MACSIS – MULTI-AGENCY COMMUNITY SERVICE INFORMATION SYSTEM

Board Operations Manual

HIPAA Claims Section

(08/07/06 Version 3.0)

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I. Introduction to HIPAA Claims Processing

This documentation is intended to guide the User through the various phases involved with processing claims in the MACSIS HIPAA[1] billing/payment system. In most cases this is done through the EDI (electronic data interchange) process. Claims may be entered into Diamond (MHHIPAA) manually, but the EDI process is the standard way for providers to submit claims through their local boards. The EDI process is an interactive process between the providers, boards and State staff (MOM team).

This manual will walk you through the various stages and processes involved in the submission and adjudication of claims. If you still have questions after reviewing this document and appendices, please contact MACSIS Support at 1-877-462-2747 or e-mail MACSIS Support at MacsisSupport@mh.state.oh.us.

II. Policies/Procedures Needed

Board

- ❑ When and how providers are to submit 837P claim file to board
- ❑ When and how board is to submit electronic 837P claim file to Diamond
- ❑ What documentation required (if any) to accompany/preclude submission of 837P claim file
- ❑ Tracking methods
- ❑ When/how to communicate held/denied claims to providers
- ❑ Provider Appeals Process
- ❑ Out-of-County Claims
- ❑ Payment to providers

Provider

- ❑ Identification of erroneous claims
- ❑ Correction of erroneous billed claims
- ❑ Tracking methods
- ❑ When and how to notify board of erroneous billings

III. Background & Prerequisites

Account Requests

Before submitting claims through the MACSIS system the board staff person(s) responsible for receiving provider files and sending them to MACSIS must have a UNIX account as well as a MACSIS Account logon. They must fill out a **Request for TCP/IP Access** form and a **MACSIS Account Request** form. Both must be returned to:

Ohio Department of Mental Health
C/O MACSIS Account Coordinator

[1] Throughout this document MACSIS HIPAA will be referred to as MACSIS.

Suite 1010
30 East Broad Street
Columbus, Ohio 43266-0414
Or fax to: 614-752-6474

837P Claim File and FTP Procedures

The board staff person responsible for receiving provider files and sending them to MACSIS for processing should be familiar with basic UNIX commands and the FTP process. There are many software programs on the market that make FTP'ing files as easy as "drag and drop". (The Ohio Dept. of Mental Health supports Ipswitch.)

This person should also be familiar with the 837P file structure **MACSIS Sample 837P UPI File**, **MACSIS 837 Professional Claim Technical Information Guide (v4010-UPI)**, **MACSIS Sample 837P NPI File** and **MACSIS 837 Professional Claim Technical Information Guide (v4010-NPI)** and the use of a text editor to troubleshoot problems that might arise. (The Ohio Dept of Mental Health supports Visual Slick Edit.)

Subdirectory Structure for Claims-Related Files

Each Board Consortium has been assigned a unique directory structure on MACSIS for uploading claim files and downloading reports and files.

/county/<board designation>/hipaa **(For use when processing 837P v4010 files)**

/holding	State use only
/input	used for submitting provider 837P claim files for production
/reject	files that did not pass 837P validation
/reports	all-non Diamond report files
/test	files submitted for Tier 1 test
tier2test	files submitted for Tier 2 test

/county/<board designation>

/extracts	weekly extract zip files
/ra	payment files

File Naming Conventions

There is a very specific naming structure for the claim files that are submitted to MACSIS. Incoming production UPI claim files must be named Axxxxxx#.julyy (8.5 format) while NPI claim files must be named Nxxxxxx#.julyy (8.5 format), where "xxxxxx" = the MACSIS UPI or Vendor number on behalf of whom the claims are being sent (right justified, zero-filled), "#" is a sequential number to identify separate and distinct file transmissions being sent on the same day, "jul" is the Julian date the file was created and "yy" is the year the file was created.

Ex. **UPI**: A0010431.31402 would be the file name for the first file sent to MACSIS from provider UPI # 001043 on November 10, 2002

Ex. **NPI**: N0010431.19406 would be the file name for the first file sent to MACSIS from provider UPI # 001043 on July 13, 2006

Incoming test claim files should be named similar to the production files, only the first character should be a "J" instead of an "A" for UPI claim files and the first character should be an "X" instead of an "N" for NPI claim files.

Maintenance of Logbook

A logbook or spreadsheet should be maintained by the board to track each production and test file that is received from providers. Files should be tracked through the entire Claims EDI process. Some fields you may want to include on your spreadsheet/logbook are: date file received, file name, verified by, claim date range, number of claim lines, total dollar amount, date FTP'd to MACSIS, batch name, date edit completed, date file posted, date APUPD run, RA/ERA/835's received, RA/ERA/835's distributed to providers, etc.

IV. 837P Claims Testing and Approval Process

Each provider must be approved before they can submit 837P claim files to the MACSIS system. Two levels of testing must be completed successfully before approval is granted. For detailed information and instructions, please refer to **HIPAA EDI Claims File Testing and Approval** and **Submitting Test HIPAA EDI Claim Files for Approval**.

Note: If a provider changes their software for producing 837P files, they must go through the testing process again and be approved by the State. If a software vendor makes programming changes to their software, the provider may be required to go through the approval process again, depending on whether the changes affect the creation of the 837P file, the mapping of procedure codes, etc.

Tier 1 Testing evaluates the form, structure and syntax of the claims EDI test file as it pertains to MACSIS-specific guidelines.

Tier 2 Testing compares the test file to a copy of the MACSIS production (MHHIPAA) environment to simulate as close as possible how claims will be processed in a live environment. 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. This is the first time data in the test file is compared to the data in the Diamond environment.

When submitting claims files for testing (tier 1 or tier 2, UPI or NPI format) a **MACSIS EDI Claims Testing Form** must be completed. There are two versions of the file on the web. The electronic version is a Word document that can be completed and submitted electronically via email while the PDF version can be printed, completed and then faxed. **Do not fax the Word version of the testing form.** The highlighted fields are unreadable when faxed.

Boards should verify the form is complete and then email or fax the completed document to the Office of Information Services, Ohio Department of Mental Health at macsistesting@mh.state.oh.us or 614-752-6474 (fax), after the test file has been placed in the appropriate FTP directory. **All information is required to process the request.**

V. HIPAA Claims Processing

All Medicaid and non-Medicaid services (including prevention) that are paid in whole or in part by public dollars are to be processed through MACSIS. These claims are to be submitted electronically. The provider submits the files to the board and the board then sends the files to MACSIS.

Providers must have software that can produce an electronic 837P file. Each provider must pass a multi-step testing process before they will be approved to go-live on claims (see **Section IV.**). Once a provider is approved for ongoing claim submission, these claim files should be sent to the board on a regular basis. Each board's policies will dictate when these files can/should be submitted, but boards must process files on a weekly basis.

Pseudo Claims Processing

Services submitted under Pseudo UCI's are processed in the same manner as those submitted for regular UCI's. Whether the claims are entered manually or through an electronic 837P file the same field requirements must be met. Modifiers, diagnosis codes and place of service codes are all procedure code driven. Refer to "**MACSIS Procedure Codes - ODMH**" and "**MACSIS Procedure Codes - ODADAS**" for modifier and diagnosis code requirements.)

For AOD prevention services, providers should pass service delivery information in the control number fields on the 837P claims file (Loop 2300, CLM01 or Loop 2400, REF02. The service delivery information identifies the population characteristics of those who received the prevention service and should be formatted as follows:

- Delimited, not fixed-length format
- Delimiters are letters which identify the values immediately following the letters
- Order of delimiters is:
    - U, S or I to indicate "universal, selected or indicated" statistics, M = # of Males, F = # of Females, S = # under the age of 21, T = # between ages of 21 and 44, U = # between ages of 45 and 64, V = # 65 and over, W = # of Whites, Not Hispanic, B = # of Blacks, Not Hispanic, N = # of Native Americans, A = # of Asian or Pacific Islander, H = # of Hispanic/Latino
- Examples:
    - Universal, 20 males, 100 Females, 75 under 21, 45 age 24-44, 65 White, 40 Black, 15 Mexican would be sent as : UM20F100S75T45W65B40H15
    - Selected, 25 males, 0 Females, 25 65 and Over, 25 White would be sent as: SM25V25W25
- As a matter of explanation, one can apply the IOM framework to an adolescent population:

  Universal - all students at Smith High School
  Selected - survey results show that the transition from 8th-9th grade is often accompanied by increased ATOD use, so the program targets all freshmen (at risk).
  Indicated - freshmen who have violated school ATOD policies.
- If one were to apply the IOM framework to an adult population:

  Universal - all senior citizens living in Smith City
  Selected - all senior citizens living in Smith City who take prescription medications
  Indicated - all senior citizens living in Smith City who drink alcohol and take prescription medications

If prevention services are provided, for example, to two elementary classes, once in the morning and once in the afternoon, the control number should be calculated with the

number of attendees totaled. Please note that the submission of service data delivery via the 837P file replaces the requirement to submit MDS data separately.

NOTE: To accommodate the use of the 837P control number fields for both service delivery data and provider-assigned control numbers, prevention providers have the option of placing a "Z" between the service delivery data and their provider-assigned control number. For example in the above case, the program would report: UM20F100S75T45W65B40H15Z##### where ##### provides uniqueness to the provider-assigned control number. This information will be returned to the provider on the 835 Health Care Claim/Payment Advice file in the appropriate control number data elements.

Pseudo clients are to be used to bill for non-client specific services (services that are not limited to a single member at a time), such as hotline, prevention, community education, training, etc. Refer to **ODADAS-ODMH Guidelines**, Topic 44. Data Content Policies).

Pseudo client UCI's must be entered manually by the board following the guidelines established on Page 7 of the **Board Operations Manual - Member Section**.

VI. Negative Offset Amounts for Claims with Other Insurance

Diamond version 8+ has a feature that prevents the net amount from being negative via a (hidden) field called "**Negative Offset Amount**" that should result in less manual work for negative claims. Claims with a **NEGPA** reason code are automatically denied under Diamond version 8+.

When what would normally be a negative net amount occurs for payable claims (due to other insurance payments exceeding the allowed amount or when a co-pay is applied in conjunction with other insurance), Diamond version 8+ populates the "Negative Offset Amount" field with the value that would make the net amount zero. When viewing the claim online, a blinking asterisk appears next to the "withhold amount" field when there is an offset amount for the claim. When you press F6-E from the detail screen (Examine hidden fields), the offset amount and reason code (NEGPA) are displayed. The reason code definition is "negative paid amount" and will always be valued to this code.

Note: Boards no longer need to manually adjust the co-pay amount when other insurance is involved in payment to make the net amount zero. The system will automatically calculate the adjustment to make the net amount zero.

Boards that manually calculate the co-pay by subtracting the insurance amount from the allowed amount and THEN calculate the co-pay will need to continue this manual calculation since they are still paying a portion of the cost.

Examine Hidden Fields Screen (Displays Negative Offset)

```
RA/EOB Print Flag :   0
Pricing Information
   Hidden Field 1 : 0LSALSOH
   Hidden Field 2 :                      0.00
   Net Amt Offset :                      5.68
   Offset Rsn Code: NEGPA
Cap Fund Detail
   Cap Fund Status:
   Cap Fund Model :
   Cap Fund WHold :                      0.00
   Unit Value     :        0.00000
Third Party Claim Audit Detail
   HPR/AA Flag    :
Billed-Allowed    :                      0.00

   1=EOB Only, 2=RA only, 3=Both, 0=none
<END> to exit
```

VII. Claims Roll-up (Same-Day Service Reporting)

In order to assure ODJFS (Ohio Department of Jobs and Family Services) that providers are not billing for the same service episode twice, MACSIS has been configured to check for duplicate claims based on the same service provided to the same client by the same provider on the same day with the same modifier codes 1 and 2 (and for MH Medicaid – place of service). ODJFS removed the duplicate claim edits from their system and, therefore, duplicate checking is no longer being performed in the manner it was pre-HIPAA.

New procedures have been implemented that require valid “same-day” services to be rolled up to one service line on the claim before submitting to MACSIS. Claims that are not rolled-up (summed) will be denied and will have a denied reason code of DUPLY.

“Same-day service” means the combination of UPI, UCI, date of service, procedure code, modifier codes 1 and 2 and place of service code (MH Medicaid reimbursable services only). These combinations result in the same medical definition (i.e., adjudication category) in MACSIS.

Exception: When claims are rolled-up, the place of service code should be ignored except same-day MH Medicaid services with the place of service codes of “99” or “51”. These claims should not be summed with the other same-day service claims. All MH Medicaid same-day

services with a place of service code of “99” should be rolled-up together and all same-day MH Medicaid service claims with a place of service code of “51” should be rolled-up together. Please refer to **ODMH Same Day Service Reporting - Roll-up Categories for Duplicate Checking** and **ODADAS Rollup Categories Used for Duplicate Claim Checking**.

Rounding conventions should be applied to episodes of treatment occurring on the same day after summing the total number of service minutes. Refer to the rounding conventions provided in Section 44C of the **ODADAS-ODMH Guidelines** for more information.

When a same-day service claim comes in after the initial claim was submitted the “straggler” claim would be denied as a duplicate claim. Follow the **Procedure for Claim Corrections Within MACSIS** to correct these “straggler” claims.

VIII. Manual Claims Entry

There will be times when board staff will need to enter claims manually into the Diamond system (i.e., claims correction). The procedure for entering a claim manually is outlined below:

1. At the Diamond main menu, type: OPCLM (outpatient/professional claims)
2. The next screen asks for Batch Number and Received date - enter through these fields
3. The next screen is the Outpatient and Professional Claims main screen (header screen)

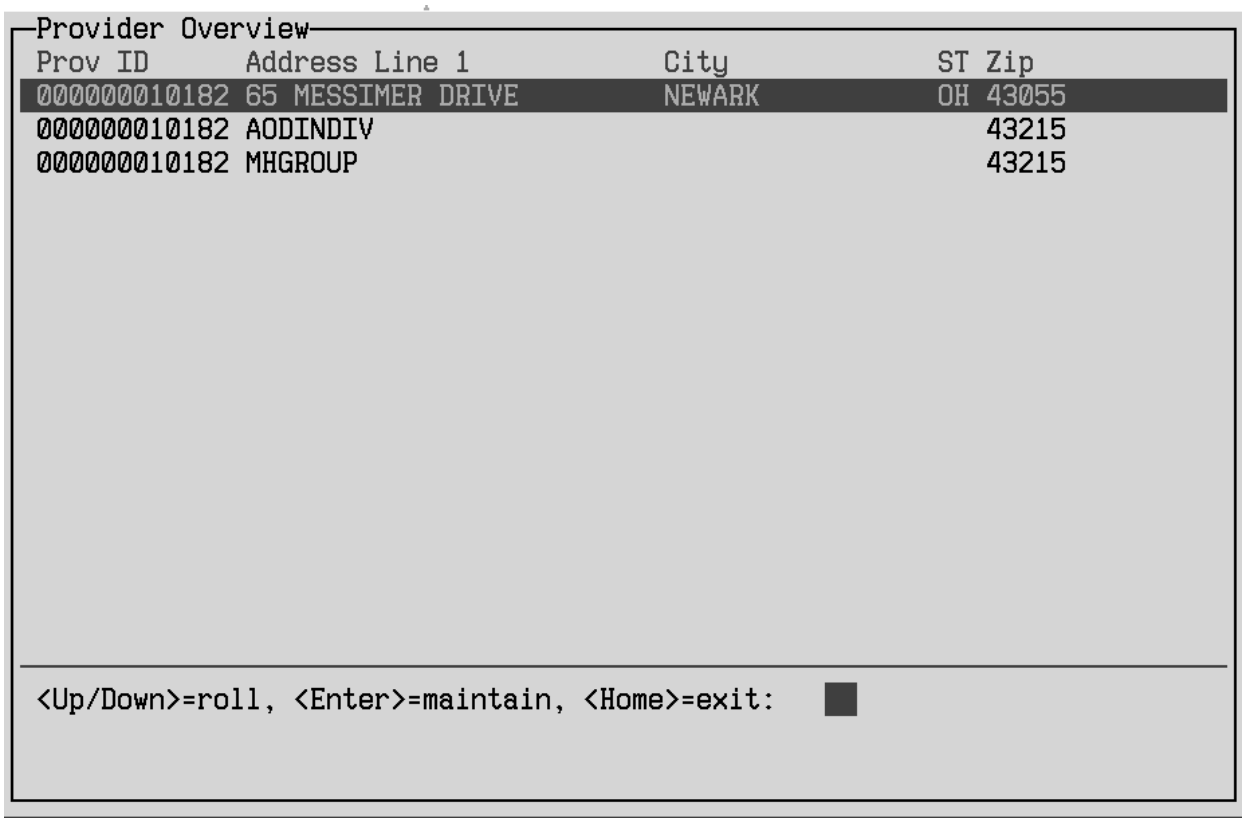
Blank OPCLM Claim Header Screen

```
OPCLM                    Outpat and Professional Claims
┌─Claim Identification──────────────────────────────────────────────────────┐
│ *Date  :   /  /          *Claim No. :                                      │
│  Thru  :                  Auth No.  :                      AuthLvl :      │
│─Member Information────────────────────────────────────────────────────────│
│  Member :                                   Age             Sex           │
│  PCP                      Type              DOB                           │
│  PCP Name                                   Spec            IPA           │
│  Group                    Plan              LOB             Panel         │
│  Group Name                                                               │
│─Provider Information──────────────────────────────────────────────────────│
│  Ref Prov :                                                               │
│  Type          Spec          Par        IPA                               │
│  Provider :                                          Prov Addr Flag :     │
│  Type          Spec          Par :      IPA                               │
│  Vendor   :                                          Vend Addr Flag :     │
│  Cov Prov :      Cov Prov Method :                                        │
│─Claim Information─────────────────────────────────────────────────────────│
│  Serv Place :            Dx1:         Rec'd:            Batch No:         │
│  Serv Reason:            Dx2:         UTILUSER1:                          │
│  Acc/Symp Dt:            Dx3:         CLIENT ID:                          │
│                          Dx4:         TotBil:                        Sec: │
└──F1=Help, F2=Delete, F3=Overview, F4=Notes, F6=Spec Functs──────────────┘
```

- The first thing you must do is enter the **Date** which is the date of service
- Next you will hit enter and Diamond will assign a claim number in the **Claim No.** field (if you were making corrections/reversals, etc. you would enter the actual claim number)
- Enter through the **Thru** and **Auth No.** fields
- Enter the UCI number of the member you are entering services for in the **Member** field and enter “00” (person no. field). This will automatically populate the ***Member Information*** (client’s name, age, DOB, sex, group, plan, LOB, panel and group name). **It is critical to make sure the information you are entering is correct.**
- Enter through the **Ref Prov** field and enter the UPI number for the provider who is providing the billable service. The **Provider Overview** will automatically pop-up. You will then need to highlight the appropriate Provider Address and hit enter.
    i. The first provider address (contains the actual address of the provider) is chosen for all services that are attached to the primary price schedule “P0” or the alternate price schedule “A0”

ii. The second provider address (**AODINDIV**) should be chosen if the service is for AOD Individual Counseling (primary price schedule “P1”) or AOD BH Hotline (alternate price schedule “A1”).

iii. The third provider address (**MHGROUP**) should be chosen if the service is for MH BH Counseling/Therapy - Group or MH Community Psychiatric Supportive Treatment - Group (primary price schedule “P2”).



- This will automatically populate the ***Provider information*** (provider name, provider address flag, type, specialty and participation status). The **Prov Addr Flag** information will be highlighted. Hit enter.
- The “Y” in the **PAR** field will now be highlighted. Hit enter and this will take you down to ***Claim Information***.
- The **Vendor** information (vendor number name) is now automatically populated. Hit enter and the fields **Cov Prov** and **Cov Prov Method** are now populated.
- Enter the place of service in the **Serv Place** field.
- Enter through the **Serv Reason** field and the **Acc/Symp Dt** field.
- You now come to the four diagnosis fields. Enter a valid diagnosis code (if required) in the **Dx1** field. You can enter up to three more diagnosis codes, if applicable, or enter through the fields
- Today’s date will automatically be placed in the **Rec’d** field, press enter.
- Enter through the **UTILUSER1** field.

- If you know the **CLIENT ID** (this is the provider's ID for the client that they use in their software/system) enter it, if not enter through the field.
- Enter the total amount billed for the service in the **TotBil** field and press enter. ***Remember: If the total billed is $100.00, you must enter 10000 - the decimal point is automatically entered by the system***.

  Note: A warning message of "**Possible duplicate of claim no:…..**" may appear after you enter the **TotBil** amount. This does not necessarily mean the claim is a duplicate. A warning message on the header screen just means that the client has received other services from this provider on the same day and the claim may be a duplicate. If the claim is in fact a duplicate, a warning message will appear on the detail screen that says "**Duplicate of claim no:……**".
- Enter through the field **Batch No**. unless your board assigns a batch number manually.
- Your security code should automatically be inserted in the **Sec** field. Press enter.
- You will now have a choice of: **A**-adjudicate, **P**-price, **S**-save or **L**-lose changes (F7 for letters is not used). The system default is "**A**". Select "A" if it is not already chosen, press enter. "A" prices and adjudicates the claim line.

The screen below is a completed header screen.
(Member UCI and name have been blanked out).

```
OPCLM                    utpat and Professional Claims
──Claim Identification──────────────────────────────────────────────────────
 *Date  :  07/25/2003        *Claim No. : 0000000421246550
  Thru  :    /  /             Auth No.  :                      AuthLvl
──Member Information────────────────────────────────────────────────────────
  Member :              00                        Age   25.1      Sex    M
  PCP                         Type                DOB   05/28/1978
  PCP Name                                        Spec            IPA
  Group    FRAN               Plan  DFNON253      LOB   NON       Panel  25B
  Group Name    FRANKLIN ADAMH
──Provider Information──────────────────────────────────────────────────────
  Ref Prov :
  Type          Spec          Par        IPA
  Provider : 000000001195     NRTHWEST COUNSL            Prov Addr Flag : 000
  Type  DCBH    Spec  DOP     Par : Y    IPA
  Vendor   : 1195               NRTHWEST COUNSL          Vend Addr Flag :
  Cov Prov : N    Cov Prov Method : A
──Claim Information─────────────────────────────────────────────────────────
  Serv Place : 11         Dx1: 290.0   Rec'd: 07/25/2003  Batch No:
  Serv Reason:            Dx2: 292.1   UTILUSER1:
  Acc/Symp Dt:   /  /     Dx3: 296.0   CLIENT ID: 123456789
  See Error Summary       Dx4: 295.35  TotBil:                  100.00  Sec:F
────F1=Help, F2=Delete, F3=Overview, F4=Notes, F6=Spec Functs──────────────
Adjudicate, Price, Save, or Lose changes?(A,P,S,L - F7 for letters): A
```

```
OPCLM                    Outpat and Professional Claims
---Claim Header---------------------------------------------------------------
 Date 07/25/2003            Clm 0000000421246550 Auth          Lv   POS 11
 Mbr  1077322     .00 PCP                Plan DFNON253  Dx1 290.0   Dx3 296.0
 Prov 000000001195   Type DCBH   Spec DOP     Rsn       Dx2 292.1   Dx4 295.35
---Previous Line Items-------------------------------------------------Status--
Line Svc Date   Proc        Qty         Billed        Allowed            Net C P



---Line Item Detail-----------------------------------------------------------
 001 █              -              Proc :
  Mod1:    Mod2:    Mod3:    Mod4:    DxPtr:   Qty :         POS :
  Billed :$
  Allowed:$                Allowed Rsn :              Claim Stat :
  Not Cov:$                NC / DN Rsn :              Proc Stat  :
  Copay  :$                Copay Rsn   :              Hold Rsn 1 :
  Deduct :$                Deduct Rsn  :              Hold Rsn 2 :
  OthCarr:$                OthCarr Rsn :              Hold Rsn 3 :
  Withhld:$                Adjust Rsn  :              Company    :
  Net     $                Medical Def                G/L Ref    :
  Method                   Post Date                  Check Date
-----F1=Help, F2=Delete, F3=Previous Line Items, F6=Special Functions, F7=Ltrs-
   Adjustment - Enter adjustment indicator, or R to reverse item
```

- This will now take you to the claim detail screen. The ***Claim Header*** information will already be populated.
- The prompt will be at the **Line** field in the ***Line Item Detail*** section of the screen. (See screen shot of Claim Detail screen - above.)

Note: If you make a mistake when entering the Procedure Code (Proc), Modifier (Mod), Quantity (Qty) or Billed Amount you should hit "Home" and start over entering the detail information. Not starting over could cause the claim line to not price and adjudicate accurately.

- Enter through the **Line** field and the **Adjustment** field (a value would be entered here if you were making an adjustment/reversal to a previous claim).
- The **Date of Service** field will be populated from the **Date** field in the ***Claim Header***.
- Hit enter and the **Thru Date** will be populated with the same date as the **Date of Service** field. *(Per Medicaid Policy, a range of dates of service is not permissible for behavioral health services. For services administered over a range of dates, only a single date of service should be provided.)*
- Insert the procedure code in the **Proc** field, press enter.
- There are four modifier fields (**Mod1, Mod2, Mod3** and **Mod4**). Enter the modifier(s) in the appropriate modifier field(s). Press enter.
    - Refer to **MACSIS Procedure Codes - ODMH** and **MACSIS Procedure Codes - ODADAS** for what modifiers can be used with each procedure

code and **MACSIS MH HIPAA Modifier Code Table** and **MACSIS AOD HIPAA Modifier Code Table** for descriptions of the modifier codes.

  - **Mod3** and **Mod4** are not used to adjudicate the claim and are for board assigned informational purposes only.

- The **DxPtr** (diagnosis pointer) field is automatically valued to 1. If more than one diagnosis code is entered, this value should point to the diagnosis code that is the primary diagnosis for the service being billed. If 1 is the correct value, press enter. If the value is other than 1, enter the correct value and press enter. However if you enter other than 1, Diamond does not use that diagnosis for adjudication purposes.
- Key in the units of service in the **Qty** field, press enter. If the units of service contains a decimal, you must key in the decimal point otherwise 1.5 units becomes 15 units.
- The **POS** (place of service) field will automatically be populated from the ***Claim Header***.
- Record the billed amount in the **Billed** field remembering to enter $100.00 as 10000, press enter.
- The **Allowed** field will automatically be filled in, press enter.

  Note: If the claim is a duplicate of another claim this is when you will see the warning: "**Duplicate of claim no: ……".**

- The client **Copay** field will automatically be populated if a client has a rider code in MACSIS.
- Enter through the remainder of the fields unless you have an Other Carrier amount that needs to be entered in the **OthCarr** field, in which case you would also need to enter the "Other Carrier Reason Code" in the **OthCarr Rsn** field.
- The remainder of the fields (listed below) will be populated automatically by the adjudication process.

  Allowed Rsn - Allowed Reason Code
  Copay Rsn - Copay Reason Code
  Medical Def - Medical Definition
  Claim Stat - Claim Status
  Proc Stat - Processing Status
  Company - Company Code
  G/L Ref - General Ledger Reference

NOTE: If the claim is for AOD Individual Counseling or AOD BH Hotline (provider address 001 - AODINDIV) or for MH BH Counseling/Therapy - Group or Community Psychiatric Supportive Treatment - Group (provider address 002 - MHGROUP), and the incorrect modifier is entered on the claim detail line, the claim defaults to the rate on the primary price schedule which is associated with provider address 000.

The screen below is a completed claim detail screen (UCI has been blanked out).

```
OPCLM                    Outpat and Professional Claims
──Claim Header──────────────────────────────────────────────────────────────
 Date 07/25/2003            Clm 0000000421246550 Auth           Lv   POS 11
 Mbr              .00 PCP                Plan DFNON253  Dx1 290.0   Dx3 296.0
 Prov 000000001195   Type DCBH   Spec DOP     Rsn       Dx2 292.1   Dx4 295.35
──Previous Line Items──────────────────────────────────────────────────Status──
Line Svc Date   Proc        Qty         Billed        Allowed            Net C P



──Line Item Detail──────────────────────────────────────────────────────────
 001   07/25/2003  -  07/25/2003  Proc : H0004    BH COUNS/THERAPY
  Mod1: HE Mod2: 99 Mod3: H9 Mod4: HB DxPtr: 1 Qty :   1.0   POS : 11
  Billed :$         100.00
  Allowed:$          22.49 Allowed Rsn : PCFSC        Claim Stat : P
  Not Cov:$           0.00 NC / DN Rsn :              Proc Stat  : U
  Copay  :$           4.50 Copay Rsn   : 20%SF        Hold Rsn 1 :
  Deduct :$           0.00 Deduct Rsn  :              Hold Rsn 2 :
  OthCarr:$           0.00 OthCarr Rsn :              Hold Rsn 3 :
  Withhld:$           0.00 Adjust Rsn  :              Company    : FRAN
  Net     $          17.99 Medical Def   2400         G/L Ref    : NMH
  Method    AA              Post Date                 Check Date
────F1=Help, F2=Delete, F3=Previous Line Items, F6=Special Functions, F7=Ltrs──
    UPDATE? (Y/N):
```

Note: Remember that if you enter a second claim line (002) and it is a Medicaid payable service, it will never be extracted and sent to ODJFS for payment.

IX. EDI Claims Process Overview for 837P

1. Board receives and verifies file from provider

There are a number of ways that providers may submit claim files to a board. The board may receive the file electronically or via a floppy disk. The board should have a notification form that the provider completes for each claim file they send to the board. This form should contain the name and UPI number of the provider submitting the file, the date the file is being sent, the name of the file, the number of claim lines and the total dollar amount of the claims in the file, the period the claims are for and the person submitting the file. This form should be either faxed or emailed to the board when the file is electronically transferred, or be delivered with the floppy disk. This serves as a record for the provider and as a notification to the board of an incoming claim file.

Once a board has received the file, it should be logged and the file should be verified that it is readable, that the file has been named correctly and it is not a duplicate file. Boards are encouraged to validate the file to make sure it passes basic HIPAA EDI format requirements.

Boards should not be rejecting claim files from providers for reasons other than the same reason the State would reject the file (ex. , bad file name, duplicate file sent, invalid file format) UNLESS the provider mutually agrees it is in their best interest to

resubmit the file. This issue has Medicaid Policy implications. On January 21, 2004 - Margie Herrel noted that ODJFS' has historically cautioned any board from rejecting a claim file that might contain valid payable Medicaid claims. The EDI sub-committee agreed to recommend the best practice of not rejecting a claim file for any other reason than as rejected by the State. It is important to note this is a board level recommendation in regards to 837P files only. The State will process claim files as approved by individual boards, even if some critical errors are included in the file.

NOTE: Boards should verify that the files are named correctly. For 837P – UPI files the naming convention is Axxxxxx#.julyy and for 837P – NPI files the naming convention is Nxxxxxx#julyy. (Refer to the section on File Naming Conventions.)

2. **Board FTP's file to MACSIS**

   Once the file has been logged and verified it is ready to be FTP'd to the MACSIS system. There are many products on the market for this purpose. **Make sure you transfer the file in ASCII mode.**

   The file should be FTP'd to the board's county/hipaa/input/ directory.

3. **File is checked to make sure submitting provider has passed Tier 2 and has been approved for production.**

4. **File is checked for duplicate submissions of the same filename.**

   Any duplicate file submissions will be rejected.

5. **MOM moves file and performs "surface" examination (OVERNIGHT Process)**

   A SAS program will move the 837P files from your county/hipaa/input/ directory (an archived copy of your original file will not be stored on the MHHUB server) and perform a surface examination much like Hublink did on the HCFA file. The program check for various errors and the file may be rejected for a number of reasons (see: Overnight Program Errors).

6. **E-mail is sent to the Board Claims/EDI Notice Group as well as the MACSIS Support Desk. The e-mail will also contain a copy of the report in PDF format. Refer to Sample EDI Notice and PDF Report File.**

7. **Copy of the above e-mail as an ASCII file is FTP'd to your /hipaa/reports/ subdirectory along with a copy of the PDF Report File.**

   Naming convention for the ASCII file is XXB.DDMONYY.TXT (25B.03JUN04.TXT) where XX would be replaced by your MACSIS Board Code, DD is the day, MON is the month and YY is the year.

   Naming convention for the PDF Report file is XXB.DDMONYY.OVERNIGHT.1.REPORT.PDF (25B.03JUNE04.OVERNIGHT.1.REPORT.PDF) where XX would be replaced by your MACSIS Board Code, DD is the day, MON is the month and YY is the year.

8. **Rejected files are moved back to your /hipaa/reject/ subdirectory**

9. **Files that pass are moved to a holding area on another server**

   The files will then be processed based on your assigned HIPAA processing day.

10. **Weekly report is produced on your assigned claims processing day and includes information on all files accepted during the overnight process. This report is e-mailed to the Board/Claims EDI Notice Group as well as the MACSIS Support Desk. The e-mail contains the report in PDF format. A copy of this report is also FTP'd to your /hipaa/reports/ subdirectory. Refer to Sample EDI Weekly Report.**

    Naming convention for the PDF file is:
    XXX.DDMONYYYY.WEEKLY.PROCESS.REPORT.1.PDF
    (25B06JUN2006.WEEKLY.PROCESS.REPORT.1.PDF) where XXX would be replaced by your MACSIS board code, DD is the day, MON is the month and YYYY is the year.

11. **Mom runs claims EDI – Edit mode**

    The MOM Production Control staff processes the board's file(s) in Diamond in edit mode and assigns the Batch ID. The format for Batch ID is **Axxxyyjjj** (e.g., where xxx is board number and type, yy is the year, and jjj is the Julian date so for Franklin for today it would be A25B03265).

    Six reports are created by MOM and are FTP'd to your /hipaa/reports/ subdirectory. MOM will notify the board by email that the edit process is complete and that the Edit reports are ready.

12. **Board review & determination of whether to post batch**

    - Check your email for notification from MOM
    - Check /hipaa/reports/ subdirectory as to status of the weekly run
    - Check /hipaa/reject/ subdirectory, notify provider, and update logbook
    - Download the PREDI Edit reports and review/print reports
    - Determine if batch should be posted and notify MOM within 5 calendar days

13. **MOM runs claims EDI – Post mode**

    - MOM processes file in Post mode
    - MOM runs OPLST and Post reports on posted claims
    - MOM FTP's reports to board /hipaa/reports/ subdirectory
    - MOM notifies board via email that post is finished

14. **Work claims reports**

    - Review critical error report and notify providers of rejected claims that need to be resubmitted
    - Review non-critical error report and research/notify provider
    - Check held claims to determine why and research, fix or deny
    - Check denied claims and notify provider
    - Check post report for duplicate warnings and rejects/adjustments

15. Delete report files stored in UNIX subdirectories

X. Claims EDI Edit Reports

After MOM runs claims through the EDI edit mode there are six reports that are created. These reports are found in the /hipaa/reports/ subdirectory and should be downloaded and saved (they will be overwritten next time the EDI edit process is run). After the reports have been downloaded and printed, they should be deleted from your UNIX directory. (The PREDI-P report is very large and printing of the entire report is not recommended). Each report should be reviewed and the proper action taken.

Description of EDI Edit Reports

Descriptions of each report and the action required by the board staff are as follows (for samples of the reports see the **Reference Documents** section or **Working PREDI Edit Reports** section):

REPORT NAME:	**CLAIMS EDI JOB LOG**
Report ID: **000**	**PREDI-J**
Frequency:	Generated one per batch – in edit mode
Purpose:	Provides time stamped detail of EDI functions performed on batch. This is one of the most important reports to determine whether a batch should be posted. It provides a summary showing the number of claims, critical errors, non-critical errors, rejected claims and accepted claims
Notes:	• This report is used in conjunction with the critical and non-critical error reports to determine whether a batch should be posted. • If the non-critical error rate is high, it may be due to something as simple as one missing PROCP record or the wrong price schedule on a PROVC record. While the records with non-critical errors could be posted and corrected in Diamond, it may be easier to enter the missing support table record and reprocess entire batch.
Action Required:	Review and determine the overall error rate for batch and evaluate quantity vs. types of errors to decide whether to post the batch.

REPORT NAME:	**DETAIL CLAIMS REPORT**
Report ID: **001**	**PREDI-D**
Frequency:	Generated one per batch – in edit mode
Purpose:	Provides summary of each claim that was submitted within the batch
Notes:	Shows line by line listing of each claim within the batch showing whether accepted or rejected.
Action Required:	None required

REPORT NAME:	**CRITICAL ERRORS REPORT**
Report ID: **002**	**PREDI-C**
Frequency:	Generated one per batch – in edit mode
Purpose:	Shows records that have missing or invalid data, generally from the header. These records will not be posted into Diamond when/if the batch is posted.

Notes:	• This report should be used in conjunction with the PREDI-D report. • Common problems include provider not found, subscriber not found, diagnosis not found, procedure not found, modifier not found, etc. • MBRIN (member ineligible at the time of service) now causes a critical error - (DTL600) No Company/GL Ref assigned - Prevents "OHIO" claims from getting into Diamond 8+ o Several related non-critical errors also appear
Action Required:	If this batch is posted, the provider for each claim on this report will need to be contacted to correct and resubmit the claim.

REPORT NAME:	**NON-CRITICAL ERRORS REPORT**
Report ID: **003**	**PREDI-N**
Frequency:	Generated one per batch – in edit mode
Purpose:	Shows records that have errors that are non-critical, but require follow-up. These errors are generally at the claim detail level.
Notes:	The following are common errors: • Imperfect Patient No. Match • Error OPE088 occurs when the provider address on the 837P does not match exactly the provide address in the PROVF keyword • No provider contract record found • Unable to use price rule 00 • No company or G/L reference code assigned
Action Required:	<u>If Imperfect Match</u>, claim will still process. May want to coordinate with provider to correct and eliminate future problems. <u>Otherwise, claim will be held or denied based on BRULE'S in effect.</u> Board will need to research and correct claim if appropriate, then re-price and adjudicate.

REPORT NAME:	**AUTH LINK REPORT**
Report ID: **004**	**PREDI-A**
Frequency:	Generated one per batch – in edit mode
Purpose:	To determine if a valid authorization record exists for each claim
Notes:	This functionality is turned off at this time. The interaction between authorizations and claims EDI is turned off. It may be implemented in the future. This report is always empty.
Action Required:	None

REPORT NAME:	**PRICING AND ADJUDICATION REPORT**
Report ID: **005**	**PREDI-P**
Frequency:	Generated one per batch – in edit mode
Purpose:	To identify the logic used for pricing and adjudication for each claim within the batch.
Notes:	It is recommended that this report be carefully examined during the <u>go-live testing process</u>. Due to the length of this report, after go-live it is not recommended to print this report on an on-going basis. For questions on a specific individual claim, can view details by selecting claim, re-

	adjudicate (F6, B), then view pricing (F6, P) and/or adjudication (F6, D)
Action Required:	Review pricing to make sure provider is billing correct amount and that necessary PROVC and PROCP records exist in Diamond.

Posting/Canceling a Batch

Once you have reviewed all of the edit reports, the decision must be made whether the batch should be posted. You have 5 calendar days in which to notify the MOM production staff whether to post or cancel the batch. This must be done via email.

There may be instances where a board needs to cancel a run due to incorrect builds and/or incorrect rates. Look very closely at the edit reports to determine what the errors are, how many providers would be affected, how many claims would have to be resubmitted and how many, if posted, are going to require manual intervention by board staff.

If you decide to cancel the run, notify MOM via email. (Remember to keep your logbook up-to-date.) Review the provider files to determine which 837P file(s) is causing the errors. Notify the provider(s) of the problems and ask them to resubmit their file.

If you decide to post the batch, notify MOM via email to post your file. You will then be notified by email when the post is finished and that your post reports are available.

**It is recommended that all boards keep copies of all 837P files submitted at least until they have been posted because archived copies of the file will no longer be kept on the MHHUB server. This way if you have to cancel the posting of the batch and only one provider needs to resubmit, you will already have copies of the 837P claim files for the other providers to load into your board's /hipaa /input/ directory. For Medicaid claims, you may want to wait until they have made it through the double loop process. Files that are resubmitted must be renamed by incrementing the counter to the left of the decimal in the file name (ex. Original file - A0010431.31402, resubmitted file - A0010432.31402).*

Best Practice: Put all source 837P files, PREDI reports and POST reports together into a subdirectory/CD.

Working PREDI Edit Reports

Whether or not you have posted the batch, the Edit Reports should be reviewed and providers notified of errors that need to be corrected. This will prevent the same errors from coming through in either the resubmitted 837P files or in future 837P files

PREDI-J/Claims EDI Job Log

This report (see **Sample PREDI-J Edit Report**) provides time stamped detail of the various EDI functions performed on the batch, as well as a summary of the number of claims, critical errors, non-critical errors, rejected claims and accepted claims. The summary totals should be checked against your logbook to make sure they agree. This report should be reviewed when determining whether to post a batch. If this report shows critical and/or non-critical errors board staff should review the other Edit Reports to determine what the errors are and what is causing them. Is there a support table record that needs to be added; are providers entering dates incorrectly, etc.? If it is a support table record that needs to be added, cancel the run, enter the record and ask for a second edit run. If you do not cancel the run and you add a support table record, the table fix will not be in effect when the file is posted. If it is a provider problem, notify the provider and have them make the corrections in their system before they resubmit their 837P claim file.

Note: Any critical errors will cause the last line of the log to say, "Process EDI Transaction set job is terminated because of fatal errors". Disregard this error message.

PREDI-D/Detail Claims Report

This report (see **Sample PREDI-D Edit Report**) provides a summary of each claim that was submitted in the batch and shows whether it was accepted or rejected. The claims that were rejected are due to critical errors. These will also show up on your Critical Error Report (PREDI-C). This report is a quick overview and requires no action to be taken by the board staff. The report, however, could be imported into a spreadsheet/database in order to summarize accepted/rejected claims by provider or member.

PREDI-C/Critical Errors Report

This report (see **Sample PREDI-C Edit Report**) shows all records with missing or invalid data. These are the same claims that showed as rejected claims on the PREDI-D report. This report is very important because it is the only report that shows all rejected claims and their errors that need to be resubmitted by providers if the batch is posted. (Refer to **PREDI Error Codes**.) Board staff should review this report, determine the corrections needed and notify the provider. The provider staff should be made aware that these claims would need to be resubmitted.

You will notice that many of the errors on this report come in pairs. For example: **FATAL OPE010 Patient Person Number cannot be determined** will automatically cause **FATAL OPE015 Claim Line Rejected!! Patient Not Found**. Because Diamond could not match the member, it could not process the claim. Correcting the first error will automatically take care of the second. The error could be as simple as the member's first name in Diamond is Edward and the provider has his first name as Eddie. (See the section on "Calculating the Person Number".)

Any critical error (i.e., OPE005, OPE006, OPE010) that cannot determine the member, whether it cannot match the name, missing UCI, invalid UCI, etc., will also cause an **OPE015 Claim Line Rejected!! Patient (or Subscriber) Not Found** error.

When a member is ineligible at the time of service the critical error **DTL600 - No company/GL Ref assigned** is generated. This is because the client is not in a plan and therefore belongs to no company. This situation also results in several non-critical errors. This error used to result in a non-critical error and created what was known as an OHIO claim

PREDI-N/Non-Critical Errors Report

This report (see **Sample PREDI-N Edit Report**) shows errors that, unlike the critical errors, will actually make it into Diamond. Many of the errors on this report will cause the claim to either be "held" or "denied" based on benefit rules (BRULE'S). One invalid data field may cause multiple errors. Correcting the first error will automatically correct the other errors.

Providers should be notified of their non-critical errors and of the information Diamond has for the respective field (if applicable). The provider then needs to determine which information is correct. If the information in Diamond is correct, providers need to update their system. If a provider feels the information they have is accurate they should submit a **New Member Enrollment/Change** form with the correct information so that Diamond can be updated. If the client is a Medicaid client and the provider is sure their information is correct and the information ODJFS has is incorrect, follow the procedure on page 19 of the **Board**

Operations Manual – Hipaa Member Section for setting the "Medicaid Name Override Flag" or having ODMH staff set the "Medicaid Override Flag".

