or a medical supply company.
Vendor Hold	Temporary suspension of payment from department to a program provider.
Working Day	Any day except Saturday, Sunday, a state holiday, or a federal holiday.
4116A Form	See *Minor Home Modification/Adaptive Aids/Dental Summary Sheet*.

County Codes

County Codes

The following table provides a list of Texas county names and codes.

County	Code
Anderson	001
Andrews	002
Angelina	003
Aransas	004
Archer	005
Armstrong	006
Atascosa	007
Austin	008
Bailey	009
Bandera	010
Bastrop	011
Baylor	012
Bee	013
Bell	014
Bexar	015
Blanco	016
Borden	017
Bosque	018
Bowie	019
Brazoria	020
Brazos	021
Brewster	022
Briscoe	023
Brooks	024
Brown	025
Burleson	026
Burnet	027
Caldwell	028

County	Code
Calhoun	029
Callahan	030
Cameron	031
Camp	032
Carson	033
Cass	034
Castro	035
Chambers	036
Cherokee	037
Childress	038
Clay	039
Cochran	040
Coke	041
Coleman	042
Collin	043
Collingsworth	044
Colorado	045
Comal	046
Comanche	047
Concho	048
Cooke	049
Coryell	050
Cottle	051
Crane	052
Crockett	053
Crosby	054
Culberson	055
Dallam	056
Dallas	057
Dawson	058
Deaf Smith	059

County	Code
Delta	060
Denton	061
Dewitt	062
Dickens	063
Dimmit	064
Donley	065
Duval	066
Eastland	067
Ector	068
Edwards	069
Ellis	070
El Paso	071
Erath	072
Falls	073
Fannin	074
Fayette	075
Fisher	076
Floyd	077
Foard	078
Fort Bend	079
Franklin	080
Freestone	081
Frio	082
Gaines	083
Galveston	084
Garza	085
Gillespie	086
Glasscock	087
Goliad	088
Gonzales	089
Gray	090

County	Code
Grayson	091
Gregg	092
Grimes	093
Guadalupe	094
Hale	095
Hall	096
Hamilton	097
Hansford	098
Hardeman	099
Hardin	100
Harris	101
Harrison	102
Hartley	103
Haskell	104
Hays	105
Hemphill	106
Henderson	107
Hidalgo	108
Hill	109
Hockley	110
Hood	111
Hopkins	112
Houston	113
Howard	114
Hudspeth	115
Hunt	116
Hutchinson	117
Irion	118
Jack	119
Jackson	120
Jasper	121

County	Code
Jeff Davis	122
Jefferson	123
Jim Hogg	124
Jim Wells	125
Johnson	126
Jones	127
Karnes	128
Kaufman	129
Kendall	130
Kenedy	131
Kent	132
Kerr	133
Kimble	134
King	135
Kinney	136
Kleberg	137
Knox	138
Lamar	139
Lamb	140
Lampasas	141
La Salle	142
Lavaca	143
Lee	144
Leon	145
Liberty	146
Limestone	147
Lipscomb	148
Live Oak	149
Llano	150
Loving	151
Lubbock	152

County	Code
Lynn	153
McCullough	154
McLennan	155
McMullen	156
Madison	157
Marion	158
Martin	159
Mason	160
Matagorda	161
Maverick	162
Medina	163
Menard	164
Midland	165
Milam	166
Mills	167
Mitchell	168
Montague	169
Montgomery	170
Moore	171
Morris	172
Motley	173
Nacogdoches	174
Navarro	175
Newton	176
Nolan	177
Nueces	178
Ochiltree	179
Oldham	180
Orange	181
Palo Pinto	182
Panola	183

County	Code
Parker	184
Parmer	185
Pecos	186
Polk	187
Potter	188
Presidio	189
Rains	190
Randall	191
Reagan	192
Real	193
Red River	194
Reeves	195
Refugio	196
Roberts	197
Robertson	198
Rockwall	199
Runnels	200
Rusk	201
Sabine	202
San Augustine	203
San Jacinto	204
San Patricio	205
San Saba	206
Schleicher	207
Scurry	208
Shackelford	209
Shelby	210
Sherman	211
Smith	212
Somervell	213
Starr	214

