

State of Ohio
MACSIS SYSTEM POLICY

Policy: HIPAA Claims EDI File Testing and Approval **Last Revised Date:** 6/16/2011

Purpose:

This document outlines the methodology and policies related to the testing and approval of electronic claim files from providers or clearinghouses for the purpose of submitting claim files in a production MACSIS environment. There are four sets of constituents who have responsibilities during the testing phase:

- Providers
- Clearinghouses (Value-Added-Networks or VANs)
- County Boards or Board Consortiums
- MACSIS Operations Management Staff (MOM)

Required Reading:

There are three minimum sets of documents all parties should read and understand before beginning the MACSIS claims testing process. They include:

- National Standard HIPAA EDI Implementation Guides for 837P and 835 Files – Copies can be downloaded from the Washington Publishing Company website (www.wpc-edi.com). Please be sure to download the 837 Professional, not Institutional, Claims Format (Version 5010) and related addenda.
- MACSIS HIPAA EDI Documents – There are several MACSIS-specific documents available to guide providers and boards regarding the requirements to successfully adjudicate claims in MACSIS under HIPAA. These documents are available at <http://www.mh.state.oh.us/ois/macsis/mac.claims.index.html> and should be thoroughly reviewed prior to test file creation.
- WEDI's Strategic National Implementation Planning (SNIP) Committee's "Transaction Compliance and Certification" White Paper - This is a document created by a sub-committee of the Workgroup For Electronic Data Interchange (WEDI). It explains and recommends the types of testing which should be done prior to approval of data for production submission. This MACSIS policy has been designed to adhere to the recommendations of the white paper, which can be retrieved via www.wedi.org/snip/public/articles/testing_whitepaper082602.pdf .

Constituent Responsibilities:

I. Providers

A. Approval Policy

Each provider who intends to bill for services under MACSIS will be required to submit test 837P files for approval prior to being granted permission to submit production claims.

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Note: Each provider must be approved at the “MACSIS UPI” level, not just at the “MACSIS Vendor” level. If a clearinghouse or main provider office creates the billing file for multiple UPI’s from the same system and location, then it is still required that the clearinghouse or provider submit one UPI per Test File. This is so each UPI’s structure can be thoroughly evaluated. (Note: Loop 2010AA and 2010AB can still be different within the file.) Once approved, then the clearinghouse or provider would submit a “combined” test file (i.e., all UPI’s submitting to the same BOARD as expected in Production) to ensure the proper combined structure is in place. Please note that a clearinghouse and/or provider must create separate billing files for UPI’s sent to different boards.

If a provider chooses to use a clearinghouse, it is the provider’s responsibility, not the State or County Board, to resolve any issues, bugs, problems identified with the files during the testing phase, as well as issues, which might occur in the production environment.

The final Testing Request Form returned to the provider will indicate if they have approval to submit claims in the production environment.

Providers are required to be re-approved through file testing, if they change software vendors and/or apply a significant upgrade to their existing system. Although not required, it is recommended that testing be re-done if there is a significant change in the provider’s benefit or contract (i.e., pricing, etc.) structure in MACSIS.

B. Pre-Testing Requirements

As noted in the White Paper mentioned above (see Required Reading), SNIP recommends covered entities perform up to seven different types of tests on a file to ensure HIPAA transaction compliance. These “types” as noted in the White Paper can be reviewed independent of one another and do not necessarily need to be conducted in any specific order.

Providers should pre-test types 1-7 for their ASC X12N 837 Version 5010 Professional Claim Files ***prior to submitting files to their main contracting board to begin the MACSIS testing process.*** This includes testing for basic HIPAA-compliant form, structure and syntax requirements at a minimum. In addition, the ASC X12N 837 Version 5010 MACSIS Specifications are <http://mentalhealth.ohio.gov/assets/macsis/claims/837-professional-claim-guide-v5010.pdf>.

Please note it is recommended per SNIP as well as MACSIS that providers use real data to the extent possible to complete testing; however, if test data is used, the provider should at a minimum ensure the same system parameters, product type and software versions are used to create the test data as established in ***the agency’s*** current production environment.

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C. Submitting Test Files To Board for MACSIS Testing and Approval

Once pre-testing is completed, providers will need to prepare their first test file for submission to their main contracting board to begin the MACSIS Testing and Approval Process. (See “Submitting Test HIPAA Claim EDI Files for Approval” <http://www.mh.state.oh.us/ois/macsis/claims/procedure.submit.macsis.hipaa.edi.claim.file.pdf>) for more information about the procedure for submitting test files.) Initial test files should include the following:

- The volume of claims representative of a typical production file submission for that agency up to a maximum of 500 claims in the file. All funded procedure codes are represented
- Real client data
- Provider Tax-ID information as stored in MACSIS exactly matches the information included on the 837P file. Since Tax-ID is private information, MACSIS-stored Tax-ID information is not available via the web. Providers must contact their Board to verify that the Tax-ID in MACSIS is correct.
- The test file name should comply with the file naming conventions as outlined in the Guidelines Pertaining to MACSIS, HIPAA EDI Policies and Procedures, Sections 42A and 43B. Please note that test files should begin with the character “X” instead of “A”, so they can easily be distinguished.
- Although not required, it is highly recommended that the provider’s address as stored in MACSIS match what the provider intends to submit on the 837P file both for Billing Provider information (Loop 2010AA) and the Pay-To Provider information (Loop 2010AB) if applicable.