Calculating the Person Number

Another common error is: ***WARN OPE011 Imperfect Patient No. Match: Level 1***. Diamond makes four attempts to match patient data on the incoming claim with that of the members on file in the system. First, it looks for a perfect match, when this fails; it tries for three (3) different types of imperfect matches. This error will not keep the claim from processing, but if left uncorrected, the error will appear on subsequent **Non-Critical Error Reports**. The client's last name, first name, date of birth and gender should be verified with the provider. Either Diamond or the provider system has the wrong information and must be corrected. If this is a Medicaid client and the provider is sure their information is correct and ODJFS' is incorrect, follow the procedure in the "Member Manual" for having ODMH staff set a "Medicaid Override Flag".

- A **Perfect Match** can be made if:

  1. There is an exact match on UCI, first name, last name, date of birth and gender between the claim and the member on file.
  2. There is an exact match on UCI, first name, last name and date of birth, but there is not enough information to make a match on gender (i.e., gender is missing from the claim, the member file or both).

When Diamond fails to make a "perfect match", it will then try to make an "imperfect match". It will try an **Imperfect Match - Type 1** first, then an **Imperfect Match - Type 2** and lastly an **Imperfect Match - Type 3**.

- An **Imperfect Match** can be made in a combination of ways. The most common being:

  1. There is an exact match on UCI, first name, last name and gender, but the dates of birth do not match.
  2. There is an exact match on UCI, first name, last name and date of birth, but the gender codes do not match.
  3. There is an exact match on UCI and a partial match on first name, a match on date of birth and a match on gender.
  4. For Pseudo clients if the gender = "U" on the member record, the date of birth and name **must match exactly**.

Note: If Diamond fails to make a "perfect" or "imperfect" match, you will receive a critical error on the PREDI-C. If it is a valid UCI, you will get an OPE010 Patient Person Number cannot be determined.

PREDI-A/Auth Link Report

Authorizations are turned off in Diamond at this time. If this function were implemented in the future, this report would determine if a valid authorization existed for each record. This report (see **Sample PREDI-A Edit Report**) will be blank as long as Authorizations are turned off in Diamond.

PREDI-P/Pricing and Adjudication Report

This report (see **Sample PREDI-P Edit Report**) identifies the logic used for pricing and adjudication of each claim line. It will tell you what benefit package was applied and the

specific benefit rules, price schedule, price region, etc. This report is extremely long and it is not recommended that boards print this on an ongoing basis after the "go-live" process. If you have questions on a specific claim you can view the details by selecting the claim, re-adjudicate (F6-B) then view pricing (F6-P) and/or adjudication decision (F6-D).

XI. Claims EDI Post Reports

Upon completion of posting of your batch, MOM will run the Post and OPLST reports on posted claims. These reports will be put in your directory and you will be notified when they are available. These reports are in the /hipaa/reports/ subdirectory and should be downloaded and printed. Once you have downloaded these reports they should be deleted from your UNIX subdirectory.

Description of EDI Post Reports

Descriptions of each report and the action required by the board staff are as follows (for samples of the reports see the **Reference Documents** section or **Working EDI Post Reports**):

REPORT NAME:	**POST REPORT**
Report ID: **101**	Report name is the same as the batch ID/TRLOG identifier
Frequency:	Generated one per batch in post mode
Purpose:	Lists all claims with changes in pricing/adjudication between edit and post due to benefit rules and duplicate rules; shows claims denied as duplicates either within a file or against the database.
Notes:	It is recommended that this report be saved as an ASCII file and then read into an editor or word processing package to search for the records that contain "warning" and "hold" messages due to application of benefit and duplicate rules. The warning messages will not appear in any other reports.,
Action Required:	Review by board.

REPORT NAME:	**OPLST – All Records (sorted by Prov ID and UCI)**
Report ID: **102**	
Frequency:	Generated one per batch after posting
Purpose:	Reference list of all accepted claims in the batch with pricing, adjudication and claim status information
Notes:	
Action Required:	Final review of claims pricing and adjudication.

Working EDI Post Reports

OPLST Report

This report lists all accepted claims in the batch that were submitted by the board. This report is an ASCII file that could be imported into various software products (i.e. Access, Excel, etc.) to generate reports for "held", "denied" and "payable" claims by provider. (See **OPLST File Layout (Report 102)**).

Denied Claims

The board should review the OPLST report and examine all denied claims to make sure they were denied appropriately and contain a "denied reason code". Providers

should be given a list of their denied claims. ***Note: If a NC (not covered) reason code is not present, it is usually because Diamond was unable to find a PROCP record.***

If the claim has been correctly denied, and has a processing status of "U" (un-posted), no further action within Diamond is required. If the denied claim has a processing status of "H" (held) and has been correctly denied, board staff must take the claim off "hold". To take the claim off hold, refer to the "**How To…"** section, "**Un-pending Denied and Held Claims**".

If a claim was denied but should be changed to a payable claim, refer to the **"How To…"** section, "**Making a Denied Claim Payable**".

Held Claims

The board should review the OPLST report and examine all held claims and the reason for the claim being placed on hold (see **Diamond Reason Codes - MHHIPAA**). After researching why the claim was placed on hold, you can fix, deny or make the claim payable. Please refer to the appropriate section under **Procedure for Claim Corrections within MACSIS**.

Payable claims

These claims, if left untouched, will process through the system and be paid and finalized.

Post Report

This Post Report lists all claims with changes in pricing/adjudication between edit and post due to benefit and duplicate rules. This report is extremely helpful in finding claims denied as duplicates.

It is recommended that this report be saved as an ASCII file and then read into an editor, a word processing package, Monarch, etc. You can then go in and search records for the words "warning" and "hold". All records with either "warning" or "hold" should be researched.

XII. Claims Corrections Policy

Claim Corrections in MACSIS (For Claims with Dates of Service Beginning July 1, 2003)

Source: MACSIS Policy Team
To establish guidelines and specific procedures for when and how boards may make claim corrections within MACSIS for erroneously billed services. All corrections must be made in accordance with the "**Procedure for Claim Corrections within MACSIS**".

Policies:

Only the following claim errors may be corrected in MACSIS:

- Finalized MH Medicaid and non-Medicaid claims
- Un-finalized MH Medicaid and non-Medicaid claims
- Finalized AOD Medicaid and non-Medicaid claims
- Un-finalized AOD Medicaid and non-Medicaid claims
- The wrong number of units were billed (i.e., straggler claim, incorrect units)
- The billed amount was incorrect
- Incorrect procedure code

- Incorrect modifier
- Incorrect third party amounts
- Wrong date of service
- Incorrect UCI
- Date of service on claim is over 365 days old when received in MACSIS
- OHIO claims
- Mismatch claims
- Claims that have been reported on the OHEXT Error Report
- Client has retroactive Medicaid eligibility
- Denied claims with missing information

Note: "Denying" a claim for payment within MACSIS because it had been billed twice is not the same as "denying" a client treatment. The term "denial" in this document refers to the denial of payment, not the denial of treatment.

1. This guideline is not to be used to reverse claims paid before a resolution to a residency dispute. This is because the provider is not responsible for creating a residency dispute and therefore their funds should not be retracted accordingly. As noted in "**ODADAS-ODMH Guidelines Pertaining to the Implementation of MACSIS under HIPAA**", Topic 8, section 16. Boards are to resolve monies owed due to residency dispute resolutions outside of MACSIS.
2. All claims adjusted/reversed/denied/etc. **MUST** have a reason code.
3. This Guideline is **NOT** to be used to adjust Medicaid rates. Medicaid rate changes are assigned an effective date based on the day they are input into Diamond by ODMH/ODADAS. Therefore, neither boards nor providers are to use the claims correction procedure to retroactively update Medicaid rate(s). In instances where boards maintain separate rates for non-Medicaid, the claims correction procedure may be used to correct non-Medicaid claims due to an incorrect or retroactive rate change.
4. To ensure consistency across provider and board areas, both ODMH and ODADAS will allow correcting of Medicaid claims and non-Medicaid claims regardless of claim status.
5. All claims (whether AOD or MH) will be corrected following the "**Procedure for Claim Corrections within MACSIS**".

   - Boards may require claims that were originally denied in Diamond (missing/invalid modifier/diagnosis code) due to provider error to be resubmitted electronically.
   - Boards cannot require providers to resubmit claims electronically if the claims were originally denied in Diamond due to board error, unless mutually agreed to.

   No other claims may be corrected by resubmission. Claims denied as duplicates (e.g., straggler claims) must be corrected following the "Procedure for Claim Corrections within MACSIS".

6. **DO NOT** reverse Medicaid claims which have not come back from the Ohio Department of Job and Family Services (ODJFS).

   If ODJFS rejects the claim and a board has already reversed the claim line in Diamond, the claim will have two reversal ACPAY records and the monies will be deducted from the provider twice. The only way to check if claims have been extracted and sent to ODJFS is to use the claims extract file. If there is a date in the

ODHSEXTD field, the claim has been extracted and sent to ODJFS. When there is a date in the DTPAID field and in the ODHSEXTD field, the claim has been extracted, sent to, and returned by ODJFS.

7. Boards **MUST** pay claims when they have been finalized and documented on the 835(s) (even if corrections are going to be made). The erroneous claims must then be "worked" following the "Procedure for Claim Corrections within MACSIS".

   The ODJFS' adjudication deadline is 365 days from the date of service. If the date of service on the Medicaid claim is 366 days or older when it is received in MACSIS, (based on the received date in Diamond) the board may deny the claim or may allow the claim to be submitted to ODJFS for adjudication.

8. Boards and providers are responsible for identifying claims billed in error to ODJFS in a timely manner.

9. Boards and providers must use the Claims Correction Form to identify erroneously billed claims. Exception: For large batches of erroneous claims, boards and providers may mutually agree to another method to identify/report errors. The key is it must be a mutual agreement; otherwise, boards and providers must accept the standard Claims Correction Form. Boards and providers MUST maintain a copy of this form (or mutually agreed upon report) to serve as written documentation that a service was or was not erroneously billed.

10. Boards are permitted to place claims in question on hold for no more than 30 days after entered into Diamond.

11. Providers are permitted 30 days from the date of notification of the potential error to respond to the board regarding the claim.

    - If no response is received from the provider within 30 days, boards may reverse a finalized claim or deny an un-finalized claim.

12. Boards are required to process corrections with little delay after receipt of a **Claims Correction Form** or a provider response to a **Claims Correction Form**.

13. The actual, year-end Medicaid cost reconciliation will be handled according to ODADAS' or ODMH's Medicaid Reconciliation Guidelines.

14. Boards **MUST** "work" the OHEXT Error Report and correct Member eligibility spans to resolve claims which are being paid as Medicaid but are not being extracted and sent to ODJFS.

15. Boards **MUST** "work" the OHIO claims, the Mismatch claims, and the Retroactive Medicaid claims in a timely manner.

***The MACSIS Claim Correction Policy is adopted as phase I of ODADAS' re-engineering of Medicaid reconciliation. Phase I represents movement toward alignment of current Medicaid reconciliation processes with MACSIS technology.**

XIII. Procedure for Claim Corrections within MACSIS

(For Claims with Dates of Service Beginning July 1, 2003)

General

- To ensure consistency across provider and board areas, both ODMH and ODADAS will allow the correction of both finalized and un-finalized Medicaid claims and finalized and un-finalized non-Medicaid claims.
- The procedure for correcting claims will vary depending on whether the claim has been finalized or is un-finalized.
- If a board identifies an erroneously billed service, a **Claims Correction Form**[1] is to be completed and sent to the provider.
- When a provider identifies a claim that was erroneously billed, a Claims Correction Form is to be completed and sent to the board that is responsible for payment of the claim.
- With the roll-up of claims, there may be occasions when a same-day service comes in after the initial claim was submitted. This is a "straggler" claim. These claims will be denied as a duplicate claim. If these claims are identified before the original claim is finalized; follow the "Un-Finalized Claim Correction Procedures" for incorrect units of service billed. If the provider identifies the "straggler" when it is reported on an 835 (denied as a duplicate claim), the "Finalized Claim Correction Procedures" for incorrect units would be followed to correct the claim.
- Refer to the **Claim Corrections in MACSIS (For Claims with Dates of Service Beginning July 1, 2003)**, for the policy regarding claims correction.

I. Procedure For Correcting Claims Prior to Reimbursement Through MACSIS (Un-Finalized Claims)

Whether these claims are identified by the board or the provider the correction procedure is the same except if it is board-identified, the board should put the claim(s) on hold with the appropriate reason code.

1. Board Identified Claims

a. Using OPCLM, access the claim line in question and change the processing status to "H"(held) and enter one of the following Held Reason Codes:

- **MCDBA – Medicaid Billed Amount Correction**
- **NONBA – non-Medicaid Billed Amount Correction**
- **MCDDU – Medicaid Duplicate Claim Correction**
- **NONDU – non-Medicaid Duplicate Claim Correction**
- **MCDMO – Medicaid Modifier Correction**
- **NONMO – non-Medicaid Modifier Correction**

[1] For large batches of erroneous claims, boards and providers may mutually agree to another method to identify/report errors. The key is it must be a mutual agreement; otherwise, Boards and Providers must accept the standard **Claims Correction Form**.

- **MCDPR – Medicaid Procedure Code Correction**
- **NONPR – non-Medicaid Procedure Code Correction**
- **MCDTP – Medicaid Third Party Amount Correction**
- **NONTP – non-Medicaid Third Party Amount Correction**
- **MCDUN – Medicaid Units of Service Correction**
- **NONUN – non-Medicaid Units of Service Correction**
- **MCDWC - Incorrect UCI Billed**
- **NONWC - Incorrect UCI Billed**
- **MCDWD - Incorrect Date of Service Billed**
- **NONWD - Incorrect Date of Service Billed**

Update (save) the claim detail.

- Claims identified by the board as billed in error will be reported to the provider on the Claims Correction Form within a week of being identified.
- Provider will have 30 days from receipt of the Claims Correction Form to provide written confirmation that the claim was or was not in fact billed in error. (If a provider states a service was not billed in error, they must have the clinical documentation on file to support their claim.)
- Boards are permitted to keep a claim in question on hold for up to 30 days after the Claims Correction Form was mailed to the provider. If there has been no response from the provider after 30 days, the board may deny the claim (see # 2-g. below).

2. <u>Board and Provider-Identified Claims</u>

Once the board receives the written confirmation from the provider that the service was or was not billed in error, or a **<u>Claims Correction Form</u>** is received from the provider (provider-identified billing error), claims must be corrected following one of the procedures below.

- **The board must keep on file all written confirmations from providers regarding the services in question (i.e., for both those services confirmed as erroneous and those which were confirmed as correct.)**
- **It is critical that the boards include the not covered reason code when correcting claims.**

a. <u>Claim Is a Duplicate</u>

These claims have already been denied in Diamond as a duplicate (Claim Stat “D”), but have not been finalized (Proc Stat “U”). No action is to be taken on these claims in Diamond. They should be allowed to finalize as a denied claim. If this is a “straggler” claim, the original claim is the one that will need to be corrected following procedure b. (below) for correcting incorrect units of service.

b. <u>Billed Amount, Units of Service, Procedure Code, Modifier, Place of Service or Third Party Amounts are Incorrect</u>

Note: Only correct the place of service code if it is changing from 51 or 99, or to 51 or 99.

Using OPCLM, access the claim line in question and then access the claim detail screen. Correct the incorrect value and re-adjudicate the claim by pressing F6- B. This also removes the held reason code(s) (if the claim was on hold) and will change the processing status to "U"(Un-posted). Enter one of the following adjustment reason codes:

- **MCDBA – Medicaid Billed Amount Correction**
- **NONBA – NON-Medicaid Billed Amount Correction**
- **MCDMO – Medicaid Modifier Correction**
- **NONMO – non-Medicaid Modifier Correction**
- **MCDPR – Medicaid Procedure Code Correction**
- **NONPR – non-Medicaid Procedure Code Correction**
- **MCDTP – Medicaid Third Party Amount Correction**
- **NONTP – non-Medicaid Third Party Amount Correction**
- **MCDUN – Medicaid Units of Service Correction**
- **NONUN – non-Medicaid Units of Service Correction**
- **MCDPS – Medicaid Place of Service Correction**
- **NONPS – non-Medicaid Place of Service Correction**

Update (save) the claim detail.

c. <u>Incorrect Date of Service or Incorrect UCI billed</u>

Using OPCLM, access the claim in question and then access the claim detail screen. If the claim is on hold, access the 001 detail line and do an F6-C to take the claim off hold. This also removes the held reason code(s), updates the benefit accumulators and will also change the processing status to "U" (Un-posted). Enter the not covered amount (this should be equal to the allowed amount). This will automatically change the claim status to "D" (Denied). Enter one of the following not covered reason codes:

- **MCDWC - Confirmed Incorrect UCI Billed**
- **NONWC - Confirmed Incorrect UCI Billed**
- **MCDWD - Confirmed Incorrect Date of Service Billed**
- **NONWD - Confirmed Incorrect Date of Service Billed**

Update (save) the claim detail.

<u>Do not split the claim because it will carry the incorrect UCI and/or incorrect DOS forward.</u> The board should manually enter a new claim with the correct information or, depending upon volume and ability, request the provider submit the "correct" claim(s). **If a board chooses to manually enter the new claim, make sure that the primary header date and the date of service on the detail line match.**

d. Claim Was Not Billed in Error Per Provider

If a claim was put on hold due to a possible billing error and it is later determined that the claim was in fact billed correctly, the board should take the claim off hold and remove the held reason code.

Using OPCLM, access the claim in question and then access the claim detail screen. Make sure the detail line is 001 and do an F6-C to take the claim off hold. This also removes the held reason code(s), updates the benefit accumulators and changes the processing status to "U" (Un-posted). Update (save) the claim detail. Do not enter an adjustment reason code since no adjustment was made.

e. Claim Is Over 365 Days Old

If the date of service on a Medicaid claim is over 365 days old when it is received in MACSIS (based on the received date in Diamond), the board may deny the claim (without having to hold and confirm with the provider first) or may allow the claim to be submitted to ODJFS for adjudication.

Using OPCLM, access the claim in question and then access the claim detail screen. Access detail line 001 and enter the not covered amount (this should be equal to the allowed amount). This will automatically change the claim status on the claim detail line to "D" (Denied). Enter the following not covered reason code:

- **MCDYO – Medicaid Claim More than a Year Old when Received**
- **NONYO – non-Medicaid Claim More than a Year Old when Rec'd**

Update (save) the claim detail.

f. Original Claim is Denied

i. If the original claim(s) was denied due to missing or invalid modifier or diagnosis code, boards may require the provider to resubmit the claim(s) electronically or may choose to correct the claim manually, depending on the volume. If the board has the provider electronically resubmit the claim(s), the original claim should be allowed to finalize. The resubmitted claim will not deny as a duplicate since the original claim was denied, not reversed. If the board chooses to manually fix the claim, they would then correct/add the missing or invalid modifier or diagnosis code and re-adjudicate the claim so that it is now a payable claim.

ii. If the original claim(s) was denied due to board error (e.g., missing PROCP), boards cannot require the provider to resubmit the claim(s) electronically, unless mutually agreed to.

Note: No other claims may be corrected by resubmission.

g. <u>No Provider Response Within 30 Days</u>

If a board has not received written confirmation from the provider that the service is or is not an erroneously billed claim, the board may deny the claim using the denied reason code of NPR30 - No Provider Response within 30 Days of Notice.

Using OPCLM, access the claim in question and then access the claim detail screen. Make sure the detail line is 001 and do an F6-C to take the claim off hold. This also removes the held reason code(s), updates the benefit accumulators and will change the processing status to "U" (Un-posted). Enter the not covered amount (this should be equal to the allowed amount). This will automatically change the detail line status to "D" (Denied). Enter the following not covered reason code:

- **NPR30 - No Provider Response Within 30 Days**

Update (save) the claim detail.

h. <u>Correcting OHIO Claims - MBRIN</u>

Using OPCLM, access the claim in question and refresh the claim header (F6-F).

i. If there is a valid plan now in effect, press "END" and enter "A" to adjudicate the claim. Access the detail line 001 and press F6-B to price and adjudicate the claim. Press "END", then "Y" to update/save the claim. Press "HOME" to return to the Header screen and update/add the correct security code. Press "END", then "S" to update (save) the changes.

ii. If after refreshing the header there is still no valid plan in effect, press "END" and then enter "A" to adjudicate the claim. Type in the correct company code and the correct G/L Ref (usually DEF). Save/Update the claim. Press "HOME" to return to the Header screen. Add the security code; press "END" then "S" to save the changes.

i. <u>Correcting Mismatch Claims</u>

Mismatch claims occur when the EPLAN (eligibility plan in member for the date of service), CPLAN (the plan on the claim header), company (company on the claim detail) or security code do not match each other. How you correct the claims depends on the type of mismatch.

i. If the company code on the claim detail, the CPLAN on the claim header and the EPLAN (eligibility plan in the member record for that date of service) all match, but the security code does not match, correct the security code on the claim header.

ii. If the CPLAN on the claim header matches the EPLAN (eligibility plan in the member record for that date of service), but the company code on the claim detail does not match, access the claim detail line by pressing

"END", then "A" to adjudicate. Access the 001 detail line and press F6-B to both re-price and re-adjudicate the claim detail. Press "END", then "Y" to update/save the claim detail. Press "HOME" to return to the header screen and add/correct the security code if necessary. Press "END" then "S" to save the changes.

iii. If the EPLAN (eligibility plan in the member record for that date of service) matches the company code on the claim detail, but the CPLAN on the claim header does not match, refresh the claim header by pressing F6-F. Add/correct the security code if necessary. Press "END" then "S" to save the changes.

iv. If the CPLAN on the claim header, the security code and the company code on the claim detail all match, but do not match the EPLAN from the member record covering that date of service you may need to investigate to find out if this is intentional. (For example, a client may have been Medicaid, the claim was reversed by ODJFS, and the board wants to pay the claim as non-MCD. In order to do this the board may have changed the client's eligibility span to non-MCD, re-adjudicated the claim and then changed the plan back to MCD. In this case the EPLAN would not match.)

If there was a retro-eligibility change made to the member record and the claim should be adjudicated based on that eligibility, then you will need to refresh the header, re-price and re-adjudicate the claim and add/change the security if necessary.

II. Procedure for Correcting Claims After Reimbursement Through MACSIS (Finalized Claims)

Whether the correction for a finalized claim (claim processing status of "P") comes in on a **Claims Correction Form** initiated by the provider or whether the board identifies the service as possibly being billed incorrectly, the procedures for correcting the claims are the same.

- Providers are permitted 30 days from the date of notification of the potential error to respond to the board regarding the claim. If no response is received, the claim may be reversed by the board.

- No action is to be taken on erroneously billed Medicaid claims that will be too old ***by the time they get extracted and sent to ODJFS for adjudication.*** Adjustments will be handled in accordance with each department's ODJFS approved Medicaid Reconciliation Process.

1. Board and Provider-Identified Claims

Once a board receives written confirmation from the provider that the service was billed in error, or receives a **Claims Correction Form** initiated by the provider, they will follow one of the correction procedures below.

- The board will keep on file all written confirmations from providers regarding the erroneously billed services in question (i.e., for both those services confirmed as erroneous and those which were not confirmed as erroneous.)
- **DO NOT** reverse Medicaid claims that have not come back from the Ohio Department of Job and Family Services (ODJFS). If ODJFS rejects the claim and a board has already reversed the claim line in Diamond, the claim will have two reversal ACPAY records and the monies will be deducted from the provider twice. The only way to check if claims have been extracted and sent to ODJFS is to use the claims extract file. If there is a date in the ODHSEXTD field, the claim has been extracted and sent to ODJFS. When there is a date in the DTPAID field and in the ODHSEXTD field, the claim has been extracted, sent to, and returned by ODJFS.

a. <u>Claim Is a Duplicate</u>

These claims have already been denied as a duplicate and no correction is to be done to a finalized, denied duplicate claim. You cannot un-deny a claim by reversing it. If this was a "straggler" claim, the original claim is the one that will need to be corrected. Follow procedure b. below (Units of Service are Incorrect).

b. <u>Billed Amount, Units of Service, Procedure Code, Modifier, Place of Service or Third Party Amount are Incorrect</u>

Note: Only correct the place of service code if it is changing from 51 or 99, or to 51 or 99.

- This correction procedure is also to be used to correct "straggler" claims.
- Do not reverse Medicaid claims that have not come back from ODJFS. If ODJFS rejects the claim and a board has already reversed the claim line in Diamond, the claim will have two reversal ACPAY records and the monies will be deducted from the provider twice. The only way to check if claims have been extracted and sent to ODJFS is to use the claims extract file. If there is a date in the ODHSEXTD field, the claim has been extracted and sent to ODJFS. When there is a date in the DTPAID field and in the ODHSEXTD field, the claim has been extracted, sent to and returned by ODJFS.
- Currently ODJFS' adjudication deadline is 365 days from the date of service. Do not correct Medicaid claims if the date of service on the claim (MCD only) is such that when the correction is going to be made, reversing the claim will take the original payment back and the split claim will get denied and reversed by ODJFS as being too old and the provider will end up with no payment. DO NOT CORRECT THESE CLAIMS.

i. For those claims that should be corrected, using OPCLM access the claim line in question and enter a reversal line (001 R) and include one of the following adjustment reason codes:

- **MCDBA – Medicaid Billed Amount Correction**

- **NONBA – non-Medicaid Billed Amount Correction**
- **MCDMO – Medicaid Modifier Correction**
- **NONMO – non-Medicaid Modifier Correction**
- **MCDPR – Medicaid Procedure Code Correction**
- **NONPR – non-Medicaid Procedure Code Correction**
- **MCDTP – Medicaid Third Party Amount Correction**
- **NONTP – non-Medicaid Third Party Amount Correction**
- **MCDUN – Medicaid Units of Service Correction**
- **NONUN – non-Medicaid Units of Service Correction**
- **MCDPS – Medicaid Place of Service Correction**
- **NONPS – non-Medicaid Place of Service Correction**

Update (save) the claim detail.

ii. Access the claim header of the original claim, do an F6-S (split); all information on the claim header screen will be automatically filled in.

iii. Enter the correct amounts on the detail line of the split claim. No adjustment reason code should be entered on the split claim.

Note: It is important for boards to enter a split claim when correcting paid (by ODJFS) claims so the claim can go back through the Double Loop. This is because the reversed line will "reclaim" the payment from the provider and the split will go back through the double loop. ODMH will calculate how much FFP to withhold from a boards future Medicaid reimbursement based upon claims, which were reversed after being paid by ODJFS.

c. <u>UCI or Date of Service are Incorrect</u>

Using OPCLM access the claim line in question, boards will enter a reversal line (001 R) and one of the following adjustment reason codes:

- **MCDWC - Confirmed Incorrect UCI billed**
- **NONWC - Confirmed Incorrect UCI billed**
- **MCDWD - Confirmed Incorrect Date of Service**
- **NONWD - Confirmed Incorrect Date of Service**

Update (save) the claim detail.

Once this is complete, the board will either enter a new claim using the correct UCI or correct Date of Service or, depending upon volume, request the provider to submit a new claim. **If a board chooses to manually enter the new claim, make sure that the primary header date and the date of service on the detail line match.**

d. <u>Original Claim is Denied</u>

i. If the original claim(s) was denied due to missing or invalid modifier or diagnosis code, boards may require that the provider resubmit the claim(s) electronically or may choose to correct the claim manually,

depending on the volume. The resubmitted claim will not deny as a duplicate since the original claim was denied, not reversed.

ii. If the original claim(s) was denied due to board error (e.g., missing PROCP), boards cannot require the provider to resubmit the claim(s) electronically, unless mutually agreed to.

Note: No other claims may be corrected by resubmission.

e. <u>No Response From the Provider Within 30 Days of Notification</u>

Using OPCLM, access the claim in question and create a reversal line (001 R). Enter the following adjustment reason code:

- **NPR30 - No Provider Response Within 30 Days**

Update (save) the claim detail.

III. OHEXT Error Report Corrections (Claim and/or Member Eligibility Changes)

It is the board's responsibility to make the necessary changes to correct the errors being reported on the OHEXT error report. These errors occur when claims are adjudicated and finalized in MACSIS as MCD (Medicaid) but are not being extracted for submission to ODJFS. The primary reasons these claim lines are not being extracted is the OHEXT program cannot find a valid Medicaid ID number on the members eligibility span for the date of service to use to bill the record or the date of service on the claim detail line is different from the date of service on the claim header (primary date).

1. Error Indication: Medicaid Number Not Found or Invalid Medicaid Number

This message identifies a claim adjudicated in MACSIS when a Member's eligibility span that covers the date of service has a Medicaid plan but the Medicaid ID field (a.k.a. USERDEF1) in this span does not have a Medicaid ID number entered or the number entered does not pass a check digit validation routine in the program. To correct this error, a valid Medicaid ID must be entered on the appropriate span. If you do not know what the valid Medicaid ID is, the board must use the MACSIS Member function "EXINQ"* to find the valid Medicaid ID for the eligibility span.

**Procedures on how to use the EXINQ keyword (also known as the "EEI" function) can be found in the Member Manual.*

a. Once you have the valid Medicaid ID, access the Members eligibility span by using the F6 "special functs" and then select "E" to "View/maintain Elig History". Select "C" to change and enter the appropriate span number. When the span appears, enter through the fields until you reach the Medicaid ID field (a.k.a. USERDEF1) and enter the valid Medicaid ID number. Press "ENTER" again, then press "END". Select "S" for Save and use the "HOME" function to get back to the main Member Screen.

b. If the person was not Medicaid eligible on the claim's date of service but the claim was adjudicated as MCD, then the method of correction requires the claim to be reversed **AND** the Member's eligibility span(s) to be corrected. There are three (3) steps to correcting these claims:

Step One: Reverse the existing claims by using OPCLM to access the claim line(s) in question and access the claim detail screen by pressing the "END" key and selecting A to Adjudicate. Manually enter a "001 R" detail line to reverse the claim. Enter the adjustment reason code "ADMBR" (Claim Adjusted due to Member Eligibility Change). Press "END", then "Y" to update.

Step Two: After all affected claim detail lines have been reversed; the Member's eligibility span(s) **MUST** be corrected before entering split claims.

Step Three: Enter "new" claims by splitting the existing claims. Using OPCLM, access the original claim(s). From the Claim Header Screen use the F6 function key and then enter S to split the claim. Use the F6 function key and then enter "F" to refresh the header. Access the claim detail screen by pressing the "END" key and selecting "A" to adjudicate. Enter all necessary information from the original claim. Double-check to see that it now has a NON-Medicaid MEDEF (Medical Definition). If this was done properly, the claim has been properly processed as non-Medicaid but remains "connected" to the original claim. This is apparent because the claim number is the same except the last character of the split claim number is now an alpha character. The resulting "split" claim will process during the next APUPD cycle.

Note: Claims originally adjudicated as Non-Medicaid, which are later identified as being Medicaid eligible, are referred to as Retroactively Eligible Claims. These claims are not listed on the OHEXT Error Report because the claim was posted with a Non-Medicaid line of business. Reference the topic below "Claims Affected by Retroactive Medicaid Eligibility" for the processes related to correcting and re-billing these claims.

Note 2: Claims that were originally paid in MACSIS with a Medicaid line of business, billed, and paid by ODJFS then subsequently lost Medicaid eligibility are known as Medicaid Retroactive Eligibility Terminations. At this time since ODJFS does not pursue repayment when they retroactively terminate eligibility, those Medicaid claims will not need to be reversed or re-adjudicated as non-Medicaid.

2. DOS not Equal to Primary Date

This message identifies a claim adjudicated in MACSIS as Medicaid but the claim has a date of service on the claim detail line (DOS) that is different from the date of service on the claim header (Primary Date). These claims can not be reversed in Diamond and therefore are not extracted and sent to ODJFS.

The OBREV process uses the date of service on the claim detail line to post reversals back to Diamond. Since the date of service on the detail line is not the same as the date of service on the claim header, the claim can not be found and

therefore, not reversed. The OHEXT process excludes these claims from being extracted.

The only way to correct these claims is:

a. Reverse the claim in Diamond using an adjustment code of **MCDWD** (Confirmed Incorrect Date of Service).

b. If the date of service is correct on the header, split the claim and enter the correct information on the claim detail making sure the date of service on the claim detail is the same as the date of service on the claim header.

c. If the date of service is incorrect on the claim header **DO NOT SPLIT THE CLAIM**. You must enter a new claim making sure the same date of service is on the claim header and the claim detail.

NOTE: The only way for the date of service on the header and detail to be different is by manual entry/corrections made by the board.

IV. Claims Affected by Retroactive Medicaid Eligibility

1. Identifying Claims and Members

In accordance with the "**ODADAS-ODMH Guidelines**" "Topic 10: Retroactive Medicaid Eligibility" **Boards are required to make the claim adjustments/corrections in this section**.

Reports of claims originally adjudicated as non-Medicaid, which are later identified as likely to be eligible to be reimbursed by Medicaid are produced every month by the ODMH MACSIS Member and Eligibility Maintenance Section. A simplified explanation of the process is:

- Compares claims to Medicaid eligibility to locate members who have not been fixed in Diamond.
- Locates claims that have CPLAN/EPLAN mismatches.
- Takes into consideration those claims that have already been reversed and split
- Takes into consideration claims that have been denied and re-billed
- Denied claims with certain reason codes have now been included

Three files created and placed in your /county/extracts directory. The files are as follows:

a. hmondd.ret.clm.group_bd (ex: jul20.ret.clm.group_25b)

This file is in claims extract format and boards can begin fixing claims immediately. To do this you would reverse the original claim, split the claim, and refresh the header to make it Medicaid billable. (This would mean additional funds for board if claims are payable by Medicaid). This file

contains records for which the eligibility has already been changed in Diamond.

b. <u>hmondd.ret.mbr.group_bd (ex: jul20.ret.mbr.group_25b)</u>

- This file is in a tilde-delimited file with seven fields. These members need to have their eligibility fixed first in order to then fix their associated claims in the next file.
- There is a field called has_claims that contains a Y or N and you can utilize this to determine who has claims and needs their eligibility fixed immediately.
- The format for this file will be contained on MHHUB in /county/common.

Note: this file contains member records that need to be fixed so that you can fix the claims records in the file listed below.

c. <u>hmondd.ret.clmfxmbr.group_bd</u> (ex: jul20.clmfxmbr.group_25b)

This file is in claims extract format and boards can begin fixing claims once the member is fixed from the mondd.ret.mbr.group_bd file. Then you can reverse the original claim, split the claim, and refresh the header to make it Medicaid billable. (This would mean additional funds for board if claims are payable by Medicaid).

Note: YOU MUST FIX THE MEMBER ELIGIBILITY RECORD BEFORE YOU FIX THESE RECORDS!

2. <u>Correcting Retroactive Medicaid Eligibility and Claims</u>

These reports list all information necessary to correct the member eligibility and correct the claims.

There are several things about this process that needs to be highlighted:

- Correcting these claims will result in additional reimbursement to the board. The board should obtain the Federal Financial Participation as reimbursement from ODJFS for claims that are re-processed and found to have Medicaid eligibility. Therefore, it is a board's responsibility to correct these claims per the correction process outlined below.
- There may have been some claims that were denied because they were for an out-of-county client and the services were non-crisis. In these cases the provider never received payment for these services. These claims must be corrected so that the provider can be paid.
- When the "corrections" are made, the boards must communicate these corrections to the providers. The provider will encounter a negative claim that will be generated by this process on their reports and an offsetting positive claim, which they did not submit on one of their claim files.

a. <u>Correct Member Eligibility (hmondd.ret.mbr.group_bd)</u>

Access the member's record. Do an F6-E (View/maintain Elig History) to access the eligibility maintenance screen. Do "C" to change and select the appropriate span. Change the member's plan to a Medicaid plan. Enter the Medicaid number in the USERDEF field in the bottom left-hand corner.

Note: Be sure to correct all spans that are incorrect.

b. <u>Correct the Claims that Should have been Billed as Medicaid</u>

i. Un-Finalized Claims paid as non-Medicaid

- Using OPCLM, access the claim header screen and do an F6-F to refresh the member eligibility so you will have the updated member eligibility information. Access the claim detail screen by hitting "END", then "A" to adjudicate. Enter 001 to access the detail line and press F6-B to price and adjudicate the claim. Update (save) the claim detail.

ii. Finalized Claims paid as non-Medicaid

- Using OPCLM, access the claim line in question and access the claim detail screen by hitting "END" and selecting "A" to adjudicate. Enter a 001 R reversal line using the adjustment reason code of "ADMBR" (Claim Adjusted Due to Member Eligibility Change). Update (save) the claim detail.
- Return to the claim header screen and do F6-S (Split Claim) to split the claim. Refresh the claim header by doing F6-F (refresh member eligibility) so you will have the updated member eligibility information. Enter all necessary information from the original claim (either make a screen shot or write down all the information from the original claim) and verify the claim now has the appropriate Medicaid MEDEF. Update (save) the claim detail.

  If the original claim contained other carrier information (other carrier amount and other carrier reason code), make sure they are entered on the split claim.

  These are two separate claims, but by splitting the claim, the original and split claim will remain linked because the split claim number will be identical to the original except the last character (usually a zero) will be replaced with an alpha character (starting with A).

  Once the split claim is finalized, it will be extracted and submitted to ODJFS for payment the next time OHEXT is run. Do not reverse and split claims that will not make it to ODJFS within the ODJFS adjudication time limit.

iii. Denied Claims

- Using OPCLM, access the claim header screen and do F6-S (Split) to split the claim. Refresh the claim header by doing F6-F (refresh member eligibility) so you will have the updated member eligibility information.
- Access the claim detail screen by hitting “END” and selecting “A” to adjudicate. Enter all necessary information from the original claim (either make a screen shot or write down all the information from the original claim) and verify the claim now has the appropriate Medicaid MEDEF.
- Update (save) the claim detail.

Note: Do not reverse a denied claim. You cannot un-deny a claim.

V. Department Reporting Procedures

The State will produce the following reports as needed:

- Reversed Medicaid Claims in MACSIS – This report will list the claims (by board and provider), which were reversed by the board after payment had been made to the provider. It will be used to determine the amount of FFP a board owes the state.

- Held Medicaid Claims in MACSIS – This report will list the potentially erroneous claims. For example, non-Medicaid claims reversed using the Medicaid-specific reason codes or claims that have been held over 60 days with no action by the board or provider. It will be used to identify when boards may not be following this procedure.

- Board Denied Medicaid Claims in MACSIS – This report will list the MH and AOD claims by board and provider, which were “denied” due to erroneous billing before payment having been made to the provider (un-finalized claims).

Boards are encouraged to produce local versions of these reports for their use in monitoring claim correction activity.

XIV. How to ……

Un-pending Payable and Held Claims

This procedure is for claims with a claim status of “P” (Payable claims only) and a processing status of “H” (held). This procedure will update any benefit accumulators that are attached to the client by way of the Plan and its associated benefit rules.

To take a payable claim off hold you must be in “change mode”. First you must access the line item detail, i.e. type in 001 and press enter, hit enter again until the claim detail information is viewable, then proceed with F6-C (C-Clear Hold/Post to Accum.), hit end then save/update the

claim. This process will take the claim off hold, update the benefit accumulator and remove the "held reason code" all in one step. (See **Taking a Claim off Hold** flowchart.)

Un-pending Denied and Held Claims

This procedure is for claims with a claim status of "D" (denied claims only) and a processing status of "H" (held). Access the claim and go to the claim detail screen and do an F6-U, U or access the line item detail and change the "H" to "U" and remove the held reason code then save/update the claim. (See **Taking a Claim off Hold** flowchart.)

Making a Denied Claim Payable

A claim may have been denied because of benefit rules, manual intervention, or incorrect support files (see **Making a Denied Claim Payable** flowchart). If the claim should be a payable claim, you should first determine why it has been denied. If it has been denied because of benefit rules or incorrect support files, the claim should first be placed on hold to prevent finalization of the claim (see the next section **Putting a Claim on Hold**). Correct the support files or benefit rules via the Change Control process and proceed with the following steps:

1. If the allowed amount is = 0:
   - Manually enter the allowed amount
   - Manually adjudicate the benefit package if applicable
   - Change the claim status to P
   - Save/update the claim line
   - If the processing status is "H" (held), follow the procedure above for **"Un-pending Payable and Held Claims"**.
2. If allowed amount is **not** = 0 and the not covered amount = allowed amount:
   - Access the claim header
   - Refresh member eligibility (F6-F)
   - Access claim line detail
   - Re-adjudicate the claim line (F6-B)

Denying a Claim

Board staff will need to deny claims if the incorrect Date of Service is billed or the incorrect UCI is billed. Please refer to **Denying a Claim** flowchart.

To deny a claim:

1. Access the line item detail for the claim
2. Enter the not covered amount (the not covered amount should equal the allowed amount)
3. Enter the "not covered reason" code (NC/DN Rsn) - this will automatically change the claim status to "D" (denied)
4. If the processing status is "H" (held), change it to a "U" (un-posted) and remove the "hold reason" code

Putting a Claim on Hold

Claims are put on hold to prevent them from being finalized. This procedure would be used to keep the claim from being finalized while board staff verifies an erroneously billed claim. (See **Putting a Claim on Hold** flowchart.)

1. Access the claim line detail of the claim
2. Change the processing status to “H” (hold)
3. Enter the “hold reason code”

OHIO Claims

Claims where the member or provider is ineligible used to become OHIO claims with a denied reason of MBRIN or PRVIN. These claims now receive a critical error and do not make it into Diamond.

Reversing a Claim

When boards discover a claim has been erroneously billed and finalized (processing status of “P” or “F”), the claim needs to be reversed. Please refer to **Section XII. Claims Correction Policy**, **Section XIII. Procedure for Claim Corrections within MACSIS** and **Reversing a Claim** flowchart.

To reverse a claim:

1. Access the claim line detail of the claim to be reversed.
2. In the sub line enter an “R” for reverse.
3. Enter the “adjustment reason” code.
4. Press the End key
5. Enter “Y” to update the claim.

Note: Do not reverse a denied claim. You cannot un-deny a claim.

Splitting a Claim

Once it has been discovered that a service was billed in error, the claim must be corrected. If the claim has already finalized (a processing status of “P” or “F”) the original claim must be split. Whether the original claim needs to be reversed or not depends on the claim status of the original claim. If the claim status of the original claim is a “D” (denied) then you just need to split the original claim and enter the correct values in the applicable fields.

If the claim status of the original claim was a “P” (payable) or “A” (adjustment), the original claim must first be reversed (see section on **Reversing a Claim**). When you split a claim, the split claim will have the same date of service as the original claim and the claim number will be the same as the original claim with the exception of the last digit; an alpha character (i.e., “A”) will replace the last “0” of the claim number. Splitting a claim ties the original claim to the new claim line and makes it easier to track what you did to a claim for audit purposes. (See **Splitting a Claim** flowchart.)

Note: You must follow the policy "Claim Corrections in MACSIS" and the "Procedure for Claim Corrections within MACSIS" when making any type of claim corrections.

It is critical for boards to enter a split claim when correcting paid claims by ODJFS so the claim can go back through the Double Loop. This is because the reversed line will "reclaim" the payment from the provider and the split or new claim will go back through the double loop and will result in a payment to the provider.

The adjustment code must be entered on the reversed line because ODMH will use it for reporting purposes to calculate how much FFP to withhold from a board's future Medicaid reimbursement.

To split a claim:

1. Access the claim header
2. Hit the F6 function key, and enter "S" for Split, press enter - the new claim number will now appear (i.e., old claim # 176811370, new claim # 17681137A).
3. Hit the F6 function key and enter "F" to refresh the member eligibility.
4. Enter through the remaining fields, making any corrections to Provider, Place of Service, Diagnosis or Billed Amount.
5. Choose "A" for adjudication, which will take you to the claim detail screen.
6. Enter the correct information in the applicable fields.
7. Save/Update the claim line.

PSDSP - Viewing Client's Claim History

There will be times that it is necessary to look up the claim history of a member. To access a member's claim history, type the keyword "**PSDSP**" at the main Diamond screen. The display may be viewed for professional, dental, or institutional claims. Keep in mind you will only be able to view claim history on the claims that have your board's security code or claims that have no security code.

The display accesses three different screens. The first screen is the set up screen where you will need to enter the member number (UCI), claim file type (will always be "P" for professional services), and the starting date. The second screen lists all the applicable claim details for the member in order by date of service. From this listing screen, you may choose to view a specific claim line in more detail. The third (claim line detail) screen will then display.