County	Code
Stephens	215
Sterling	216
Stonewall	217
Sutton	218
Swisher	219
Tarrant	220
Taylor	221
Terrell	222
Terry	223
Throckmorton	224
Titus	225
Tom Green	226
Travis	227
Trinity	228
Tyler	229
Upshur	230
Upton	231
Uvalde	232
Val Verde	233
Van Zandt	234
Victoria	235
Walker	236
Waller	237
Ward	238
Washington	239
Webb	240
Wharton	241
Wheeler	242
Wichita	243
Wilbarger	244
Willacy	245

County	Code
Williamson	246
Wilson	247
Winkler	248
Wise	249
Wood	250
Yoakum	251
Young	252
Zapata	253
Zavala	254

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Quick Reference

Introduction

The *Quick Reference* section of the manual provides quick references for the following procedures.

Consumer Discharge (C18): Add (Permanent)

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of discharge and type of entry.

On the **C18: Consumer Discharge: Add/ Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **P** (Permanent) in the TYPE OF DISCHARGE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Enter an individual's permanent discharge.

On the **C18: Consumer Discharge: Add** screen:

- Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.
- Type the discharge date in the DISCHARGE DATE field.
- Type **Y** (Yes) or **N** (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE DATE? field.

Note: 24-hour services *cannot* be billed on the Discharge Date.

- Type the number representing the reason for termination in the TERMINATION REASON field.

If the reason of discharge is death:

- Type the date of death in the DATE OF DEATH field.
- Type the time of death in the TIME OF DEATH field. (HHMMA/P format)

- Type **Y** in the READY TO ADD? field to submit the data to the system.
- Press **Enter**.

Consumer Discharge (C18): Change (Permanent)

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of discharge and type of entry.

On the **C18: Consumer Discharge: Add/ Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **P** (Permanent) in the TYPE OF DISCHARGE field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change an individual's permanent discharge.

On the **C18: Consumer Discharge: Change** screen:

- Type changes to the discharge information in the appropriate fields.
- Type **Y** in the READY TO CHANGE? field to submit the data to the system.
- Press **Enter**.

Consumer Discharge (C18): Delete (Permanent)

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of discharge and type of entry.

On the **C18: Consumer Discharge: Add/ Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **P** (Permanent) in the TYPE OF DISCHARGE field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete an individual's permanent discharge.

On the **C18: Consumer Discharge: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Consumer Discharge (C18): Add (Temporary)

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of discharge and type of entry.

On the **C18: Consumer Discharge: Add/ Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **T** (Temporary) in the TYPE OF DISCHARGE field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Enter an individual's temporary discharge.

On the **C18: Consumer Discharge: Add** screen:

- Type the name of the provider representative in the PROVIDER REPRESENTATIVE NAME field.
- Type the discharge begin date in the DISCHARGE BEGIN DATE field.
- Type the projected return date in the PROJECTED RETURN DATE field.
- Type **Y** (Yes) or **N** (No) in the DID CONSUMER RECEIVE SERVICES ON DISCHARGE BEGIN DATE? field.

Note: 24-hour services *cannot* be billed on the Discharge Date.

- Type the reason for temporary discharge in the TERMINATION REASON field.
- Type **Y** in the READY TO ADD? field to submit the data to the system.
- Press **Enter**.

Consumer Discharge (C18): Change (Temporary)

The change function is used to change an individual's temporary discharge *and* to end a temporary discharge.

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of discharge and type of entry.

On the **C18: Consumer Discharge: Add/ Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **T** (Temporary) in the TYPE OF DISCHARGE field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change *or* end an individual's temporary discharge.

On the **C18: Consumer Discharge: Change** screen:

- Type changes to the discharge information in the appropriate fields.

Note: If the individual is ending his/her temporary discharge, type the end date in the END DATE field.

- Type **Y** in the READY TO CHANGE? field to submit the data to the system.
- Press **Enter**.

Consumer Discharge (C18): Delete (Temporary)

Step 1 – Access the Consumer Discharge option.

- Type **C18** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate the type of discharge and the type of entry.

On the **C18: Consumer Discharge: Add/ Change/Delete** header screen:

- Type the requested identifying information in the appropriate fields.

Rule: You must enter the Client ID, the local case number, *or* the Medicaid number.

- Type **T** (Temporary) in the TYPE OF DISCHARGE field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete an individual's temporary discharge.

