

Ohio Department of Mental Health  
MACSIS SYSTEM PROCEDURE

**Procedure:** Submitting Test Claim EDI Files For Approval

**Last Revised Date:** 11/17/2011

**Purpose:**

This procedure outlines how test claim files should be submitted for MACSIS approval using the HIPAA-mandated format (837 Professional Claims Format, Version 5010A1). This procedure indicates where files should be sent, any corresponding forms needed and how errors or approval will be communicated to the Board and subsequently Provider.

**Related Policies**

[Guidelines Pertaining to MACSIS under HIPAA](#)<sup>1</sup> – Topics 40-45 denote the Electronic Data Interchange (EDI) standards for MACSIS. Topic 41(B) “Becoming a Business Associate/Trading Partner” outlines the specific EDI testing policy associated with this procedure.

**Provider Procedures:**

1. Providers should thoroughly review Topics 40-45 of the Guidelines Pertaining to MACSIS under HIPAA prior to submitting test claim files.
  - Topic 41(B) “Becoming a Business Associate/Trading Partner” in the Guidelines Pertaining to MACSIS under HIPAA relates specifically to MACSIS EDI testing policy. This guideline will outline under what circumstances Providers are required to submit test files, any pre-testing requirements, and what types of claim scenarios must be included in each test file.
2. The Provider should make sure they have supplied the required Medicaid Uniform Cost Report and Rate Sheet(s) information to the ODMH and/or ODADAS Medicaid Policy staff prior to beginning EDI testing.
3. The Provider should discuss with their local contracting Board how they expect to receive and/or be notified of test file submissions. This procedure will vary by Board depending on the file transfer arrangements they have made for their Providers.
4. When ready to submit a test file, the Provider should ensure that the test file is appropriately named as follows:
  - **For 837P v5010 files containing NPI:** Txxxxxx#.julyy (ex., T0010431.31411), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.
5. When the Provider submits the test file, it must include the following;
  - One file test request per email.
  - Due to the volume anticipated, please send no more than 500 claims in one file.
6. Upon submission of the test file, the Provider should notify their Board that the test file is available per Board procedure.

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<sup>1</sup> Please note that the Guidelines Pertaining to MACSIS Under HIPAA are currently in the process of being revised.

### **Provider Procedure After Final Approval:**

1. If approved prior to 12/12/11, Providers should continue to submit claim files using the 4010 format through 12/11/11. On 12/12/11, those Providers must start submitting production claim files using the 5010 format. All Providers approved on or after 12/12/11 must start submitting production 837P claim files using the 5010 format the day after the approval.
2. Providers should submit production 837P claim files using the following naming conventions:
  - **For 837P v5010 files containing NPI:** Wxxxxxx#.julyy (ex., W0010431.31411), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.

### **Board Procedure For Test Files:**

1. Once a test file is received by the Board, the Board should, at a minimum, verify the file follows the appropriate test file naming convention as noted under the Provider procedures.
  - Boards have the option and are encouraged to verify test files pass additional requirements by verifying HIPAA form, structure and syntax compliance as well as checking for the MACSIS-specific requirements outlined in the Guidelines Pertaining to MACSIS under HIPAA. If errors are found, the Board can communicate the errors to the Provider prior to any involvement by the MACSIS staff, however, Boards are not encouraged to actually change the Provider file before submitting it onto the MACSIS staff.
  - If the Provider or the Board would like rates checked in MACSIS, the Board should complete the HIPAA Service Rate Forms(s) pertaining to the State Fiscal Year being tested for the Departments under which the Provider will be submitting claims ([ODMH](#) and/or [ODADAS](#))
    - ◆ Boards should make sure they have entered/updated the Provider's Non-Medicaid rates and contracts in MACSIS and/or the Provider has supplied the required Medicaid Uniform Cost Report and Rate Sheet(s) to the Medicaid Policy staff before beginning testing.
2. The Board should FTP the file to the MACSIS mhub server to the /county/<Board designation>/hipaa/test/ subdirectory. The Board should then complete the [MACSIS EDI Claims Testing Form](#) and email it along with the HIPAA Service Rate Form(s) if rates are being checked to [macsistesting@mh.state.oh.us](mailto:macsistesting@mh.state.oh.us).
  - It is very important for the Boards to complete all requested information on the HIPAA Service Rate (if they are being checked) and EDI Claims Test forms and to submit them at the same time the test file is made available.
  - It is important to check the correct box in the Type of Test section according to the type of file being submitted, otherwise there is a risk the file could be rejected based on the incorrect information being submitted on the form.
  - The email subject line needs to include the test file name.
3. Once received, the MACSIS staff will make sure the test environment is a current copy of Production and will run the test file through the Claims EDI process in the test environment.
  - Due to the number of test files being submitted at one time, existing Provider test files will only be verified whether the file was accepted by Diamond. For new Providers, and those that request additional testing, the MACSIS staff will review the PREDI-Edit and Post reports to determine why records created critical and noncritical errors, why warnings were created, if the procedures priced as expected, and if all benefit rules were applied appropriately.
4. If the file meets the acceptance criteria as determined per the policy, the Provider will be approved for submission to Production. A copy of the final Testing Request Form will then be emailed back to the Board indicating the Provider has been approved for production claim submission.

- If the file does not pass the acceptance criteria due to problems with the source file, the Board should contact the Provider, who will need to correct their file creation program and resubmit a new file beginning with step 1.
- If the file does not pass the acceptance criteria due to problems with the Diamond benefit, contract and pricing tables, the Board will need to follow appropriate change control procedures to correct the Diamond tables. Changes to PANEL, PLAN, BENEF, and BRULE records should be submitted to the [MACSIS Support Desk](#). The Board should then submit a new test form (when ready) to request the process begin starting at step 3.
  - ◆ The Board is responsible for changes to the PROVC or PROCP records pertaining to the Provider's non-Medicaid agreement.
  - ◆ If changes need to be made to either Medicaid Provider contracts or Medicaid PROCP records, the Provider must contact Debbie Downs to make the needed updates before proceeding.
- If the Board has not received communication regarding the status of a test file after three business days, please contact the [MACSIS Support Desk](#).