This function may be accessed directly from the main menu, as well as from claim processing (OPCLM) and authorization functions.

Enter the member (UCI number) and person number (00) for which you wish to view claims history. If you do not know the member number, use the <F5> function to locate the member (from MEMBR). The member number must be a valid entry in the member file.

- Enter the claim file type. Valid entries are P (professional), I (institutional), or D (dental).
- In the field Production or Archive files, enter a “P” for production (you would only enter an “A” if the claims you wished to view had been archived).
- In primary date, enter the first date you want to view claims for the client. If you leave it blank, it will show you all claims for the client.
- Enter “Y” (default) at the “OK?” prompt.

```
PSDSP                    Member Utilization Display                STEMP=PSDSP

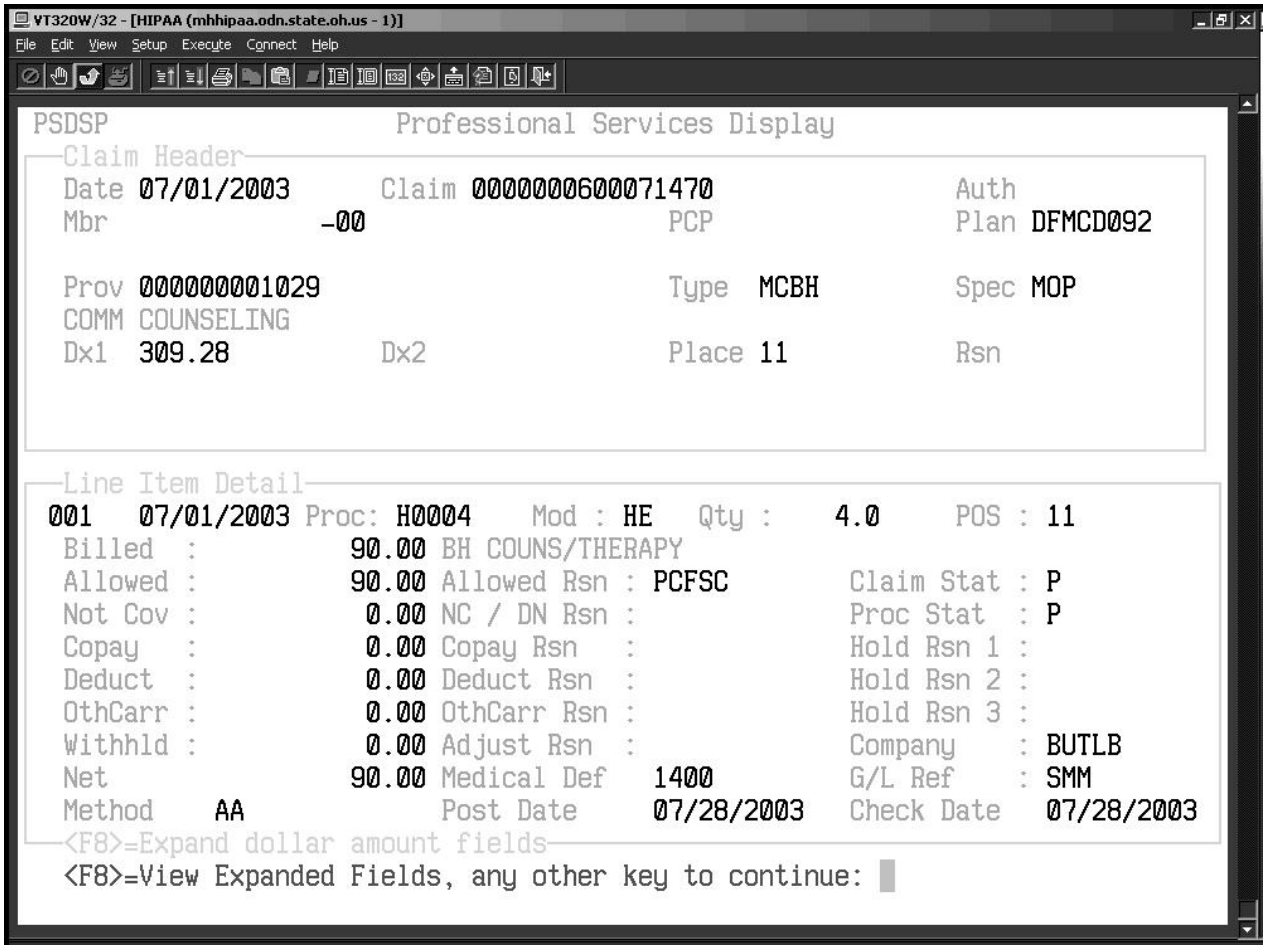
 Memb                                                      DOB

                                                           STAT
CLAIM NUM         DATE  NET AMOUNT PROC  M1 M2 UNITS LOB CL PR  PROVIDER
----------------  ---------------- ----- -- -------- --- -------------------
0000000700366940  09/26       4.97 H0006 HF HD   0.1 MCD P  P FIVE COUNTY
0000000626683360  11/13       4.97 H0006 HA      0.1 MCD P  P FIVE COUNTY
0000000635587560  12/09      88.20 H0004 HF      5.0 MCD P  P FIVE COUNTY
0000000644984570  01/16      70.56 H0004 HF HD   4.0 MCD P  P FIVE COUNTY
0000000644959710  01/23       4.97 H0006 HF HD   0.1 MCD P  P FIVE COUNTY
0000000654308770  02/19       4.97 H0006 HF HD   0.1 MCD P  P FIVE COUNTY
0000000661501210  03/04      70.56 H0004 HF HD   4.0 MCD P  P FIVE COUNTY
0000000661488590  03/05       4.97 H0006 HF HD   0.1 MCD P  P FIVE COUNTY
0000000665643170  03/18      52.92 H0004 HF HD   3.0 MCD P  P FIVE COUNTY
0000000665601960  03/25       4.97 H0006 HF HD   0.1 MCD P  P FIVE COUNTY

<Up/Down>=roll, D=Claims detail display, <Home>=exit:
```

The above screen then displays the following information for each claim: claim number, date of service, net amount of the claim, procedure code, modifiers 1 and 2, units, line of business, claim status, processing status and the provider. If there are too many claims to view on one screen, you page down to see the remainder. You can also print the screen by clicking on the printer icon on the toolbar. From this listing screen, you may choose to view a specific claim line in more detail.

To view a claim in more detail, highlight the claim you wish to view and enter a “D” for Claims detail display (see screen below).



XV. Special Functions in OPCLM

Special Functions from the Claim Header Screen

Press the F6 function key from the main OPCLM screen to access the Special Functions menu. Your access to some of the functions may depend on your Diamond Keyword access. For example, if you do not have access to the Keyword **MEMBR**, any of the special functions that take you to that Keyword will not be accessible to you. The same applies to Special Functions that indicate you can make changes/edit a screen. If you have read-only access and do not have write access, you will only be able to view the screen in read-only mode.

```
Special Functions
B - Change Default Batch        X - MEMBR Gateway
E - Error Message Summary       Y - PROVF Gateway
A - View Addresses              Z - AUTHF Gateway
V - Edit Vendor Info            J - Claims Change History
R - Display Remaining Auths     P - Covering Provider Summary
S - Split Claim                 5 - Attach EOB/RA Remarks
M - Add Member                  6 - Other Claim Information
T - Toggle Vendor/Payee
H - Claim History
L - Eligibility Status
C - COB Status
D - Display Authorization
F - Refresh Member Eligibility
Q - Query Group Services
I - Display Benefit Accumulators
N - Change Vendor
W - Newborn Demographic Data

Enter Choice:
```

- **B - Change Default Batch** - Allows you to change the Batch Number and Received date for the claim you are entering and all subsequent claims. **Do not use.**

- **E - Error Message Summary** - Displays any error messages that may have occurred on the Claims Header screen.

- **A - View Addresses** - Displays the member, provider and vendor primary addresses.

- **V - Edit Vendor Information** - Allows you to edit the vendor information. **Do not use.**

- **R - Display Remaining Auths** - Displays detailed information about the authorization entered on the claim. **Authorization function is turned off in Diamond so the only information shown on this screen pertains to this claim only.**

- **S - Split Claim** - Allows you to split a claim. Splitting a claim creates a duplicate copy of the claim header by adding an alpha suffix to the claim number in place of the last zero, i.e. original claim number - 145675800, split claim number - 14567580A.

- **M- Add Member** - Allows you to add a member to keyword MEMBR (Members) as the claim is being entered. **This is not activated.**

- **T - Toggle Vendor/Payee** - Allows you to switch the default vendor with the subscriber number. This may be used to directly pay the subscriber, rather than the assigned vendor. **Do not use.**

- **H - Claim History** - Allows you to view claims history. Displays the same information as the keyword **PSDSP**.

- **L - Eligibility Status** - Displays the member's eligibility as of the claim entry date. The following fields are displayed: Member ID, Eligibility Status, Eligible Through (same as Term in keyword MEMBR) and Member Riders.

- **C - COB Status** - Displays the existing coordination of benefit data for the member entered on the claim. COB data can also be entered using this screen.

- **D - Display Authorization** - Displays the existing authorization detail records. **Authorizations are not being used**.

- **F - Refresh Member Eligibility** - Updates the member's eligibility information on this claim. This can be valuable if a claim is being re-adjudicated and the member's eligibility may have changed since the claim was entered. **Note: You must re-adjudicate all claim line items after member eligibility is refreshed.**

- **Q - Query Group Services** - Lets you view the group services data entered using the keyword GRUPS.

- **I - Display Benefit Accumulators** - Lets you display eligibility and benefit information for the member as of a specific date. Displays the same information as the keyword **DSPBN**.

- **N - Change Vendor** - Lets you change an alternate vendor assignment on a manually entered claim after it has posted to production. **Do not use.**

- **W - Newborn Demographic Data** - Use this function if the claim is a Mother/Baby claim. **Not used for MACSIS purposes since the subscriber is always the client and not a dependent.**

- **X - MEMBR Gateway** - Displays keyword MEMBR with read-only access. You can access certain selected F6 Special Functions, as well as the F4 Notes function which will allow you to add notes to the member record.

- **Y - PROVF Gateway** - Displays keyword PROVF with read-only access. You can access certain selected F6 Special Functions, as well as the F4 Notes function that will allow you to add notes to the PROVF record.

- **Z - Authorization Gateway** - Displays keyword AUTH with read-only access. **Authorizations are not used for MACSIS.**

- **J - Claims Change History** - Displays keyword CHIST (Claim Change History Detail) with read-only access. **The Claim Change History Detail is not turned on in Diamond. You can access the keyword, but it will not display any information.**

- **P - Covering Provider Summary - Covering provider feature is not used for MACSIS purposes.**

- **5 - Attach EOB/RA Remarks - Not used.**

- **6 - Other Claim Information** - Displays the patient control number or allows you to enter the patient control number. It also allows you to provide information about an accident related to a claim. These fields are not used for MACSIS purposes.

Special Functions from the Claim Detail Screen

Press the F6 function key from the OPCLM detail screen to access the Special Functions menu. Your access to some of the functions may depend on your Diamond Keyword access. For example, if you do not have access to the Keyword **MEMBR**, any of the special functions that take you to that Keyword will not be accessible to you. The same applies to Special Functions that indicate you can make changes/edit a screen. If you have read-only access and do not have write access, you will only be able to view the screen in read-only mode.

```
Special Functions
H - Claim History                    1 - DME Information
O - Original Procedure               2 - Spinal Manipulation Info
D - Adjudication Decision            3 - Other Claim Data Info
P - Price Rule                       4 - Display Expanded Amount Fields
R - Display Remaining Auths          5 - EOB/RA Remarks
E - Examine Hidden Fields            6 - Claim Measurement Info
B - Both Price and Adjudicate
F - Allowed Factor
U - Unhold/Hold Detail Lines
A - Amounts and Reasons
L - Display Member Eligibility
V - View Authorization Detail
T - View Anesthesia Times
N - NDC Codes
M - M/Care Ded/Coins Amounts
S - Sum Net Amounts
J - Claims Change History
Y - Payment Detail
I - Special Programs Indicator
C - Clear Hold/ Post to Accum


Enter Choice :
```

- **H - Claim History** - Allows you to view claims history. Displays the same information as the keyword **PSDSP**.

- **O - Original Procedure** - Lets you view or enter an original billed procedure, an original billed modifier and an original allowed amount that may differ from the data actually entered on the claim line item. For example, if an incorrect procedure code was billed on the original claim and the board is notified by the provider of the error (before the claim is finalized) and the board corrects the procedure code and re-adjudicates the claim, choosing the F6 - O function would display the original procedure code.

- **D - Adjudication Decision** - Displays information used during claim line item adjudication, including medical definitions, Benefit package (including group and plan

codes) Co-pay amounts, percentage of billed or allowed amount, Benefit rules applied, provider withholding, Authorization claim status and Claim line item status.

- **P - Price Rule** - Displays the price rule definition and the price rule details used o price the claim line item as well as the basis for Diamond's calculation of the allowed amount.

- **R - Display Remaining Authorizations** - Displays the current status of the authorization entered on the claim. **Authorizations are not being used.**

- **E - Examine Hidden Fields** - Lets you view the following "hidden fields" on the claim: RA/EOB Print Flag, Hidden Field 1, Hidden Field 2, Net Amount Offset, Offset Reason Code and Cap Fund Status.

- **B - Both Price and Adjudicate** - Allows you to re-price or re-adjudicate a claim line item. If any information on the Professional Claims Header or Professional Claims Detail is changed after the initial claim entry, then you must re-adjudicate each line item.

- **F- Allowed Factor** - Allows you to view or enter the allowed factor. **Do not use to change the allowed factor.**

- **U - Unhold/Hold Detail Lines** - Allows you to either place all un-finalized claim line items on hold or remove the hold on all previously held claim line items. **Do not use this method to take a payable claim off hold. If you do, Diamond does not update the benefit Accumulator file.**

- **A - Amounts and Reasons** - Lets you view individual amounts and reason codes in the Hidden Component fields.

- **L - Display Member Eligibility** - Displays the Member Eligibility as of the claim entry date. The fields displayed are Member ID number, Eligibility status, Eligibility through date and Member riders.

- **T - View Anesthesia Time - NOT USED FOR MACSIS**

- **N - NDC Codes - NOT USED FOR MACSIS. NO NDC CODES IN SYSTEM.**

- **M - M/Care Ded/Coins Amounts - ONLY USED IN CALIFORNIA.**

- **S - Sum Net Amounts** - Displays the total net amounts for this claim.

- **J - Claims Change History** - Displays keyword CHIST (Claim Change History Detail) with read-only access. **The Claim Change History Detail is not turned on in Diamond. You can access the keyword, but it will not display any information.**

- **Y - Payment Detail** - Displays detailed payment information for the claim line. The fields displayed are: Sequence Number, A/P Trans ID, Check Number, Payment Status, Payment Status Date, Status Reason, RA/EOB Print Flag, Check Print Date, Vendor Name, Vendor Address1, Vendor Address 2 and Vendor City, ST, Zip.

- **I** - **Other Claim Information** - This screen allows you to specify if (EPSDT) Early and Periodic Screening, Diagnosis and Treatment was provided and whether Family Planning services were provided. **Not used in MACSIS.**

- **C - Clear Hold/Post to Accum** - This special function clears hold status, hold reasons and adjudications fields, then it re-adjudicates the claim line without applying any additional holds and updates the Benefit Accumulator file.

- **1 - DME Information - Not Used**

- **2 - Spinal Manipulation Info - Not Used**

- **3 - Other Claim Data Info - Not Used**

- **4 - View Expanded Dollar Amounts** - Displays full length of dollar fields.

- **5 - Attach EOB/RA Remarks - Not Used**

- **6 - Claim Measurement Info - Not Used**

XVI. Contracts, Pricing and Adjudication of Claims

How a claim prices and adjudicates is based on the member's eligibility, plan, panel, benefit package, as well as the provider contract, panel, price region and rates (PROCP). There are many elements involved in the pricing and adjudication of claims. Incorrectly built contracts and benefit rules can cause unexpected pricing and adjudication problems.

Price Schedule

Price Schedule is the value assigned to the fee schedule that is assigned to a specific provider. Each provider is assigned five price schedules. (**PSCHD** is the Diamond keyword for price schedule.)

Providers have three primary price schedules for services that are considered Medicaid reimbursable and two alternate price schedules for the non-Medicaid reimbursable services. The primary price schedules begin with a number and the alternate price schedules begin with a letter.

- P0 (0xx) Medicaid services
- P1 (1xx) AOD Individual Counseling (H0004 - HF)
- P2 (2xx)
    - MH Group Counseling (H0004 - HQ)
    - MH Group CSP (H0036 - HQ)
- A0 (Axx) Non-Medicaid services
- A1 (Bxx) AOD Hotline (H0030 - HF)

Please refer to **Procedure Codes and Affiliated Price Schedules** to see which procedure codes (PROCP's) should be attached to each primary and alternate price schedule. ***Attaching a PROCP to the wrong price schedule may cause incorrect pricing of claims.***

Panel

Panels are used in Diamond to categorize membership and it is one of the key fields Diamond uses when pricing claims.

- Panels will allow you to enroll clients in the same plan and apply the same benefits, but provide a different range of services, different rates, different funding sources, etc.

- Panels also allow a provider to contract with multiple boards using the same UPI and price schedules. Most boards have one panel, but some boards use panel to distinguish groups by age, SMD status, programs, funding sources etc. For example, if you wanted to categorize people into smaller groups - either by age, programs, types of service, etc. you could use various panels: 18A - ADAS clients, 18M - MH clients, 18D - dually funded clients, 18S - SMD clients, etc.

Price Region

Price Region is used along with price schedule to attach rates to a contract. All Standard and Default contracts are built with an OH (Ohio) price region. The use of other than an OH price region on Non-Medicaid Standard contracts is only necessary if you have different rates, a different range of services, or different withholds than the Standard Medicaid contract.

- If a board has different rates, a different range of services, or different withholds than the Standard Medicaid contract (which requires other than an OH price region on the contract), it is up to the board to make the changes to the Non-Medicaid contracts.

    - The board is also responsible for entering all rates (PROCP's) in Diamond with the new price region.

- UPI, LOB and Panel point Diamond to the correct contract while Price Region and Price Schedule point Diamond to the correct rates (PROCP's).

PROCP

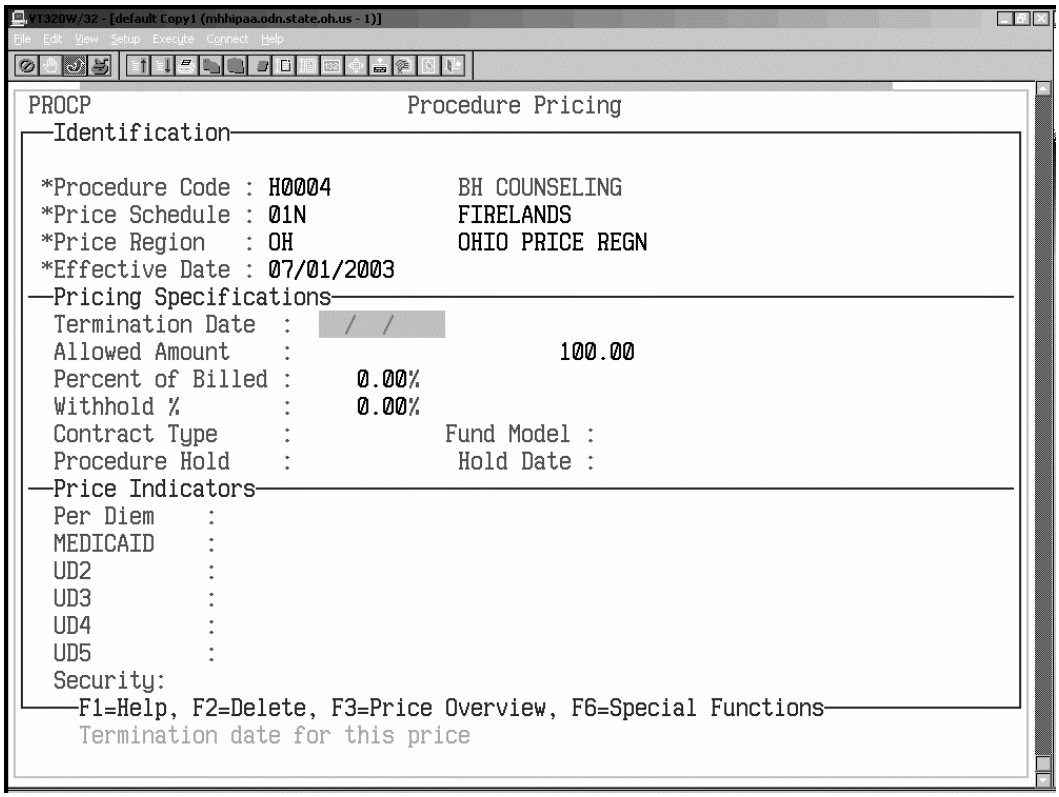
PROCP is the Diamond keyword for Procedure Pricing. This is the record in Diamond that holds the rate for a service (procedure).

- Medicaid rates (PROCP's) are entered and maintained by the State. These rates can only be viewed by logging on to Diamond using MEDRATES as the login and password. Medicaid rates will have a security code of "9" for AOD and "0" for MH.
- Non-Medicaid rates (PROCP's) are entered and maintained by the boards and will have the board's security code.

The Price Schedule (PSCHD) and the Price Region are the only things that tie a PROCP (rate) to a contract.

- If you have a different price region on the contract than is on the PROCP or vice versa, the rate will never be found and Diamond will not be able to price the claim (there will be no allowed amount).
- When you have a denied claim with no allowed amount and no reason code it is usually because there is no PROCP or Diamond could not find one with the correct price schedule and price region.

Sample PROCP



```
PROCP                          Procedure Pricing
 Identification

 *Procedure Code : H0004          BH COUNSELING
 *Price Schedule : 01N            FIRELANDS
 *Price Region   : OH             OHIO PRICE REGN
 *Effective Date : 07/01/2003
 Pricing Specifications
  Termination Date  :   /  /
  Allowed Amount    :                    100.00
  Percent of Billed :     0.00%
  Withhold %        :     0.00%
  Contract Type     :            Fund Model :
  Procedure Hold    :             Hold Date :
 Price Indicators
  Per Diem    :
  MEDICAID    :
  UD2         :
  UD3         :
  UD4         :
  UD5         :
  Security:
   F1=Help, F2=Delete, F3=Price Overview, F6=Special Functions
    Termination date for this price
```

Price Rule

Price Rule identifies the pricing method for each procedure code and is attached to the PROVC or Provider Contract record.

- PRULE 1 is for professional pricing and PRULE 2 is for institutional pricing.
- MACSIS uses PRULE 1 only and the name of the Price Rule is OH.
- Pre-FY04 contracts use a PRULE PH (PH = pre-Hipaa) that denies all services.

Provider Contracts

PROVC

PROVC is the Diamond keyword for Provider Contracts. In order for a provider to be paid for services, a provider must have a contract created in Diamond. Each provider (UPI) will have multiple contracts, based on line of business, panels, price regions and effective dates.

If a provider only contracts with one board, they will have four PROVC records for the current contract year:

- FYxx Medicaid Standard Contract
- FYxx Medicaid Default Contract
- FYxx Non-Medicaid Standard Contract
- FYxx Non-Medicaid Default Contract

The number of contracts in Diamond for any provider depends on how long they have been billing services to MACSIS, whether their contracts span multiple years and whether they contract with multiple boards.

Note: There will be two additional default PROVC records created for each provider that will deny all services with a date of service prior to 7/1/2003.

Sample PROVC

```
VT320W/32 - [default Copy1 (mhhipaa.odn.state.oh.us - 1)]
File Edit View Setup Execute Connect Help

PROVC                          Provider Contracts     Contract Details on File
 Identification
*Prov ID: 000000001168 FIRELANDS-ERIE     *LineBus   : MCD
*Panel  : 22B                             *Effective : 07/01/2003
 Status
 Terminated    :  /  /          Par Flag    : Y
 Term Reason   :                PCP Flag    : N      Thresh Met    :
 Default Contr : P              Enroll Limit:      0 Thresh Month  :   /
 PROVCUSERDEF  :                Specialty   : DOP    Print RA?(Y/N): N
 Primary Taxonomy Code :
 Pricing
 Price Rule 1 : OH          % Billed  :   0.00       Claim Hold :
 Price Rule 2 :             % Allowed : 100.00       Hold Date  :   /  /
 Price Sched  : 01N         Withhold  :   0.00       Geo Region :
 Alt Schedule : A1N         % AWP     :   0.00       Svc Region :
 Price Region : OH          Disp Fee  :   0.00       Cov Group?   N
 Fund Model   :
 Associations
 IPA          :                     Fed Tax ID : 344428218
 FFS Vendor   : 1168                FIRELANDS-ERIE
 CAP Vendor   : 1168                FIRELANDS-ERIE
 Security     : 9
 F1=Help,F2=Delete,F3=Contract Overview,F4=Notes,F6=SpecFuncts,F7=Letters
    Contract Termination Date
```

PROVD

PROVD is the Diamond keyword for Provider Contract Detail. This keyword is used to control pricing for “shared” procedure codes under HIPAA. PROVD may be accessed as a keyword or it may also be accessed from the PROVC screen by choosing F6-T. The “shared” procedure codes are:

- Counseling (H0004)
  - MH Individual Counseling (H0004, modifier 1 = HE)
  - MH Group Counseling (H0004, modifier 1 = HQ)
  - AOD Individual Counseling (H0004, modifier 1 = HF)
- Hotline (H0030)
  - BH Hotline (H0030, modifier 1 = HE)
  - AOD Hotline (H0030, modifier 1 = HF)
- MH CSP (H0030)
  - MH Individual CSP (H0030, modifier 1 = HE)
  - MH Group CSP (H0030, modifier 1 = HQ)

The PROVD record allows you to create multiple contract records defined by the provider address and claim type. Each PROVC record will have two PROVD records. In order to use the PROVD feature, each UPI will be assigned three PROVA records that define the three addresses for a UPI. They are as follows:

- 000 - Main Address (s/match 837P, 2010AA, N301)
- 001 - AODINDIV (valued by pre-processor for claims submitted electronically)
- 002 - MHGROUP (valued by pre-processor for claims submitted electronically)

Sample PROVD (AOD)

```
VT320W/32 - [default Copy1 (mhhipaa.odn.state.oh.us - 1)]
File  Edit  View  Setup  Execute  Connect  Help

PROVC                        Provider Contract Detail
 Provider Contract Identification
*Prov ID: 000000001168 FIRELANDS-ERIE            *LineBus   : MCD
*Panel  : 22B                                    *Effective : 07/01/2003
 Provider Contract Detail Identification
*Address      : 001  AODINDIV                    *Detail Eff: 07/01/2003
*Claim Type   : P                                Term Date  :  /  /
*Order Num    : 001
 Status Override
 Contract Type : P
 Pricing Detail Override
 Price Rule 1  : OH       % Billed  :   0.00        Claim Hold :
 Price Rule 2  :          % Allowed : 100.00        Hold Date  :
 Price Sched   : 11N      Withhold  :   0.00        Geo Region :
 Alt Schedule  : B1N      % AWP     :   0.00        Svc Region :
 Price Region  : OH       Disp Fee  :   0.00
 Fund Model    :

 Security      : 9
 F1=Help, F2=Delete, F3=Contract Detail Overview, F6=Special Functions
    Enter the term date of the contract pricing detail
```

Sample PROVD (MH)

```
PROVC                          Provider Contract Detail
──Provider Contract Identification──────────────────────────────────────
*Prov ID: 000000001168 FIRELANDS-ERIE            *LineBus   : MCD
*Panel  : 22B                                    *Effective : 07/01/2003
──Provider Contract Detail Identification───────────────────────────────
*Address      : 002  MHGROUP                     *Detail Eff: 07/01/2003
*Claim Type   : P                                Term Date  :  /  /
*Order Num    : 001
──Status Override───────────────────────────────────────────────────────
 Contract Type : P
──Pricing Detail Override───────────────────────────────────────────────
 Price Rule 1  : OH       % Billed  :   0.00        Claim Hold :
 Price Rule 2  :          % Allowed : 100.00        Hold Date  :
 Price Sched   : 21N      Withhold  :   0.00        Geo Region :
 Alt Schedule  :          % AWP     :   0.00        Svc Region :
 Price Region  : OH       Disp Fee  :   0.00
 Fund Model    :

 Security      : 9
──F1=Help, F2=Delete, F3=Contract Detail Overview, F6=Special Functions──
   Enter the term date of the contract pricing detail
```

Sample - PROVA (Sequence 000)

```
PROVA                          Provider Addresses
──Identification────────────────────────────────────────────────────────

  *Prov ID   : 000000001168                      *Sequence : 000
               FIRELANDS-ERIE
   Name 1    : Firelands Counselings And
   Name 2    : Recovery Services
   Address 1 : 2020 HAYES AVENUE
   Address 2 :
   City      : Sandusky
   State     : OH
   Zip Code  : 44870
   Country   :
   Contact   : Marsha Mruk
   Phone     : (419)627-5177     Extension :
   County    : ERIE
   Group     :
   Fax       : (419)627-5179
   Default?  : N

   Security  :

────F2=Delete, F3=Overview, F6=Special Functions──────────────────────
```

Sample PROVA (Sequence 001)

```
PROVA                                Provider Addresses
 Identification

   *Prov ID    : 000000001168                        *Sequence : 001
                 FIRELANDS-ERIE
    Name 1     : AODINDIV-FIRELANDS-ERIE
    Name 2     :
    Address 1  : AODINDIV
    Address 2  :
    City       :
    State      :
    Zip Code   : 43215
    Country    :
    Contact    : Marsha Mruk
    Phone      : (419)627-5177      Extension :
    County     : ERIE
    Group      :
    Fax        : (419)627-5179
    Default?   : N

    Security   :

   F2=Delete, F3=Overview, F6=Special Functions
```

Sample PROVA (Sequence 002)

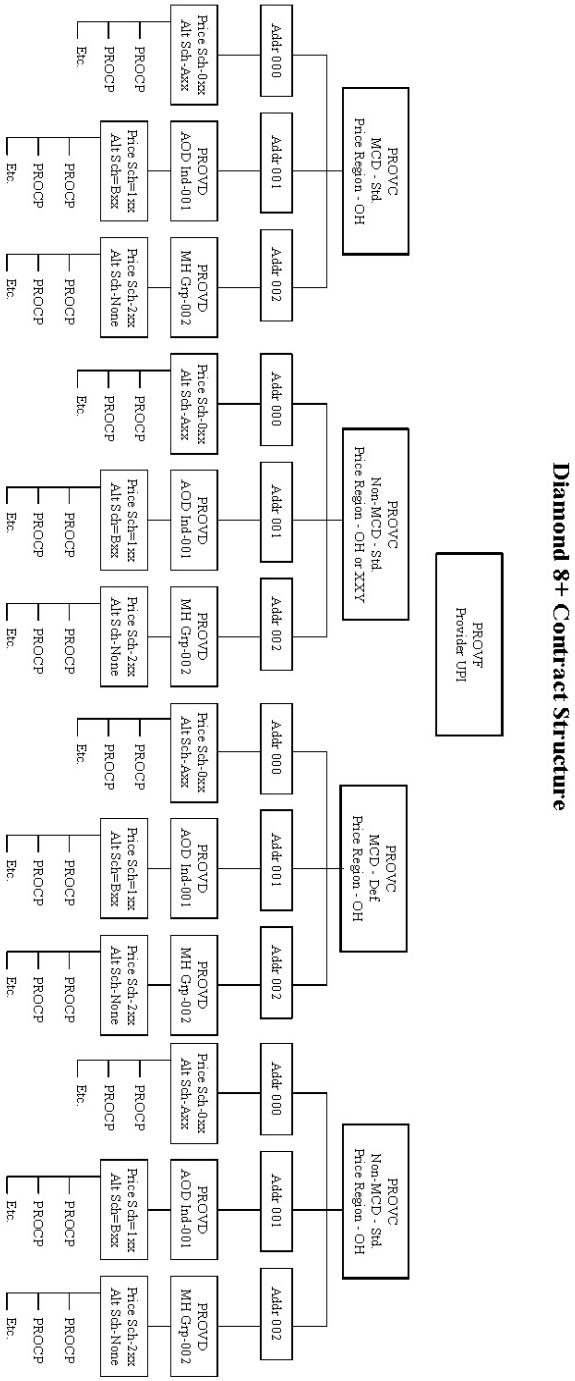
```
PROVA                                Provider Addresses
 Identification

   *Prov ID    : 000000001168                        *Sequence : 002
                 FIRELANDS-ERIE
    Name 1     : FIRELANDS-ERIE
    Name 2     :
    Address 1  : MHGROUP
    Address 2  :
    City       :
    State      :
    Zip Code   : 43215
    Country    :
    Contact    : Marsha Mruk
    Phone      : (419)627-5177      Extension :
    County     : ERIE
    Group      :
    Fax        : (419)627-5179
    Default?   : N

    Security   :

   F2=Delete, F3=Overview, F6=Special Functions
```

The Flowchart below diagrams the Diamond 8+ Contract Structure.



Standard versus Default Contracts

Standard Contracts price claims for services when a board contracts directly with a provider. Default Contracts price claims for services that are provided to an out-of-county (out-of-panel) client. For every Standard Contract there is a corresponding Default Contract no matter what the line of business.

Medicaid versus Non-Medicaid Contracts

Medicaid Contracts price claims for clients who are enrolled in a Medicaid plan and therefore have a MCD line of business. Non-Medicaid Contracts price claims for clients who are enrolled in a Non-Medicaid plan and therefore have a "NON" line of business.

- **LineBus** - Line of business (LOB)

  This refers to the client's Medicaid eligibility. They are either MCD (Medicaid eligible) or NON (non-Medicaid eligible). **Do not confuse the client's line of business with whether the claim was reimbursed as Medicaid or non-Medicaid**.

You can have a client with a Medicaid line of business who receives a non-Medicaid reimbursable service. The service is paid as a non-Medicaid claim, but the client is still a Medicaid client with a MCD LOB.

- These services are paid with a non-MCD G/L reference code
- This does not mean the client is non-MCD; just that as part of the client's eligibility they can receive non-Medicaid services that may be paid by other board funds. The services are just not reimbursed by Medicaid.

There is both a MCD and a NON-MCD Default Contract (out-of-county). The NON-MCD default contract puts all claims on hold with a reason code of OOCTY. The MCD Default Contract will pay the Medicaid reimbursable services and will deny the non-Medicaid reimbursable services.

Note: If a MCD client receives a Medicaid eligible service from an out-of-county provider, but because of the modifier the service is assigned a non-Medicaid MEDEF (not reimbursable by Medicaid) this claim will not be put on hold. It will be paid with a non-MCD G/L reference code. Only services that hit the non-MCD default contract go on hold.
Note: Default and Standard Contracts illustrates the way the contracts are set up in regards to line of business, price schedules, panels and price region.

Claims Pricing

Two steps occur when a claim is entered into Diamond (whether EDI or manual entry). The first process prices the claim (assigns an allowed amount) and assigns a MEDEF (medical definition) and the second process adjudicates the claim or applies the benefit rules (BENEF). The information on the member's eligibility span that encompasses the date of service on the claim determines the contract under which a claim is priced. The contracts and PROCP's price the claim and determine the allowed amount.

MEDEF

MEDEF is the keyword, which stands for Medical Definition. MEDEF's are a way to categorize the type of service rendered and expense the claim (assign G/L reference codes).

A MEDEF is assigned based on the client's line of business (MCD/NON) the procedure code, modifier 1, modifier 2 and in some instances the place of service. Each MEDEF that is payable under a board's plan is assigned a G/L reference code. The assigned MEDEF is used later in the adjudication process.

The valid MEDEF's are assigned by the State. Please refer to **ODMH Procedure Code, Modifier and Medical Definitions Matrix** and **AOD Procedure Code, Modifier and Medical Definitions Matrix** for the valid medical definitions.

Note: MEDEF's can also be used for ad-hoc utilization reporting.

How Claims Price

During the claims pricing process Diamond asks several questions (See **Contracts and Pricing** and **Contracts and Pricing after PROVC Record Found** flowchart):

1. Is the client eligible on the date of service?
   - **No:** If the client is not eligible the claim will critical error and will not make it into Diamond. If the client is eligible it looks to see if the provider (UPI) who provided the service has a contract in Diamond that matches the clients LOB (line of business).
2. Is there a contract in Diamond for the provider (UPI) that matches the client's line of business (LOB)?
   - **No:** If there is no contract for the provider in Diamond that matches the client's line of business, the claim is denied due to PRVIN (provider ineligible).
3. Is there a contract based on the client's panel?
   - **No:** If there is no provider contract that matches the client's panel then it hits the default contract.
     - If the LOB is Medicaid - The MCD services (primary price schedules) are priced (assigned an allowed amount) and a MEDEF is assigned. The non-MCD reimbursable services (alternate price schedules) are denied.
     - If the LOB is NON - All services (on either the primary or alternate price schedules) are priced (assigned an allowed amount), a MEDEF is assigned and the claim is put on hold with an OOCTY hold reason.
   - **Yes:** If there is a contract with the client's LOB and panel, Diamond then prices the claim (assigns an allowed amount) and assigns a MEDEF.
4. Is the service for AOD Individual Counseling (H0004-HF), MH Group Counseling (H0004-HQ) or MH Group CSP (H0036-HQ)?
   - If the service is AOD Individual Counseling, the pre-processor will force the "Rendering Provider Address" value in the XML file to AODINDIV (sequence 001).
     - For manual claim entry you will need to make sure you enter **001** in the **Prov Addr Flag** field on the claim header.
   - If the service is for MH Group Counseling or MH Group CSP the pre-processor will force the "Rendering Provider Address" value in the XML file to MHGROUP (sequence 002).

- For manual claim entry you will need to make sure you enter **002** in the **Prov Addr Flag** field on the claim header.

- If the service is **not** for AOD Individual Counseling (H0004-HF), MH Group Counseling (H0004-HQ) or MH Group CSP (H0036-HQ) the Rendering Provider Address will equal the Billing Provider Address (Loop 2010AA, N301).
  - For manual claim entry you will need to make sure you enter **000** in the **Prov Addr Flag** field on the claim header.

5. Is there a rate in for the service received by the client?
   - Diamond looks at the **Rendering Prov Addr** on the claim and then assigns the **Prov Addr Flag to 000 (default), 001 or 002**. (For manually entered claims, Diamond does not need to assign a **Prov Addr Flag**. It was already assigned when the claim was entered manually into Diamond.)
     - If the **Prov Addr Flag** is 000, Diamond looks at the primary and alternate price schedule on the PROVC record. If Diamond finds a rate (PROCP) attached to the primary or alternate price schedule, the claim is priced and a MEDEF is assigned.
     - If the **Prov Addr Flag** is 001, Diamond will look at the PROVD record with the Address 001 AODINDIV. If Diamond finds a rate (PROCP) attached to the primary or alternate price schedule, the claim is priced and a MEDEF is assigned.
     - If the **Prov Addr Flag** is 002, Diamond will look at the PROVD record with the Address 002 MHGROUP. If Diamond finds a rate (PROCP) attached to the primary price schedule, the claim is priced and a MEDEF is assigned.

Claim Adjudication

Once a claim is priced (allowed amount and MEDEF assigned) the second process adjudicates the claim. During the adjudication process the Benefit Rules (BRULE'S) that are associated with a client's plan via the Benefit Package (BENEF) are applied and a net amount is determined.

BRULE

Benefit Rules are used to define how member benefits are administered. For example, your board can create benefit rules that apply co-payments to specific services, deny services that exceed a limit, restrict the amount of out-of-pocket expenses incurred by a member, place services on hold for further review, etc. Benefit Rules are built around MEDEF's. There are six types of benefit rules:

- BRULE 10 - **Coinsurance** - also known as sliding fee and computes the client's out-of-pocket expense by applying a percentage times the allowed amount based on MEDEF's.

- BRULE 20 - **Limits** - used to limit the number of services a client can receive based on MEDEF's. Those claims that exceed the limit will deny with a reason code of LMBEN. Limit rules are tracked through Benefit Accumulators. You can view this information by accessing the Diamond keyword DSPBN (display benefit accumulators).

- BRULE 30 - **Deductibles** - establishes a set amount a client is required to pay towards a particular service based on MEDEF's. The difference between Deductibles and Coinsurance is a deductible is a set amount based on service no matter how much the allowed amount while coinsurance is based on a percentage of the allowed amount.

- BRULE 40 - **Out-of-Pocket Maximums** - limits the maximum out-of-pocket expense a client will have to pay for specific services (based on MEDEF's) in a specific time period.

- BRULE 50 - **Message and Pend** - places a claim on hold with a specific message for services based on MEDEF's.

- BRULE 60 - **Exclusions** - used to exclude services (based on specific MEDEF's) from payment and will cause the claim status to be "D" (denied)

BENEF

The Benefit Package is attached to a board's plan and contains all the Benefit Rules that are to be applied to each member of that plan. Each member is enrolled in a plan. Each plan is assigned a benefit package (BENEF).

How Claims Adjudicate

Once a claim has priced and been assigned a MEDEF, the adjudication process begins. Diamond looks at the member's eligibility to see what plan the client was enrolled in on the date of service. Next it determines which benefit package (BENEF) corresponds to the client's plan.

After determining the client's benefit package Diamond reviews the benefit rules associated with the benefit package to determine which should be applied to the claim.

Diamond will apply a rule if the medical definition assigned to the claim detail line is one of the medical definitions entered on one of the benefit rules. Once the appropriate benefit rules have been applied, a net amount is assigned to the claim.

The application of the benefit rules may change the claim status on the claim. For example, during the pricing process an allowed amount and MEDEF are assigned along with a claim status of "P" (payable), but during the adjudication process if there is a benefit rule that excludes this service from payment based on the MEDEF, the claim status would then become a "D" (denied), a not covered amount would be calculated and a not covered reason code assigned.

Pricing versus Adjudication

The pricing process determines an allowed amount and assigns a MEDEF based on UPI (provider), LOB (line of business), member's panel, procedure code, modifier 1, modifier 2 and place of service. Adjudication applies the benefit rules (BRULE'S) based on the benefit package (BENEF) and determines the net amount and claim status.

If claims are not pricing/paying properly it is usually caused by:

- Improperly built contract

- Missing or improperly entered PROCP's

- Incorrectly built benefit rules

TIP: When claims do not price properly (either incorrect allowed amount or no allowed amount) use the ***Contracts and Pricing*** flowchart to go through each step to try to pinpoint what is causing the problem.

XVII. Denying Non-Medicaid Claims beyond Submission Deadline

Some boards set deadlines with their providers for submission of non-Medicaid claims for the prior fiscal year. For example, all non-Medicaid claims for FY06 must be submitted by 9/30/2006 in order to receive payment.

To meet this need the State has come up with a procedure that will automatically deny these claims. (**This does not apply to the Default Medicaid or Default Non-Medicaid contracts.)** The drawbacks are:

1. New contracts must be built and the old contracts termed.
2. The alternate price schedules must be removed from the termed Medicaid contract and both primary and alternate price schedules must be removed from the non-Medicaid contracts.
3. There will be no denied reason code on the claim.
4. This cannot be set up until the submission deadline has been reached.
5. This is an all or none scenario - must deny all non-Medicaid services. It is not procedure code specific.

In order to implement this procedure, boards must notify MACSIS Support with the appropriate information as outlined in the procedure documentation (see **Denying Non-MCD Claims beyond Submission Deadline.**

XVIII. Reference Documents

The reference documents included in this section are updated as needed. The most current versions available have been included. Please check the MACSIS Website periodically for any updates that may become available (http://www.mh.state.oh.us/ois/macsis/macsis.index.html).

TCP/IP Access

Office of Information Technology
Request for TCP/IP Access

Applicant Information

Name (first, middle initial, last)		Job Title	
Preferred Name		Soc. Sec. No. **	Birthdate
Driver's License No. and State	Driver's License Exp. Date	Secret Key (enter a word you will not forget)	
Work Information			
Agency			
Street Address		City, State, Zip	
Phone No.	Fax No.	Email Address	
Home Information			
Street Address			
City, State, Zip		Phone No.	