On the **C18: Consumer Discharge: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Critical Incident Data (686): Add

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Enter critical incident data for a specified reporting month.

On the **686: Critical Incident Data: Add** screen:

- Type the contract number in the CONTRACT NUMBER field, if the contract for which you are entering data is other than the one entered on the header screen.
- Type the number of medication errors during the report month for every person served in your contract in the MEDICATION ERRORS field.
- Type the number of serious injuries during the report month for every person served in your contract in the SERIOUS INJURIES field.
- Type the number of behavior intervention plans authorizing personal, mechanical, or psychoactive medication restraint during the report month in the BEHAVIOR INTERVENTION PLANS AUTHORIZING RESTRAINT field.

Number Of Emergency Restraints Used

- Type the total number of emergency restraints used by category during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields.

Number Of Individuals Requiring Emergency Restraint

- Type the total number of individuals requiring emergency restraint during the report month in the PERSONAL RESTRAINTS, MECHANICAL RESTRAINTS, and PSYCHOACTIVE MEDICATION TOTAL fields.

Number Of Restraint Related Injuries

- Type the total number of restraint related injuries during the report month in the EMERGENCY PERSONAL RESTRAINTS, EMERGENCY MECHANICAL RESTRAINTS, and EMERGENCY PSYCHOACTIVE MEDICATION TOTAL fields.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Result: The screen is redisplayed with cleared fields to allow for the entry of data for additional contracts, and the message, *"Previous Information Added"* is displayed.

- Repeat this step for all contracts.
  - When all contracts have been entered, type **N** in the READY TO ADD? field and press **Enter** to return to the header screen.

Critical Incident Data (686): Change

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change critical incident data that has been entered incorrectly.

On the **686: Critical Incident Data: Change** screen:

- Type changes to the critical incident data in the appropriate fields.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Critical Incident Data (686): Delete

Step 1 – Access the Critical Incident Data option.

- Type **686** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the report month and type of entry.

On the **686: Critical Incident Data: Add/ Change/ Delete** header screen:

- Type the month and year being reported in the MONTH AND YEAR (MMYYYY) field.
- Type the contract number in the CONTRACT NUMBER field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete critical incident data that has been entered in error.

On the **686: Critical Incident Data: Delete** screen:

- Type **Y** in the READY TO DELETE? field.
- Press **Enter**.

Provider Staff Entry (C13): Add

Note: Providers define their own staff ID numbers. The numbers can be alpha, numeric, or alphanumeric and up to five characters in length.

Step 1 – Access the Provider Staff Entry option.

- Type **C13** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the staff member and indicate the type of entry.

On the **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen:

- Type the staff member's identification number in the STAFF ID field.
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Add information on a staff member who provides services to individuals.

On the **C13: Provider Staff Entry: Add** screen:

- Type the date the staff member began providing services at your program in the STAFF BEGIN DATE field.
- Type the date of the last day the staff member provided services in the END DATE field. This field can be left blank.
- Type the last name of the service provider in the LAST NAME field.
- Type the suffix, if any, of the service provider in the SUF field.
- Type the first name of the service provider in the FIRST NAME field.
- Type the middle initial of the service provider, if available, in the MIDDLE INITIAL field.
- Type **Y** in the READY TO ADD? field to submit the data to the system.
- Press **Enter**.

Provider Staff Entry (C13): Change

If a staff member leaves employment in the program, this function is used to enter the staff member's last date of employment.

Step 1 – Access the Provider Staff Entry option.

- Type **C13** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the staff member and indicate the type of entry.

On the **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen:

- Type the staff member's identification number in the STAFF ID field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Change information about a staff member.

On the **C13: Provider Staff Entry: Change** screen:

- Type the date the staff member began providing services at your program in the STAFF BEGIN DATE field.
- Type the date of the last day the staff member provided services in the END DATE field.
- Type the last name of the service provider in the LAST NAME field.
- Type the suffix, if any, of the service provider in the SUF field.
- Type the first name of the service provider in the FIRST NAME field.
- Type the middle initial of the service provider, if available, in the MIDDLE INITIAL field.
- Type **Y** in the READY TO CHANGE? field to submit the data to the system.
- Press **Enter**.