When submitting test files to the board, providers must initiate the “MACSIS Claims EDI Testing Request Form”

(<http://www.mh.state.oh.us/ois/macsis/claims/tier1.test.form.rev.pdf>). In an effort to identify common problems across software vendors, providers will be asked to provide information about the software used to create the file on this form. They will be given the opportunity to request a return 835 Health Care Claim Payment/Advice file as a part of the testing process via this form.

II. Clearinghouses

Clearinghouses will be responsible for ensuring their contracting provider’s outbound claim files (i.e., ASC X12N 837P Version 5010 Files) have successfully passed the testing requirements as noted above. They will also be responsible for ensuring policies and procedures related to the transmission of test or real claim files are adhered to. Policies and/or procedures related to the access of or exchange of EDI data between a clearinghouse, provider and board should be clearly outlined in any trading partner agreements between the provider and board and/or provider and clearinghouse.

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III. County Boards or Board Consortiums

County Boards or Board Consortiums will be responsible for the following:

- Instructing their contracting providers on how to submit files for the purposes of testing to their attention
- Verifying the test file naming convention used is accurate
- Following the appropriate procedure to transfer the test files to the State to begin the testing process
- Completing the MACSIS EDI Claims Testing Request Form and fax to the State
- Verifying test files comply with HIPAA-mandated and MACSIS-specific EDI requirements
- Evaluating Error Reports resulting from testing to ensure valid codes are being submitted, pricing and adjudication decisions are accurate, all PROCP records exist and that benefit rules are functioning as planned.
- Updating the Diamond Support Tables within the board's control to correct errors resulting from Diamond "build" issues.
- Receiving and communicating results from the test process to the provider. This includes answering questions about format and value requirements under HIPAA. If the board is unsure of an answer, the Board, not the provider, should contact the MACSIS Support Desk for clarification.
- Monitoring and encouraging their contracting providers to begin the testing process if they have not already done so
- Training and maintaining staff knowledge of the EDI format and value requirements, testing policies, procedures, FTP and Unix Commands necessary for testing
- Submitting HIPAA Service Rate Forms when rates are requested to be tested
- Initiating Medicaid Contract Agreements or Amendments per ODMH and/or ODADAS Medicaid Policy.
- Maintaining Non-Medicaid rates in MACSIS.

IV. MACSIS Operations Management

The MACSIS Operations Management Staff (MOM) will be responsible for the following:

- Providing and maintaining the appropriate test sub-directories for board use
- Supporting "testing" programs used by MOM
- Maintaining Test Environments
- Completing the MACSIS Testing and Approval Process (see below)
- Communicating results to the boards
- Disbursing any related MACSIS reports to the boards
- Final approval of the provider for production submission

V. Cross-Constituent Shared Responsibilities:

All constituents will be responsible for:

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- Ensuring all transmitted data sent for testing purposes adheres to the HIPAA Privacy requirements with respect to the confidentiality of patient identifiable information. All precautions should be made to eliminate the possibility that patient information be exposed.
- In keeping with the above policy, no testing files should be emailed as attachments to the Boards.

MACSIS Testing and Approval Methodology:

MACSIS will be utilizing a test form to test 837P v5010A1.

I. File Testing – Production Simulation Testing

This testing will compare the test file to a copy of the MACSIS production environment to simulate as close as possible how claims will be processed in a live environment. This will compare the data in the Diamond environment to the data submitted in the file and issues such as discrepancies in Tax-ID and/or provider addresses will become apparent.

All files must be created by the provider's software and no manual (or other) corrections or adjustments should be performed (by Provider, Board, or State staff). Every effort should be made to emulate standard operating procedures.

- Exception: If a provider and/or clearinghouse plans to submit production 837P claim files with more than one UPI number represented on the file, they should initially submit test files containing just one UPI per file. Once the test files are approved on a per-UPI basis, then a final combined test file (i.e., multiple UPIs) will be necessary to ensure the proper "combined" structure is in place.

The primary goal is to ensure that the provider software has created a standard, MACSIS-compliant ANSI X12 837P 5010 file; that provider contracts are in place (in the HIPAA compliant Diamond 725 database) and accurate for all lines of business and panels; that PROCP (procedure code pricing) records exists for all contracted services; G/L (general ledger) references are present and correct; and that all procedures that are expected to result in claims being denied or held as specified in the benefit rules are applied as intended.

The testing file should be large enough to approximate at least one-week worth of data (up to 500 claims) with all possible funded procedure codes from the provider..

Clients for whom claims are submitted must have member records in the HIPAA-compliant Diamond 725 Production database. All claims-related tables must be present in the HIPAA-compliant Production database. When this level of testing is to be performed, MOM will create an exact copy of the production database and perform the new HIPAA-compliant EDI process.

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Providers will have the option to request a simulated 835 Health Care Claim Payment/Advice file in return, if the final test file is processed successfully into the MACSIS test environment.

II. Test File Rejection

Test files submitted by providers via their boards may be rejected for the following reasons:

- HIPAA-mandated and/or ASC X12N requirements are not met
- MACSIS-specific billing requirements are not met, including having one claim loop per service loop or invalid tax ID submitted
- Fatal errors occur on the MACSIS Edit Reports
- Less than 90% of the claims pass MACSIS edits
- Duplicate claims contained on the file violate the Duplicate Claim Check Policy under HIPAA.