** Soc. Sec. No is optional for SecurID Token **only**

The Office of Information Technology has the right to deny or restrict TCP/IP access at its discretion.

ORC 2913.04(B) states that "No person shall knowingly gain access to, attempt to gain access to, or cause access to be gained to any computer, computer system, or computer network without the consent of, or beyond the scope of the express or implied consent of, the owner of the computer, computer system, or computer network, or other person authorized to give consent by the owner".

Please review the Internet Security policy(ITP B.6) located at: http://oit.ohio.gov/IGD/policy/OhioITPolicies.aspx

I agree to use this TCP/IP access solely for the reasons disclosed above. I agree that I will not allow anyone else to use my access and will report any suspicions regarding such misuse.

Applicant's Signature	Date

SPONSOR USE ONLY

Sponsor Information

Name (first, middle initial, last)			
Agency		UID.	
Resource Information			
System(s) to be Accessed			Is the requestor a state employee?
			☐ Yes ☐ No

I hereby acknowledge and authorize the applicant of this document to be granted access to the resource(s) noted above.

Applicant's Signature	Date

OIT SECURITY PERSONNEL USE ONLY

Login Name	DCE ID	
Token Serial	Client(s)	
Expiration Date	Token Type	
Purchased by	Date	
OIT Network Security Administrator's Signature		Date

Rev.8/06

MACSIS Account Request

MACSIS ACCOUNT REQUEST

Instructions: This form must be used to open, close, or otherwise modify a MACSIS (Diamond 725) on-line account. Please note that without proper authentication and required signatures, no account may be altered or established.

This form should be returned to the Ohio Department of Mental Health C/O MACSIS Account Coordinator, Suite 1010, 30 East Broad Street, Columbus, Ohio 43266-0414. You may submit via Fax to 614-752-6474.

Please note there are 4 Diamond Environments (see description on back). **A separate form is required for opening an account in each Environment.** It is especially important that there be clear definition of the needed access rights for each.

The Board/Consortium MACSIS Administrator (or appointing authority) will be notified when this account request has been completed.

As of January 1, 1999, a completed and signed "MACSIS Statement Regarding Disclosure of Information" form (DMH-OIS-043) is also required to open a MACSIS account in TEST or PRODUCTION.

Board/Office	Today's Date

Complete the information below for the person who will be using this

Last Name	First Name	Middle Initial **(required)**	
Telephone No. ( )	Extension (if applicable)	Fax No. ( )	Existing Logon (if applicable)
Job Title		E-Mail Address	

Environment		Action Requested	
☐ Production	☐ Test	☐ Create New Account	☐ Remove Existing Account
☐ Demo	☐ Training	☐ Modify Existing	☐ Recover Lost Password

Access Key: 0 = No Access 2 = Read/Write
1 = Read only 3 = Read/Write/Delete

Security Group	No.	Access	Security Group	No.	Access	Keyword	Access
System Administration Only	01		Enrollment Maintenance	35			
EDI Production Control	02		Claims Supervisor	40			
Security/System Parameters	03		Claims Processing	45			
MOM Only	10		Authorizations Supervisor	50			
State Tables (boards read-only)	15		Authorizations Maintenance	55			
Feedback	17		Capitation Supervisor	70			
Shared Board and State Tables	18		Capitation	75			
Board Tables	20		Customer Services	80			
General Supervisor	21		Supervisor	85			
Pricing	25		Customer Services	99			
Membership Supervisor	30		Universal				

Signature of New Account User	Date
Signature of Authorizing Responsibility (i.e., executive office, MACSIS project coordinator)	Date

For Ohio Department of Mental Health Use Only

Date Received	Logon	Password	Initials	Security Code
Date Completed	Processor			

(continued on reverse)

DMH-OIS-040 (Rev. 1/99)

MACSIS ACCOUNT REQUEST

General Background Information

Environments:

There are currently 4 Diamond 725 Environments being used in the MACSIS project: PRODUCTION, TEST, DEMO, and TRAINING. Individuals may have accounts in some or all, typically with different "access rights" or functionality in each.

PRODUCTION

This is completely reserved for real business operations. All accounts must be assigned specific Security Group privileges. The general guidelines suggest that only "live" Board/Consortium will be enabled for this area, that access authority shall be narrowly defined, and in particular, delete authority will be severely limited.

TEST

This is a serious evaluation area where new definitions, system upgrades, and the like are evaluated for coherency and fit with PRODUCTION functionality. The TEST Environment will be maintained as a duplicate of PRODUCTION except that Boards/Consortium which are about to "go live" will be enabled for test/evaluation to work in this area. It is recommended that TEST accounts include Security Group definition though it is imaginable that read-write and read-write-delete be more available here then in PRODUCTION. It is possible to request a rather general READ ONLY access if you are not yet close to "go live" and would benefit from being able to review a more "real data area."

DEMO

The material in this Environment is refreshed from PRODUCTION on a (yet to be determined) scheduled basis. There will be real or realistic definition and structure but our intent is to reduce or eliminate direct client identifying information.

DEMO is provided for much more wide open exploration and testing. It is not planned at this time to include Security Group definition on these accounts. In general all accounts will have complete access including read-write-delete. Access should still be limited to staff with real identifiable need to be involved with client related material.

TRAINING

This is the sample distribution dataset provided by HSD with the Diamond 725 product. It no longer matches the MACSIS developments on a one-to-one basis but still provides an excellent tool to introduce the general concepts, especially to staff or individuals who have no business reason to be involved with real client related information.

There are a number of generic "user" accounts available for your use in this environment. Also, a specific person or "shared" account can be defined as well.

MACSIS Sample 837P UPI File

ISA*00* *00* *ZZ**000000000012345***ZZ***25B** *030707*0812*U*00401*000000257*0*T*:
GS*HC***12345*25B***20030715*0812*1*X*004010X098A1

S. 69 – Appl Sender and Receiver Code

S. 68 – Sender and Receiver ID

TRANSACTION SET HEADER
ST*837*000000001
BHT*0019*00*258*20030715*0812*CH
REF*87*004010X098DA1

LOOP 1000A SUBMITTER NAME
NM1*41*2*DO GOOD THINGS*****46***12345**
PER*IC*PETE MARAVICH*TE*6142222222

LOOP 1000B RECEIVER NAME
NM1*40*2*FRANKLIN ADAMH*****46***25B**

S. 70 – Submitter and Receiver ID Code

LOOP 2000A BILLING/PAY-TO-PROVIDER HL
HL*1**20*1

LOOP 2010AA BILLING PROVIDER NAME
NM1*85*2*DO GOOD THINGS*****24***31-12345678**
N3*405 WEST SOUTH AVENUE
N4*COLUMBUS*OH*43231
REF*1G***000000012345**
PER*IC*AGENCY ADMINIS DESK*TE*6145772104

S. 71 – Billing Provider Tax-ID and UPI

LOOP 2010AB PAY-TO-PROVIDER NAME
NM1*87*2*XYZ CORPORATION*****24***31-12345678**
N3*400 EAST WEST STREET
N4*COLUMBUS*OH*43313
REF*1G***000000000022345**

S. 72 – Pay-To Provider Tax-ID and MACSIS Vendor Number

LOOP 2000B SUBSCRIBER HL
HL*2*1*22*0
SBR*P*18*******ZZ

LOOP 2010BA SUBSCRIBER NAME
NM1*IL*1*KRACOTO*KILE*A***JR***MI***3445555**
N3*1928 EAST 56TH ST
N4*LORAIN*OH*44254
DMG*D8*19510127*M
REF*SY*268445400

S. 75 – Subscriber Suffix and UCI

LOOP 2010BB PAYER NAME

NM1*PR*2*MACSIS*****PI*MACSIS

N3*SUITE 1001*30 E. BROAD STREET

N4*COLUMBUS*OH*43266-0414

S. 76 –Payer Name and ID

LOOP 2300

CLM*1156478910*40.00***11::1*Y*A*Y*Y*C

HI*BK:3050

S. 77 – Patient Control Number, Claim Level

S. 78 – Facility Code, Claim Level

LOOP 2320 OTHER SUBSCRIBER INFORMATION

SBR*S*18***C1****ZZ

AMT*D*30.00

DMG*D8*19520804*F

OI***Y***Y

S. 79 – Other Payer Paid Amount

LOOP 2330A OTHER SUBSCRIBER NAME

NM1*IL*1*KRACOTO*MITZY****MI*555656666

REF*IG*S

S. 81 – ODJFS COB Indicator (S = Non-Covered Service)

LOOP 2330B OTHER PAYER NAME

NM1*PR*2*AETNA HMO*****PI*AETNA HMO

LOOP 2400 SERVICE LINE

LX*1

SV1*HC:H0004:HE:HR::HX*40.00*UN*1*53**1**N

S. 82 –Product/Service Qualifier and Procedure Code

S. 83 – Modifiers

S. 86 – Line Item Charge Amt and Place of Service

DTP*472*D8*20030702

REF*6R*BB973AF65341F8B5AA862CEB23B0B1

S. 87 –Line Item Control Number

TRAILER SEGMENTS

SE*40*000000001

GE*1*1

IEA*1*000000257

MACSIS 837 Professional Claim Informational Guide

837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
B.3	ISA	**Interchange Control Header**					**Please note that the ISA control segment is a fixed length segment. It is the only fixed length segment in the 837P v4010 file.**	
	ISA01	Auth Information Qualifier	**00**-No autho info present	ID 2/2	R			
	ISA02	Auth Information	SPACES	AN 10/10	R			
	ISA03	Security Info Qualifier	**00**-No Security info present	ID 2/2	R			
	ISA04	Security Information	SPACES	AN 10/10	R			
	ISA05	Interchange ID Qualifier	**ZZ**- Mutually defined	ID 2/2	R			
	ISA06	Interchange Sender ID	UPI/VENDR ID/VAN ID Right Justified, zero fill	AN 15/15	R		**· If provider and vendor number are the same and provider is the creator, value to MACSIS UPI. · If provider and vendor number are different, value to either MACSIS UPI or MACSIS Vendor Number depending on who created it. · If a clearinghouse is the creator, value to MACSIS-assigned VAN ID.**	41A2
	ISA07	Interchange ID Qualifier	**ZZ**- Mutually defined	ID 2/2	R			
	ISA08	Interchange Receiver ID	BOARD NUMBER and TYPE Left-justified, blank-fill	AN 15/15	R		This field should identify the board receiving the file (ex. 25B for Franklin County).	41A2
	ISA09	Interchange Date	YYMMDD	DT 6/6	R			
	ISA10	Interchange Time	HHMM	TM 4/4	R			
	ISA11	Interchange Control Standards ID	**U**	ID 1/1	R			
	ISA12	Interchange Control Version Number	**00401**	ID 5/5	R			
	ISA13	Interchange Control Number	same as in IEA02	N0 9/9	R		The interchange sender determines this value. Per the standard implementation guide, this field must match IEA02 or the file will fail ANSI validation edits.	
	ISA14	Acknowledgement Requested	**0** - No Acknowledgement requested	ID 1/1	R		**The receipt of an interchange acknowledgement is determined by the TPA. Per this document, the State will not be providing an acknowledgement transaction to the Boards. However, Boards may choose to negotiate this item in the TPAs with their providers if the board can and wants to create the acknowledgement transaction themselves.**	42D
	ISA15	Usage Indicator	**P**-Production **T**-Test	ID 1/1	R		This field will be referenced by MACSIS to determine if the file is a production or test file.	
	ISA16	Component Element Separator	:	ID 1/1	R		To guarantee accurate evaluation and processing of the file, this field should be valued to :	40D6
B.8	GS	**Functional Group Header**						
	GS01	Functional Identifier Code	**HC**	ID 2/2	R			

IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
		837 FILE SPECIFICATIONS						
	GS02	Application Sender Code	UPI/VENDR ID	AN 2/15	R		- This field should identify the entity responsible for the claims contained in the functional group. In most cases, this field should equal the value in ISA06. Since this field is not a fixed-length field, the leading zeros are not required. (Note: It is not a problem if they are provided, however). -If a provider contracts with a clearinghouse to create this file on their behalf, then ISA06 would identify the clearinghouse and this field would identify the provider (Ex. UPI). Please note: This means clearinghouses should send one file per provider or vendor.	
	GS03	Application Receiver Code	BOARD NUMBER and TYPE	AN 2/15	R		This field should identify the entity receiving the claims contained in the functional group. This field should equal ISA08.	
	GS04	Date	CCYYMMDD	DT 8/8	R			
	GS05	Time	HHMM	TM 4/8	R			
	GS06	Group Control Number	Same as GE02	N0 1/9	R		The application sender determines this value. Per the standard implementation guide, this field must match GE02 or the file will fail ANSI validation edits.	
	GS07	Responsible Agency Code	**X**	ID 1/2	R			
	GS08	Version/Release Code	004010X098A1	AN 1/12	R		Addenda changes were adopted by the HHS Secretary on 2/13/03.	40B4
	TABLE 1 - HEADER							
62	**ST**	**Transaction Set Header**			**R**			
	ST01	TS ID Code	**837**	ID 3/3	R			
	ST02	TS Control Number	Transaction Set Control Number	AN 4/9	R		It must match the value in SE02, but it will not be stored in MACSIS.	
63	**BHT**	**Beginning of Hierarchical Transaction**			**R**			
	BHT01	Hierarchical Structure Code	**0019**	ID 4/4	R			
	BHT02	TS Purpose Code	**00**-Original	ID 2/2	R			
	BHT03	Originator Application Transaction Identifier	Batch number assigned by application sender	AN 1/30	R	BA0/4 YA0/4	This number is determined by the application sender. It will not be stored in MACSIS.	
	BHT04	TS Creation Date	CCYYMMDD	DT 8/8	R	AA0/15		
	BHT05	TS Creation Time	HHMM	TM 4/8	R			
	BHT06	TS Type Code	**CH**-chargeable	ID 2/2	R		MACSIS will consider for payment "CH" transaction types only.	
66	**REF**	**Transmission Type Identification**			**R**			
	REF01	Reference Identification Qualifier	**87**	ID 2/3	R			
	REF02	Transmission Type Code	**004010X098A1 (Prod)** **004010X098DA1 (Test)**	AN 1/30	R		Addenda changes were adopted by the HHS Secretary on 2/13/03.	
	-- LOOP ID 1000A SUBMITTER NAME							
67	**NM1**	**Submitter Name**			**R**			
	NM101	Entity Identifier Code	**41**	ID 2/3	R			
	NM102	Entity Type Qualifier	**2** - non-person entity	ID 1/1	R			
	NM103	Submitter Name	Provider Name/Vendor Name/VAN Name	AN 1/35	R	AA0/6	It is recommended this field contain the name of the organization corresponding to the Sender ID in ISA06. Do not use "&" in the name.	
	NM108	Identification Code Qualifier	**46**-ETIN	ID 1/2	R			

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	NM109	Identification Code	UPI/VENDR ID/VAN ID	AN 2/80	R	AA0/2 ZA0/2	It is recommended this field contain the same value as noted in ISA06. Since this is not a fixed length field, the leading zeros are not required.	
71	**PER**	**Submitter EDI contact Information**			**R**			
	PER01	Contact Function Code	**IC**	ID 2/2	R			
	PER02	Submitter Contact Name	Contact person at provider, vendor, or clearinghouse	AN 1/60	R	AA0/13		
	PER03	Communication Number Qualifier	**TE**-Telephone	ID 2/2	R			
	PER04	Communication Number	Format: AAABBBCCCC, where AAA is the area code, BBB is the telephone number pre-fix and CCCC is the telephone number.	AN 1/80	R		The extension, when applicable, should be included immediately after the telephone number.	
	– LOOP ID 1000B RECEIVER NAME							
74	**NM1**	**Individual or Organizational Name**			**R**			
	NM101	Receiver Code	**40**	ID 2/3	R			
	NM102	Entity Type Qualifier	**2** - non-person Entity	ID 1/1	R			
	NM103	Receiver Name	Board Name	AN 1/35	R		It is recommended this field contain the name of the board corresponding to the value in ISA08.	
	NM108	Identification Code Qualifier (ETIN)	**46**	ID 1/2	R			
	NM109	Receiver Primary Identifier	BOARD NUMBER and TYPE	AN 2/80	R		It is recommended this field contain the same value as noted in ISA08.	
	TABLE 2 - BILLING/PAY-TO PROVIDER DETAIL							
	– LOOP ID 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL						Implied max of 5000	
77	**HL**	**Hierarchical Level**			**R**			
	HL01	Hierarchical ID Number	start with 1, increment by 1	AN 1/12	R			
	HL03	Hierarchical Level Code	**20**	ID 1/2	R			
	HL04	Hierarchical Child Code	**1**	ID 1/1	R			
	– LOOP ID 2010AA BILLING PROVIDER NAME							
84	**NM1**	**Individual or Organizational Name**			**R**			
	NM101	Billing Provider	**85**	ID 2/3	R			
	NM102	Entity Type Qualifier	**2** - Non-Person Entity	ID 1/1	R			
	NM103	Billing Provider Name	Agency Name	AN 1/35	R		This field should contain the name of the provider agency corresponding to the MACSIS-assigned UPI Number. Do not use "&" in the name.	
	NM108	Identification Code Qualifier	**24**-Employer's ID Number	ID 1/2	R			
	NM109	Billing Provider Identifier	Agency Tax-ID Number Hyphen included	AN 2/80	R		This field should contain the tax-id number of the agency. Please contact your Board representative to verify that your Tax-ID as recorded in MACSIS is correct prior to submitting test files.	
88	**N3**	**Billing Provider Address**			**R**			
	N301	Billing Provider Address 1	Agency Address Line 1	AN 1/55	R		**This is the address associated with the MACSIS-assigned UPI number. It is recommended that the address be an exact match to what is stored in MACSIS. To determine value in MACSIS, refer to http://www.mh.state.oh.us/ois/mac.provf.top.html**	
	N302	Billing Provider Address 2	Agency Address Line 2	AN 1/55	S		This is the address associated with the MACSIS-assigned UPI number. See note above (on N301).	
89	**N4**	**Billing Provider Geographic Location**			**R**			

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	N401	Billing Provider's City	Agency City	AN 2/30	R		This is the city associated with the MACSIS-assigned UPI number. See note on N301.	
	N402	Billing Provider's State	Agency State	ID 2/2	R		This is the State abbreviation associated with the MACSIS-assigned UPI number. See note on N301.	
	N403	Billing Provider's Zip Code	Agency Zip Code	ID 3/15	R		This is the zip code associated with the MACSIS-assigned UPI number. See note on N301.	
91	**REF**	**Billing Provider Secondary Identification**			S		This segment will be required to ensure proper adjudication of the claim in MACSIS.	
	REF01	Reference Identification Qualifier	**1G** - Provider UPIN Number	ID 2/3	R			
	REF02	Billing Provider Secondary Identification	MACSIS-Assigned UPI Number 12 bytes with leading zeros	AN 1/30	R	BA0/2 YA0/2	This field should contain the MACSIS-Assigned UPI number. Please note the value must be 12 bytes in length and contain leading zeros.	
96	**PER**	**Billing Provider contact Information**			**S**		This segment is required if different than the submitter contact information in Loop 1000A, segment PER, but the information will not be used by MACSIS.	
	PER01	Contact Function Code	**IC**	ID 2/2	R			
	PER02	Billing Provider Contact Name	Agency Billing Contact Name	AN 1/60	R			
	PER03	Comm Number Qualifier	**TE**-Telephone	ID 2/2	R			
	PER04	Comm Number	Agency Contact Telephone Number	AN 1/60	R			
	– LOOP ID 2010AB PAY-TO PROVIDER NAME						**This loop is only required if the pay-to provider is a different entity than the billing provider.**	
99	**NM1**	**Individual or Organizational Name**			**R**			
	NM101	Billing Provider	**87**	ID 2/3	R			
	NM102	Entity Type Qualifier	**2** - Non-Person Entity	ID 1/1	R			
	NM103	Pay-To Provider Name	Pay-To Provider Name	AN 1/35	R		This field should contain the name of the organization associated with the MACSIS-assigned Vendor Number. Do not use "&" in the name.	
	NM108	Identification Code Qualifier	**24**-Employer's ID Number	ID 1/2	R			
	NM109	Pay-To Provider Identifier	Pay-To Provider Tax-ID Number Hyphen included	AN 2/80	R		This field should contain the tax-id of the organization associated with the MACSIS-assigned Vendor Number. Please contact your Board representative to verify that your Tax-ID as recorded in MACSIS is correct prior to submitting test files.	
103	**N3**	**Pay-To Provider Address**			**R**			

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	N301	Pay-To Provider Address 1	Pay-To Provider Address Line 1	AN 1/55	R		This field should contain the address of the organization associated with the MACSIS-assigned Vendor Number. It is recommended that the address be an exact match to what is stored in MACSIS. To determine value in MACSIS, refer to http://www.mh.state.oh.us/ois/macsis/mac.provf.top.html	
	N302	Pay-To Provider Address 2	Pay-To Provider Address Line 2	AN 1/55	S		This feld should contain the address of the organization associated with the MACSIS-assigned Vendor Number. See note on N301.	
104	**N4**	**Vendor Geographic Location**			**R**			
	N401	Pay-To Provider's City	Pay-To Provider City	AN 2/30	R			
	N402	Pay-To Provider's State	Pay-To Provider State	ID 2/2	R			
	N403	Pay-To Provider's Zip Code	Pay-To Provider Zip Code	ID 3/15	R			
106	**REF**	**Pay-to Provider Secondary Identification**						
	REF01	Reference Identification Qualifier	**1G** - Provider UPIN Number	ID 2/3	R			
	REF02	Pay-to Provider Additional Identifier	MACSIS-Assigned Vendor Number 15 bytes, leading zeros	AN 1/30	R			
	TABLE 2 - SUBSCRIBER DETAIL							
	– LOOP ID 2000B SUBSCRIBER HIERARCHICAL LEVEL						Implied max of 5000	
108	**HL**	**Hierarchical Level**			**R**			
	HL01	Hierarchical ID Number	start with 1, increment by 1	AN 1/12	R			
	HL02	Hierarchical Parent Id Number	**1**-Subscribe self	AN 1/12	R			
	HL03	Subscriber Level Code	**22**-Subscriber	ID 1/2	R			
	HL04	Hierarchical Child Code	**0**- No subordinate HL segment	ID 1/1	R			
110	**SBR**	**Subscriber Information**			**R**			
	SBR01	Payer Responsibility Seq # Code	**P** - Primary **S** - Secondary **T** - Tertiary	ID 1/1	R	DA0/2		
	SBR02	Relationship Code	**18** - Self	AN 1/30	S			
	SBR09	Claim Filing Indicator Code	**ZZ- Mutually defined**	ID 1/2	S		This code is required prior to the mandated use of a national plan ID code. It will not be used by MACSIS for adjudication purposes.	
	– LOOP ID 2010BA SUBSCRIBER NAME							
117	**NM1**	**Subscriber Name Information**			**R**			
	NM101	Insured or Subscriber	**IL**-Insured	ID 2/3	R			
	NM102	Entity Type Qualifier	**1**-Person	ID 1/1	R			
	NM103	Subscriber Last Name	MACSIS Client Last Name	AN 1/35	R	CA0/4		44B
	NM104	Subscriber First Name	MACSIS Client First Name	AN 1/25	S	CA0/5	Since all MACSIS clients are "person's", not "entities", first name should always be provided, even for pseudo-UCI's.	44B
	NM105	Subscriber Middle Name	MACSIS Client Middle Initial	AN 1/25	S	CA0/6		

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	NM107	Subscriber Name Suffix	MACSIS Client Suffix	AN 1/10	S	CA0/4	This field should contain the suffix of the client (ex. Jr, Sr, I, II, III). Do not value the suffix here and in NM103.	
	NM108	ID Code Qualifier	**MI** - Member ID Number	ID 1/2	R			
	NM109	Subscriber Primary Identifier	MACSIS UCI Number	AN 2/80	R	DA0/18		44B
121	**N3**	**Subscriber Address**			**R**		This segment data is required, but will not be validated by MACSIS.	
	N301	Subscriber address 1	MACSIS Client/Enrollment Address 1	AN 1/55	R			
	N302	Subscriber address 2	MACSIS Client/Enrollment Address 2	AN 1/55	S			
122	**N4**	**Subscriber City/State/Zip Code**			**R**		This segment data is required, but will not be validated by MACSIS.	
	N401	Subscriber City Name	MACSIS Client City Name	AN 2/30	R			
	N402	Subscriber or Province Code	MACSIS Client State	ID 2/2	R			
	N403	Subscriber zip code	MACSIS Client Zip Code	ID 3/15	R			
124	**DMG**	**Subscriber Demographic Info**			**R**		This segment will likely be used by MACSIS for matching the claim to an existing client.	
	DMG01	Date Time Period Format Qualifier	**D8**	ID 2/3	R			
	DMG02	Subscriber Birth Date	MACSIS Client Date of Birth CCYYMMDD	AN 1/35	R	CA0/8		
	DMG03	Subscriber Gender	**F,M,U**	ID 1/1	R	CA0/9		
126	**REF**	**Subscriber Secondary Identification**			**S**			
	REF01	Reference Identification Qualifier	**SY**-Social Security Number	ID 2/3	R		To ensure proper adjudication of the claim in MACSIS, the social security number of the client should be provided. It will be used to help link the incoming claim to the appropriate client's records in MACSIS.	
	REF02	Subscriber Supplemental Identifier	MACSIS Client SSN	AN 1/30	R		Do not include dashes.	
	– LOOP ID 2010BB PAYER NAME							
130	**NM1**	**Payer Name Information**			**R**			
	NM101	Entity Identifier Code	**PR**	ID 2/3	R			
	NM102	Entity Type Qualifier	**2** - Non-Person Entity	ID 1/1	R			
	NM103	Payer Name	**MACSIS**	AN 1/35	R	DA0/9		
	NM108	Identification Code Qualifier	**PI**-Payer ID	ID 1/2	R			
	NM109	Payer Primary Identifier	**MACSIS**	AN 2/80	R			
	– LOOP ID 2300 CLAIM INFORMATION							44A and 44H
170	**CLM**	**Claim Information**			**R**			

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	CLM01	Patient Control Number	Provider-assigned claim-level control number	AN 1/38	R	CA0/3	If this element is valued and Loop 2400, field REF02 (Line Item Control Number) is not, this field will be returned on the 835 in Loop 2100, field CLP01. Alphanumeric values are permissible, but not special characters. Please note this field is longer in length (up to 38 characters) than the REF02 field. It is also longer in length than the 15-character HCFA 1500 NSF control number (CA0/3) and the control number returned on the ERA/RA. Therefore, MACSIS will return all 38 characters on the 835 for dates of service on or after July 1, 2003, if REF02 is not provided. For dates of service before July 1, 2003 and/or any transactions on the ERA/RA, the control number returned will be a maximum of 15-characters. See guidelines for specific requirements for AOD prevention services.	44B
	CLM02	Total Claim Charge Amount		R 1/18	R	XA0/12	The addenda further clarified how decimal points should be used for Type "R" fields. If there are no "cents" involved in the amount (ex., $100), then the value should not include the decimal point or subsequent decimal positions (ex., 100). If however, there are "cents" involved in the amount (ex., $100.50), then the value must include the decimal point and subsequent decimal positions (ex. 100.50)	
	CLM05	Health Care Service Location Info		ID 1/2	R			
	CLM05 - 1	Facility Code Value	See http://www.cms.gov/states/posdata.pdf for a complete list of codes.	AN 1/2	R	FA0/7	This information will be stored at the claim header level in MACSIS. If no information is provided in Loop 2400, SV105, then this code will default to the service location on the associated claim detail record(s) and will be used for adjudication purposes. Please note that the new HIPAA-compliant place of service codes must be used when reporting dates of service on or after July 1, 2003. In May 2003, CMS announced availability of several new place of service codes. The "old" MACSIS place of service codes must be used when reporting dates of service prior to July 1, 2003.	44E
	CLM05 - 3	Claim Frequency Code		ID 1/1	R		MACSIS will not use this information for adjudication purposes.	
	CLM06	Provider Signature on File	Y-Yes	ID 1/1	R			

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	CLM07	Medicare Assignment Code	**A**-Assigned **B**-Assignment Accepted on Clinical Lab Services Only **C**-Not Assigned **P**-Patient Refuses to Assign Benefits	ID 1/1	R		This information will not be used by MACSIS for adjudication purposes.	
	CLM08	Assignment of Benefits Indicator	**N**-No **Y**- Yes	ID 1/1	R		This information will not be used by MACSIS for adjudication purposes.	
	CLM09	Release of Information Code	**A**-Appropriate Release of Info on File **I**-Informed Consent to Release Medical Info **M**-Limited or restricted ability release data **N**-Not allowed to release data **O**-On file at Payer or plan sponsor **Y**-Signed statement permitting release of data	ID 1/1	R		This information will not be used by MACSIS for adjudication purposes. Existing policies regarding obtaining appropriate release information still apply.	4
	CLM10	Patient Signature Source Code	**B**-Signed on HCFA-1500, block 12 and block 13 **C**-Signed on HCFA-1500 **M**-Signed on HCFA-1500 block 13 **P**-Physician signed due to patient not present **S**-Signed on HCFA-1500 block 12	ID 1/1	S		Although this information is required (except if CLM09=N), it will not be used by MACSIS for adjudication purposes.	
	CLM11	Related Causes Info	Composite field - see below	O	S		Although this information is required if the cause of the client's condition is related to other factors, it will not be used for adjudication purposes in MACSIS.	
	CLM11-1	Related Causes Code	**AA** - Auto Accident **AP** - Another Party Responsible **EM** - Employment **OA** - Other Accident	ID 2/3	R		The value of "AB" for abuse was deleted in the October 2002 Addenda. MACSIS does not use this information for adjudication purposes.	
	CLM11-2	Related Causes Code	**AA** - Auto Accident **AP** - Another Party Responsible **EM** - Employment **OA** - Other Accident	ID 2/3	S		The value of "AB" for abuse was deleted in the October 2002 Addenda. MACSIS does not use this information for adjudication purposes.	
	CLM11-3	Related Causes Code	**AA** - Auto Accident **AP** - Another Party Responsible **EM** - Employment **OA** - Other Accident	ID 2/3	S		The value of "AB" for abuse was deleted in the October 2002 Addenda. MACSIS does not use this information for adjudication purposes.	
	CLM11-4	Auto Accident State or Province Code	State where accident occurred	ID 2/2	S			
	CLM11-5	Country Code	Country where accident occurred	ID 2/3	S			
	CLM12	Special Program Indicator	**01** - Early & Periodic Screening **02** - Physically Handicapped Childrens' program **03** - Special Federal Funding **05** - Disability etc.	ID 2/3	S		This information will not be used by MACSIS for adjudication purposes.	
265	**HI**	**Health Care Diagnosis Code**			**S**		**As with current MACSIS billing policy, not all procedure codes require a diagnosis code. Please refer to MH and AOD Procedure Code Matrices to determine which procedures require a diagnosis code.**	44F
	HI01	Health Care Code Information		AN 1/30	R			

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	HI01-1	Diagnosis Type Code	**BK**-Principle Diagnosis ICD-9 Codes	ID 1/3	R			
	HI01-2	Diagnosis Code	ICD-9 Code	AN 1/30	R	EA0/30	Only the principal diagnosis code will be sent to ODJFS for Medicaid eligible services to Medicaid eligible clients. Do not include decimal point.	
	HI02	Health Care Code Information	R if additional Diagnosis	AN 1/30	S			
	HI02-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/3	R			
	HI02-2	Diagnosis Code	ICD-9 Code	AN 1/30	R	EA0/31		
	HI03	Health Care Code Information	R if additional Diagnosis	AN 1/31	S			
	HI03-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/4	R			
	HI03-2	Diagnosis Code	ICD-9 Code	AN 1/31	R	EA0/32		
	HI04	Health Care Code Information	R if additional Diagnosis	AN 1/32	S			
	HI04-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/5	R			
	HI04-2	Diagnosis Code	ICD-9 Code	AN 1/32	R			
	HI05	Health Care Code Information	R if additional Diagnosis	AN 1/33	S			
	HI05-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/6	R			
	HI05-2	Diagnosis Code	ICD-9 Code	AN 1/33	R			
	HI06	Health Care Code Information	R if additional Diagnosis	AN 1/34	S			
	HI06-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/7	R			
	HI06-2	Diagnosis Code	ICD-9 Code	AN 1/34	R			
	HI07	Health Care Code Information	R if additional Diagnosis	AN 1/35	S			
	HI07-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/8	R			
	HI07-2	Diagnosis Code	ICD-9 Code	AN 1/35	R			
	HI08	Health Care Code Information	R if additional Diagnosis	AN 1/36	S			
	HI08-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/9	R			
	HI08-2	Diagnosis Code	ICD-9 Code	AN 1/36	R			
	– LOOP ID 2310B RENDERING PROVIDER NAME						Required if different than billing provider noted in Loop 2010AA. However, this segment will not be used by MACSIS for adjudication purposes.	
290	**NM1**	**Rendering Provider Name Info**			**S**			
	NM101	Entity Identifier Code	**82** - Rendering Provider		R			
	NM102	Entity Type Qualifier	**2**-Non-Person Entity	ID 1/1	R			
	NM103	Rendering Provider Last Name	Rendering Provider Organization Name	AN 1/35	R		Do not use "&" in the name.	
	NM108	Identification Code Qualifier	**24**-Employer's ID Number	ID 1/2	R			
	NM109	Rendering Provider ID	Rendering Provider ID	AN 2/80	R			
	– LOOP ID 2320 OTHER SUBSCRIBER INFORMATION (CLAIM LEVEL ADJUSTMENTS)						This loop is required to be sent by the provider when another payer has adjudicated the claim. MACSIS plans on using only the first iteration of the segments noted below for adjudication purposes. If the provider submitted claims in FY03 with other payer information, they must include atleast one claim with this loop, Loop 2330A and 2330B in their Tier 1 and 2 test files.	44G
318	**SBR**	**Other Subscriber Information**			S			
	SBR01	Payer Responsibility Sequence Number Code	**P** - Primary **S** - Secondary **T** - Tertiary	ID 1/1	R			
	SBR02	Individual Relationship Code	See guide for valid values	ID 2/2	R			
	SBR05	Insurance Type Code	See guide for valid values	ID 1/3	R			

837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	SBR09	Claim Filing Indicator Code	**ZZ** - Mutually Defined	ID 1/2	S		This code is required prior to the mandated use of a national plan ID code. It will not be used by MACSIS for adjudication purposes.	
332	**AMT**	**COB Amount**			**S**		Payments from another payer should be reported in this segment. MACSIS will reference this segment for adjudication purposes. Please note MACSIS will not use prior payer paid amounts reported in Loop 2430, SVD Segment for adjudication purposes.	
	AMT01	Amount Qualifier Code	**D**- Payer Amount Paid	ID 1/3	R		MACSIS plans to only use COB amount reported as "D" - Payer Amount Paid for adjudication purposes.	
	AMT02	Amount	Payer Amount Paid	R 1/18	R	FA0/35	**Report the amount paid by the prior payer in this field. Do not include any amounts paid or due from the patient including provider-determined sliding fee amounts here. If the payer denied the claim or adjudicated the claim payment as zero, enter zero. If the provider determines the patient copayment at the time of service and therefore must reflect patient paid amounts,they can reduce the amount billed rather than report patient paid amounts here. Please see clarification in addenda as to how Type "R" amount fields should be reported in terms of including or excluding the decimal point.**	
342	**DMG**	**Subscriber Demographic Info**			**R**		This information will not be used by MACSIS for adjudication purposes.	
	DMG01	Date Time Period Format Qualifier	**D8**	ID 2/3	R			
	DMG02	Date of Birth - Subscriber	CCYYMMDD	AN 1/35	R			
	DMG03	Gender - Subscriber	**F**-Female **M**-Male **U**-Unknown	ID 1/1	R			
344	**OI**	**Other Insurance Coverage Information**			**R**		This information will not be used by MACSIS for adjudication purposes.	
	OI03	Assignment of Benefits Indicator	**N**-No **Y**-Yes	ID 1/1	R			
	OI06	Release of Information Code	**A**-Appropriate Release of Info on File **I**-Informed Consent to Release Medical Info **M**-Limited or Restricted Ability to Release Info **N**-Not Allowed to Release info **O**-On file **Y**-Yes, signed release form	ID 1/1	R			
	– LOOP ID 2330A OTHER SUBSCRIBER NAME						This loop is required when Loop 2320 is used. To be consistent with ODJFS requirements, MACSIS plans on using the first iteration of this loop to capture the ODJFS COB indicator.	
350	**NM1**	**Other subscriber name**			**R**			
	NM101	Entity Identifier Code	**IL**	ID 2/3	R			

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	NM102	Entity Type Qualifier	**1**-Person	ID 1/1	R			
	NM103	Subscriber Last Name	Other Subscriber Last Name	AN 1/35	R			
	NM104	Subscriber First Name	Other Subscriber First Name	AN 1/25	R			
	NM108	Identification Code Qualifier	**MI**-Member ID Number	ID 1/2	R			
	NM109	Other subscriber primary identifier	Other Subscriber Member ID Number	AN 2/80	R			
357	**REF**	**Other Subscriber Secondary Identification**						
	REF01	Reference Identification Qualifier	**IG** - Insurance Policy Number	ID 2/3	S			
	REF02	Other Insured Additional Identifier	**2** – Blue Cross/Blue Shield 3 – A private carrier **4** – Employer or Union **5** – Public Agency (Medicare, Worker's Comp) **6** – Other carrier **R** – No response from carrier **P** – No coverage for this recipient number **F** – No coverage for all recipient numbers **L** – Disputed or contest liability **S** – Non-covered service **E** – Insurance benefits exhausted **X** – Non-cooperative member.	AN 1/30	R	FA0/21	ODJFS is using this element to capture the third party COB indicator currently on the NSF file. If this field is valued, an amount must be provided in Loop 2320, Field AMT02 (COB Amount) and AMT01 must equal "D" (Payer Amount Paid).	
	– LOOP ID 2330B OTHER PAYER NAME					CA0/22 (Other Ins. Ind.)	Although required when Loop 2320 is used, this loop will not be used for adjudication purposes in MACSIS.	
359	**NM1**	**Other Payer Name**			**R**			
	NM101	Entity Identifier Code	**PR**-Payer	ID 2/3	R			
	NM102	Entity Type Qualifier	**2**-Non-Person Entity	ID 1/1	R			
	NM103	Payer Name	Other Payer Name	AN 1/35	R			
	NM108	Identification Code Qualifier	**PI**-Payer ID	ID 1/2	R			
	NM109	Other payer primary id number	Other Payer ID Number	AN 2/80	R			
366	**DTP**	**Claim Adjudication Date**			**S**		Although required if claim was previously adjudicated and a service level adjudication date is not reported in Loop 2430, this information will not be used by MACSIS for adjudication purposes.	
	DTP01	Date/Time Qualifier	**573**-Date Claim Paid	ID 3/3	R			
	DTP02	Date Time Period Format Qualifier	**D8**	ID 2/3	R			
	DTP03	Adjudication or Payment Date	Date claim adjudicated by other payer	AN 1/35	R			
	– LOOP ID 2400 - SERVICE LINE							44A and 44I
398	**LX**	**Service Line - repeat >=1**			**R**			
	LX01	Line Counter	Incremented by 1 for each service line	N0 1/6	R			
400	**SV1**	**Professional Service**			**R**			
	SV101	**Composite Medical Procedure Identifier**						
	SV101-1	Product/Service ID Qualifier	**HC**-HCPCS (incl. CPT, for Healthcare) **ZZ**-Mutually Defined (Non-Healthcare)	ID 2/2	R			

837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	SV101-2	Procedure Code	HCPCS/CPT/Non-Healthcare Procedure Code	AN 1/48	R	FA0/9 FA0/10	It is important to note that the new HIPAA-compliant procedure codes must be used when reporting claims with dates of service on or after July 1, 2003. The "old" MACSIS procedure codes must be used when reporting claims with dates of service prior to July 1, 2003.	40A, 40C, 44C
	SV101-3 thru SV101 - 6	Procedure Modifier	HCPCS/CPT Modifiers	AN 2/2	S	FA0/11	It is important to note that the new HIPAA-compliant modifier codes must be used when reporting claims with dates of service on or after July 1, 2003. Additionally, modifier 1 must always be valued. The "old" MACSIS modifier codes must be used when reporting claims with dates of service prior to July 1, 2003.	40A, 40C, 44D
	SV102	Line Item Charge Amount	Amount billed for service	R 1/18	R	FA0/13	The addenda further clarified how decimal points should be used for Type "R" fields. If there are no "cents" involved in the amount (ex., $100), then the value should not include the decimal point or subsequent decimal positions (ex., 100). If however, there are "cents" involved in the amount (ex., $100.50), then the value must include the decimal point and subsequent decimal positions (ex. 100.50)	
	SV103	Unit or Basis for Measurement Code	UN-Unit	ID 2/2	R			
	SV104	Quantity	Units of Service	R 1/15	R	FA0/18	To report partial units, include the decimal and only one tenth decimal position to assure proper adjudication in MACSIS (ex., 15.6). Refer to addenda for clarification as to how Type "R" fields should be reported (in terms of including or excluding the decimal point). Please note that for same day services occurring on or after July 1, 2003, these services must be "summed and rounded" according to the MACSIS guidelines and reported as one service line.	44C and 44I

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	SV105	Place of Service Code	See http://www.cms.gov/states/posdata.pdf for a complete list of codes.	AN 1/2	S	FA0/7	**Required if different than facility code value reported in Loop 2300, CLM05-1. It will be stored in MACSIS at the claim detail level for only the associated service being reported.** **If provided, use new HIPAA-compliant place of service codes for dates of service on or after July 1, 2003. In May 2003, CMS announced the availability of several new place of service codes.** **Use "old" place of service codes for dates of service prior to July 1, 2003.**	44E
	SV107	Composite Diagnosis Code Pointer			S		This segment is required if the diagnosis is reported in the HI segment of Loop 2300.	
	SV107-1 thru SV107-4	Diagnois Code Pointer		N0 1/2	R	FA0/14 FA0/15 FA0/16	This value can be repeated up to four times, but only the first value will be used by MACSIS for adjudication purposes.	
	SV109	Emergency Indicator	Y	ID 1/1	S		This field was changed to "situational" usage per the Oct 2002 addenda. The allowable values also changed from "Y or N" to just "Y". Do not value the data element if it does not apply. Even if valued, MACSIS will not use it for adjudication purposes.	
435	**DTP**	**Service Date**			**R**			
	DTP01	Date/Time Qualifier	**472**-Service	ID 3/3	R			
	DTP02	Date Time Period Format Qualifier	**D8**	ID 2/3	R		Per Medicaid Policy, a range of dates of service (i.e., RD8) is not permissible for behavioral health services. For services administered over range of dates, only a single start date of service should be provided.	
	DTP03	Service Date	CCYYMMDD	AN 1/35	R	FA0/5		40A and 40C
472	**REF**	**Line Item Control Number**			**S**			
	REF01	Provider Control Number	**6R**	ID 2/3	R			

	837 FILE SPECIFICATIONS							
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS NSF Ref.	MACSIS Comments	MACSIS Guide-Line
	REF02	Line Item Control Number	Provider-assigned line item control number	AN 1/30	R	FA0/4	If this field is valued, MACSIS will store this number as the control number, not the value sent in Loop 2300, CLM01. It will be returned on the 835 file in Loop 2100, CLP01. Alphanumeric values are permissible, but not special characters. Please note this field is shorter in length (up to 30 characters) than the CLM01 field. It is longer in length that the 15-character HCFA 1500 NSF Control Number (FA0/4) and the control number on the ERA/RA. Therefore, MACSIS will return all 30 characters if provided for dates of service on or after July 1, 2003. For dates of service before July 1, 2003 and/or for transactions on the ERA/RA, the maximum returned will be 15-characters. See guidelines for specific requirements for AOD prevention services.	44B
572	SE	**TRANSACTION SET TRAILER**			R			
	SE01	Segment Count	Total number of segments including SE and ST	N0 1/10	R			
	SE02	Transaction Set Control Number	Same as in ST02	AN 4/9	R		This value must equal the value in ST02, but it will not be stored in MACSIS.	
B.10	GE	**Functional Group Trailer**			R			
	GE01	# of Transaction Sets included	# of STs	N0 1/6	R			
	GE02	Group Control Number	Save as in GS06	N0 1/9	R		The application sender determines this value. Per the standard implementation guide, this field must match GS06 or the file will fail ANSI validation edits.	
B.7	IEA	**Interchange Control Trailer**			R			
	IEA01	# of Included functional Groups	# of GS	N0 1/5	R			
	IEA02	Interchange Control Number	same as in ISA13	N0 9/9	R		The interchange sender determines this value. Per the standard implementation guide, this field must match ISA13 or the file will fail ANSI validation edits.	