Provider Staff Entry (C13): Delete

The *Delete* function is used if a staff member record was entered in error. A staff member record *cannot* be deleted if that staff member's ID was used on the Service Delivery screen (**C22**).

Step 1 – Access the Provider Staff Entry option.

- Type **C13** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the staff member and indicate the type of entry.

On the **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen:

- Type the staff member's identification number in the STAFF ID field.
- Type **D** (Delete) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Delete information about a staff member.

On the **C13: Provider Staff Entry: Delete** screen:

- Type **Y** in the READY TO DELETE? field to submit the data to the system.
- Press **Enter**.

Provider Staff Entry (C13): Reactivate

Step 1 – Access the Provider Staff Entry option.

- Type **C13** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the staff member and indicate the type of entry.

On the **C13: Provider Staff Entry: Add/Change/Delete/Reactivate** header screen:

- Type the staff member's identification number in the STAFF ID field.
- Type **R** (Reactivate) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Reactivate a staff member record that was previously ended.

On the **C13: Provider Staff Entry: Reactivate** screen:

- Type the date the staff member began providing services at your program in the STAFF BEGIN DATE field.
- Type the date of the last day the staff member provided services in the END DATE field. This field can be left blank.
- Type the last name of the service provider in the LAST NAME field.
- Type the suffix, if any, of the service provider in the SUF field.
- Type the first name of the service provider in the FIRST NAME field.
- Type the middle initial of the service provider, if available, in the MIDDLE INITIAL field.
- Type **Y** in the READY TO REACTIVATE? field to submit the data to the system.
- Press **Enter**.

Provider/Contract Update (C14): Provider Physical Address

Step 1 – Access the Provider/Contract Update option.

- Type **C14** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Indicate the address type.

On the **C14: Provider/Contract Update** header screen:

- Type **1** (Provider Physical) in the ADDRESS TYPE field.
- Press **Enter**.

Step 3 – Update the provider's physical address information.

On the **C14: Provider/Contract Update** screen:

- Type update information in the appropriate **Provider Physical Address Update** fields.

Note: The physical address, street, city, state, zip code, and email address information can be updated on this screen.

- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Provider/Contract Update (C14): Provider Mailing Address

Step 1 – Access the Provider/Contract Update option.

- Type **C14** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Indicate the address type.

On the **C14: Provider/Contract Update** header screen:

- Type **2** (Provider Mailing) in the ADDRESS TYPE field.
- Press **Enter**.

Step 3 – Update the provider's mailing address information.

On the **C14: Provider/Contract Update** screen:

- Type update information in the appropriate **Provider Mailing Address Update** fields.
- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Provider/Contract Update (C14): Provider Billing Address

Step 1 – Access the Provider/Contract Update option.

- Type **C14** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Indicate the address type.

On the **C14: Provider/Contract Update** header screen:

- Type **3** (Provider Billing) in the ADDRESS TYPE field.
- Press **Enter**.

Step 3 – Update the provider's billing address information.

On the **C14: Provider/Contract Update** screen:

- Type update information in the appropriate **Provider Billing Address Update** fields.
- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Provider/Contract Update (C14): Contract Physical Address

This procedure is also used to update Program Contact information.

Step 1 – Access the Provider/Contract Update option.

- Type **C14** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Indicate the address type and contract number.

On the **C14: Provider/Contract Update** header screen:

- Type **4** (Contract Physical) in the ADDRESS TYPE field.
- Type the contract number in the FOR ADDRESS TYPE 4, 5, 6 OR 7 ENTER CONTRACT NUMBER field.
- Press **Enter**.

Step 3 – Update the contract physical address information.

On the **C14: Provider/Contract Update** screen:

- Type update information in the appropriate **Contract Physical Address Update** fields.

Note: The program contact name, telephone, and fax number information as well as the physical address, street, city, state, and zip code information can be updated on this screen.

- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Provider/Contract Update (C14): Contract Mailing Address

Step 1 – Access the Provider/Contract Update option.

- Type **C14** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Indicate the address type and contract number.

On the **C14: Provider/Contract Update** header screen:

- Type **5** (Contract Mailing) in the ADDRESS TYPE field.
- Type the contract number in the FOR ADDRESS TYPE 4, 5, 6 OR 7 ENTER CONTRACT NUMBER field.
- Press **Enter**.