HIPAA EDI Claims File Testing and Approval

State of Ohio
MACSIS SYSTEM POLICY

Policy: HIPAA EDI Claims File Testing and Approval **Last Revised Date**: 1/27/05

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 4010) 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.

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 Tier 1 and 2 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 for both Tiers, 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 Tier 2 File Analysis Report returned to the provider will indicate if they have approval to submit claims in the production environment.

Although we encourage software vendors to work through their providers to submit test files via the boards, it is possible for software vendors to submit an initial test file directly to the MACSIS staff to determine how close their file formats fit the basic MACSIS requirements. The latter will be managed by the MACSIS Support Desk (macsissupport@mh.state.oh.us) via an independent process and the test file must contain no real client data. However, approval for production submission will not be granted at a software vendor level, only at a provider level.

Providers are required to be re-approved through Tier 1 and Tier 2 testing, if they change software vendors and/or apply a significant upgrade to their existing system. Although not required, it is recommended that Tier 2 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 4010 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, **Appendix A** outlines examples of what to test and verify as it pertains to MACSIS-specific requirements.

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.

C. Submitting Initial Test Files To Board for MACSIS Testing and Approval (Tier 1)

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 EDI Claim 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:

- A maximum of 100 claims per initial test file
- The test file must contain at least one scenario of each of the required testing scenarios noted in **Appendix B,** if the scenario could at all apply (even in the future) to the provider
- The test file may or may not use actual client or service data
- 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 "J" instead of "A", so they can easily be distinguished.

When submitting test files to the board, providers must initiate the "MACSIS Claims Tier 1 Testing 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.

D. Submitting Final Test Files to Board for MACSIS Testing and Approval (Tier 2)

Once the initial test file(s) has been approved, providers will need to prepare their final test file for submission to their main contracting board to complete the MACSIS Testing and Approval Process. Final test files should include:

- The volume of claims representative of a typical production file submission for that agency up to a maximum of 500 claims in the file. If you are not sure what your average weekly claim volume is for MACSIS, see SFY03 (State Fiscal Year 2003) data available at http://www.mh.state.oh.us/ois/macsis/claims/prov_fy03_clms.XLS
- All funded procedure codes are represented
- Real client data
- Claims for dates of service on or after July 1, 2003, must be demonstrated on the test file. Fictitious service data may be used, as long as all currently funded procedure codes and corresponding rates are represented. HIPAA-compliant procedure, modifier and place of service codes must be used.
- 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.
- As in Tier 1, 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.

- 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 the final test file for approval, providers must initiate the "MACSIS Claims Tier 2 Testing Form" (http://www.mh.state.oh.us/ois/macsis/claims/tier2.test.form.rev.pdf). 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 4010 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.

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 Claims Testing Forms and faxing them to the State
- Verifying test files comply with HIPAA-mandated and MACSIS-specific EDI requirements under Tier 1
- Evaluating Error Reports resulting from Tier 1 and 2 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.
- Notifying the MACSIS staff via the Tier 2 form that a new copy of Production is necessary before re-testing, when applicable.
- 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 with Tier 2 Test File Forms

- 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 Tiers 1 and 2 of 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:

- 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.
- Ensuring file handling protocols are followed to ensure the proper translation of file end of line markers. See http://www.mh.state.oh.us/ois/macsis/mac.tech.revisited.EOL.issues.html for more information.

MACSIS Testing and Approval Methodology:

MACSIS will be using a two-tiered approach to test files received from providers via the boards. This approach allows the staff to identify simple, basic file problems in the first tier and then focus on more complex problems which may only manifest themselves in a large, production-simulation environment in the second tier.

I. Tier 1 – Basic Form, Structure, Syntax Testing

The primary purpose of Tier 1 testing is to evaluate the form, structure and syntax of the claims EDI test file as it pertains to MACSIS-specific guidelines. The type of review includes but is not limited to:

- Conformance to file naming conventions
- Envelope Structure and Control Numbers
- Appropriate End-of-Line (EOL) marker and other delimiter definitions
- Appropriate use of sender and receiver identification numbers

- Appropriate use of provider identification numbers
- One-To-One Correspondence of Loops 2300 and 2400 (i.e., one service line per claim)
- Appropriate Segment Usage For MACSIS Adjudication Purposes as outlined in the MACSIS 837P Technical Information Guide

Tier 1 testing does not require information related to "real" clients, although the latter is preferable. These files can contain fictitious names, dates of birth, Unique Client Identifiers (UCI), etc. Segment, field and component usage will be examined, but no comparisons will be made between the EDI file and the MACSIS database content at this point in the testing process. Appendix A provides a list of the types of items examined in Tier 1 Testing by the MACSIS staff.

II. Tier 2 – Production Simulation Testing

Tier 2 testing is the final stage before approval is granted to submit claims into the HIPAA-compliant Diamond Production Environment.

This level of 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. Since Tier 2 testing is the first time the data in the test files is compared to the data in the Diamond environment, issues such as discrepancies in Tax-ID and/or provider addresses will become apparent in Tier 2 testing. Appendix C provides a list of the types of items examined in Tier 2 Testing by the MACSIS staff.

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 Tier 2 test files containing just one UPI per file. Once the Tier 2 test files are approved on a per-UPI basis, then a final combined Tier 2 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 4010 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 Tier 2 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 before Tier 2 approval will be granted.

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.

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.

III. 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.

APPENDIX A
MACSIS HIPAA EDI TESTING CHECKLIST FOR TIER 1

#	Requirement	MACSIS Guideline	Loop/Segment /Element	SNIP Type
	FILE NAMING CONVENTION			
O1	Proper file naming convention is used (Jxxxxxx#.julyy)	42A	N/a	7
	CONTROL SEGMENT USAGE			
C1	Expected segment, field and component delimiters used as outlined in Guidelines	40D6	ISA	7
C2	ISA envelope is a fixed length of 105 bytes	N/A	ISA	7
C3	ISA-06 and ISA-08 are properly coded	41A2	ISA	7
C4	ISA-13 matches IEA-02 (Interchange Control Numbers)	N/A	ISA and IEA	7
C5	GS-02 and GS-03 (Application Sender and Receiver Codes) are properly coded	N/A	GS	7
C5	SE02 (Trans Set Control #) equals the total number of lines in the file minus four	N/A	SE	7
	SUBMITTER/RECEIVER Ids			
S1	Submitter ID equals valid MACSIS UPI number, MACSIS Vendor number or MACSIS-Assigned VAN ID	41A2	1000A/NM109	7
S2	Receiver ID is valid Board Number and Type	41A2	1000B/NM109	7
S3	Receiver Name is valid Board Name	41A2	1000B/NM103	7
	PROVIDER INFORMATION			
P1	Agency Tax-ID is valued and is in the correct format (ex., with hyphen is present)	N/A	2010AA/NM109	7
P2	Agency UPI number is present; 12 bytes, leading zeros	N/A	2010AA/REF02	7
P3	If Pay-To Provider information is applicable, tax-id is provided with hyphen	N/A	2010AB/NM109	7
P4	If Pay-To Provider information is applicable, the MACSIS-assigned vendor number is provided in a 15-byte, leading zero format.	N/A	2010AB/REF02	7
P5	If rendering provider information is sent (i.e., not used for MACSIS adjudication purposes), then it is coded correctly	N/A	Loop 2310B	7
	SUBSCRIBER INFORMATION			
B1	Claim Filing Indicator Code equals “ZZ”	N/A	2000B/SBR09	7
B2	Client First and Last Name are provided	N/A	2010BA/NM103 and NM104	7
B3	Client suffix is provided in EITHER NM107 or NM103	N/A	2010BA/NM107 or NM103	7
B4	Valid date or birth and gender code is provided		2010BA/DMG02 and DMG03	7
B6	Client SSN is provided (without hyphens)	N/A	2010BA/ REF02	7
B7	Destination Payer Name and ID is MACSIS	N/A	2010BB/NM103 and NM109	7
	CLAIM INFORMATION			
M1	Patient Control Number contains expected value per provider’s system needs (see Guidelines for specific AOD prevention requirements).	44B	2300/CLM01	7
M2	Total claim charge amount and corresponding	N/A	2300/CLM02	7

#	Requirement	MACSIS Guideline	Loop/Segment /Element	SNIP Type
	decimal point usage (implied or explicit) is correct			
M3	ICD-9-CM diagnosis code is present when required for procedure, billable under MACSIS and does not contain a period	44E	2300/HI segment	7
	OTHER PROVIDER INFORMATION			
X1	Rendering Provider Information, if provided, is properly coded. (Note: Not required for MACSIS)	N/A	Loop 2310B	7
	OTHER PAYER INFORMATION (IF APPLICABLE)			
R1	If other payer involved with claim, other payer paid amount is provided and logically corresponds to the ODJFS Coordination of Benefits (COB) Indicator value in Loop 2330A/REF02. The amount is correct given decimal point usage (implied or explicit).	44F	2320/AMT02	7
R2	For Medicaid eligible services to Medicaid eligible clients, Other Subscriber Secondary ID is valued to ODJFS COB Indicator.	N/A	2330A/REF02	7
R3	For Medicaid eligible services to Medicaid eligible clients, other payer paid amount is valued correctly when ODJFS COB indicator is present	N/A	2320/AMT02	7
	SERVICE INFORMATION			
L1	One service loop per claim loop is provided	44A1	2400 Loop	7
L2	Proper "product/service qualifier" is used for the procedure being billed (i.e., HC for HCPCS and ZZ for non-healthcare procedure codes)	N/A	2400/SV101-1	7
L3	Service code is valid for date of service	N/A	2400/SV101-2	7
L4	Modifier 1 is always present	N/A	2400/SV101-3	7
L5	Unit or Basis for Measurement Code is valued to "UN"	N/A	2400/SV103	7
L6	Units of service were accurately calculated per rounding tables and do not exceed a one-tenth decimal place.	44C1	2400/SV104	7
L6	Emergency Indicator is "null" or "N"	N/A	2400/SV109	7
L7	Date/Time Qualifier is "472" for Service Date	N/A	2400/DTP01	7

Certain items beyond those noted above may be reported in the Tier 1 Test results as "Notes". These are items which will not prevent Tier 1 approval, however, offer further explanation or clarification so the submitter can assess if/how the data should be provided. Examples of "notes" are below:

- Loop 2010BB (Payer Name), N3 and N4 (Payer Address) are not required; however, if sent, the values should be "30 E. Broad Street, Columbus, OH 43215-3430".
- All PRV segments are no longer required per the October 2002 addenda.
- If both Loop 2300, CLM01 and Loop 2400, REF02 (where REF01 = 6R) are provided, MACSIS will only return Loop 2400, REF02 on the 835 remittance file.

APPENDIX B
MACSIS HIPAA EDI SCENARIOS FOR TIER 1 TESTING

#	***Test Scenario***	***Used to Verify***
1	• Other payer is involved with the claim • Client is Medicaid Eligible • Service is Medicaid Eligible	• Provider system can properly generate the Loops related to Other Payer Information (2320, 2330A and 2330B)
2	• Other payer is involved with the claim • Service is not Medicaid Eligible	• Provider system can properly generate the Loops related to Other Payer Information (2320 and 2330B)
3	• Date of service is after July 1, 2003 • Billed service uses “new” MACSIS procedure, modifier codes and place of service codes	• Provider system is using “new” MACSIS procedure, modifier and place of service codes for dates of service on or after July 1, 2003.
4	• Same-day services (for dates of service on or after July 1, 2003) are “summed” per the MACSIS same-day service policies under HIPAA.	• Provider system is “summing” same-day services appropriately. • Refer to MH Duplicate Claim Check Roll-Up Category Matrix for more information.

APPENDIX C
MACSIS HIPAA EDI TESTING CHECKLIST FOR TIER 2

#	Requirement	Loop/Segment/Element
1	Non-Medicaid rate changes have been updated by the board.	N/A
2	Current Medicaid Agreements have been submitted to Medicaid Policy Staff (ODMH and/or ODADAS).	N/A
3	• HIPAA Service Rate Forms (Medicaid and Non-Medicaid) have been faxed along with the Tier 2 Test form. • The rates as represented on the HIPAA Service Rate Form must match the rates as stored in Diamond (MHHIPAA). Additionally, the rates as provided on the Tier 2 Test file[1] must not be less than the rates on the HIPAA Service Rate Form and in Diamond.	N/A
4	The number of claims on the file represents a typical weekly submission for the provider, but does not exceed 500 claims[2].	N/A
5	Real Tax-ID is used on the test file	Loop 2010AA and/or Loop 2010AB, NM109
6	Although not required, it is highly recommended that the Billing Provider address match the address associated with the "UPI" number in MACSIS[3].	Loop 2010AA, N3/N4 segments
7	Although not required, it is highly recommended that the Pay-To Provider address match the address associated with the MACSIS Vendor Number3.	Loop 2010AB, N3/N4 segments
8	Real client data is used on the test file for all services.	Loop 2010BA
9	Valid place of services under HIPAA are used	Loop 2300, CLM05-1 and Loop 2400, SV105
10	At least one claim includes ODJFS COB (coordination of benefits) information, if provider submitted COB information in SFY03	Loop 2320, AMT02 and Loop 2330A, REF02
11	All current contracted services are represented on file with correct HIPAA procedure, modifier and place of service code combinations as well as the correct rate.	Loop 2400/Segment SV1

[1] Once approved, it is not required that providers submit billed amounts that do not exceed their contracted Medicaid or Non-Medicaid rate in the production environment. It is only necessary during the testing phase so that it is clear that the provider and board have the same understanding about what the contracted rate is.

[2] See http://www.mh.state.oh.us/ois/macsis/claims/prov_fy03_clms.XLS for information about your average weekly volume of claim submission in FY03.

[3] See http://www.mh.state.oh.us/ois/macsis/mac.provf.top.html to verify address information as stored in MACSIS.

Submitting Test HIPAA Claim Files for Approval

Ohio Department of Mental Health
MACSIS SYSTEM PROCEDURE

Procedure: Submitting Test EDI Claim Files for Approval **Last Revised Date:** 7/25/06

Purpose:

This procedure outlines how test claim files should be submitted for MACSIS approval using the HIPAA-mandated format (837 Professional Claims Format, Version 4010A1). The 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 – 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 (for both Tier 1 and Tier 2):

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. The guideline will outline under what circumstances providers are required to submit test files, any pre-testing requirements, the differences between Tier 1 and Tier 2 testing 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 main contracting board how they expect to receive and/or be notified of test files 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 v4010 files containing NPI**: **X**xxxxxx#.julyy (ex., X0010431.31406), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.

    - **For 837P v4010 files containing UPI only**: **J**xxxxxx#.julyy (ex. J0010431.31406)

5. Upon submission of the test file, the provider should notify their Board that the test file is available per Board procedure and make sure they know what type of test file it is (Tier 1 or Tier 2).

6. Upon approval for "Tier 1" testing, the providers will need to follow the same steps noted above to submit a test file for "Tier 2" testing.

7. **Special notes for previously-approved providers who are submitting 837P files containing NPI:**

    - Previously-approved providers are not required to submit Tier 1 NPI-format files (i.e., they can submit Tier 2 NPI test files first) except in the following circumstances
        - If the provider has changed software
        - If the provider is testing a new UPI which was not previously approved
        - If the provider has installed a major software upgrade
        - If the provider has failed basic syntax/structure compliance with Tier 2 submission
        - Note: If the provider is submitting the first NPI-format file produced from a vendor product/version which has never been tested, Tier 1 testing is highly recommended
    - Providers are encouraged to submit a minimum of 10 claims per procedure/modifier code combination for contracted services in their Tier 2 NPI-format files.
        - Do not include more than 500 claims per test file.
    - Providers should include all lines of business (Medicaid and Non-Medicaid) if applicable.
    - Providers should include at least one "other payer" scenario if they bill other insurance.
    - Providers must roll up same day services on the Tier 2 file.

Provider Procedure After Final Approval for Tier 2:

1. Once approved, providers may submit production 837P claim files using the following naming conventions:

    - **For 837P v4010 files containing NPI**: Nxxxxxx#.julyy (ex., N0010431.31406), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.

    - **For 837P v4010 files containing UPI only**: Axxxxxx#.julyy (ex. A0010431.31406)

Board Procedure For Tier 1:

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, in fact, encouraged to verify test files pass additional requirements for Tier 1 testing 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 possible, the board should also use a text editor to verify each end of line marker contains a line feed and that no special characters or text follow the IEA segment. (See http://www.mh.state.oh.us/ois/macsis/mac.tech.revisited.EOL.issues.html for more information on end of line markers.) If errors are found, the Board can communicate the errors to the provider prior to any involvement by the MACSIS staff, but they (Boards) are not encouraged to actually change the provider file before submitting it onto the MACSIS staff. "Tier 1" review is an optional step depending upon the capabilities of the Board.

2. The board should FTP the file to the MACSIS mhhub server to the /county/<Board designation>/hipaa/test/ subdirectory. The board should then complete the MACSIS EDI Claims Testing Form and email it to macsistesting@mh.state.oh.us.

    - It is very important for the boards to complete all requested information on the test form and to submit it at the same time the test file is made available. Emailing the form is preferred; however, if the Board does not have MS Word, a PDF version of the form is available and can be faxed to 614-752-6474. If faxing, please make sure information is legible.

3. Once received, the MACSIS staff will analyze the agency's test file and return a Test Analysis Form denoting the approval status and/or any errors detected to the Board.

    - Although test file analysis is often completed within 24 business hours, Boards should wait three business days after the submission of a test file to the MACSIS staff before inquiring about the status (if they have not heard). Inquiries about test file status should be sent to the MACSIS Support Desk.

4. The Board is then responsible for providing and reviewing the results with the provider. If not approved, providers will need to repeat this procedure before initiating Tier 2 testing. Boards should assist the provider in understanding what corrections are needed to submit a subsequent test files.

Board Procedure For Tier 2:

1. Once a Tier 2 test file is received by the board, the board should verify the file follows the appropriate test file naming convention.

2. 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 Tier 2 Testing.

3. The board should FTP the file to the MACSIS mhhub server to the /county/<Board designation>/hipaa/tier2test/ subdirectory. The board should then complete the MACSIS

EDI Claims Testing Form and email it along with the HIPAA Service Rate Form(s) to macsistesting@mh.state.oh.us.

- It is very important for the boards to complete all requested information on the HIPAA Service Rate and EDI Claims Test forms and to submit them at the same time the test file is made available. Emailing the form is preferred; however, if the Board does not have MS Word, a PDF version of the form is available and can be faxed to 614-752-6474. If faxing, please make sure information is legible.

4. Once received, the MACSIS staff will make sure the test environment is a current copy of Production and will attempt to run the Tier 2 test file through the PREDI-Edit process in the test environment.

   - ♦ The MACSIS staff will review the PREDI-Edit and Post reports to determine why records created critical or non-critical errors, why warnings were created, if the procedures priced as expected and if all benefit rules were applied appropriately. This review is an evaluation of whether the benefit, contract and pricing rules in Production are indeed intact, accurate and working as expected.

5. If the file meets the acceptance criteria as determined per the policy, the provider will be approved for submission of 837P v4010A1 claim files for Production for either the NPI or UPI format depending on which file format was approved. A copy of the final Tier 2 Testing Analysis 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 Tier 2 form (when ready) to request the process begin starting at step 4.

     i. The board is responsible for changes to the PROVC or PROCP records pertaining to the provider's non-Medicaid agreement.

     ii. If changes need to be made to either Medicaid provider contracts or Medicaid PROCP records, the provider must contact Margie Herrel at ODMH or Doug Day at ODADAS to make the needed updates before proceeding.

   - Boards should wait three business days after the submission of a test file to the MACSIS staff before inquiring about the status (if they have not heard). Inquiries about test file status should be sent to the MACSIS Support Desk.

MACSIS Procedure Codes - ODMH

Procedures Codes considered for payment within MACSIS Under HIPAA
Codes to be used by both ODMH and ODADAS

Service Code Description	Former MACSIS Code	Cert. Reference	Health care or Non-HealthCare	Code Description	Type of Code	Proposed time increment (blank = hourly)	Diagnosis Required
Individual Counseling	M1410 A0120	5122-29-03 3793:2-1-08(N)	Medicaid Health Care	BH counseling AND therapy	*HCPCS* H0004	15 minute	X
Hotline	M3110 A0530	5122-29-08 3793:2-1-08(H)	Non-Medicaid Health Care	BH Hotline Service	*HCPCS* H0030	Hour	

Footnotes:

- Healthcare services versus non-healthcare services are broadly grouped as follows:
  - In this case HealthCare applies to those services where CMS assigned a healthcare code and/or description that generally aligns with the ODMH definition and non-healthcare applies when a code or its description does not align with a code assigned by CMS.
- Updates to the OAC may be necessary to properly align standard procedure code and definitions
- This Procedure code table should be used in combination with the ODMH Modifier table to assure accurate claims pricing and adjudication and the ODMH Same Day Service Reporting: Roll-up Categories for Duplicate Checking (http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.rollup.pdf)

Procedures Codes considered for payment within MACSIS Under HIPAA
Procedures Codes - Mental Health

Service Code Description	Former MACSIS Code	Cert. Reference	Health care or Non-HealthCare	Code Description	Type of Code	Proposed time increment (blank = hourly)	Diagnosis Required
Crisis Intervention	M1110	5122-29-10	Medicaid Health Care	Crisis Intervention MH Services	*HCPCS* S9484	Hour	X
Diagnostic Assessment	M1210	5122-29-04	Medicaid Health Care	MH Assessment, Non-Phys	*HCPCS* H0031	Hour	X
			Medicaid Health Care	Psychiatric diagnostic interview – PHYSICIAN	*CPT* 90801	Hour	X
Medication Somatic	M1310	5122-29-05	Medicaid Health Care	Pharmacologic Mgt	*CPT* 90862	Hour	X
Individual Counseling	M1410	5122-29-03	Medicaid Health Care	BH counseling AND therapy	*HCPCS* H0004	15 minute	X
Group Counseling	M1420	5122-29-03	Medicaid Health Care	BH counseling AND therapy	*HCPCS* H0004	15 minute	X
Individual Cmty Support	M1510	5122-29-17	Medicaid Health Care	Community Psychiatric Supportive Tx	*HCPCS* H0036	15 minute	X
Group Cmty Support	M1520	5122-29-17	Medicaid Health Care	Community Psychiatric Supportive Tx	*HCPCS* H0036	15 minute	X
Partial Hospitalization	M1710	5122-29-06	Medicaid Health Care	Partial Hospitalization, less than 24 hrs	*HCPCS* S0201	Program Day	X
[2]IHBT - Clinical	n/a	5122-29-28	Medicaid Health Care	Intensive Home Based Treatment	*HCPCS* H2016	Daily	X
[3]ACT – Clinical	n/a	5122-29-29	Medicaid Health Care	Assertive Community Treatment	*HCPCS* H0040	Daily	X
Occupational Therapy	M1430	5122-29-24	Non-Medicaid Non-Health Care	Occupational Therapy	*MACSIS* M143*0*	Hour	
Adjunctive Therapy	M1440	5122-29-23	Non-Medicaid Non-Health Care	Adjunctive Therapy	*MACSIS* M144*0*	Hour	
School Psychology	M1530	5122-29-25	Non-Medicaid Non-Health Care	School Psychology	*MACSIS* M153*0*	Hour	
Adult Education	M1540	5122-29-13	Non-Medicaid Non-Health Care	Adult Education	*MACSIS* M154*0*	Hour	
Social & Recreational	M1550	5122-29-14	Non-Medicaid Non-Health Care	Social & Recreational	*MACSIS* M155*0*	Hour	
Employment	M1620	5122-29-11	Non-Medicaid Non-Health Care	Employment/Vocational	*MACSIS* M162*0*	Hour	
IHBT – Non-Clinical	n/a	5122-29-28	Non-Medicaid Health Care	Intensive Home Based Treatment	*MACSIS* M1810	Daily	
ACT – Non-Clinical	n/a	5122-29-29	Non-Medicaid Health Care	Assertive Community Treatment	*MACSIS* M1910	Daily	

Service Code Description	Former MACSIS Code	Cert. Reference	Health care or Non-HealthCare	Code Description	Type of Code	Proposed time increment (blank = hourly)	Diagnosis Required
Res Tx Comprehensive	M2210	*	Non-Medicaid Non-Health Care	Residential Care[1] (new name)	*MACSIS* M2200	Daily	
Res Treatment Facility	M2220	*	Non-Medicaid Non-Health Care	Residential Care[1] (new name)	*MACSIS* M2200	Daily	
Residential Support	M2230	*	Non-Medicaid Non-Health Care	Residential Care[1] (new name)	*MACSIS* M2200	Daily	
Community Residence	M2240	*	Non-Medicaid Non-Health Care	Community Residence[1]	*MACSIS* M2240	Daily or Monthly	
Foster Care	M2250	*	Non-Medicaid Non-Health Care	Foster Care [1]	*MACSIS* M2250	Daily	
Housing	M2260	*	Non-Medicaid Non-Health Care	Subsidized Housing (new name)[1]	*MACSIS* M2260	Daily or Monthly	
Respite Care	M2270	*	Non-Medicaid Non-Health Care	Respite Care (new name) [1]	*MACSIS* M2270	Daily	
Crisis Care	M2280	*	Non-Medicaid Non-Health Care	Crisis Care (new name) [1]	*MACSIS* M2280	Daily	
N/A	N/A	*	Non-Medicaid Non-Health Care	Temporary Housing[1]	*MACSIS* M2290	Daily	
Consumer Operated Svc	M3120	5122-29-16	Non-Medicaid Non-Health Care	Consumer Operated Svc	*MACSIS* M3120	Hour	
Peer Support	M3130	5122-29-15	Non-Medicaid Health Care	Self-Help/Peer Svcs	*HCPCS* H0038	15 minute	
Other MH Svc	M3140	5122-29-27	Non-Medicaid Non-Health Care	Other MH Svc – non – Healthcare services	*MACSIS* M3140	Hour	
Other MH Svc	M3140	5122-29-27	Non-Medicaid Health Care	MH Services, not otherwise specified (Healthcare)	*HCPCS* H0046	Variable	
Prevention	M4110	5122-29-20	Non-Medicaid Non-Health Care	Prevention	*MACSIS* M4110	Hour	
Consultation	M4120	5122-29-19	Non-Medicaid Non-Health Care	Consultation	*MACSIS* M4120	Hour	
Mental Health Education	M4140	5122-29-21	Non-Medicaid Non-Health Care	Mental Health Education	*MACSIS* M4140	Hour	
Information and Referral	M4130	5122-29-22	Non-Medicaid Non-Health	Information and Referral	*MACSIS* M4130	Hour	

Footnotes:

1 Housing and Residential services have been developed to help the publicly funded mental health system better define and track these services. These services are further defined in the Housing and Residential Service Categories Table available at http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.housing.table.pdf.

2 Until this service has been approved for reimbursement from Medicaid, this procedure code will process and pay as a non-Medicaid reimbursable service.

[3] Until this service has been approved for reimbursement from Medicaid, this procedure code will process and pay as a non-Medicaid reimbursable service.

- Healthcare services versus non-healthcare services are broadly grouped as follows:
  - In this case HealthCare applies to those services where CMS assigned a healthcare code and/or description that generally aligns with the ODMH definition and non-healthcare applies when a code or its description does not align with a code assigned by CMS.

- Updates to the OAC may be necessary to properly align standard procedure code and definitions

- This Procedure code table should be used in combination with the ODMH Modifier table to assure accurate claims pricing and adjudication and the ODMH Same Day Service Reporting: Roll-up Categories for Duplicate Checking. (http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.rollup.pdf)

MACSIS Procedure Codes - ODADAS

MACSIS Procedure Codes – Codes to be used by both ODMH and ODADAS

Service Code Description	Former MACSIS Code (ODMH ODADAS)	Cert. Reference (see footnote 1)	Health Care or Non-Health Care	Code Description	Type of Code	Proposed time increment (blank= hourly)	Modifier 1 (used in pricing & adjudication)	Modifier 2 (used in pricing & adjudication)	Modifier 3 (information only)	Modifier 4 (Information only)	Diagnosis Required
Individual Counseling	M1410	5122-29-03	Medicaid Health Care	BH counseling and therapy	HCPCS H0004	15 minute	HE	Blank, UK, 99			Yes
	A0120	3793:2-1-08(N)					HF	Blank, 99, H9, HD			
Hotline	M3110	5122-29-08	Non-Medicaid Health Care	BH Hotline Service*	HCPCS H0030		HE	Blank, 99			No
	A0530	3793:2-1-08(H)					HF	Blank, 99			

MACSIS Procedure Codes - ODADAS

Service Code Description	Former MACSIS Code (ODMH ODADAS)	Cert. Reference (see footnote 1)	Health Care or Non-Health Care	Code Description	Type of Code	Proposed time increment (blank= hourly)	Modifier 1 (used in pricing & adjudication)	Modifier 2 (used in pricing & adjudication)	Modifier 3 (information only)	Modifier 4 (Information only)	Diagnosis Required
Assessment	A0110/ Z1850	3793:2-1-08(K)	Medicaid Health Care	Alcohol and/or Other Drug Service Assessment	HCPCS H0001		HA, HF	Blank, 99, HD, H9			Yes
Group Counseling	A0130/ Z1853	3793:2-1-08(O)	Medicaid Health Care	Alcohol and/or Other Drug Service Group Counseling	HCPCS H0005	15 minute	HA, HF	Blank, 99, HD, H9			Yes
Case Management	A0140/ Z1857	3793:2-1-08	Medicaid Health Care	Alcohol and/or Other Drug Service Case Management	HCPCS H0006		HA, HF	Blank, 99, HD, H9			Yes
Crisis Intervention	A0150/ Z1851	3793:2-1-08(L)	Medicaid Health Care	Alcohol and/or Other Drug Service Crisis Intervention	HCPCS H0007		HA, HF	Blank, 99, HD, H9			Yes
Medical/ Somatic	A0170/ Z1854	3793:2-1-08(S)	Medicaid Health Care	Alcohol and/or Other Drug Service Medical/Somatic Services	HCPCS H0016		HA, HF	Blank, 99, HD, H9			Yes
Methadone	A0180/ Z1856	3793:2-1-08(T)	Medicaid Health Care	Alcohol and/or Other Drug Service Methadone Administration including LAAM	HCPCS H0020	Per dose	HF	Blank, 99, H9			Yes
Intensive Outpatient	A0190/ Z1858	3793:2-1-08(Q)	Medicaid Health Care	Alcohol and/or Other Drug Service Intensive Outpatient (tx program that operates at least 8 hrs/week and at least 3 days/wk and is based on an ind tx plan), including assessment, individual and group counseling, crisis intervention	HCPCS H0015	Per diem	HA, HF	Blank, 99, HD, H9			Yes
Ambulatory Detox	A0310/ Z1859	3793:2-1-08(X)	Medicaid Health Care	Alcohol and/or Other Drug Service Ambulatory Detoxification	HCPCS H0014	Per diem	HA, HF	Blank, 99, HD, H9			Yes
Consultation	A0560	3793:2-1-08(F)	Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Consultation	MACSIS A0560		HA, HF	Blank, 99, HD, H9			No
Intervention	A0520	3793:2-1-08(G)	Non-Medicaid Health Care	Alcohol and/or Other Drug Service Intervention	HCPCS H0022		HA, HF	Blank, 99, HD, H9			No
Family Counseling	A0131	3793:2-1-08(P)	Non-Medicaid Health Care	Alcohol and/or Other Substance Abuse Service Family/Couple Counseling	HCPCS T1006	15 minute	HA, HF	Blank, 99, HD, H9			Yes
Urinalysis: lab analysis	A0160/ Z1855	3793:2-1-08(R)	Medicaid Health Care	Alcohol and/or Other Drug Service Urinalysis: lab analysis of specimens for presence of alcohol and/or drugs	HCPCS H0003	Per screen regardless of no. of panels	HA, HF	Blank, 99, HD, H9			Yes
Urine Dip Screening	A4250	3793:2-1-08(R)(2)	Non-Medicaid Non-Health Care	Urine Dip Screening	MACSIS A0780	Per screen	HA, HF	Blank, 99, HD, H9			No

Service Code Description	Former MACSIS Code (ODMH ODADAS)	Cert. Reference (see footnote 1)	Health Care or Non-Health Care	Code Description	Type of Code	Proposed time increment (blank= hourly)	Modifier 1 (used in pricing & adjudication)	Modifier 2 (used in pricing & adjudication)	Modifier 3 (information only)	Modifier 4 (Information only)	Diagnosis Required
Medical Community Residential: Hospital	A0210	3793:2-1-08(U)	Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Medical Community Residential Treatment Hospital setting (includes room and board)	MACSIS A121*0*	Per diem	HA, HF	Blank, 99, H9			Yes Must be AOD
BH Medical Community Residential: Hospital	New	3793:2-1-08(U)	Non-Medicaid Health Care	BH Medical Community Residential Treatment Hospital setting (without room and board) Bill room and board as A0740. See A0210 for combined billing.	HCPCS H0017	Per diem	HA, HF	Blank, 99, H9			Yes Must be AOD
Medical Community Residential: Non-Hospital	A0230	3793:2-1-08(U)	Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Medical Community Residential Treatment Non-hospital Setting (includes room and board) See H0018 and A0740 for unbundled billing.	MACSIS A023*0*	Per diem	HA, HF	Blank, 99, HD, H9			Yes Must be AOD
BH Medical Community Residential: Non-Hospital	New	3793:2-1-08(U)	Non-Medicaid Non-Health Care	BH Medical Community Residential Treatment Non-hospital Setting (without room and board) Bill room and board as A0740. See A0230 for combined billing.	HCPCS H0018	Per diem	HA, HF	Blank, 99, HD, H9			Yes Must be AOD
Non-medical Non-acute Residential	A0220	3793:2-1-08(V)	Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Non-medical Community Residential Treatment (includes room and board) See H0019 and A0740 for unbundled billing.	MACSIS A122*0*	Per diem	HA, HF	Blank, 99, HD, H9			Yes Must be AOD
BH Non-medical Non-acute Residential	New	3793:2-1-08(V)	Non-Medicaid Health Care	BH Non-medical Community Residential Treatment (without room and board) Bill room and board as A0740. See A0220 for combined billed.	HCPCS H0019	Per diem	HA, HF	Blank, 99, HD, H9			Yes Must be AOD
23 hr Observation bed	A0320	3793:2-1-08(W)	Non-Medicaid Health Care	Alcohol and/or Other Drug Service Observation or inpatient hospital care for a patient who is admitted and discharged on the same date with a presenting problem of high severity	CPT 99236	Per diem	HA, HF	Blank, 99, HD, H9			Yes Must be AOD
Sub-acute detox	A0330	3793:2-1-08(Y)	Non-Medicaid Health Care	Alcohol and/or Other Drug Service Sub-acute detoxification (includes room and board. No code for un-bundled billing.	HCPCS H0012	Per diem	HA, HF	Blank, 99, HD, H9			Yes Must be AOD

Service Code Description	Former MACSIS Code (ODMH ODADAS)	Cert. Reference (see footnote 1)	Health Care or Non-Health Care	Code Description	Type of Code	Proposed time increment (blank= hourly)	Modifier 1 (used in pricing & adjudication)	Modifier 2 (used in pricing & adjudication)	Modifier 3 (information only)	Modifier 4 (Information only)	Diagnosis Required
Acute Detox Hospital	A0420	3793:2-1-08(T)	Non-Medicaid Health Care	Alcohol and/or Other Drug Service Acute Detox (Hospital inpatient) (includes room and board. No code for un-bundled billing.	HCPCS H0009	Per diem	HA, HF	Blank, 99, H9			Yes Must be AOD
Referral and Information	A0510	3793:2-1-08(F)	Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Referral and Information Service	MACSIS A0510		HA, HF	Blank, 99, HD, H9			No
Training	A0540	3793:2-1-08(I)	Non-Medicaid Health Care	Alcohol and/or Other Drug Service Training* (for staff and personnel not employed by providers)	HCPCS H0021		HA, HF	Blank, 99, HD, H9			No
Outreach	A0550	3793:2-1-08(J)	Non-Medicaid Health Care	BH Outreach	HCPCS H0023		HF	Blank, 99, HA, HD, H9			No
Information Dissemination	A0610		Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Prevention Information Dissemination**	MACSIS A0610	Time/event based on hour unit	HA, HF	Blank, 99, HD, H9			No
Education	A0620		Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Prevention Education Service**	MACSIS A0620	Time/event based on hour unit	HA, HF	Blank, 99, HD, H9			No
Community-Based process	A0630		Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Prevention Community-based Process Service**	MACSIS A0630	Time/event based on hour unit	HA, HF	Blank, 99, HD, H9			No
Environmental	A0640		Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Prevention Environmental Service**	MACSIS A0640		HA, HF	Blank, 99, HD, H9			No
Problem Ident & Referral	A0650		Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service Prevention Problem Identification and Referral Service**	MACSIS A0650		HA, HF	Blank, 99, HD, H9			No
Alternatives	A0660		Non-Medicaid Non-Health Care	Alcohol and/or Other Drug Service	MACSIS A0660	Time/event based on hour unit	HA, HF	Blank, 99, HD, H9			No
Childcare	A0710		Non-Medicaid Health Care	Child sitting services for children of the individual receiving alcohol and/or substance abuse services	HCPCS T1009		HA, HF	Blank, 99, HD			No
Meals	A0730		Non-Medicaid Health Care	Meals for individual receiving alcohol and/or substance abuse services (when meals not included in the program)	HCPCS T1010	Per meal (max 3/day)	HA, HF	Blank, 99, HD			No
Room and Board	A0740		Non-Medicaid Non-Health Care	Room and Board	MACSIS A0740	Per diem	HA, HF	Blank, 99, HD			No
Transportation	A0750		Non-Medicaid Non-Health Care	Transportation**	MACSIS A0750	Cost per month	HA, HF	Blank, 99, HD			No

Service Code Description	Former MACSIS Code (ODMH ODADAS)	Cert. Reference (see footnote 1)	Health Care or Non-Health Care	Code Description	Type of Code	Proposed time increment (blank= hourly)	Modifier 1 (used in pricing & adjudication)	Modifier 2 (used in pricing & adjudication)	Modifier 3 (information only)	Modifier 4 (Information only)	Diagnosis Required
AOD Services, NOC	A0760	3793:2-1-08(Z)	Non-Medicaid Health Care	Alcohol and/or Substance Abuse Services, Not Otherwise Classified	HCPCS H0047		HA, HF	Blank, 99, HD, H9			No

Footnotes:

- Updates to the Ohio Administrative Code may be necessary to properly align standard procedure code and definitions
- Modifier 1 and 2 will be used in the pricing and adjudication processes while Modifiers 3 and 4 (shaded area) will be for information purposes and CANNOT be used for pricing or adjudication.
- Certain services are designated as "non-client specific" and provider must use Pseudo UCI for billing and are marked with "*".
- MARP has a special MACSIS service code assigned which is not part of this list and is limited to a single provider usage.
- Modifiers: HA: Child/adolescent Program; HF: Substance Abuse; HD: Women's Program; 99: used as a placeholder; Blank is also acceptable only where designated.

MACSIS MH HIPAA Modifier Code Table

Ohio Dept of Mental Health
Modifier Codes accepted within MACSIS Under HIPAA

Values for Modifier 1 – REQUIRED on ALL MH claims

Position	Code	Description	Special notes
1	HE	Mental health program	• Assumed face to face if used without UK in Modifier 2
1	GT	Interactive Telecommunication	• GT should be used in Modifier 1 only if for crisis intervention or individual CSP provided via phone o Crisis intervention provided via phone is NOT a Medicaid reimbursable service
1	HQ	Group setting	• HQ should be used in Modifier 1 only for Group counseling or Group CSP or Group Pharmocologic Mgt

- **Modifier 1 WILL BE used to price or adjudicate claims.**

Values for Modifier 2

Position	Code	Description	Special notes
2	99	Multiple modifiers on claim	• Placeholder when no information is being requested in Modifier 2 and but information is being valued in Modifier 3 and/or 4. • It CANNOT be used in Modifier 1. • Optional placeholder if only Modifier 1 is required.
2	Blank	Not applicable	• No value is required unless modifier 3 and/or 4 will be valued
2	UK	Services provided on behalf of the client to someone other than the client	• No value is required if client IS present

- **Modifier 2 WILL BE used to price or adjudicate claims.**

Values for Modifier 3 and 4

Position	Code	Description	Special notes
3 or 4	H9	Court-ordered	• May be used as appropriate
3 or 4	HA	Child/Adolescent program	• May be used as appropriate
3 or 4	HB	Adult program, non-geriatric	• May be used as appropriate
3 or 4	HC	Adult program, geriatric	• May be used as appropriate
3 or 4	HD	Women's program	• May be used as appropriate
3 or 4	HF	Substance abuse program	• May be used as appropriate
3 or 4	HG	Opiod Addiction Treatment program	• May be used as appropriate
3 or 4	HH	Integrated MH/SA program	• May be used as appropriate
3 or 4	HI	Integrated MH and MR/DD	• May be used as appropriate
3 or 4	HJ	Employee Assistance program	• May be used as appropriate
3 or 4	HK	Specialized MH programs for high risk populations	• May be used as appropriate
3 or 4	HL	Intern	• May be used as appropriate
3 or 4	HM	Less than bachelor degree level	• May be used as appropriate
3 or 4	HN	Bachelors degree level	• May be used as appropriate
3 or 4	HO	Masters degree level	• May be used as appropriate
3 or 4	HP	Doctoral level	• May be used as appropriate
3 or 4	HR	Family/couple with client present	• May be used as appropriate
3 or 4	HS	Family/couple without client present	• May be used as appropriate
3 or 4	HT	Multi-disciplinary team	• May be used as appropriate
3 or 4	HU	Funded by child welfare agency	• May be used as appropriate
3 or 4	HV	Funded by state addictions agency	• May be used as appropriate
3 or 4	HW	Funded by state mental health agency	• May be used as appropriate
3 or 4	HX	Funded by county / local agency	• May be used as appropriate
3 or 4	HY	Funded by juvenile justice agency	• May be used as appropriate
3 or 4	HZ	Funded by criminal justice agency	• May be used as appropriate
3 or 4	99	Multiple modifiers on claim (CPT)	• Placeholder when no information is being requested in Modifier 2 but information is being valued in Modifier 3 or 4 • Optional placeholder if only Modifier 1 is required.

Modifier 3 and 4 will NOT be used to price or adjudicate claims. These values are available to collect information as necessary to the local system.

MACSIS AOD HIPAA Modifier Code

Ohio Department of Alcohol and Drug Addiction Services
Valid AOD MACSIS Modifier Codes by Position

Valid values for Modifier One

Modifier	Description	Special Notes
HA	Child/Adolescent Program	Not available for use as Modifier one for Individual Counseling, Methadone Administration, Outreach and Behavioral Health Hotline.
HF	Substance Abuse Program	

* **All AOD claims must have either HA or HF in Modifier one. Any AOD claim submitted with a blank or invalid Modifier one will be denied.**

Valid Values for Modifier Two

Modifier	Description	Special Notes
HA	Child/Adolescent Program	Only available for use as Modifier two with Behavioral Health Outreach when Modifier one is HF.
HD	Women's Program	Not available for use as Modifier two for Acute Hospital Detoxification, Behavioral Health Hotline, Behavioral Health Medical Community Residential: Hospital Setting, DIP Services, Medical Community Residential: Hospital Setting and Methadone Administration.
H9	Court-Ordered	Not available for use as Modifier two for Behavioral Health Hotline, Childcare, Meals, Room & Board and Transportation.
	Blank	May be used if other second place modifier values does not apply.
99	Multiple Modifiers	Must be used as Modifier two for all DIP services. May be used if more modifiers follow in Modifier Three or Modifier Four.