Step 3 – Update the contract mailing address information.

On the **C14: Provider/Contract Update** screen:

- Type update information in the appropriate **Contract Mailing Address Update** fields.

Note: The mailing address, street, city, state, and zip code information can be updated on this screen.

- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Provider/Contract Update (C14): Applicant Contact Physical Address

Step 1 – Access the Provider/Contract Update option.

- Type **C14** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Indicate the address type and contract number.

On the **C14: Provider/Contract Update** header screen:

- Type **6** (Applicant Contact Physical) in the ADDRESS TYPE field.
- Type the contract number in the FOR ADDRESS TYPE 4, 5, 6 OR 7ENTER CONTRACT NUMBER field.
- Type the MRA Code in the FOR ADDRESS TYPE 6 OR 7 ENTER MRA CODE field.

Note: This field is *optional*. If you enter the MRA Code, the code must be valid and the correct MRA for the contract number entered. If you do *not* enter the MRA Code, an informational message is displayed that you are updating the default applicant contact for the contract and not an MRA-specific applicant contact.

- Press **Enter**.

Step 3 – Update the applicant contact physical address information.

On the **C14: Provider/Contract Update** screen:

- Type update information in the appropriate **Applicant Contact Physical Address Update** fields.

Note: The applicant contact name, phone, fax, physical address, street, city, state, zip code, and e-mail address information can be updated on this screen.

- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

Provider/Contract Update (C14): Applicant Contact Mailing Address

Step 1 – Access the Provider/Contract Update option.

- Type **C14** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Indicate the address type and contract number.

On the **C14: Provider/Contract Update** header screen:

Your component code is displayed based on your logon account number.

- Type **7** (Applicant Contact Mailing) in the ADDRESS TYPE field.
- Type the contract number in the FOR ADDRESS TYPE 4, 5, 6 OR 7ENTER CONTRACT NUMBER field.
- Type the MRA Code in the FOR ADDRESS TYPE 6 OR 7 ENTER MRA CODE field.

Note: This field is *optional*. If you enter the MRA Code, the code must be valid and the correct MRA for the contract number entered. If you do *not* enter the MRA Code, an informational message is displayed that you are updating the default applicant contact for the contract and not an MRA-specific applicant contact.

- Press **Enter**.

Step 3 – Update the applicant contact mailing address information.

On the **C14: Provider/Contract Update** screen:

- Type update information in the appropriate **Applicant Contact Mailing Address Update** fields.

Note: The mailing address, street, city, state, and zip code information can be updated on this screen.

- Type **Y** in the READY TO UPDATE? field to submit the data to the system.
- Press **Enter**.

C22: Service Delivery: Add
C28: Actual Units of Service: Add

The provider has 95 days from the end of the month of service to enter claims information into **C22**.

Step 1 – Access the Service Delivery option.
- Type **C22** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the individual and indicate service information and type of entry.

On the **C22: Service Delivery: Add/Change** header screen:
- Type the client ID in the CLIENT ID field, *or*
- Type the local case number in the LOCAL CASE NUMBER field.

*For all services **except** AA (Adaptive Aids), MHM (Minor Home Modifications), and DE (Dental Services)*:
- Type the national provider ID in the NPI field.
- Type the Procedure Qualifier code in the QUALIFIER field.
- Type the HCPCS/CPT® code in the SERVICE CODE field.
- Type the modifier (if required) in the MODIFIER field.

Note: The MODIFIER field has been changed to allow entry for the modifier code for TxHmL CDS Nursing Services Specialized – LVN and TxHmL CDS Nursing Services Specialized – RN. The modifier codes for these services are TG/UC and they **must be entered in that order**. The system will reject any other combination. If a modifier is used for any other category, you must type the modifier in the first field and leave the second field blank.
- Type the place where the service was provided in the PLACE OF SERVICE field.
- Type the revenue code in the REVENUE CODE field.
- Type the date services were provided in the SERVICE DATE field.
- Type the staff ID (if required) in the STAFF ID field.

Note 1: See the Bill Code Crosswalk document at **http://www.dads.state.tx.us/providers/hipaa/billcodes/index.html** for the entry of the QUALIFIER, SERVICE CODE, MODIFIER, PLACE OF SERVICE, and REVENUE CODE fields and to determine the services that require a Staff ID for the STAFF ID field.

Note 2: Support Consultation Services (SCV) will not be entered in the **C22: Service Delivery** screen.

Step 2, continued

For AA/MHM/DE service entry:
- Type the authorization number in the AUTHORIZATION NUMBER field.

Note: Use **C77: Reimbursement Authorization Inquiry** to verify status and obtain a Reimbursement Authorization Tracking Number. Only *Reimbursement Authorization Numbers with approved* status can be used as an authorization number on this screen.

*For **all** services:*
- Type **A** (Add) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 3 – Add billing information.

On the **C22: Service Delivery: Add** screen:
- Type information in the appropriate fields. The BILL UNITS fields allow you to enter the units of service provided.
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

Result: A message screen displays the **Client ID**, **ICN**, and **Line Numbers**.

Step 4 – The message screen.

On the message screen:
- Press **Enter**.

If…	Then…
the service is ***not*** self-directed	The **C22: Service Delivery** header screen is displayed with the message, *"Previous Information Added."*
the service ***is self-directed and not Financial Management (FMSV)***	The **C28: Actual Units of Service: Add** screen is displayed. *Continue with Step 5*.

Step 5 – Add actual units of service.

On the **C28: Actual Units of Service: Add** screen:
- Type the actual units of service provided in the ACTUAL UNITS field.
- Type the employer cost allocation units in the EMP ALLOC field.

  Note: The employer cost allocation codes are:
  1 = Indirect cost only (one actual unit must equal 0)
  2 = Indirect + direct cost (actual units must be greater than 0)
  3 = Direct cost only (actual units must be greater than 0)
- Type **Y** in the READY TO ADD? field.
- Press **Enter**.

The provider has 95 days from the end of the month of service to enter claims information into **C22**.

C22: Service Delivery: Change
C28: Actual Units of Service: Change

Step 1 – Obtain the ICN and Line Number.

- Access **C89: Claims Inquiry** to obtain the ICN and Line Number. See *C89: Claims Inquiry*.

Step 2 – Access the Service Delivery option.

- Type **C22** in the ACT: field of any screen.
- Press **Enter**.

Step 3 – Identify the individual and indicate service information and type of entry.

On the **C22: Service Delivery: Add/Change** header screen:

- Type the client ID in the CLIENT ID field, *or*
- Type the local case number in the LOCAL CASE NUMBER field.
- Type the internal control number in the ICN field.
- Type the line number in the LINE NO field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 4 – Change billing information.

On the **C22: Service Delivery: Change** screen:

- Type corrections for units of service errors.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Result: A message screen displays the **Client ID**, **ICN**, and **Line Numbers**.

Note: For corrections to POS (Place of Service) errors, units must be changed to **00.00** and services re-entered using the correct POS code.

Step 5 – The message screen.

On the message screen.

If…	Then…
the service is ***not*** self-directed	The **C22: Service Delivery** header screen is displayed with the message, *"Previous Information Changed."*
the service ***is self-directed***	The **C28: Actual Units of Service: Add** screen is displayed. *Continue with Step 6.*

Step 6 – Add actual units of service.

On the **C28: Actual Units of Service: Change** screen:

- Type corrections to the actual units of service provided in the ACTUAL UNITS field.
- Type corrections to the employer cost allocation units in the EMP ALLOC field.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Service Delivery (C22/C28) – How to Delete

This procedure is used if the service delivery entered was entered in error and the service was not actually delivered.

Step 1 – Access C89: Claims Inquiry to obtain the ICN and Line Number.

Step 2 – Access the Service Delivery option.

- Type **C22** in the ACT: field of any screen.
- Press **Enter**.

Step 3 – Identify the individual and indicate service information and type of entry.

On the **C22: Service Delivery: Add/Change** header screen:

- Type the client ID in the CLIENT ID field, *or*
- Type the local case number in the LOCAL CASE NUMBER field.
- Type the internal control number in the ICN field.
- Type the line number in the LINE NO field.
- Type **C** (Change) in the TYPE OF ENTRY field.
- Press **Enter**.

Step 4 – Delete service delivery information.

On the **C22: Service Delivery: Change** screen:

- Type **00.00** in the UNITS field.
- Type **Y** in the READY TO CHANGE? field.
- Press **Enter**.