* **All AOD claims without HA, HD, H9, 99 or Blank in Modifier Two will be denied.** Do not replicate Modifier One value as a value in Modifier Two.

aod.hipaa.modifier.code.table.050606.doc

Ohio Department of Alcohol and Drug Addiction Services
Valid MACSIS Modifier Codes by Position

Valid Values for Modifiers Three and Four

Modifier	Description	Special Notes
	Blank	Because Modifiers three and four are not used to price or adjudicate, these may be left blank.
H9	Court-ordered	Table verification only.
HA	Child/Adolescent program	Table verification only.
HB	Adult program, non-geriatric	Table verification only.
HC	Adult program, geriatric	Table verification only.
HD	Women's program	Table verification only.
HF	Substance abuse program	Table verification only.
HG	Opioid Addiction Treatment program	Table verification only.
HH	Integrated MH/SA program	Table verification only.
HI	Integrated MH and MR/DD	Table verification only.
HJ	Employee Assistance program	Table verification only.
HK	Specialized mental health programs for high risk populations	Table verification only.
HL	Intern	Table verification only.
HM	Less than bachelor degree level	Table verification only.
HN	Bachelors degree level	Table verification only.
HO	Masters degree level	Table verification only.
HP	Doctoral level	Table verification only.
HT	Multi-disciplinary team	Table verification only.
HU	Funded by child welfare agency	Table verification only.
HV	Funded by state addictions agency	Table verification only.
HW	Funded by state mental health agency	Table verification only.
HX	Funded by county / local agency	Table verification only.
HY	Funded by juvenile justice agency	Table verification only.
HZ	Funded by criminal justice agency	Table verification only.
TS	Follow-up Service	Table verification only.
GT	Telephone	Table verification only.
99	Multiple modifiers	Table verification only.

Sample EDI Notice and PDF Report File

Sample EDI Notice

PLEASE DO NOT REPLY TO THIS EMAIL!

Overnight Processing has analyzed the following files:

Claims	File Name	Error (if any)
45	J0013111.16003	ACCEPTED
51	J0013221.16803	ACCEPTED
33	J0018751.15603	ACCEPTED
52	J0068711.16003	ACCEPTED
47	J0070991.15603	ACCEPTED
47	J0071671.15603	ACCEPTED
902	J0082581.15503	ACCEPTED
53	J0100651.14603	ACCEPTED
29	J0101421.14703	ACCEPTED
29	J0101421.15204	ACCEPTED
2	J0101991.15603	ACCEPTED
1,105	J0103521.14903	ACCEPTED
.	J0010578.2452808	BACK WRONG LENGTH
.	J0012901.03803.038	BACK WRONG LENGTH
.	J0081681.1560445	BACK WRONG LENGTH
.	J0201991.15603	BAD PROVNO
.	J0013811.11303	EOL-TILDE ERR
.	J0067561.17403	EOL-TILDE ERR
.	J0067562.17403	EOL-TILDE ERR
.	J0067564.17403	EOL-TILDE ERR
.	H0101991.10303	FIRST LETTER
.	j0101421.14803	FIRST LETTER
.	J001875.156031	FRONT WRONG LENGTH
.	J0082581A.15503	FRONT WRONG LENGTH
.	J0070951.15403	LINES NE SEGNO
.	J0082271.15703	LINES NE SEGNO
.	J0100201.10703	LINES NE SEGNO
.	J0103841.10803	LINES NE SEGNO
.	J0106861.16203	LINES NE SEGNO

This action performed at 21JUN03:20:28:32.

2,395 claims pass through screening of 29 files.

Sample of PDF Report File

REPORT examining: 47M ON 18MAY2006, PASS: 1, 07:05 1

No#	File Name	Status	No of Claims	FY04-DOS	FY05 DOS	FY06 DOS	FY07 DOS	FY08+ DOS	BILLED in CLM-03
1	A0104151.13706	ACCEPTABLE	97	0	0	97	0	0	$9,214.87
2	A0104152.13706	ACCEPTABLE	18	0	0	18	0	0	$5,875.52
3	A0112351.13606	ACCEPTABLE	37	0	0	37	0	0	$22,480.00
4	A0112351.13706	ACCEPTABLE	38	0	0	38	0	0	$23,030.00
			190		*0*	*190*	*0*	*0*	*$60,600.39*

Red Cell background means FY04 or before Claims Found.

Sample PREDI-J Edit Report

```
CLMVD-J 3/4/04
ECLMED02.PUB                                                    ADTEST SYSTEM
Page 1
Run on 3/4/04 @ 2:48 PM                                       DIAMOND Solutions
                                                                  Claims EDI
                                                              Claims EDI Job Log
   ---------------------------------------------------------------------------------------------------
---------------------------
   Batch ID            :  FIVECLMSJ
   Trading Partner ID  :  000000000NOPOST
   Claim Record Type   :  Professional
   Action              :  Edit
   Comments            :  LLD
   ---------------------------------------------------------------------------------------------------
---------------------------
   Time      Type   MsgNo.  Message Text
   ---------------------------------------------------------------------------------------------------
---------------------------
   2:47 PM   INFO   OPE032  Pricing is turned ON for this transaction set.

   2:47 PM   INFO   OPE035  Adjudication is turned ON for this transaction set.

   2:47 PM   INFO   OPE052  Duplicate check is turned ON for this transaction.

   2:47 PM   INFO   OPE119  Bill Type/POS Check is turned OFF for this transaction set.

   2:47 PM   INFO   OPE054  Auth-claim link is turned OFF for this transaction set.

   2:47 PM   INFO   OPE120  Revenue Code/HCPCS Check is turned OFF for this transaction set.

   2:47 PM   INFO   OPE101  Processing Information: Validate=YES, Post=NO, Partial Post=NO, Re-
workable=YES, Process by Batch=YES

   2:47 PM   INFO   OPE030  DIAMOND Claims EDI Summary Statistics:
                             Number of Critical Errors:            7
                             Number of Non-Critical Errors:        1
                             Number of Claim Headers Read:         5
                             Number of Claim Details Read:         5
                             Number of Claim Details Accepted:     1
                             Number of Claim Details Rejected:     4
                             Total Claim Charges:                   $926.13
```

Sample PREDI-D Edit Report

CLMVD-D 3/4/04
ECLMED02.PUB
Run on 3/4/04 @ 2:48 PM

ADTEST SYSTEM
DIAMOND Solutions
Claims EDI
Detail Claims Report

Batch ID : FIVECLMSJ
Trading Partner ID : 000000000NOPOST
Claim Record Type : Professional
Action : Edit
Comments : LLD

	Patient Control Number	DIAMOND Claim Number	DIAMOND Provider ID	DIAMOND Member ID		Service Date	Ln #	Proc Code	Mod	Billed Charges
R	000000933002400		000000001365	4444444	-	07/11/03	001	H0001	HF	88.76
R	000000933002401		000000001365	7777777	-	07/11/03	001	H0003	HF	222.32
	000000933002402	0000000646519880	000000001365	7777777	-00	07/11/03	001	H0004	HF	222.32
R	000000933002403		000000001365	7777777	-00	07/11/03	001	H0005		222.32
R	000000933002404		000000001365	7777777	-	07/11/03	001	H0015	HF	170.41

Number of Claim Lines Accepted : 1
Number of Claim Lines Rejected (R) : 4
Number of Claim Lines Warning Messages (W) : 0

Sample PREDI-C Edit Report

```
CLMVD-C 3/4/04
ECLMED02.PUB                                    ADTEST SYSTEM                                                    Page 1
Run on 3/4/04 @ 2:48 PM                       DIAMOND Solutions
                                                  Claims EDI
                                             Critical Errors Report
-------------------------------------------------------------------------------------------------------------------------
Batch ID           :  FIVECLMSJ
Trading Partner ID :  000000000NOPOST
Claim Record Type  :  Professional
Action             :  Edit
Comments           :  LLD
-------------------------------------------------------------------------------------------------------------------------
Ref. No.      SSN          Last Name                          First Name                      M  Gndr  Birth Date
-------------------------------------------------------------------------------------------------------------------------
4444444       123-45-6789  LASTNAME                            FIRSTNAME                       D   F    01/01/50
FATAL  OPE006  Subscriber not found in DIAMOND system.

Patient Control Number                DIAMOND Claim    DIAMOND Prov DIAMOND Member  Serv Dt  LN# Proc cd  Mod    Billed Charges
-------------------------------------------------------------------------------------------------------------------------
000000933002400                                        000000001365 4444444     -   07/11/03 001 H0001    HF              88.76
FATAL  OPE015  Claim Line Rejected!! Subscriber not found in DIAMOND system.

Ref. No.      SSN          Last Name                          First Name                      M  Gndr  Birth Date
-------------------------------------------------------------------------------------------------------------------------
7777777       123-45-6789  LASTNAME                            XXXXXNAME                           F    01/01/50
FATAL  OPE010  Patient Person Number connot be determined.

Patient Control Number                DIAMOND Claim    DIAMOND Prov DIAMOND Member  Serv Dt  LN# Proc cd  Mod    Billed Charges
-------------------------------------------------------------------------------------------------------------------------
000000933002401                                        000000001365 7777777     -   07/11/03 001 H0003    HF             222.32
FATAL  OPE015  Claim Line Rejected!! Patient Person Number connot be determined.

Patient Control Number                DIAMOND Claim    DIAMOND Prov DIAMOND Member  Serv Dt  LN# Proc cd  Mod    Billed Charges
-------------------------------------------------------------------------------------------------------------------------
000000933002403                                        000000001365 7777777     -00 07/11/03 001 H0005                   222.32
FATAL  OPE015  Claim Line Rejected!! Modifier 1 'XX' Not Found.

Ref. No.      SSN          Last Name                          First Name                      M  Gndr  Birth Date
-------------------------------------------------------------------------------------------------------------------------
7777777       123-45-6789  LASTNAME                            XXXXXNAME                           F    01/01/50
FATAL  OPE010  Patient Person Number connot be determined.

Patient Control Number                DIAMOND Claim    DIAMOND Prov DIAMOND Member  Serv Dt  LN# Proc cd  Mod    Billed Charges
-------------------------------------------------------------------------------------------------------------------------
000000933002404                                        000000001365 7777777     -   07/11/03 001 H0015    HF             170.41
FATAL  OPE015  Claim Line Rejected!! Patient Person Number connot be determined.

Number of Critical Errors :        7
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Sample PREDI-N Edit Report

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CLMVD-N 3/4/04                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                
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ADTEST SYSTEM
DIAMOND Solutions
Claims EDI
Non-Critical Errors Report

Page 1

Batch ID : FIVECLMSJ
Trading Partner ID : 000000000NOPOST
Claim Record Type : Professional
Action : Edit
Comments : LLD

Patient Control Number	DIAMOND Claim	DIAMOND Prov	DIAMOND Member	Serv Dt	LN#	Proc cd	Mod	Billed Charges
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Batch ID : FIVECLMSJ
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Claim Record Type : Professional
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Patient Control Number	DIAMOND Provider	DIAMOND Member ID	Service Date	Submitter Auth No.	DIAMOND Auth No.

No messages for this report

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Run on 3/4/04 @ 2:48 PM                         DIAMOND Solutions
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                                        DIAMOND          DIAMOND      DIAMOND         Service  Ln  Proc                  Billed
Patient Control Number                  Claim Number     Provider ID  Member ID       Date     #   Code     Mod           Charges
-------------------------------------------------------------------------------------------------------------------------------

000000933002402                         0000000646519880 000000001365 7777777     -00 07/11/03 001 H0004    HF             222.32
  Pricing Decisions:      Provider ID: 000000001365, LOB: MCD, Panel:    , Eff Date: 07/01/2003
                          Prov Addr Seq: 001, Order Num: 001, Detail Eff Date: 07/01/2003
                          Grp Price Rule    or   , Price Region OH , Price Sch     or
                          Percent billed=0%, Percent allowed=100%, Geo Region
                          Price rule overridden by PROVD price rule OH
                          Price sch overridden by PROVD Sch 1 12Z, Sch 2 B2Z, Geo Region
                          Percent allowed overridden by PROVD 100%
                          Price Rule OH - OHIO PRULE
                          Procedure Code H0004, Price Schedule 12Z and Price Region OH
                          Eff Date 07/01/2003, Allowed price per unit 19.22
                          times      1 units                  19.22

  Adjudication Decisions: Medical Definition 5050: AOD IND COUN MCD;AOD
                          Ben Pack:25B00001 for group FRAN and plan DFMCD252
                          No Copay Restriction, WCP Pt Liab: Allowed Amount
                          Benefit rules applied:
                           ADMCDOUTP1002
                          Prov withhold:  0.00%
                          Claim Status: from provider contract type P
                          Claim status: Proc contract P overrides prov contract type P
                          AOD IND COUN MCD;AOD
```

Sample Post Report

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CLMPS-Post 03/04/04                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                
ECLMPS00.PUB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                
Run on 03/04/04 @ 2:51 PM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                
                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                
                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                
                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                
```

ADTEST SYSTEM
DIAMOND Solutions
Claims EDI
Post Transaction Set Job Log

Page 1

```
---------------------------------------------------------------------------------------------------------------------------------------------------------------
  Batch ID           :      FIVECLMSJ
  Trading Partner ID :      000000000NOPOST
  Claim Record Type  :      Professional
  Action             :      Post
  Comments           :      LLD
---------------------------------------------------------------------------------------------------------------------------------------------------------------
                   Billed      Allowed      Not Cov       Copay        Deduct     Oth Carr     Withhold          Net        Offset
---------------------------------------------------------------------------------------------------------------------------------------------------------------

 Total amounts read from workfile:
                   222.32        19.22         0.00         0.00         0.00         0.00         0.00        19.22         0.00

 Total amounts written to production:
                   222.32        19.22         0.00         0.00         0.00         0.00         0.00        19.22         0.00

     Claim header records read:              1
     Claim header records written:           1
     Claim detail records read:              1
     Claim detail records written:           1
     Accounts Payable records written:       1
```

PREDI Error Codes

Message Number	Message Type	Message Description	Notes
AN8001	FATAL	Segment identifier is more than 3 characters. Possible problem with the Data Element Separator.	Either the incoming data is not in ANSI-837 format, or the data element separator is not the default character (asterisk "*").
AN8002	FATAL	Segment has more than 200 data elements. Possible problem with the Data Element Separator.	Either the incoming data is not in ANSI-837 format, or the data element separator is not the default character (asterisk "*").
AN8003	FATAL	Cannot determine Segment Identifier. Possible problem with the Data Element Separator.	Either the incoming data is not in ANSI-837 format, or the data element separator is not the default character (asterisk "*").
AN8004	WARN	Is not a valid ANSI 837 segment identifier.	Diamond uses the Release 3, Version 4.1 standard of the 837 transaction set; check submitter's data for conformance.
AN8005	WARN	Segment has [num] data elements. Maximum number allowed for this segment is [num].	Diamond uses the Release 3, Version 4.1 standard of the 837 transaction set; check submitter's data for conformance.
AN8006	FATAL	Multiple Transaction Set Header Segments (ST) found.	Diamond expects one 837 transaction set per EDI run. If incoming data contains multiple sets, then it must be split up before processing in Diamond.
AN8007	FATAL	Multiple Transaction Set Trailer Segments (SE) found.	Diamond expects one 837 transaction set per EDI run. If incoming data contains multiple sets, then it must be split up before processing in Diamond.
AN8008	FATAL	Segment sequence error. [segment] segment found with no prior [segment] segment.	Diamond requires that every PRV segment has at least one SBR segment; that each SBR has at least one PAT; that each PAT has at least one CLM; and that each CLM has at least one SV1. For inpatient claims, each CLM must have at least one SV2 segment.
AN8009	FATAL	Transaction Set Identifier Code must be '837'.	Diamond EDI for claims can only process data in the ANSI 837 format. Transaction set identifier is element ST 01.
AN8010	FATAL	Transaction Set Control Number invalid/required.	Control number is required, and must be between four and nine bytes in length.
AN8011	FATAL	Provider Code invalid/required.	The Provider Code (element PRV 01) must contain a valid ANSI value.
AN8012	WARN	Provider Reference Number Qualifier invalid/required.	The Provider Reference Number Qualifier (element PRV 02) should contain a valid ANSI value.
AN8013	FATAL	Provider Reference Number required.	The Provider Reference Number (element PRV 03) is required.
AN8014	WARN	Payor Responsibility Sequence Number Code invalid/required.	The Subscriber Payor Responsibility Sequence Number Code (element SBR 01) should contain a valid ANSI value.

Message Number	Message Type	Message Description	Notes
AN8015	FATAL	Subscriber Policy Number required.	The Subscriber Policy Number (element SBR 03) is required. At this point the system is checking for non-blank value; during the claims edit and pricing step this field is mapped directly to the Diamond Subscriber Number.
AN8016	WARN	Patient Individual Relationship Code invalid/required.	The Patient Individual Relationship Code (element PAT 01) should contain a valid ANSI value.
AN8017	WARN	Submitter's Claim Identifier required.	The Submitter's Claim Identifier (element CLM 01) should be present.
AN8018	WARN	Claim Total Billed Charges is zero or not numeric.	The Claim Total Billed Charges (element CLM 02) should be present or numeric.
AN8019	FATAL	Outpatient Claim Service ID Qualifier invalid/required.	The Claim Service ID Qualifier (element SV1 01) must contain a valid ANSI value.
AN8020	FATAL	Outpatient Claim Service Procedure Code required.	The Claim Service Procedure Code (element SV1 01b) is required. At this point the system is checking for non-blank value; during the claims edit and pricing step this field is mapped directly to the Diamond Procedure Code file.
AN8021	WARN	Outpatient Claim Service Charges invalid/required.	The Claim Service Charges (element SV1 02) should be present.
AN8022	WARN	Outpatient Claim Service Unit of Measurement Code invalid/required.	The Claim Service Unit of Measurement Code (element SV1 03) should contain a valid ANSI value.
AN8023	WARN	Outpatient Claim Service Quantity required.	The Claim Service Quantity (element SV1 04) should be present. This field is mapped directly to the Diamond claim service quantity field.
AN8024	FATAL	Segment count in SE ([num]) does not agree with total number read ([num]).	This is a control edit on the transaction set.
AN8026	FATAL	Sequence error. [segment] segment has no Corresponding [segment] segment.	Diamond requires that every PRV segment has at least one SBR segment; that each SBR has at least one PAT; that each PAT has at least one CLM; and that each CLM has at least one SV1.
AN8027	INFO	ANSI-837 Conformance Edit Summary:	This summary prints at the end of the conformance edit step, and will show number of fatal errors, number of non-fatal errors, number of segments read, number of claims (service lines) read and the total amount of claim charges. Informational messages are not counted in the error totals. Element SV1 03 is used for total charges for professional claims; element SV2 04 is used for inpatient claims.
AN8028	FATAL	Cannot open source input file [file]. Exiting now.	Could be an environmental problem. The name of this file is identified by the "Conversion Object" field in the transaction log file, and it is located in the directory named in the DIRXTRNLDAT parameter in the DIAMOND.ENV file.

Message Number	Message Type	Message Description	Notes
AN8029	FATAL	Cannot open segment table file. Exiting now.	Could be an environmental problem - check the directory indicated by the DIRXTRNLPGM parameter for the segment data workfile SEGTB837.DAT.
AN8030	FATAL	ERROR on READ from source file. [errortext]	A BBx file system error was issued when reading records from the transaction set source file. The name of this file is the identified by the "Conversion Object" field in the transaction log file, and it is located in the directory named in the DIRXTRNLDAT parameter in the DIAMOND.ENV file.
AN8031	FATAL	Invalid END_OF_FILE on source file.	
AN8032	FATAL	Inpatient Claim Service ID Qualifier invalid/required.	The Claim Service ID Qualifier (element SV2 02) must contain a valid ANSI value.
AN8033	FATAL	Inpatient Claim Service Procedure Code required.	The Claim Service Procedure Code (element SV2 01) is required. If element C003 exists, then element SV2 02a is required. At this point the system is checking for non-blank value; during the claims edit and pricing step this field is mapped directly to the Diamond Procedure Code file.
AN8034	WARN	Inpatient Claim Service Charges invalid/required.	The Claim Service Charges (element SV2 03) should be present.
AN8035	WARN	Inpatient Claim Service Unit of Measurement Code invalid/required.	The Claim Service Unit of Measurement Code (element SV2 04) should contain a valid ANSI value.
AN8036	WARN	Inpatient Claim Service Quantity required.	The Claim Service Quantity (element SV2 05) should be present. This field is mapped directly to the Diamond claim service quantity field.
AN8037	WARN	Inpatient Service segment ignored for Outpatient Claims Transaction Set.	The system found an SV2 (inpatient claims) segment in this transaction set, which has been identified as outpatient claims. The SV1 segment should be used for each service line. The SV2 segment is ignored. See the transaction set report for details.
AN8038	WARN	Outpatient Service segment ignored for Inpatient Claims Transaction Set.	The system found an SV1 (outpatient claims) segment in this transaction set, which has been identified as inpatient claims. The SV2 segment should be used for each service line. The SV1 segment is ignored. See the transaction set report for details.
AN8039	FATAL	Segment found after End of Transaction Set (IEA).	The system encountered extra segments after the end of the transaction set was found. This condition should be corrected by the submitter's system.
AN8040	FATAL	Date/Time qualifier required.	
AN8041	FATAL	Date/Time period qualifier required.	
AN8042	FATAL	Date/Time Period invalid/required.	
AN8043	FATAL	Place of service required.	The facility code value (element CLM06) should be present.

Message Number	Message Type	Message Description	Notes
AN8044	FATAL	[date] date element is NOT Y2K compliant.	The Date/Time (element DTP) must contain eight digits, CCYYMMDD format.
AN8045	FATAL	Bad date format.	The Date (element DTP) must contain an ANSI value.
AN8046	WARN	DMG Date Invalid	The DMG date (element DMG) must contain a valid ANSI value (CCYYMMDD).
AN8047	WARN	DMG Bad Date Format.	The DMG date (element DMG) must contain a valid ANSI value.
AN8048	WARN	DMG Date/Time Qualifier required.	The DMG Date/Time Qualifier (element DMG01) must be present.
AN8049	WARN	DMG Date/Time Period required	The DMG Date/Time Period (element DMG02) must be present.
AN8050	FATAL	Claim Total Billed Charges exceed 9999999999999999 or -9999999999999999.	Basis Pro/5 and Visual Pro/5 limit numbers to 14 digits before the decimal and 2 digits after the decimal.
CLM001	FATAL	The STBL for DIRXTRNLDAT is not defined in your config file.	Your DIAMOND.ENV file must contain an entry for DIRXTRNLDAT, specifying a valid UNIX path (e.g. /diamextdta/). This directory will contain the incoming raw EDI claims data, as well as workfiles created during the PREDI process.
CLM002	FATAL	The STBL for DIRXTRNLPGM is not defined in your config file.	Your DIAMOND.ENV file must contain an entry for DIRXTRNLPGM, specifying a valid UNIX path (e.g. /diamextpgm/). Any custom EDI conversion, pricing or adjudication programs developed by HSD or by the client will also be in this directory.
CLM003	INFO	Process EDI Initialization has been completed.	Indicates the end of basic EDI initialization tasks.
CLM004	INFO	Process EDI Transaction Set job is terminated because of fatal errors.	There have been one or more fatal errors during the PREDI edit process, which will be indicated by other more specific messages. Fatal errors during the ANSI-837 edits will result in the entire transaction set being rejected. Fatal errors during the claims edits, pricing and adjudication steps indicate that one or more claim lines were rejected.
CLM005	INFO	Process EDI Transaction Set job completed normally.	There were no fatal errors reported during the EDI edit, pricing and adjudication steps.
CLM006	INFO	Beginning ANSI-837 conversion process.	Indicates the beginning of the ANSI 837 conversion. This will either involve a custom conversion from a non-ANSI format, or a simple copy if the data is already in ANSI format. A fatal error during this step will cause the entire transaction set to be rejected.
CLM007	FATAL	Can't find TRLOG Record for Transaction Set ID: [id]	Could be an environmental problem - check the transaction log file using TRLOG function.
CLM008	FATAL	Cannot open source conversion file: [file]	Could be an environmental problem - check the directory indicated by the DIRXTRNLDAT parameter for the source conversion file (the incoming raw claims data).
CLM009	INFO	Existing PREDI workfile [file] has been deleted.	Any existing (previous) claims header and detail workfiles for this transaction set are deleted. This is normal.

Message Number	Message Type	Message Description	Notes
CLM010	INFO	No custom conversion program found. Assume conversion object is already in ANSI-837 format.	If no conversion program is specified in the transaction log file, then the system simply copies the incoming source file to a workfile of the name <transset#>.837
CLM011	INFO	Copying [file] to workfile [file].	See message CLM010.
CLM012	FATAL	Cannot copy [file] to workfile [file].	The system is unable to perform the UNIX cp command on the incoming source file. Check UNIX file permissions.
CLM013	INFO	Custom conversion program: [pgm] has been specified.	A custom conversion program has been specified in the transaction log file for this set.
CLM014	FATAL	Cannot open conversion program: [pgm].	Check file permissions and program type of custom conversion program.
CLM015	FATAL	Conversion Program is not a BBx Program. See User Docs for more details.	Check file permissions, program type and parameter lists of custom conversion program.
CLM016	INFO	Running custom conversion program [pgm].	Custom conversion program was found, and it is being run.
CLM017	INFO	Custom conversion complete.	Indicates a normal completion of the custom conversion program.
CLM018	INFO	Performing ANSI-837 Conformance Edits.	Indicates the beginning of the ANSI 837 conformance edits, which will check the converted data to adherence to the ANSI standards. Any messages which start with "AN8" are part of this editing process. A fatal error during this step will cause the entire transaction set to be rejected.
CLM019	INFO	ANSI-837 Conformance Edits complete.	There were no fatal errors detected during the ANSI 837 conformance edit step.
CLM020	INFO	Performing Diamond Claims Edits, Pricing and Adjudication.	Indicates the beginning of the Diamond claims edits, pricing and adjudication step. This step is only performed if there were no fatal errors detected during the ANSI-837 edit step. A fatal error during this step will cause claim lines to be rejected, but not the entire transaction set.
CLM021	INFO	Claims Edits, Pricing and Adjudication complete.	There were no fatal errors detected during the claims edits, pricing and adjudication step.
CLM022	FATAL	Selected Printer is not available. Resubmit this job.	UNIX system problem. Check printer configuration.
CLM023	FATAL	Printer Error ... ERR = [errortext]	UNIX system problem. Check printer configuration.
CLM024	WARN	Possible duplicate transaction set found for this submitter.	The system has found another previously processed transaction set for this submitter which has the same total number of claim details, the same number of ANSI segments, and the same total charges. This is a warning only; research is necessary to determine if this is an actual duplicate.
CLM025	FATAL	Error opening the EDI report workfile. Job Terminating.	
DTL000	WARN	Claim Detail record messages not otherwise specified.	

Message Number	Message Type	Message Description	Notes
DTL510	WARN	Price rule location messages returned from JUTILD01.PUB.	Includes any of the following messages, some of which are FATAL: Date of service must be within claim header date range (FATAL), Member ineligible at date of service, No detail record found for group.
DTL520	WARN or FATAL	Messages returned from pricing programs (JUTILP*.PUB and JPRICE00.PUB) (pre-pricing pass).	Depends on which price rule is used. WARN or FATAL depends on the severity of error. If encountering an error during online pricing that allows pricing to continue, then WARN returns. Else it returns FATAL.
DTL530	WARN or FATAL	Claim detail rejected. Unable to use price rule [price rule].	Diamond uses separate programs for claims pricing. The name of each program is "JUTILP" + the 2-character price rule code + ".PUB". This error message is issued if the program is not found, is not a BBx program or cannot be read. WARN or FATAL depends on the severity of error. If encountering an error during online pricing that allows pricing to continue, then WARN returns. Else it returns FATAL.
DTL535	FATAL	Claim detail rejected. Custom pricing program [id] not located.	A special custom pricing program for EDI claims was specified in the TRLOG setup file, but the system could not locate it. Custom pricing and adjudication programs for EDI must reside in the directory named in the DIRXTRNLPGM entry in the DIAMOND.ENV file.
DTL540	WARN	Procedure code only valid for sex [sex].	Issued if the sex (gender) code on the PROCD record is not blank and it does not match the member's sex.
DTL541	WARN	Procedure [proc] only valid for ages [from] - [to].	Issued if the age range code on the PROCD record is not blank and it does not match the member's age (as determined by the primary date of service).
DTL542	WARN	WARNING: Asterisk procedure.	This message is issued if the Asterisk field in the PROCD file is set to Y.
DTL543	FATAL	Claim detail rejected. Procedure code [code] not found in PROCD file.	A procedure code (element SV1 01b for professional claims, SV2 01 or SV2 02b for inpatient claims) is required for each claim detail line. This field is mapped directly to the Diamond PROCD file. The Product/Service ID Qualifier (element SV1 01) is not used to determine if the procedure code is valid, but this field ideally should be "CJ" - CPT code, "HC" - HCPCS or "XX" - mutually defined code.
DTL544	WARN or FATAL	Procedure code [code] not in effect for this date of service.	
DTL550	WARN	Messages returned from modifier pre-processing programs (JMODIA*.PUB).	Depends on which price rule is used.

Message Number	Message Type	Message Description	Notes
DTL551	FATAL	Claim detail rejected. No modifier program for [price rule].	Diamond uses separate programs for claims pricing. The name of the modifier program is "JMODIA" + the 2-character price rule code + ".PUB". This error message is issued if the program is not found, is not a BBx program or cannot be read.
DTL552	FATAL	Modif [modifier] not found in MODIF file	The modifier in the SV1 segment is not found in the MODIF file for the table driven price rule.
DTL560	WARN	Ineligible member messages returned from JUTILD08.PUB	Includes any of the following messages: Member eligibility record does not include this date of service, No provider contract for this date of service, No group detail record found.
DTL570	WARN	Allowed amount for original billed procedure is zero.	
DTL580	WARN	WARNING: No medical definition assigned.	Issued if a medical definition is not assigned to the claim line. Medical definitions are assigned based on the rules established in the MEDEF, MEDLU, MEDTP functions.
DTL585	FATAL	Claim detail rejected. Custom adjudication program [id] not located.	A special custom adjudication program for EDI claims was specified in the TRLOG setup file, but the system could not locate it. Custom adjudication and pricing programs for EDI must reside in the directory named in the DIRXTRNLPGM entry in the DIAMOND.ENV file.
DTL590	WARN	Messages returned from JADJUD01.PUB, pertaining to locating benefit packages.	Includes any of the following messages: No premium record found for group <id>, Plan <id>, as of <date>.
DTL600	WARN	Messages returned from G/L reference code and Company code assignment (JADJUD06.PUB).	Includes any of the following messages: No company or G/L reference code assigned.
DTL610	INFO	All pricing messages returned through the DECISION$ array.	These informational messages are collected during the pricing process, and include such information as price rule used, benefit package used, price region, price schedule, etc.
DTL620	INFO	All adjudication messages returned through the ADJDECISION$ array.	These informational messages are collected during the adjudication process, and include such information as medical definition, benefit package, benefit rules used, authorization link, etc.
DTL630	WARN	Messages returned from the pricing programs (pricing pass).	Depends on which price rule is used.
DTL640	WARN	Messages returned from adjudication (JADJUD22.PUB).	Includes any of the following messages: Benefit package <code> not found in BENEF file, Claim straddles minimum quantity of <num>, Claim straddles both minimum and maximum quantities, Claim straddles maximum quantity of <num>, Manual adjudication required, More than 10 interactive rules; unable to process.
DTL650	WARN	Messages returned from Whole Claim Pricing (JINSTP00.PUB).	
DTL655	FATAL	Messages returned from Whole Claim Pricing (JINSTP00.PUB).	

Message Number	Message Type	Message Description	Notes
DTL660	INFO	Messages returned from Whole Claim Pricing (JINSTP00.PUB).	
DTL700	FATAL	Thru dates must be later than from date.	
DTL710	FATAL	Thru date cannot be beyond header discharge date.	
DTL720	WARN	Line item quantity set to [quantity].	
HDR000	WARN	Claim Header messages not otherwise specified.	
HDR010	WARN	Warning: Claim date is more than [claimage] days old.	Issued whenever the system date less the primary date of service is greater than the number of days setup in the CLAIMAGE system parameter.
HDR020	FATAL	Claim header rejected. Thru date may not be earlier than primary date.	The dates of service which appear for each claim line in the transaction set should be in ascending order, or there should be a "from and through" service date specified for the claim.
HDR030	WARN	Member validation messages returned from program JUTILH03.PUB.	Includes any of the following messages, some of which are FATAL: Invalid member number (FATAL), Member date of birth not on file, Invalid member sex (gender code), WARNING: Potential COB claim, Member not eligible at time of claim, Bad eligibility result (FATAL), Continuous member eligibility only through <date>, Member eligibility status is pended, Unable to locate LINBS record, Invalid group code in member eligibility file (FATAL), Invalid PCP (FATAL), No group header contract located for this date of service, WARNING: Check overage dependent verification status.
HDR040	WARN	Pre existing condition warnings returned from JUTILH17.PUB.	Includes any of the following messages: No premium record located for pre-existing conditions test, No BENEF record found for package <package>, Pre-exist test: No eligibility for this member as of <date>, Pre-exist test: Member not eligible as of <date>, Pre-exist test: Bad eligibility result as of <date>, Pre-exist test: Member in group <group#> as of <date>, WARNING: check for pre-existing conditions back to <date>.
HDR050	WARN	Line of business [LOB] not located.	Issued if the member's line of business code is not found on the LINBS file. Line of business comes from the member's history record, based on the primary date of service.
HDR060	WARN	Referral Provider Messages returned from JUTILH04.PUB	Includes any of the following messages, one of which is fatal: Referring Provider not in PROVF file (FATAL), Date of Service not covered by contract period, No Provider Contract record found.

Message Number	Message Type	Message Description	Notes
HDR070	WARN	Provider validation messages returned from JUTILH05.PUB	Includes any of the following messages, some of which are FATAL: No provider sent for this claim (a FATAL internal program error), Provider not in PROVF file (FATAL), Alternate provider addresses on file, WARNING: Provider not continuously eligible, Vendor not in VENDR file (FATAL).
HDR080	FATAL	Claim header rejected. EDI Vendor [id] does not match provider contract vendor [vendor].	If the PRV segments in loop 2000 of the transaction set identify a Diamond vendor, then this vendor must have a valid contractual relationship with the provider of service which must have been specified in the CLM segments (loop 2310) or the SV1 segments (loop 2420). Use the contract detail screen in function PROVF to establish a relationship between a provider and a vendor.
HDR081	WARN	Multiple vendors exist for provider contract - verify vendor.	
HDR090	FATAL	Claim header rejected. Place of service [code] not found in REASN file.	The place of service code (element CLM 06) is required. The Facility Code Qualifier (element CLM 05) must be the value "B", which identifies element CLM 06 as a place of service code. This field is mapped directly to the Diamond REASN file.
HDR100	WARN	Reason code [code] not found in REASN file.	
HDR110	WARN	Diagnosis code not found in DIAGN file.	Up to three diagnosis codes can be taken from the PC segments in the 2300 loop (claim header level). The product/service ID qualifier (element PC 01) must be the value "DX", which identifies element PC 02 as a ICD-9-CM diagnosis code. This field is mapped directly to the Diamond DIAGN file.
HDR111	WARN	Diagnosis only valid for sex [sex].	Issued if the sex (gender) code on the DIAGN record is not blank and it does not match the member's sex.
HDR112	WARN	Diagnosis only valid for ages [from] - [to].	Issued if the age range code on the DIAGN record is not blank and it does not match the member's age (as determined by the primary date of service).
HDR113	FATAL	Code [diagnosis] not in effect for this admit date.	Issued if from and thru date range on the DIAGN record does not fall between the claim's admit and discharge dates.
HDR120	FATAL	Claim header rejected. NEXTCLAIMNO Parameter record not located.	Claim numbers are auto-assigned by the PREDI function. There must exist a valid NEXTCLAIMNO record in the system parameters file (PARAM).

Message Number	Message Type	Message Description	Notes
HDR130	FATAL	No more than 26 claim splits allowed.	Claims may be automatically "split" in cases where there is a different provider for one or more service lines in the 2420 loop. When this occurs, the claim is split into multiple claims, one for each different provider specified. Split claims are identified with the same base claim number, except for the right-most character, which is a letter starting with "A" for the first split.
HDR140	FATAL	Claim header rejected. Unable to locate group detail for [group].	The member's group ID, plan code and primary date of service are used to lookup the type "P" (premium) group detail record. This record is used for various claims pricing rules.
HDR150	WARN	Claim header messages returned from JUTILH03.PUB and JUTILH05.PUB	See HDR030 for messages from JUTILH03.PUB. See HDR070 for messages from JUTILH05.PUB.
HDR160	WARN	DRG grouper messages from JINSTH18.PUB.	Include any of the following messages: DRG Grouping successful, Grouper Directory not found, Grouper not found in directory, Write to grouper input file was unsuccessful, Read from grouper output file was unsuccessful, E-Codes cannot be used as principal diagnosis codes, No DRG match in MDC indicated by principal diagnosis, A principal diagnosis code of 76509 conflicts with this data, Principal diagnosis code could not be found in grouper's table, Birthweight outside the range that the grouper expects, birthweight conflicted with categories derived from codes, Birthweight category derived indicates a non-specific birthweight, Invalid discharge age. Non-numeric or less than zero, Grouper unsuccessful. Return code value was [return code].
HDR200	WARN	Messages returned from JINSTH03.PUB for testing the bill type.	Includes any of the following messages: Zero Balance Claim, WARNING: Interim Claim - first claim, WARNING: Interim Claim - continuation, WARNING: Interim Claim - final claim, Late charges to previous claim, Adjusted bill, WARNING: Replacement to prior claim, Void or cancelled claim, Invalid bill type - Third digit cannot be 9.
HDR210	WARN	Continuation flag set to Y based on bill type.	
HDR220	WARN	Messages returned from JUTILH04.PUB for validating the attending provider and its eligibility.	Includes any of the following messages: Date of service not covered by contract period, No provider contract record found, Referring Provider not in PROVF file
HDR230	FATAL	Invalid authorization [auth key] not on file.	
HDR240	FATAL	Authorization type [auth type] not valid for institutional service claim.	

Message Number	Message Type	Message Description	Notes
HDR250	WARN	Auth [value 1: Subscriber number/Person ID/PCP/Ref Provider/Provider number/Proc Code 1/Proc Code 2/Proc Code3/Place of svc/Reason Code/ Diagnosis code 1/ Diagnosis code 2/ Diagnosis code 3] does not match claim [value 2: value on the AUTH record that corresponds to value 1]	The values of 1 and 2 are mismatched when attempting the auth claim link.
HDR260	WARN	Messages from JUTILH16.PUB for comparing the auth to the member.	Includes any of the following messages: Current group [group code from MELIG record] does not match group [group code from AUTH record] from auth, Current plan [plan code from MELIG record] does not match plan [plan code from AUTH record] from auth
HDR270	WARN	Messages from JUTILH17.PUB for testing pre-existing conditions.	Includes any of the following messages: No premium record located for pre-existing condition test, No BENEF record found for package [benefit package from GRUPD record], various messages regarding pre-existing conditions
HDR280	WARN	Messages returned from Whole Claim Pricing (JINSTP00.PUB).	These are the only Whole Claim Pricing messages that signify Whole Claim Pricing was not attempted. They will result from the Bill Type position 3 being equal to a 2 or 3, or if the Discharge Date is missing.
OPE001	FATAL	System parameter EDIPRVXREF contains invalid key codes: [codes] Program terminating.	The valid provider cross-reference key codes are: P0 (provider number), P2 (xref number), P3 (user ID field 1), V0 (vendor number) and V2 (vendor tax ID#).
OPE002	WARN	Provider Code: [code] Should be either BI, PE or PT.	The Provider Code (element PRV 01) should ideally contain the BI, PE (performing or rendering provider) or PT (pay-to provider) code. Any other codes may indicate a payment or reporting arrangement not supported by Diamond EDI.
OPE003	WARN	Prov Ref Qual not found on EDIPRVXREF rules. Using Diamond provider number as key.	All of the Provider Reference Number Qualifier values (element PRV 02) should appear on a Diamond EDIPRVXREF system parameter. If a code is not found, then the system will start searching for a match using the Diamond provider ID.
OPE004	FATAL	Provider/Vendor not found in Diamond system.	This message is printed whenever a provider cannot be mapped to Diamond. Each claim line for this provider will be rejected and printed in detail on the error log.
OPE005	FATAL	Subscriber Policy Number missing.	The Subscriber Policy Number (element SBR 03) is required. This field is mapped directly to the Diamond Subscriber Number.

Message Number	Message Type	Message Description	Notes
OPE006	FATAL	Subscriber not found in Diamond system.	This message is printed whenever a subscriber number cannot be mapped to Diamond (meaning that there are no members with this Subscriber Number). Each claim line for this subscriber will be rejected and printed in detail on the error log.
OPE007	FATAL	Parameter EDIPRVXREFn does not exist in Parameter File.	There must be at least one EDIPRVXREFn system parameter set up in Diamond.
OPE008	FATAL	Values specified incorrectly in EDIPRVXREFn parameter: [values]	The values in the EDIPRVXREFn system parameters record is not in the correct format.
OPE009	WARN	Patient DOB Qualifier should be D8 or D6, [code].	The Patient Date of Birth qualifier code (element DMG 01) should be "D6" (YYMMDD-format) or "D8", which specifies a date in CCYYMMDD format.
OPE010	FATAL	Patient Person Number cannot be determined.	The subscriber number is valid, meaning that a family has been located in Diamond, but the system cannot match to a specific member in a family. This match is based on various combinations of name, gender and date of birth.
OPE011	WARN	Imperfect Patient No. Match: Level 1. Person number [num] used.	A perfect match could not be made based on name, gender and date of birth. Imperfect match level 1 is considered almost as accurate as a perfect match.
OPE012	WARN	Imperfect Patient No. Match: Level 2. Person number [num] used.	A perfect match could not be made based on name, gender and date of birth. Imperfect match level 2 is less accurate than level 1.
OPE013	WARN	Imperfect Patient No. Match: Level 3. Person number [num] used.	A perfect match could not be made based on name, gender and date of birth. Imperfect match level 3 is the least accurate match. Manually check the Diamond member file to make sure that the correct member was selected.
OPE014	FATAL	Internal Program Error occurred, [errortext].	This error message indicates that there is an internal program error within the person number match routine.

Message Number	Message Type	Message Description	Notes
OPE015	FATAL	Claim Line Rejected!! [reason]	Claim lines will be rejected if any of the following conditions are true: ▪ Vendor missing or cannot be found. ▪ Provider missing or cannot be found. ▪ Subscriber missing or cannot be found. ▪ Patient missing or cannot be found. ▪ No Place of Service code. ▪ No date of service. ▪ Service Thru date is earlier than the From date. ▪ Service Thru date on the claim detail is later that the Thru date on the claim header. ▪ Procedure code missing or cannot be found. ▪ Procedure code modifier cannot be found. ▪ Diagnosis code pointer is invalid. ▪ Diagnosis code pointer on the claim detail does not correspond to the diagnosis code on the claim header. ▪ Claim detail line has a diagnosis code pointer, but there is no diagnosis code on the header. Rejected claim lines are not written to the EDI claims workfiles, and will not be written to Diamond production claims files should the transaction set be posted. The error messages print in the Critical Error Report For additional information about error messages pertaining to batch processing of Professional Claims, see the document entitled OPCLM-Batch Processing Enhancements.
OPE016	FATAL	Cannot find Vendor associated with Prov. ID.	The Provider's DIAMOND ID (element PRV03) cannot be found in DIAMOND
OPE017	FATAL	Cannot find Provider specified in 2310 Loop for Claim # [id].	The claim has a provider override specified in loop 2310, which is supposed to supersede the provider in loop 2000 (for just this claim). The system is unable to locate this provider in the Diamond system. All claim lines for this claim will be rejected. See the ANSI 837 Transaction Set report for details.
OPE018	FATAL	Cannot find a Primary Date.	All claims must have at least one service date. Dates of service can be at the claim level, the service line level or both. The DTP segment is used, and the system currently checks only for Date Qualifier "150"; this logic in the EDI system will probably have to be expanded to check for other valid date qualifiers.

Message Number	Message Type	Message Description	Notes
OPE019	WARN	Cannot find Provider specified in 2420 Loop for Claim..	The claim has a provider override specified in loop 2420, which is supposed to supersede the provider in loop 2000 (for just this claim line). The system is unable to locate this provider in the Diamond system. The particular claim line with the missing provider will be rejected. See the ANSI 837 Transaction Set report for details.
OPE020	WARN	ANSI Provider Code is not valid for provider rendering services in 2310 Loop.	
OPE021	WARN	ANSI Provider Code is not valid for provider rendering services in 2420 Loop.	
OPE025	FATAL	Family size > 30. Cannot find Patient Person No.	The patient number algorithm will search through an entire family trying to match on a member based on name, gender and date of birth. Families are identified by subscriber number (element SBR 03). The table used to store a family is limited to 30 members.
OPE026	FATAL	ERROR on READ from source file. ERR=[errortext].	A BBx file system error was issued when reading records from the transaction set source file. The name of this file is the transaction set ID + ".837", and it is located in the directory named in the DIRXTRNLDAT parameter in the DIAMOND.ENV file.
OPE027	FATAL	Invalid Transaction ID passed to [pgm] in TRANSSET$.	Indicates that there is a parameter passing problem between the programs JCLMED00.PGM and JOPEDI00.PGM (or JIPEDI00.PGM), or that the transaction set log file (TRLOG) has been inappropriately deleted.
OPE028	WARN	Provider key [key] was specified, but a provider was located using key [key].	There are five possible keys on which a provider match can be made. The Provider Reference Number Qualifier (element PRV 02) in conjunction with the Diamond EDIPRVXREF system parameters determine the primary search method. If a provider cannot be located using the primary method, then the other four possible keys are checked. This message is printed if a provider is located using one of these alternate methods.
OPE029	WARN	There are multiple providers using key [key]. The first one found is being used.	

Message Number	Message Type	Message Description	Notes
OPE030	INFO	DIAMOND Claims EDI Summary Statistics:	This summary prints at the end of the claims edits, pricing and adjudication step, and will show number of fatal errors, number of non-fatal errors, number of claims read (service lines), number of claim lines accepted (i.e. written to the EDI workfiles), number of claim lines rejected, and the total claim charges. Informational messages are not counted in the error totals. Element SV1 03 is summed to calculate total charges for professional claims, element SV2 04 for inpatient claims. The number of claim lines written plus the number of claim lines rejected should always equal the number of claim lines read.
OPE031	INFO	Pricing is turned OFF for this transaction set.	This message is determined by the Pricing "switch" which is in the transaction log file (TRLOG).
OPE032	INFO	Pricing is turned ON for this transaction set.	This message is determined by the Pricing "switch" which is in the transaction log file (TRLOG).
OPE033	INFO	Custom pricing program [pgm] will be used instead of DIAMOND pricing.	This message is printed if there is a custom pricing program named in the transaction log file (TRLOG). This program must be in the directory indicated by the DIRXTRNLPGM parameter in the DIAMOND.ENV file.
OPE034	INFO	Adjudication is turned OFF for this transaction set.	This message is determined by the Adjudication "switch" which is in the transaction log file (TRLOG).
OPE035	INFO	Adjudication is turned ON for this transaction set.	This message is determined by the Adjudication "switch" which is in the transaction log file (TRLOG).
OPE036	INFO	Custom adj. program [pgm] will be used instead of DIAMOND adjudication.	This message is printed if there is a custom adjudication program named in the transaction log file (TRLOG). This program must be in the directory indicated by the DIRXTRNLPGM parameter in the DIAMOND.ENV file.
OPE037	WARN	Total Billed Charges not numeric.	The total billed charges (element CLM 02) must be numeric. If CLM 02 is missing or zero, the system will use the AMT segment from loop 2300 if AMT 01 = "T3".
OPE038	WARN	Uniform Billing Claim Form Bill Type not found; assume first two digits are 1,1 (hosp. inp.)	The Facility Code (element CLM 06) is used for the first two digits of the Bill Type if the Facility Code Qualifier (element CLM 05) is "A". This warning message indicates that these fields were not found in the transaction set for this claim, and the system is assuming that the values are 1,1 (hospital inpatient). See the user documentation for INCLM for details on this code.

Message Number	Message Type	Message Description	Notes
OPE039	WARN	Claim Frequency not found; assume third digit of Uniform Billing Claim Form Bill Type is 1.	The Claim Frequency Type Code (element CLM 07) is used for the third digit of the Bill Type. This warning message indicates that this field was not found in the transaction set for this claim, and the system is assuming that the value is 1 (admit through discharge date). See the user documentation for the INCLM function for details on this code.
OPE040	WARN	Provider key [key] was specified in 2310 loop, but a provider was located using key [key].	This message was generated while looking up a provider which was specified at the claim level (loop 2310). See explanation for message OPE028 for more details.
OPE041	WARN	Provider key [key] was specified in 2420 loop, but a provider was located using key [key].	This message was generated while looking up a provider which was specified at the claim line level (loop 2420). See explanation for message OPE028 for more details.
OPE042	WARN	Claim Total Billed amount of [amt] does not agree with detail total of [amt].	Element CLM 02 contains the total submitted charges for each claim. This amount is compared to the sum of the detail charges for each service line in the claim. Element SV1 02 is used for professional claims detail charge amount; element SV2 03 is used for inpatient claims.
OPE043	WARN	More than 300 authorizations for this member; only first 300 checked for match.	The claim-auth match for inpatient claims will only search through the first 300 authorizations for the member. This limit can be increased by HSD if necessary. The system is only targeting authorizations of type inpatient.
OPE044	WARN	Submitter's authorization no. [#] not found in Diamond auth file.	The submitter sent a Diamond authorization number with the claim data, but the system could not find an authorization for that number. The claim is adjudication without a link to an authorization.
OPE045	INFO	Auths on file for member, but no match made to claim.	The member has (inpatient) authorizations in Diamond and these were searched, but the system could not find one for the same date, institution and/or referring provider.
OPE046	WARN	Imperfect match on submitter's auth no. [#]; auth not linked to claim.	The submitter of the claim supplied a Diamond authorization number, but the authorization did not match up with the claim. This claim should be researched, and if the authorization is valid a manual link to the auth can be done after the claim is posted to production.
OPE047	WARN	Imperfect match on submitter's auth no. [#]; auth linked to claim.	The submitter of the claim supplied a Diamond authorization number, but the authorization did not match up perfectly with the claim. There was enough common information however to make the link to the claim. This claim should be researched, and if the auth is invalid the link can be un-done after the claim is posted to production.

Message Number	Message Type	Message Description	Notes
OPE048	WARN	Imperfect match on Diamond auth no. [#]; auth not linked to claim.	The claim-auth search detected an authorization for the member, but the authorization did not match up with the claim enough to make a positive link. This claim should be researched, and if the authorization is valid a manual link to the auth can be done after the claim is posted to production.
OPE049	WARN	Imperfect match on submitter's auth no. [#]; auth linked to claim.	The claim-auth search detected an authorization for the member, but the authorization did not match up perfectly with the claim. There was enough common information however to make the link to the claim. This claim should be researched, and if the authorization is invalid the link can be un-done after the claim is posted to production.
OPE050	INFO	Claim has been linked to DIAMOND Authorization Claim No. [#].	The claim-auth search detected an authorization for the member and a perfect match was established.
OPE051	FATAL	Custom auth-claim link program [program name] not located.	A special custom auth-claim link program for EDI claims was specified in the TRLOG setup file, but the system could not locate it or it is not a valid BBx program. All custom EDI programs must reside in the directory named in the DIRXTRNLPGM entry in the DIAMOND.ENV file.
OPE052	INFO	Duplicate check is turned [ON/OFF] for this transaction set.	This message is determined by the Duplicate checking "switch" which is in the transaction log file (TRLOG).
OPE053	INFO	Custom duplicate check program [pgm] will be used instead of DIAMOND dup check.	This message is printed if there is a custom Duplicate Check program named in the transaction log file (TRLOG). This program must be in the directory indicated by the DIRXTRNLPGM parameter in the DIAMOND.ENV file.
OPE054	INFO	Auth-claim link is turned [ON/OFF] for this transaction set.	This message is determined by the Match Auths "switch" which is in the transaction log file (TRLOG).
OPE055	INFO	Custom auth-claim link program [pgm] will be used instead of DIAMOND auth link.	This message is printed if there is a custom Match Auths program named in the transaction log file (TRLOG). This program must be in the directory indicated by the DIRXTRNLPGM parameter in the DIAMOND.ENV file.
OPE056	WARN	E-Codes cannot be used as primary diagnosis codes.	
OPE057	WARN	No DRG match in MDC indicated by primary diagnosis.	
OPE058	WARN	Invalid admit. Outside range 1-124 years.	
OPE059	WARN	Patient's sex must be specified for MDC 14.	
OPE060	WARN	Patient's discharge status must be specified for this MDC.	
OPE061	WARN	A principal diagnosis code of 76509 conflicts with this data.	
OPE062	WARN	Principal diagnosis code could not be found in DRG grouper's	

Message Number	Message Type	Message Description	Notes
		table.	
OPE063	WARN	DRG Grouper unsuccessful. Return code was: [code].	
OPE064	WARN	DRG Grouper unsuccessful. Return code was: [code].	
OPE065	WARN	DRG Grouper unsuccessful. Return code was: [code].	
OPE066	WARN	DRG Grouper directory not found: [directory].	
OPE067	WARN	DRG Grouper not found in directory: [directory].	
OPE068	WARN	Write to DRG Grouper input file was unsuccessful.	
OPE069	WARN	Read from DRG Grouper input file was unsuccessful.	
OPE070	WARN	Birthweight outside the range that DRG grouper expects.	
OPE071	WARN	Birthweight conflicted with categories derived from codes.	
OPE072	WARN	Birthweight category derived indicates a non- specific birthweight.	
OPE073	WARN	Invalid discharge age. Non-numeric or less than zero.	
OPE074	WARN	DRG Grouper unsuccessful. Return code was : [code].	
OPE075	WARN	DRG Grouper unsuccessful. Return code was >=20.	
OPE076	WARN	Imperfect Match, Missing Date and Prov # on Diamond Authorization [Auth #], auth not link to claim.	This message is printed if an authorization exists for the member, and the following is missing on the Authorization: Req Start Date, Auth Start Date, and Ren Provider. This condition will not link the Auth to the claim.
OPE077	WARN	Imperfect Match, Missing Date on Diamond Authorization [Auth #], auth not link to claim.	This message is printed if an authorization exists for the member, and the Req Start Date and Auth Start Date is missing on the auth. This condition will not link the Auth to the claim.
OPE078	WARN	Imperfect Match, Missing Prov # on Diamond Authorization [Auth #], auth not link to claim.	This message is printed if an authorization exists for the member, and the Ren Provider is missing on the authorization. This condition will not link the Auth to the claim.
OPE079	WARN	Imperfect Match, Diamond Authorization [Auth #], auth not link to claim.	This message is printed if an authorization exists for the member, and the claim and auth date match. However, the Ren Provider on the claim does not match the Ren Provider on the authorization. This condition will not link the Auth to the claim.

Message Number	Message Type	Message Description	Notes
OPE080	WARN	Error in AUTHEDIDATES PARAMETER RECORD.	This message is printed if an invalid value (other than numeric) is encountered in the Parameter Record, AUTHEDIDATES. The Transaction set is processed with default number of days, 0 days before and 0 days after. This means that the Claim date must match the date on the Authorization exactly and no window is provided.
OPE081	INFO	Unable to Link Submitter's Auth No. to claim.	Auth Claim Match has been turned on for EDI processing. The Authorization Number was submitted in the transaction set but no match was made to the claim based on Auth Claim Match criteria.