Repeat the steps in this procedure for each day of services that you want to delete.

C89: Claims Inquiry

Note: Using **C89: Claims Inquiry** allows the provider to view billing-related items *and* obtain the ICN and line number necessary for entry on the **C22: Service Delivery** screen.

Step 1 – Access the Claims Inquiry option.

- Type **C89** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the inquiry.

On the **C89: Claims Inquiry** header screen:

- If you want to limit the results of your inquiry, type the requested information in the appropriate fields.

Note: The MODIFIER field has been changed to allow entry for the modifier code for TxHmL CDS Nursing Services Specialized – LVN and TxHmL CDS Nursing Services Specialized – RN. The modifier codes for these services are TG/UC and they **must be entered in that order**. The system will reject any other combination. If a modifier is used for any other category, you must type the modifier in the first field and leave the second field blank.

- If you want a hard copy of the inquiry results, type your printer code in the PRINTER CODE field.
- Press **Enter**.

Step 3 – View the inquiry results.

Data displayed for each claim includes:

- Name
- Medicaid Number
- Billable Units
- Billable Amount
- Service Date
- Service Category/HCPCS/CPT Code/POS Code
- ICN/Line Number/Status
- Contract Number
- Staff ID (if used)
- Authorization Number (for AA, MHM, and DE only)

C75: Prior Approval Inquiry
Adaptive Aids/Minor Home Modifications/Dental

Using **C75: Prior Approval Inquiry** allows the provider to view/verify the status of a prior approval submission for Adaptive Aids, Minor Home Modifications, and Dental services *and* obtain the PA (prior approval) Tracking Number necessary for reimbursement.

Step 1 – Access the Prior Approval option.

- Type **C75** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the inquiry.

On the **C75: Prior Approval Inquiry** header screen:

- If you want to limit the results of your inquiry, type the requested information in the appropriate fields.
- If you want to view contact information for Central Office staff who reviewed your PA packet, type **Y** (Yes) in the CONTACT INFO field.
- If you want to view comments made by your reviewer concerning your packet, type **Y** (Yes) in the VIEW COMMENTS field.
- If you want a hard copy of the inquiry results, type your printer code in the PRINTER CODE field.
- Press **Enter**.

Step 3 – View the inquiry results.

Data displayed for each claim includes:

- Name
- Local Case Number
- Authorization Date
- Service Category
- Service Code (Local)
- Authorization Amount
- Status
- PA Tracking Number
- Denied/Pending Messages
- Contact Information (if requested)
- Comments (if requested)
- Reimbursement Authorization information (if available)

Note: Use PA Tracking Numbers with an "approved" status to submit for reimbursement authorization on the 4116A form.

C77: Reimbursement Authorization Inquiry
Adaptive Aids/Minor Home Modifications/Dental

Using **C77: Reimbursement Authorization Inquiry** allows the provider to view/verify the status of a reimbursement authorization submission for Adaptive Aids, Minor Home Modifications, and Dental services *and* obtain the Reimbursement Authorization Tracking Number necessary for entry on the **C22: Service Delivery** screen.

Step 1 – Access the Reimbursement Authorization option.

- Type **C77** in the ACT: field of any screen.
- Press **Enter**.

Step 2 – Identify the inquiry.

On the **C77: Reimbursement Authorization Inquiry** header screen:

- If you want to limit the results of your inquiry, type the requested information in the appropriate fields.
- If you want to view contact information for Central Office staff who reviewed your 4116A, type **Y** (Yes) in the CONTACT INFO field.
- If you want to view comments made by your reviewer concerning your 4116A, type **Y** (Yes) in the VIEW COMMENTS field.
- If you want a hard copy of the inquiry results, type your printer code in the PRINTER CODE field.
- Press **Enter**.

Step 3 – View the inquiry results.

Data displayed for each claim includes:

- Name
- Local Case Number
- Service Date
- Service Category
- Service Code
- Authorization Amount
- Status

Note: A status of **Approved** on this screen means that you can take the Tracking/Authorization Number to the **C22: Service Delivery** screen and file the claim for payment.

- Tracking/Authorization Number
- Denial Messages (if STATUS is Denied)
- Contact Information (if requested)
- Comments (if requested)

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