OPE082	FATAL	Primary Date is before submitted Date of Birth.	
OPE083	FATAL	Primary Date exceeds Mother/Baby eligibility.	
OPE084	WARN	**Mother's demographic info has been substituted with the Newborn's demographic information.	
OPE085	WARN	Illegal PC01 element.	
OPE089	WARN	Diagnosis code pointer was assigned to the first non-blank diag code.	If a batch (EDI) source file contains a blank diagnosis code pointer (DxPtr=blank) but includes valid diagnosis codes (valid field values in Dx1, Dx2, Dx3, or Dx4), DIAMOND assigns the first valid diagnosis code. Warning message #89 appears in the Batch File Report.
OPE100	FATAL	Vendor not found in Diamond.	If the Tax ID on the claim file does not match the Tax ID stored in the VENDR record, claim line is rejected. Rejected claim lines are not written to the EDI claims workfiles, and will not be written to Diamond production claims files should the transaction set be posted. The error messages print in the Critical Error Report.

Diamond Reason Codes - MHHIPAA

DIAMOND REASON CODES - MHHIPAA		
REASON TYPE	**REASON CODE**	**REASON DESCRIPTION**
Adjustment		
AD	ADAPL	CLAIM ADJUSTED DUE TO PROVIDER APPEAL
AD	ADAUT	CLAIM ADJUSTED DUE TO CHANGE IN AUTHORIZATION
AD	ADCOB	CLAIM ADJUSTED FOR COB
AD	ADCOR	CLAIM ADJUSTED
AD	ADERP	CLAIM ADJUSTED DUE TO PROVIDER ERROR
AD	ADERR	CLAIM ADJUSTED DUE TO PROCESSOR ERROR
AD	ADMBR	CLAIM ADJUSTED DUE TO CHANGE IN MEMBER ELIGIBILITY
AD	ADWSA	AOD WOMENS SETASIDE
AD	LMBEN	MAXIMUM BENEFIT FOR THIS SERVICE REACHED
AD	MCDBA	MEDICAID BILLED AMOUNT CORRECTION
AD	MCDCR	CLAIM ADJUSTED FOLLOWING MH COMPLIANCE REVIEW
AD	MCDDU	CONFIRMED MEDICAID DUPLICATE CLAIM (MH ONLY)
AD	MCDIA	MEDICAID CLAIM ADJUSTED (INTERNAL AUDIT) MH ONLY
AD	MCDMO	MEDICAID MODIFIER CORRECTION
AD	MCDPR	MEDICAID PROCEDURE CODE CORRECTION
AD	MCDSC	CONFIRMED NOT COVERED DUE TO MH SERVICE CONTENT
AD	MCDTP	MEDICAID THIRD PARTY PAYMENT CORRECTION
AD	MCDUN	MEDICAID UNITS OF SERVICE CORRECTION
AD	MCDWC	CONFIRMED INCORRECT UCI BILLED
AD	MCDWD	CONFIRMED INCORRECT DATE OF SERVICE BILLED
AD	MCDYO	MEDICAID CLAIM MORE THAN A YEAR OLD WHEN RECEIVED
AD	NEGPA	NEGATIVE PAID AMOUNT
AD	NONBA	NON-MEDICAID BILLED AMOUNT CORRECTION
AD	NONCR	CLAIM ADJUSTED FOLLOWING MH COMPLIANCE REVIEW
AD	NONDU	CONFIRMED NON-MEDICAID DUPLICATE CLAIM (MH ONLY)
AD	NONIA	NONMEDICAID CLAIM ADJUSTED (INTERNAL AUDIT)
AD	NONMO	NON-MEDICAID MODIFIER CORRECTION
AD	NONON	SERVICE NOT INCLUDED IN NON-MEDICAID CONTRACT
AD	NONPR	NON-MEDICAID PROCEDURE CODE CORRECTION
AD	NONSC	CONFIRMED NOT COVERED DUE TO SERVICE CONTENT
AD	NONTP	NON-MEDICAID THIRD PARTY PAYMENT CORRECTION
AD	NONUN	NON-MEDICAID UNITS OF SERVICE CORRECTION
AD	NONWC	CONFIRMED INCORRECT UCI BILLED
AD	NONWD	CONFIRMED INCORRECT DATE OF SERVICE BILLED
AD	NONYO	NON-MEDICAID CLAIM MORE THAN A YEAR OLD WHEN RECD
AD	NPR30	NO PROVIDER RESPONSE WITHIN 30 DAYS
AD	RWJCF	RWJ ADJUST CAP TO FFS

DIAMOND REASON CODES - MHHIPAA		
REASON TYPE	**REASON CODE**	**REASON DESCRIPTION**
AD	RWJFC	RWJ ADJUST FFS TO CAP
Allowed		
AL	DUPOP	POTENTIAL DUP O/P CLAIM
AL	GRPIN	SYSTEM GENERATED - GROUP INELIGIBLE
AL	HIPAA	HIPAA
AL	INFOR	INFORMATIONAL LINE ITEM
AL	IPCAR	INPATIENT CARVE OUT
AL	MARP	CUYAHOGA COUNTY MARP PROJECT
AL	MBDEC	MEMBER DECEASED
AL	MBRIN	SYSTEM GENERATED - MEMBER INELIGIBLE
AL	MCDBA	MEDICAID BILLED AMOUNT CORRECTION
AL	MCDUN	MEDICAID UNITS OF SERVICE CORRECTION
AL	NOAUT	NO AUTHORIZATION ON FILE
AL	NONBA	NON-MEDICAID BILLED AMOUNT CORRECTION
AL	NONUN	NON-MEDICAID UNITS OF SERVICE CORRECTION
AL	PCCNV	AMOUNT ALLOWED PER CONVERSION FACTOR
AL	PCCRT	AMOUNT ALLOWED PER CASE RATE
AL	PCFSC	AMOUNT ALLOWED PER FEE SCHEDULE
AL	PCMNR	MODIFIER NOT USED FOR THIS PROCEDURE
AL	PCMNV	MODIFIER NOT VALID FOR PROCEDURE CODE
AL	PCMOD	A MODIFIER IS REQUIRED FOR THIS PROCEDURE
AL	PCPDM	AMOUNT ALLOWED PER PER DIEM RATE
AL	PCTBI	SYSTEM GENERATED - PRECENT OF BILLED
AL	PERD1	PER DIEM DAYS 1 THROUGH 3
AL	PERD4	PER DIEM DAYS 4 PLUS
AL	PRE04	PRE FY04
AL	PRE2K	CLOSED AS PRE-FY-2000 SPAN
AL	PRE99	SERVICE PROVIDER PRE SFY 1999
AL	PREGL	PRE GO-LIVE ALLOWED REASON
AL	PRVIN	SYSTEM GENERATED - PROVIDER INELIGIBLE
AL	SPLUC	SPECIAL LUCAS COUNTY CONTRACTING
Check		
CK	ALIGN	CHECK ALIGNMENT
CK	CANCL	CHECK CANCEL
Copay		
CP	00%SF	0% SLIDING FEE
CP	05%SF	5% SLIDING FEE SCALE
CP	10%SF	10% SLIDING FEE SCALE
CP	100%F	100% CLIENT PAY
CP	15%SF	15% SLIDING FEE SCALE
CP	20%SF	20% SLIDING FEE SCALE
CP	25%SF	25% SLIDING FEE SCALE
CP	30%SF	30% SLIDING FEE SCALE
CP	35%SF	35% SLIDING FEE SCALE
CP	40%SF	40% SLIDING FEE SCALE
CP	45%SF	45% SLIDING FEE SCALE
CP	50%SF	50% SLIDING FEE SCALE
CP	55%SF	55% SLIDING FEE SCALE
CP	60%SF	60% SLIDING FEE SCALE
CP	65%SF	65% SLIDING FEE SCALE

DIAMOND REASON CODES - MHHIPAA		
REASON TYPE	**REASON CODE**	**REASON DESCRIPTION**
CP	70%SF	70% SLIDING FEE SCALE
CP	75%SF	75% SLIDING FEE SCALE
CP	80%SF	80% SLIDING FEE SCALE
CP	85%SF	85% SLIDING FEE SCALE
CP	90%SF	90% SLIDING FEE SCALE
CP	90W	FFSE FOR ODADAS WOMENS SET-ASIDE PROGRAMS
CP	95%SF	95% SLIDING FEE SCALE
CP	CIOOP	MEMBER COINSURANCE = 0
CP	CISTP	DEACTIVATED, DUPLICATE WITH COINS
CP	COINS	MEMBER COINSURANCE
CP	COPAY	CLIENT COPAYMENT
CP	CPPCP	PRIMARY CARE COPAYMENT
CP	FF10	$10/MONTH FLAT FEE SCALE
CP	FF100	$100/MONTH FLAT FEE SCALE
CP	FF125	$125/MONTH FLAT FEE SCALE
CP	FF15	$15/MONTH FLAT FEE SCALE
CP	FF150	SUMMIT COUNTY FLAT FEE SCALE
CP	FF175	$175/MONTH FLAT FEE SCALE
CP	FF200	$200/MONTH FLAT FEE SCALE
CP	FF225	$225/MO FLAT FEE SCALE
CP	FF25	$25/MONTH FLAT FEE SCALE
CP	FF250	$250/MONTH FLAT FEE SCALE
CP	FF5	$5/MONTH FLAT FEE SCALE
CP	FF50	$50/MONTH FLAT FEE SCALE
CP	FF75	$75/MO FLAT FEE SCALE
CP	MAXED	SYSTEM GENERATED - OOP LIMIT HAS BEEN SATISFIED
CP	MCDDF	NO COPAY APPLIED FOR MEDICAID MEMBER
CP	VERIF	100% COPAY ON NONMCD/NONEMER UNTIL INCOME VERIFIED
Deductible		
DD	MAXED	SYSTEM GENERATED - OOP LIMIT HAS BEEN SATISFIED
Hold		
HD	CLATH	CLAIM REQUIRES APPROVAL
HD	CLBIL	PLEASE SUBMIT AN ITEMIZED BILL FROM THE PROVIDER
HD	CLHLD	CLAIM PLACED ON HOLD DUE TO B-RULE
HD	CLMAN	CLAIM MANUALLY PLACED ON HOLD
HD	DUPDA	DUP RES/DAY SERVICES
HD	DUPLM	POTENTIAL DUPLICATE CLAIM
HD	FRHLD	FRANKLIN CLAIMS HOLD
HD	FRMOD	FRANKLIN COUNTY MODIFIERS - HOSPITAL/PENAL SYS
HD	GRHLD	GROUP ON HOLD
HD	LMARP	LIMIT OF ONE PER ELAPSED YEAR
HD	LMBEN	BENEFIT LIMIT REACHED
HD	LMDAY	DAY SERVS LIMIT 1 PER DAY
HD	LMOUT	O/P LIMIT 24 HRS/DAY
HD	LMPHA	MH PAR HOSP LIMIT 1/DAY ADULTS
HD	LMPHC	MH PAR HOSP LIMIT 2/DAY CHILDREN

DIAMOND REASON CODES - MHHIPAA		
REASON TYPE	**REASON CODE**	**REASON DESCRIPTION**
HD	LMRWJ	MH RWJ CUYAHOGA WAIVER
HD	MBRIN	SYSTEM GENERATED - MEMBER IS INELIGIBLE
HD	MCDBA	POTENTIAL MEDICAID BILLED AMOUNT CORRECTION
HD	MCDCR	HELD DUE TO MH MEDICAID COMPLIANCE REVIEW RESULTS
HD	MCDDU	MEDICAID POTENTIAL DUPLICATE SERVICE
HD	MCDMO	POTENTIAL MEDICAID MODIFIER CORRECTION
HD	MCDPR	POTENTIAL MEDICAID PROCEDURE CODE CORRECTION
HD	MCDTP	POTENTIAL MEDICAID THIRD PARTY PAYMENT CORRECTION
HD	MCDUN	POTENTIAL MEDICAID UNITS OF SERVICE CORRECTION
HD	MCDWC	INCORRECT UCI BILLED
HD	MCDWD	INCORRECT DATE OF SERVICE BILLED
HD	MEDEF	HELD FOR INVALID MEDEF
HD	NEGPA	NEGATIVE PAID AMOUNT
HD	NOGLR	SYSTEM GENERATED - COMP OR G/L REF CODE IS MISSING
HD	NOMCD	SERVICE NOT INCLUDED IN MCD CONTRACT
HD	NONBA	POTENTIAL NON-MEDICAID BILLED AMOUNT CORRECTION
HD	NONCR	HELD DUE TO NON-MEDICAID COMPLIANCE REVIEW RESULTS
HD	NONDU	POTENTIAL NON-MEDICAID DUPLICATE SERVICE
HD	NONMO	POTENTIAL NON-MEDICAID MODIFIER CORRECTION
HD	NONON	SERVICE NOT INCLUDED IN NON-MEDICAID CONTRACT
HD	NONPR	POTENTIAL NON-MEDICAID PROCEDURE CODE CORRECTION
HD	NONTP	POTENTIAL NON-MEDICAID THIRD PARTY PMT. CORRECTION
HD	NONUN	POTENTIAL NON-MEDICAID UNITS OF SERVICE CORRECTION
HD	NONWC	INCORRECT UCI BILLED
HD	NONWD	INCORRECT DATE OF SERVICE BILLED
HD	NOQTY	NO UNITS OF SERVICE BILLED
HD	OOCTY	OUT OF COUNTY
HD	PCINV	PROCEDURE CODE INACTIVE
HD	PCREV	PROCEDURE CODE/MODIFIER REVIEW
HD	PRCLD	NON-MEDICAID PROVIDER CONTRACT ON HOLD
HD	PRHLD	SYSTEM GENERATED - PROVIDER ON HOLD
HD	PRINF	ADDITIONAL INFORMATION REQUIRED FROM PROVIDER
HD	VEHLD	VENDOR ON HOLD
Not Covered		
NC	AUTHC	SYSTEM GENERATED - AUTHORIZATION IS CLOSED
NC	AUTHD	SYSTEM GENERATED - AUTHORIZATION HAS BEEN DENIED
NC	DUPLY	DUPLICATE CLAIM
NC	DXMIS	NOT COVERED BECAUSE DIAGNOSIS IS MISSING
NC	GRANT	GRANT BASED NONMCD FUNDING (100% WITHHOLD)

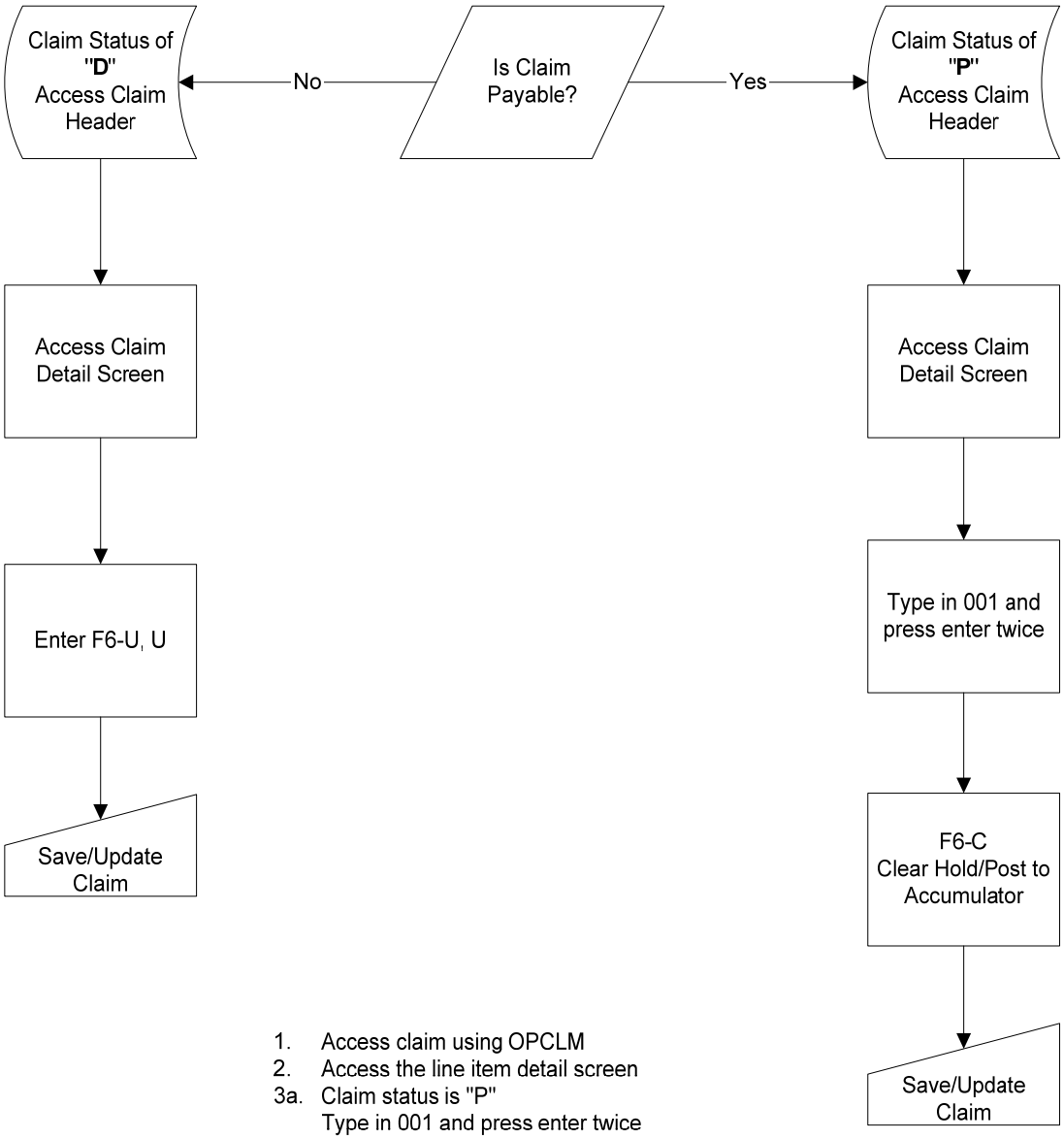
DIAMOND REASON CODES - MHHIPAA		
REASON TYPE	**REASON CODE**	**REASON DESCRIPTION**
NC	INVPC	INVALID PROCEDURE CODE/MODIFIER COMBINATION
NC	LMARP	LIMIT OF ONE PER ELAPSED YEAR
NC	LMBEN	MAXIMUM BENEFIT FOR THIS SERVICE REACHED
NC	LMDAY	DAY SERVS LIMIT 1 PER DAY
NC	LMDIP	AOD DIP SERVICES LIMIT OF ONE PER YEAR
NC	LMEAT	MEALS SERVICE LIMITED TO 3 MEALS PER DAY
NC	LMMTH	LIMITS BILLING TO ONE PER ELAPSED MONTH (28 DAYS)
NC	LMOUT	O/P LIMIT 24 HRS/DAY
NC	LMPHA	MH PAR HOSP LIMIT 1/DAY ADULTS
NC	LMPHC	MH PAR HOSP LIMIT 2/DAY CHILDREN
NC	LMRWJ	MH RWJ CUYAHOGA WAIVER LIMIT
NC	LMTRS	LIMITS TRANSPORTATION TO ONE PER ELAPSED MONTH
NC	MAXED	SYSTEM GENERATED - OOP LIMIT HAS BEEN SATISFIED
NC	MBDEC	MEMBER DECEASED
NC	MCDBA	CONFIRMED MEDICAID BILLED AMOUNT CORRECTION
NC	MCDCR	CLAIM NOT COVERED FOLLOWING MH COMPLIANCE REVIEW
NC	MCDDU	CONFIRMED MEDICAID DUPLICATE SERVICE
NC	MCDEL	MEMBER NOT MEDICAID ELIGIBLE AT TIME OF SERVICE
NC	MCDIA	MEDICAID CLAIM ADJUSTED (INTERNAL AUDIT) MH ONLY
NC	MCDMO	CONFIRMED MEDICAID MODIFIER CORRECTION
NC	MCDPR	CONFIRMED MEDICAID PROCEDURE CODE CORRECTION
NC	MCDSC	CONFIRMED NOT COVERED DUE TO SERVICE CONTENT
NC	MCDTP	CONFIRMED MEDICAID THIRD PARTY PAYMENT CORRECTION
NC	MCDUN	CONFIRMED MEDICAID UNITS OF SERVICE CORRECTION
NC	MCDWC	CONFIRMED INCORRECT UCI BILLED
NC	MCDWD	CONFIRMED INCORRECT DATE OF SERVICE BILLED
NC	MCDYO	MEDICAID CLAIM OVER 365 DAYS OLD WHEN RECEIVED
NC	MEDEF	DENIED FOR INVALID MEDEF
NC	MODFM	MISSING OR INVALID MODIFIER CODE
NC	NCSVC	SERVICE/SUPPLY NOT COVERED
NC	NEGPA	NEGATIVE PAID AMOUNT
NC	NOAUT	NO AUTHORIZATION ON FILE
NC	NONBA	CONFIRMED NON-MEDICAID BILLED AMOUNT CORRECTION
NC	NONCR	N-M ADJUSTMENT FOLLOWING MH COMPLIANCE REVIEW
NC	NONDU	CONFIRMED NON-MEDICAID DUPLICATE SERVICE
NC	NONIA	NON-MEDICAID CLAIM ADJUSTED (INTERNAL AUDIT)
NC	NONMO	CONFIRMED NON-MEDICAID MODIFIER CORRECTION
NC	NONON	SERVICE NOT INCLUDED IN NON-MEDICAID CONTRACT
NC	NONPR	CONFIRMED NON-MEDICAID PROCEDURE CODE

DIAMOND REASON CODES - MHHIPAA		
REASON TYPE	**REASON CODE**	**REASON DESCRIPTION**
		CORRECTION
NC	NONSC	CONFIRMED NOT COVERED DUE TO SERVICE CONTENT
NC	NONTP	CONFIRMED NON-MEDICAID THIRD PARTY AMT. CORRECTION
NC	NONUN	CONFIRMED NON-MEDICAID UNITS OF SERVICE CORRECTION
NC	NONWC	CONFIRMED INCORRECT UCI BILLED
NC	NONWD	CONFIRMED INCORRECT DATE OF SERVICE BILLED
NC	NONYO	NON-MEDICAID CLAIM IS OVER 365 DAYS OLD WHEN RCVD.
NC	NOQTY	NO UNITS OF SERVICE BILLED
NC	NPR30	NO PROVIDER RESPONSE WITHIN 30 DAYS
NC	OOCTY	OUT OF COUNTY NOT COVERED
NC	PCINV	PROCEDURE CODE INVALID OR NONSPECIFIC
Other Carrier		
OC	2	BLUE CROSS/BLUE SHIELD
OC	3	OTHER PRIV INS
OC	4	EMPLOYER/UNION
OC	5	PUBLIC AGENCY
OC	6	OTHER CARRIER
OC	9	HARBOR OTHER CARIER
OC	E	BENEFITS EXHAUSTED
OC	F	NO COVERAGE FOR ANY FAMILY MEMBER
OC	L	DISPUTED
OC	P	NO COVERAGE FOR THIS MEMBER
OC	R	NO RESPONSE FROM INS CO
OC	S	NOT COVERED SERVICE
OC	X	NON-COOPERATIVE MEMBER WITH INSURANCE
Place of Service		
PL	03	SCHOOL
PL	04	HOMELESS SHELTER
PL	05	INDIAN HEALTH SVC FREE-STANDING FACILITY
PL	06	INDIAN HEALTH SVC PROVIDER-BASED FACILITY
PL	07	TRIBAL 638 FREE-STANDING FACILITY
PL	08	TRIBAL 638 PROVIDER-BASED FACILITY
PL	11	OFFICE
PL	12	HOME
PL	13	ASSISTED LIVING FACILITY
PL	14	GROUP HOME FOSTER CARE STATE CUSTODY
PL	15	MOBILE UNIT
PL	20	URGENT CARE FACILITY
PL	21	HOSPITAL -- MED/SURG INPATIENT
PL	22	HOSPITAL -- OUTPATIENT
PL	23	HOSPITAL -- ER
PL	24	AMBULATORY SURGICAL CENTER
PL	25	BIRTHING CENTER
PL	26	MILITARY TREATMENT CENTER/VA HOSPITAL
PL	31	SKILLED NURSING FACILITY
PL	32	NURSING FACILITY

DIAMOND REASON CODES - MHHIPAA		
REASON TYPE	**REASON CODE**	**REASON DESCRIPTION**
PL	33	CUSTODIAL CARE FACILITY
PL	34	HOSPICE
PL	41	AMBULANCE -- LAND
PL	42	AMBULANCE -- AIR
PL	49	INDEPENDENT CLINIC
PL	50	FEDERALLY QUALIFIED HEALTH CENTER
PL	51	INPATIENT PSYCHIATRIC FACILITY (IMD)
PL	52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
PL	53	COMMUNITY BEHAVIORAL HEALTH CENTER
PL	54	INTERMEDIATE CARE FACILITY/MR
PL	55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
PL	56	PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
PL	57	NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
PL	60	MASS IMMUNIZATION CENTER
PL	61	COMPREHENSIVE INPATIENT REHABILITATION FACILITY
PL	62	COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
PL	65	END STAGE RENAL DISEASE TREATMENT CENTER
PL	71	PUBLIC HEALTH CLINIC
PL	72	RURAL HEALTH CLINIC
PL	81	INDEPENDENT LABORATORY
PL	99	OTHER
Term		
TM	CLSED	PROVIDER CLOSED
TM	EDUP1	ELECTRONIC DUPLICATE SAME SSN/D.O.B.
TM	EDUP2	ELECTRONIC DUPLICATE - INVALID D.O.B
TM	EDUP3	ELECTRONIC DUPLICATE - INVALID SSN
TM	ERR01	INVALID REQUIRED FIELD
TM	ETERM	MEMBER TERMINATED ELECTRONICALLY
TM	HIPAA	HIPAA
TM	IPUCI	INVALID PSEUDO UCI CODE
TM	LBCLR	LOCAL BOARD CONTRACT LIMITS REACHED
TM	MBDEC	MEMBER DECEASED
TM	MBINL	MEMBER INELIGIBLE DUE TO INCOME INCREASE
TM	MBMOS	MEMBER MOVED OUT OF STATE
TM	MBMOV	MEMBER HAS MOVED OUT OF COUNTY
TM	MBPLC	PLAN CHANGED MANUALLY BY BOARD
TM	MERGR	PROVIDER MERGED
TM	PRAEX	PROVIDERS AOD CERTIFICATION HAS EXPIRED
TM	PRDEX	BOTH AOD AND MH CERTIFICATIONS HAVE EXPIRED
TM	PRE2K	PROVC TERM REASON OF PRE SFY 2000
TM	PREGL	PRE GO-LIVE CONTRACT TERMINATED
TM	PRMEX	PROVIDERS MH CERTIFICATION HAS EXPIRED
TM	PRVOL	PROVIDER CONTRACT TERMINATED (VOLUNTARY)
TM	PSCHG	PRIMARY AND/OR ALTERNATE PRICE SCHEDULE CHANGED
TM	RIDER	RIDER CHANGE

DIAMOND REASON CODES - MHHIPAA		
REASON TYPE	**REASON CODE**	**REASON DESCRIPTION**
TM	VNDCH	VENDOR CHANGED

Taking a Claim Off Hold

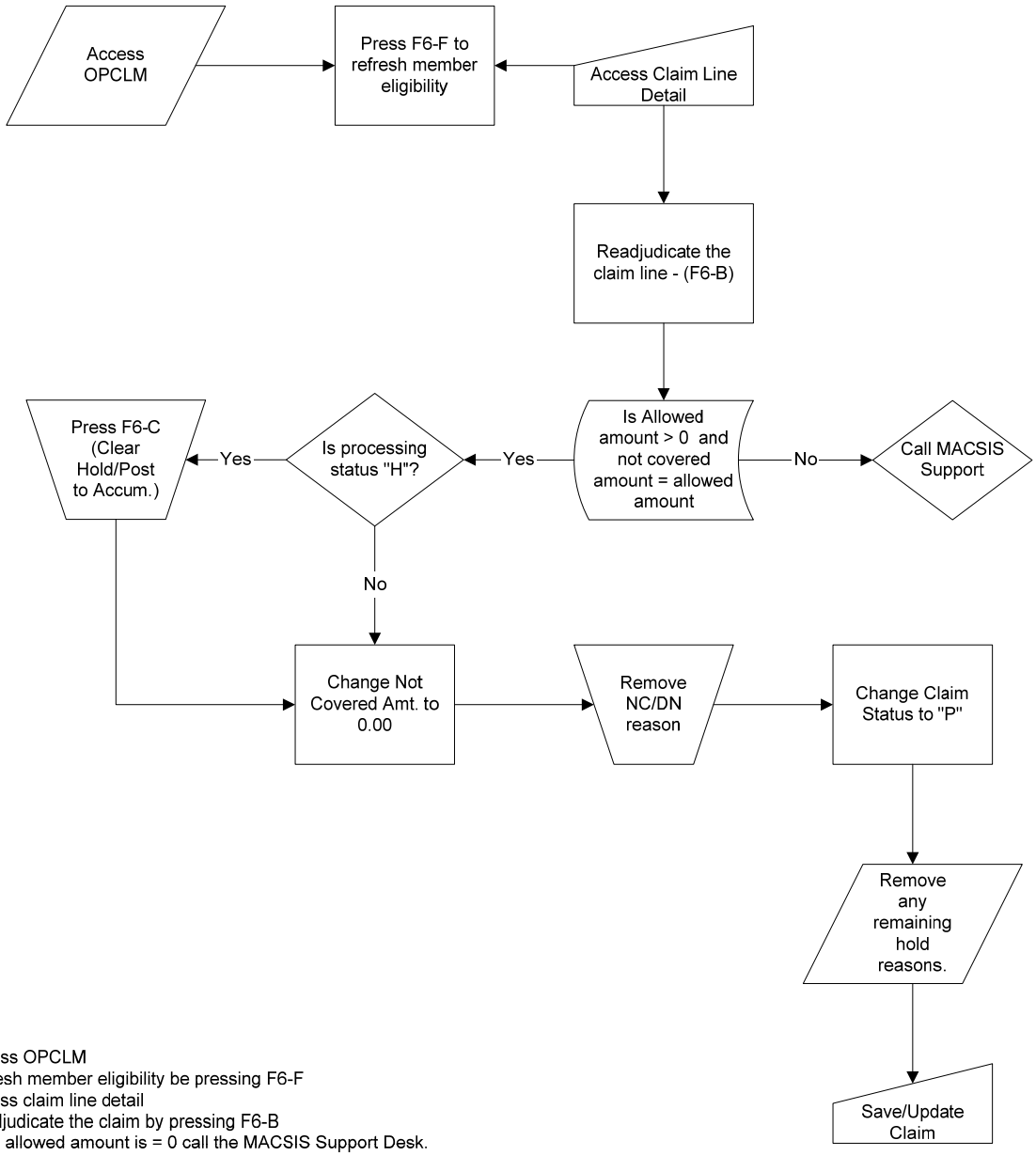


1. Access claim using OPCLM
2. Access the line item detail screen

3a. Claim status is "P"
Type in 001 and press enter twice
Enter F6-C (C-Clear Hold/Post to Accum.)
Hit End
Save/Update Claim

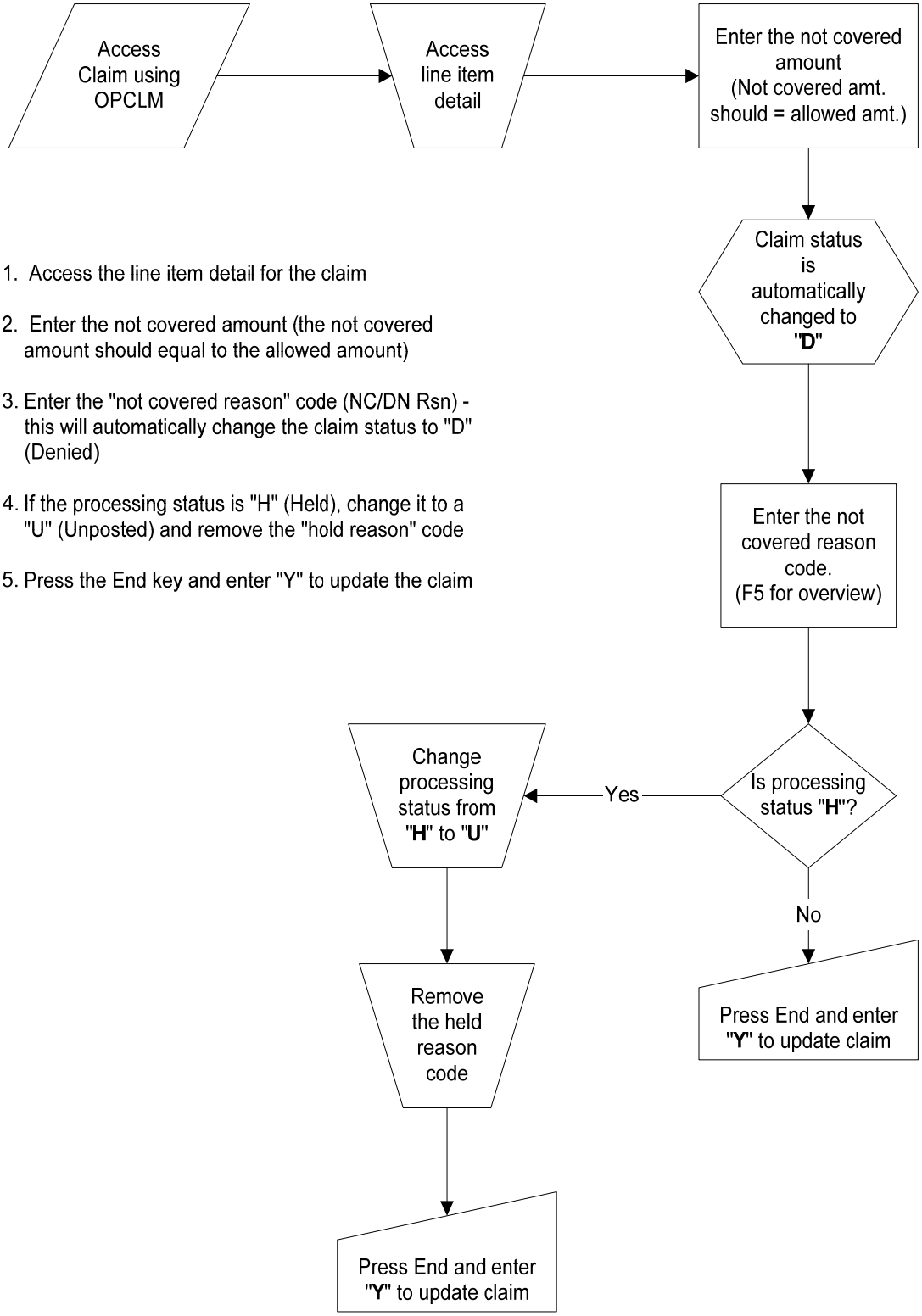
3b. Claim status is "D"
Enter F6-U,U
Save/Update Claim

Making a Denied Claim Payable



1. Access OPCLM
2. Refresh member eligibility be pressing F6-F
3. Access claim line detail
4. Readjudicate the claim by pressing F6-B
5. If the allowed amount is = 0 call the MACSIS Support Desk.
   If the allowed amount is <0 and the not covered amount = the allowed go to 6.
6. Is the claim on hold?
   Yes - Press F6-C to Clear the hold and post to the benefit accumulator
   No - go to 7.
7. Change the not covered amount to 0.00
8. Remove the not covered/denied reason code
9. Change the claim status to "P"
10. Remove any remaining hold reasons (1, 2, 3)
11. Save/Update the claim

Denying a Claim



1. Access the line item detail for the claim

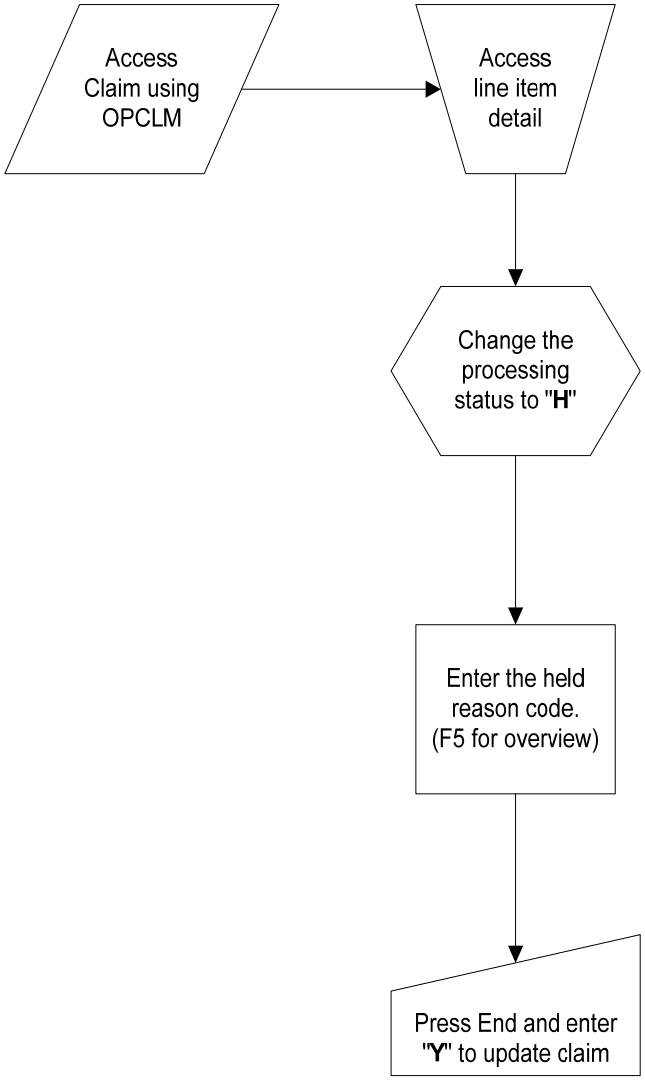
2. Enter the not covered amount (the not covered amount should equal to the allowed amount)

3. Enter the "not covered reason" code (NC/DN Rsn) - this will automatically change the claim status to "D" (Denied)

4. If the processing status is "H" (Held), change it to a "U" (Unposted) and remove the "hold reason" code

5. Press the End key and enter "Y" to update the claim

Putting a Claim on Hold



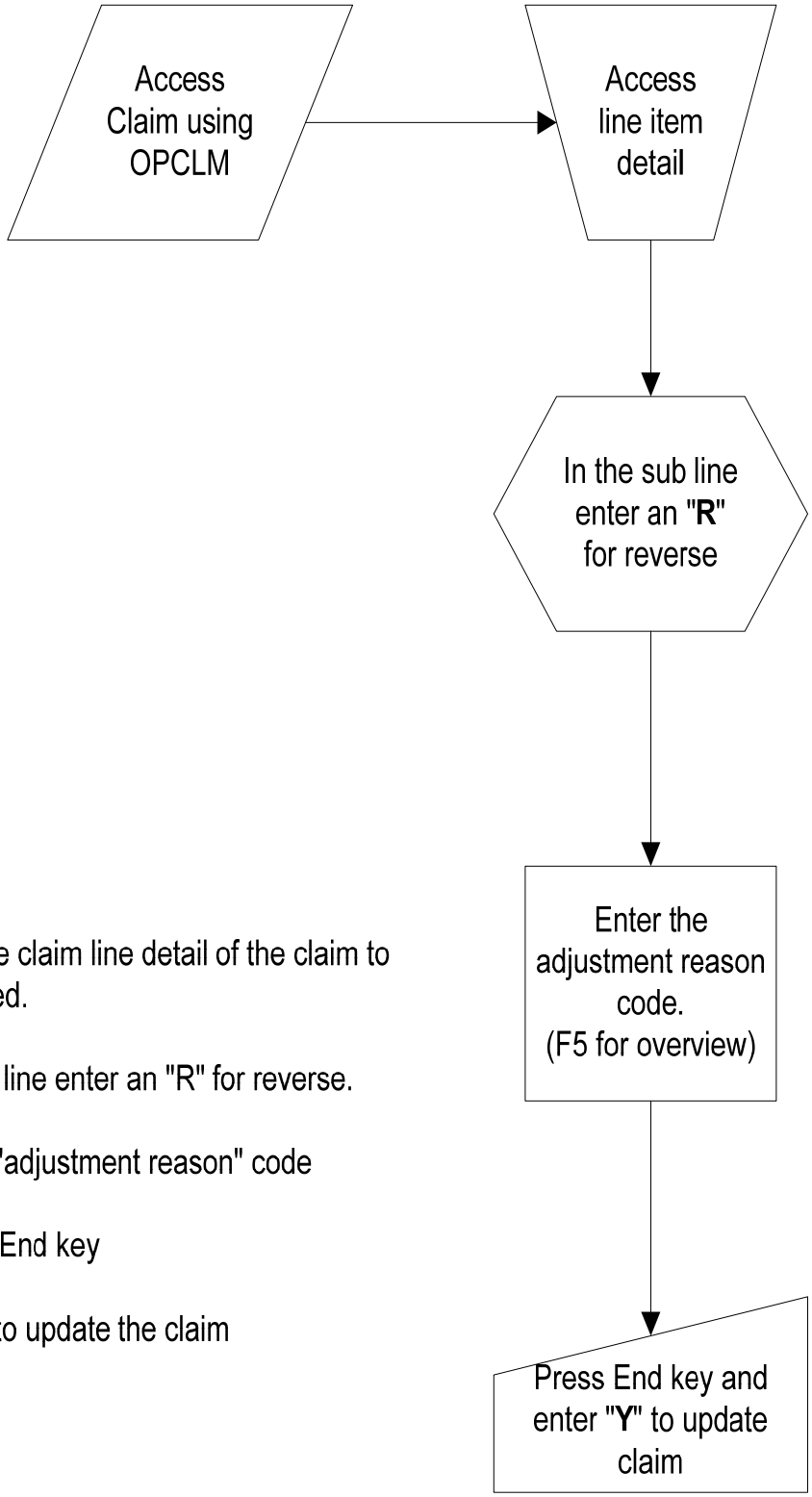
1. Access the claim line detail of the claim

2. Change the processing status to "H" (Hold)

3. Enter the "hold reason" code

4. Save/Update the claim line

Reversing a Claim



1. Access the claim line detail of the claim to be reversed.

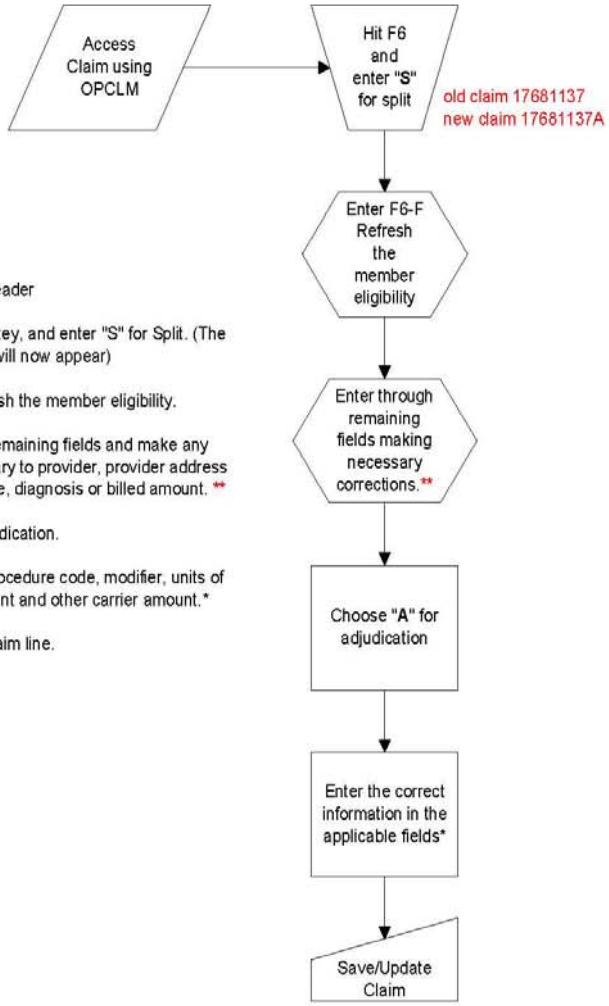
2. In the sub line enter an "R" for reverse.

3. Enter the "adjustment reason" code

4. Press the End key

5. Enter "Y" to update the claim

Splitting a Claim



1. Access the claim header
2. Hit the F6 function key, and enter "S" for Split. (The new claim number will now appear)
3. Enter F6-F to Refresh the member eligibility.
4. Enter through the remaining fields and make any corrections necessary to provider, provider address flag, place of service, diagnosis or billed amount. **
5. Choose "A" for adjudication.
6. Enter the correct procedure code, modifier, units of service, billed amount and other carrier amount.*
7. .Save/Update the claim line.

*If you make a mistake in entering information in the Proc, Mod, Qty, POS or Billed fields, back out of line 001 completely and start over or the claim may not price and adjudicate properly,

**** If you enter through the provider address field it will default to 000. Make sure you enter the correct value or the claim will not price properly.**

Splitclaim, 08/02/04

Ohio Dept. of Job and Family Services
Reject Errors
Most Often Encountered
07/20/2006

Code	Description
101	Exact duplicate claim.
102	Claim is a possible duplicate claim but amount is different.
103	Line item contains errors, however claim denied for another error.
120	Claim filing limit exceeded (365-day limit).
123	Future date of service was submitted.
127	Date of service greater than date claim was submitted to ODJFS.
130	The recipient number entered on the claim may have an incorrect digit, missing digits or contain zeroes.
133	The total claim charge billed does not equal the sum of the individual line item charges billed on the claim.
160	A 2, 3, 4 or 6 was entered as the Other Carrier Reason and there was no Other Carrier Amount.
202	The last two digits of the twelve digit billing number is missing on the invoice. Check medical card for accurate eligibility information.
218	According to ODJFS eligibility file, the recipient number entered on the claim is covered by another insurance source for the date of service billed and no 3rd party amount was entered on the claim. Bill other insurer prior to billing ODJFS. If the service is not eligible for the 3rd party, use the letter code “S”.
219	Other Carrier Reason (3rd Party) = “R” and claim received prior to 91 day filing limit.
225	For a UB-82 last date or non UB-82 first date of service on the claim greater than the Mental Health filing limit. [Note: In MACSIS terms, if the claim service date is greater than 365 days old.]
244	The recipient’s billing number that was entered on the claim is eligible for Medicaid but not for this date of service.
246	The Other Carrier Amount (3rd Party) is greater than $0.00 and the Other Carrier Reason code is missing.
250	The 12 digit Medicaid Recipient Number entered on the claim is not on the ODJFS eligibility file.
271	The recipient number that was entered on the claim is eligible for Medicaid but not for this date of service.
278	The Medicaid Recipient is a Qualified Medicare Beneficiary (QMB) who did not qualify for full Medicaid.
305	The service date entered on the claim form is over two years old.
322	The procedure code and/or revenue code billed is not covered by the Ohio Medicaid Program for the date of service billed.

Code	Description
323	Recipient age is less than minimum on Diagnosis Master or greater than maximum age.
328	The procedure code which was billed is inappropriate for the recipient's age. Review the procedure code and recipient id that was entered on the claim for accuracy.
330	The procedure code billed is not covered by the Ohio Medicaid Program for the date of service billed.
361	Recipient is on GA (General Assistance) or DA (Disability Assistance).
598	All line item service dates occurred after the date of death listed on our recipient master file.
666	Although not an official ODJFS error code, this code will appear when "the amount requested from ODJFS" is not the same as "the amount paid by ODJFS." It usually appears when too many units are billed.
730	On the first date of service, the recipient is eligible for GA or DA and eligible for Medicaid on the last date of service or vice versa. Claim cannot be priced when this condition exists.
927	PACE participants must obtain service through PACE provider. Providers must contract with PACE provider to obtain PACE reimbursement.
992	Recipient enrolled in county GA program or invalid recipient ID submitted.

MACSIS CLAIMS CORRECTION FORM

For reporting erroneous claims

Sending Organization Name:_____
Receiving Organization Name:_____
Provider MACSIS Unique Provider Identifier (UPI): _____
Date Received: _____
Date Completed:_____

Person Reporting Errors: _____
Phone Number: _____
Return Form to Attn: _____
Errors Apply to Fiscal Year: _____

	UCI #	DOS	MACSIS Claim #	Billed Amount	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Units	POS	COB Amt	Cob Ind[1]	Prov Pt Ctrl #
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment[2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment[2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment[2]:														
Board Action/Response:												*Date:*		*Initials:*
Orig Clm Info:														
Corr'd Clm Info:														
Corr Reason/Comment[2]:														
Board Action/Response:												*Date:*		*Initials:*

[1] Must use one of the allowable ODJFS COB Indicator values: 2-6, R, P, F, L S, E, X
[2] Denote reason for error: wrong patient, date of service, units, procedure, modifier, 3rd party pmt/indicator, etc. or MACSIS Reason Code

Provider Representative Signature (required): _____ Date (required): _____
If submitting via electronic media, type name above; add electronic signature: (check box) ☐

Instructions for Completing MACSIS Claims Correction Form

DRAFT

Last Revised Date: 4/30/03

I. Purpose

This form should be completed whenever an error in a claim, which was previously submitted to MACSIS, has been identified. The following is a list of scenarios under which a provider or board may initiate this form:

Billed Amount Was Incorrect

Units of Service Were Incorrect

Billed Procedure Code Was Incorrect

Billed Modifier(s) Was Incorrect

Third Party COB Amount Was Incorrect

Service Was Billed Under Wrong UCI (Unique Client Identifier)

Service Was Billed Under Wrong Date of Service

Service Was Billed Under Wrong Place of Service

Service is "Straggler" Claim[1]

[1] The term "straggler" claim has often been used to describe the instance where the provider originally billed for a service and later discovered additional units of the same service were provided on the same day. This form should be used to report the correct total number of units, whether the original claim has been remitted or not.

II. Related Policies and Procedures

This form was developed in conjunction with the Claims Correction Policy and Procedure for MACSIS under HIPAA. Please refer to the policy and procedure for a full explanation of when and how this form should be used.

III. General Instructions

1. Fields highlighted in **BLUE** must be completed by the sender**.**
2. If the form is initiated by the provider, the provider should sign and date the bottom of the form (see Provider Representative Signature).
3. Once complete, **the form should be sent to the receiver per the receiver's instructions (ex., mail, fax or in some instances, electronic submission).**
   - The method of sending the information is determined by the receiver, since this form does contain "protected health information (PHI) and, therefore, the receiver must determine its own submission policies to ensure the protection of information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
4. **If a board initiates the form, the provider has 30 days from receipt of the form to respond in writing (via the form) to the board that the claim was in fact billed in error.** Providers should be sure to sign and date the bottom of the form when responding. If no response within 30 days, the boards can deny or reverse payment on the claim(s).
   - If a provider responds that a service was not billed in error, they must have the clinical documentation on file to support their claim.
   - Boards should refer to the Claims Correction Policy and Procedure for specific rules around when Medicaid claims can and cannot be reversed.
5. If a provider initiates the form, the board should review the information, take the necessary correction action and return the form with the actions noted in a timely manner.
   - The Claims Correction Policy requires boards to process corrections with "little delay". Boards and providers should be particularly sensitive to processing Medicaid claims corrections timely, so as to not exceed the ODJFS filing limits.

IV. Sending and Receiving Information

1. **Sending Organization Name**

Enter the name of the entity that is initiating the form, which could be either a provider agency name or county board name. This should be the entity that identified the error.

2. **Receiving Organization Name**

Enter the name of the entity to which the form will be sent. This could be either the provider agency name or the county board name. If this form is initiated by the provider, it should be sent to the county board responsible for payment of the claim.

3. **Provider MACSIS Unique Provider Identified (UPI)**

Enter the 5-digit provider identification number assigned by MACSIS to identify the provider agency whose claim contained the error. If the agency does not know its assigned MACSIS UPI Number, you can obtain the number via the MAC-Search feature available on the MACSIS website (http://www.mh.state.oh.us/ois/macsis/macsis.index.html) or you can contact your county board.

4. **Date Received**

This field is completed by the receiver and denotes the date the form was received.

5. **Date Completed**

This field is completed by the receiver. If the receiver is a board, this is the date the board corrected the claims in MACSIS. If the receiver is a provider, this is the date the provider provided the corrected claims information on the form and returned it to the board for correction in MACSIS.

V. Contact and Fiscal Year Information

1. **Person Reporting Errors**

This is the name of the individual at the organization who is initiating the form. This should be a person's name.

2. **Phone Number**

This is the phone number for the individual (reported above) who initiated the form.

3. **Return Form to Attn**

This is the person to whom the form should be returned once complete.

4. **Errors Apply to Fiscal Year**

This field should contain the State fiscal year under which the dates of service for the claims in error occurred. ODMH/ODADAS' fiscal year is July 1 through June 30. If the claims span more than one fiscal year, list all fiscal years pertaining to the claims.

VI. Erroneous and Corrected Claim Information

There are four rows of information which appear on this section of the form.

- The **first row should be used to report the original claim information** pertaining to the claim submitted in error.

- **The second row should be used to report the correct claim information** pertaining to the claim submitted in error.

- You do not need to complete all information in the second row, "Corr'd Claim Information". Only the changed (i.e., corrected) claim information needs to be completed in the second row. That way the changed (corrected) information will "stand out".

- **The third row should be used to explain what was incorrect about the claim billed in error**. Providers should be a specific as possible when describing the reason for the error. (Do not just note "billed in error".) State "wrong UCI originally billed", "wrong date of service", "claim denied as duplicate" etc., and/or include the MACSIS Not Covered Reason Code reported on the original remittance transaction (See ERA, field 43) or the Claim Adjustment Reason Code reported on the 835 Health Care Claim Payment Advice (Loop 2110, CAS02). If the board is initiating the form, the board should be a specific as possible as to why they thought the claim was billed in error.

- **The fourth row should be used by the board to indicate what action was taken to correct the claim in MACSIS**. If no action was taken in MACSIS (ex., claim was Medicaid and over 365-days old), boards should indicate how reconciliation of the claim will be handled.

If the form is initiated by a provider, the provider should complete the first three rows of information. If the form is initiated by a board, the board will initially complete the first row of information and the provider who receives the form must complete the second row. Upon correction in MACSIS, the board would then complete the fourth row.

1. **UCI #**

This column should contain the Unique Client Identifier (UCI) Number assigned to the client in MACSIS. This number is assigned to the client by the board upon enrollment in MACSIS.

2. **DOS**

This column should contain the date of service pertaining to the claim.

3. **MACSIS Claim #**

This column should contain the MACSIS Claim Number. This number is assigned to the claim upon entry into the MACSIS system. The number appears on the MACSIS Electronic Remittance Advice (ERA - field 18), and on the 835 Health Care Claim Payment Advice (Loop 2100, CLP07). **Do not enter the provider-assigned claim control number in this column.**

- When reporting straggler claims[1], if the original claim has not been remitted, the provider may not know the MACSIS Claim Number. In this case, the MACSIS Claim Number can be left blank.

4. **Billed Amount**

This column should contain the amount billed for the service.

- When reporting straggler claims[1], providers should indicate the total correct amount billed on the second row, not just the additional amount billed.

5. **Procedure Code**

This column should contain the MACSIS/HIPAA procedure code for the service. For a list of procedure codes considered for payment under HIPAA see http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.code.table.pdf or http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf. **Do not report the internal provider-assigned service code here.**

- Providers and boards should verify that the procedure code noted is a contracted service for which the provider is licensed and certified to provide.

6. **Mod 1-4**

These columns should contain the MACSIS/HIPAA modifiers applicable to the service. For a list of modifiers considered for payment under HIPAA, see http://www.mh.state.oh.us/ois/macsis/codes/mh.hipaa.modifier.code.table.pdf or http://www.mh.state.oh.us/ois/macsis/codes/aod.hipaa.modifier.code.table.pdf.

7. **Units**

This column should contain the units of service. Do not report service minutes here, just units of service. Be sure to report **whole units** of service for procedures defined under HIPAA to be billed in **"15-minute" service increments** and for **day-based services** (ex., 1, 2, 3)**.** You may report "partial" units of service (ex., .5,.6,.7) for procedures defined to be billed in "60-minute" service increments (i.e., hourly-based services).

Services should be rounded according to the tables and instructions outlined in the "Guidelines Pertaining to MACSIS, HIPAA EDI Policies and Procedures" (http://www.mh.state.oh.us/ois/macsis/policies/macsis.hipaa.edi.guidelines.pdf), Section 44C1.

- When denoting "correct" units of service, the provider should double-check their service records and make sure they have summed the service minutes and then rounded according to the MACSIS tables correctly.

- When reporting straggler claims[1], providers should indicate the total correct number of units on the second row, not just the additional units of service.

8. **POS**

This column should contain the HIPAA Place of Service Code pertaining to the service. For a list of allowable place of service codes under HIPAA, see http://www.mh.state.oh.us/ois/macsis/mac.codes.macsis.pos.codes.html.

- Please note that you only need to “correct” a claim for place of service, when the “corrected” place of service code affects the adjudication of the claim in MACSIS (i.e., when the place of service code changes from or to “51” – IMD or “99” – Penal System).

9. **COB Amount**

This column should contain the amount paid by another payer toward the service. The amount can be zero, if the other payer did not respond and/or denied the claim. If this column is completed, the initiator must provider the “COB Indicator” in the next column. Please note this column **should not** contain any amounts paid by the client.

10. **COB Ind (Indicator)**

This column should contain one of the acceptable ODJFS COB Indicators noted below:

2 – Blue Cross/Blue Shield
3 – A private carrier
4 – Employer or Union
5 – Public Agency (Medicare, Worker’s Comp)
6 – Other carrier
R – No response from carrier
P – No coverage for this recipient number
F – No coverage for all recipient numbers
L – Disputed or contest liability
S – Non-covered service
E – Insurance benefits exhausted
X – Non-cooperative member.

If two or more payers (other than MACSIS) previously adjudicated the claim, use the COB indicator pertaining to the payer who actually made a payment toward the claim.

11. **Prov Pt Control #**

This column should contain the control number assigned by the provider to track this service. This is the number which was or will be used to report related remittance transactions. It is recommended that this number be a service-level control number, not a claim or patient level control number.

- The term “patient control number” is widely used within the industry, as well as within the 837 Professional Claim implementation guide, to refer to the provider-assigned control number related to a service line. Therefore, it is a misnomer. It really should be “service control number”.

Procedure Codes and Affiliated Price Schedules

Procedure Codes and Affiliated Price Schedules

	Mental Health Services		AOD Services	
Medicaid Reimbursable Services	(P0) Primary Price Schedule 044	(P2) Primary Price Schedule 244	(P0) Primary Price Schedule 044	(P1) Primary Price Schedule 144
	90801 90862 H0004 (ind) H0031 H0036 (ind) H0040* H2016* S0201 S9484	H0004 (grp) H0036 (grp)	H0001 H0003 H0005 H0006 H0007 H0014 H0015 H0016 H0020	H0004 (ind)
Non-Medicaid Reimbursable Services	(A0) Alt. Price Schedule A44	n/a	(A0) Alt. Price Schedule A44	(A1) Alt. Price Schedule B44
	H0030 H0038 H0046 M143x M144x M153x M154x M155x M162x M181x M191x M220x M224x M225x M226x M227x M228x M229x M312x M314x M411x M412x M413x M414x		99236 A023x A051x A056x A061x A062x A063x A064x A065x A066x A074x A075x A078x A121x A122x H0009 H0012 H0017 H0018 H0019 H0021 H0022 H0023 H0047 T1006 T1009 T1010	H0030

*Until service is approved for reimbursement from Medicaid, use the Alt. Psched for entering rates.

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Default and Standard Contracts

Medicaid Default Contracts
Provider + LOB
Medicaid Eligible Client

	Mental Health Services		AOD Services	
	(P0) **Primary Psched - 044** **Panel - None** **Price Region - OH**	**(P2)** **Primary Psched - 244** **Panel - None** **Price Region - OH**	**(P0)** **Primary Psched - 044** **Panel - None** **Price Region - OH**	**(P1)** **Primary Psched - 144** **Panel - None** **Price Region - OH**
Medicaid Reimbursable Services	90801 90862 H0004 (ind) H0031 H0036 (ind) H0040* H2016* S0201 S9484	H0004 (grp) H0036 (grp)	H0001 H0003 H0005 H0006 H0007 H0014 H0015 H0016 H0020	H0004 (ind)
Non-Medicaid Reimbursable Services	Alt. Psched - None	Alt. Psched - None	Alt. Psched - None	Alt. Psched - None
	Any claims for non-Medicaid reimbursable services will be denied in Diamond.	Any claims for non-Medicaid reimbursable services will be denied in Diamond.	Any claims for non-Medicaid reimbursable services will be denied in Diamond.	Any claims for non-Medicaid reimbursable services will be denied in Diamond.

*Until service is approved for reimbursement from Medicaid, use the Alt. Psched for entering rates.

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Non-Medicaid - Default Contracts
Provider + LOB
Non-Medicaid Eligible Client
ALL CLAIMS FOR NON-MEDICAID ARE PLACED ON HOLD

	Mental Health Services		AOD Services	
Medicaid Reimbursable Services	**(P0)** **Primary Psched - 044** **Panel - None** **Price Region - OH**	**(P2)** **Primary Psched - 244** **Panel - None** **Price Region - OH**	**(P0)** **Primary Psched - 044** **Panel - None** **Price Region - OH**	**(P1)** **Primary Psched - 144** **Panel - None** **Price Region - OH**
	90801 90862 H0004 (ind) H0031 H0036 (ind) H0040* H2016* S0201 S9484	H0004 (grp) H0036 (grp)	H0001 H0003 H0005 H0006 H0007 H0014 H0015 H0016 H0020	H0004 (ind)
Non-Medicaid Reimbursable Services.	**(A0)** **Alt. Psched - A44** **Panel - None** **Price Region - OH**	**N/A**	**(A0)** **Alt. Psched - A44** **Panel - None** **Price Region - OH**	**(A1)** **Alt. Psched - B44** **Panel - None** **Price Region - OH**
	H0030 H0038 H0046 M143x M144x M153x M154x M155x M162x M181x M191x M220x M224x M225x M226x M227x M228x M229x M312x M314x M411x M412x M413x M414x		99236 A023x A051x A056x A061x A062x A063x A064x A065x A066x A074x A075x A078x A121x A122x H0009 H0012 H0017 H0018 H0019 H0021 H0022 H0023 H0047 T1006 T1009 T1010	H0030

*Until service is approved for reimbursement from Medicaid, use the Alt. Psched for entering rates.

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Medicaid Standard Contracts

Provider + LOB + Panel

Medicaid Eligible Cleint

	Mental Health Services		AOD Services	
Medicaid Reimbursable Services	**(P0)** **Primary Psched - 044** **Panel - 25B** **Price Region - OH**	**(P2)** **Primary Psched - 244** **Panel - 25B** **Price Region - OH**	**(P0)** **Primary Psched - 044** **Panel - 25B** **Price Region - OH**	**(P1)** **Primary Psched - 144** **Panel - 25B** **Price Region - OH**
	90801 90862 H0004 (ind) H0031 H0036 (ind) H0040* H2016* S0201 S9484	H0004 (grp) H0036 (grp)	H0001 H0003 H0005 H0006 H0007 H0014 H0015 H0016 H0020	H0004 (ind)
Non-Medicaid Reimbursable Services	**(A0)** **Alt. Psched - A44** **Panel - 25B** **Price Region - OH**	**n/a**	**(A0)** **Alt. Psched - A44** **Panel - 25B** **Price Region - OH**	**(A1)** **Alt. Psched - B44** **Panel - 25B** **Price Region - OH**
	H0030 H0038 H0046 M143x M144x M153x M154x M155x M162x M181x M191x M220x M224x M225x M226x M227x M228x M229x M312x M314x M411x M412x M413x M414x		99236 A023x A051x A056x A061x A062x A063x A064x A065x A066x A074x A075x A078x A121x A122x H0009 H0012 H0017 H0018 H0019 H0021 H0022 H0023 H0047 T1006 T1009 T1010	H0030

*Until service is approved for reimbursement from Medicaid, use the Alt. Psched for entering rates.

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MH Non-Medicaid - Standard Contracts
Provider + LOB + Panel
Non-Medicaid Eligible Client

	Mental Health Services			
Medicaid Reimbursable Services	**(P0)** **Primary Psched - 044** **Panel - 25B** **Price Region - OH**	**(P2)** **Primary Psched - 244** **Panel - 25B** **Price Region - OH**	**(P0)** **Primary Psched - 044** **Panel - 25B** **Price Region - 25B**	**(P2)** **Primary Psched - 244** **Panel - 25B** **Price Region - 25B**
	(same rates and services as for Medicaid eligible client)		***(different rates, services, or withholds than for Medicaid eligible client)***	
	90801 90862 H0004 (ind) H0031 H0036 (ind) H0040* H2016* S0201 S9484	H0004 (grp) H0036 (grp)	90801 90862 H0004 (ind) H0031 H0036 (ind) H0040 H2016 S0201 S9484	H0004 (grp) H0036 (grp)
Non-Medicaid Reimbursable Services.	**(A0)** **Alt. Psched - A44** **Panel - 25B** **Price Region - OH**	**N/A**	**(A0)** **Alt. Psched - A44** **Panel - 25B** **Price Region - 25B**	**N/A**
	(same rates and services as for Medicaid eligible client)		***(different rates, services, or withholds than for Medicaid eligible client)***	
	H0030 H0038 H0046 M143x M144x M153x M154x M155x M162x M181x M191x M220x M224x M225x M226x M227x M228x M229x M312x M314x M411x M412x M413x M414x		H0030 H0038 H0046 M143x M144x M153x M154x M155x M162x M181x M191x M220x M224x M225x M226x M227x M228x M229x M312x M314x M411x M412x M413x M414x	

*Until service is approved for reimbursement from Medicaid, use the Alt. Psched for entering rates.

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AOD Non-Medicaid - Standard Contracts
Provider + LOB + Panel
Non-Medicaid Eligible Client

	AOD Services			
Medicaid Reimbursable Services	**(P0)** **Primary Psched - 044** **Panel - 25B** **Price Region - OH**	**(P1)** **Primary Psched - 144** **Panel - 25B** **Price Region - OH**	**(P0)** **Primary Psched - 044** **Panel - 25B** **Price Region - 25B**	**(P1)** **Primary Psched - 144** **Panel - 25B** **Price Region - 25B**
	(same rates and services as for Medicaid eligible client)		***(different rates, services, or withholds than for Medicaid eligible client)***	
	H0001	H0004 (ind)	H0001	H0004 (ind)
	H0003		H0003	
	H0005		H0005	
	H0006		H0006	
	H0007		H0007	
	H0014		H0014	
	H0015		H0015	
	H0016		H0016	
	H0020		H0020	
Non-Medicaid Reimbursable Services.	**(A0)** **Panel - 25B** **Price Region - OH**	**(A1)** **Panel - 25B** **Price Region - OH**	**(A0)** **Panel - 25B** **Price Region - 25B**	**(A1)** **Panel - 25B** **Price Region - 25B**
	(same rates and services as for Medicaid eligible client)		***(different rates, services, or withholds than for Medicaid eligible client)***	
	99236	H0030	99236	H0030
	A023x		A023x	
	A051x		A051x	
	A056x		A056x	
	A061x		A061x	
	A062x		A062x	
	A063x		A063x	
	A064x		A064x	
	A065x		A065x	
	A066x		A066x	
	A074x		A074x	
	A075x		A075x	
	A078x		A078x	
	A121x		A121x	
	A122x		A122x	
	H0009		H0009	
	H0012		H0012	
	H0017		H0017	
	H0018		H0018	
	H0019		H0019	
	H0021		H0021	
	H0022		H0022	
	H0023		H0023	
	H0047		H0047	
	T1006		T1006	
	T1009		T1009	
	T1010		T1010	

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ODMH Procedure Code, Modifier and Medical Definitions Matrix

ODMH Procedure Code, Modifier and Medical Definitions Matrix

			PAYABLE MEDICAL DEFINITIONS																	
		Modifier 1	HE	HE	HE	HE	HE	HE	HQ	HQ	HQ	HQ	HQ	HQ	GT	GT	GT	GT	GT	GT
		Modifier 2	blank/99	UK	blank/99	UK	blank/99	UK	blank/99	UK	blank/99	UK	blank/99	UK	blank/99	UK	blank/99	UK	blank/99	UK
		POS	not 51/99	not 51/99	99	99	51	51	not 51/99	not 51/99	99	99	51	51	not 51/99	not 51/99	99	99	51	51
Code	Procedure Name	LOB																		
90801	PSYCH DIAG INT EXAM - PHYS	MCD	1200	*1220	1230	*1235	**1240	*1245												
90801	PSYCH DIAG INT EXAM - PHYS	NON	2200	*2220	2230	*2235	2240	*2245												
90862	PHARMOCOLOGIC MGMT	MCD	1300	*1320	1330	*1335	**1340	*1345	1305											
90862	PHARMOCOLOGIC MGMT	NON	2300	*2320	2330	*2335	2340	*2345	2305											
H0004	BH COUNS/THERAPY - IND	MCD	1400	*1420	1430	*1435	**1440	*1445												
H0004	BH COUNS/THERAPY - IND	NON	2400	*2420	2430	*2435	2440	*2445												
H0004	BH COUNS/THERAPY - GRP	MCD							1500	*1520	1530	*1535	**1540	*1545						
H0004	BH COUNS/THERAPY - GRP	NON							2500	*2520	2530	*2535	2540	2545						
H0031	MH ASSESSMENT - NON-PHYS.	MCD	1200	*1220	1230	*1235	**1240	*1245												
H0031	MH ASSESSMENT - NON-PHYS.	NON	2200	*2220	2230	*2235	2240	*2245												
H0036	COM PSYCH SUP THERAPY - IND	MCD	1600	1620	1630	1635	**1640	**1645							1650	1660	1670	1675	**1680	**1685
H0036	COM PSYCH SUP THERAPY - IND	NON	2600	2620	2630	2635	2640	2645							2650	2660	2670	2675	2680	2685
H0036	COM PSYCH SUP THERAPY - GRP	MCD							1700	1720	1730	1735	**1740	**1745						
H0036	COM PSYCH SUP THERAPY - GRP	NON							2700	2720	2730	2735	2740	2745						
H0040	ACT CLINICAL COMPONENT	MCD	#2850		2850		2850													
H0040	ACT CLINICAL COMPONENT	NON	2850				2850													
H2016	IHBT CLINICAL COMPONENT	MCD	#2860		2860		2860													
H2016	IHBT CLINICAL COMPONENT	NON	2860				2860													
S0201	PAR HOSP-ADULTS	MCD	1800				**2800													
S0201	PAR HOSP-ADULTS	NON	2800																	
S0201	PAR HOSP-CHILDREN	MCD	1805																	
S0201	PAR HOSP-CHILDREN	NON	2805																	
S9484	CRISIS INT MH SVCS	MCD	1000	1020	1030	1035	**1040	**1045							2050	2060	2070	2075	2080	2085
S9484	CRISIS INT MH SVCS	NON	2000	2020	2030	2035	2040	2045							2050	2060	2070	2075	2080	2085
H0030	BH HOTLINE	ALL	3620		3620		3620													
H0038	SELF HELP/PEER SUPPORT	ALL	3660		3660		3660													
H0046	MH SVCS NOT OTHERWISE SPECIFIED	ALL	3680		3680		3680													
M143X	OCCUPATIONAL THERAPY	ALL	3100		3100		3100													
M144X	ADJUNCTIVE THERAPY	ALL	3120		3120		3120													
M153X	SCHOOL PSYCHOLOGY	ALL	3140		3140		3140													
M154X	ADULT EDUCATION	ALL	3160		3160		3160													
M155X	SOCIAL RECREATION	ALL	3200		3200		3200													
M162X	EMPLOYMENT/VOCATIONAL	ALL	3350		3350		3350													
M181x	IHBT NON-CLINICAL COMPONENT	ALL	2865				2865													
M191x	ACT NON-CLINICAL COMPONENT	ALL	2855				2855													
M220X	RESIDENTIAL CARE	ALL	3480		3480		3480													
M224X	COMMUNITY RESIDENCE	ALL	3460		3460		3460													
M225X	FOSTER CARE	ALL	3500		3500		3500													
M226X	SUBSIDIZED HOUSING	ALL	3520		3520		3520													
M227X	RESPITE CARE	ALL	3540		3540		3540													
M228X	CRISIS CARE	ALL	3560		3560		3560													
M229X	TEMPORARY HOUSING	ALL	3580		3580		3580													
M312X	CONSUMER OPERATED	ALL	3640		3640		3640													
M314X	OTHER MH SVC (NON HEALTHCARE)	ALL	3680		3680		3680													
M411X	PREVENTION	ALL	3720		3720		3720													

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M412X	CONSULTATION	ALL	3740		3740		3740												
M413X	INFO AND REFERRAL	ALL	3760		3760		3760												
M414X	COMM EDUCATION	ALL	3780		3780		3780												

*** Kids Only**

**** Only clients under 22 and 65 and over**

 # Until this service has been approved for reimbursment from Medicaid, this procedure code will process and pay as a non-Medicaid reimbursable service.

The following are MH non-payable Medical Definitions:

MMCD	MH MCD Fall - Through
MNON	Non-MCD Fall - Through
MMOD	MH Modifier Problem
MMPU	MH MCD Partial Units
MNPU	MH Non-MCD Partial Units
MMDX	MH DX Required/MCD Service
MNDX	MH DX Required/Non-MCD Service
MAGE	MH Client not Under 18
MTEL	MH Telephone not Valid

These are shared non-payable MEDEF's that will default to a MH Company Code:

MINV	BH Code/Modifier Problem
NPUA	No Partial Units - BH
NODX	Missing Diagnosis - BH
ZMCD	MCD BH Fall - Through
ZNON	Non-MCD BH Fall - Through

AOD Procedure Code, Modifier and Medical Definitions Matrix

AOD Procedure Code, Modifier and Medical Definitions Matrix

			PAYABLE MEDICAL DEFINITIONS							
		Modifier 1	HA	HA	HA	HF	HF	HF	HF	H9
		Modifier 2	blank/99	H9	HD	blank/99	H9	HA	HD	blank/99
Proc	Procedure Name	LOB								
H0001	ASSESSMENT	MCD	5010	5011	5012	5013	5014		5015	
H0001	ASSESSMENT	NON	6010	6011	6012	6013	6014		6015	
H0003	LABORATORY URINALYSIS	MCD	5070	5071	5072	5073	5074		5075	
H0003	LABORATORY URINALYSIS	NON	6070	6071	6072	6073	6074		6075	
H0004	IND COUNSELING	MCD				5050	5051		5052	
H0004	IND COUNSELING	NON				6050	6051		6052	
H0005	GROUP COUNSELING	MCD	5040	5041	5042	5043	5044		5045	
H0005	GROUP COUNSELING	NON	6040	6041	6042	6043	6044		6045	
H0006	CASE MGMT	MCD	5020	5021	5022	5023	5024		5025	
H0006	CASE MGMT	NON	6020	6021	6022	6023	6024		6025	
H0007	CRISIS INTERVENTION	MCD	5030	5031	5032	5033	5034		5035	
H0007	CRISIS INTERVENTION	NON	6030	6031	6032	6033	6034		6035	
H0014	AMBULATORY DETOX	MCD	5000	5001	5002	5003	5004		5005	
H0014	AMBULATORY DETOX	NON	6000	6001	6002	6003	6004		6005	
H0015	INTENSIVE OUTPATIENT	MCD	5060	5061	5062	5063	5064		5065	
H0015	INTENSIVE OUTPATIENT	NON	6060	6061	6062	6063	6064		6065	
H0016	MEDICAL/SOMATIC	MCD	5080	5081	5082	5083	5084		5085	
H0016	MEDICAL/SOMATIC	NON	6080	6081	6082	6083	6084		6085	
H0020	METHADONE ADMIN	MCD				5090	5091			
H0020	METHADONE ADMIN	NON				6090	6091			
99236	23 HOUR OBSERVATION BED	ALL	6120	6121	6122	6123	6124		6125	
A023X	MED COMM RES - NON-HOSP SETTING	ALL	7020	7021	7022	7023	7024		7025	
A051X	REFERRAL AND INFORMATION	ALL	7610	7611	7612	7613	7614		7615	
A056X	CONSULTATION	ALL	7540	7541	7542	7543	7544		7545	
A061X	INFORMATION DISSEMINATION	ALL	7570	7571	7572	7573		7574	7575	
A062X	EDUCATION (PREVENTION	ALL	7550	7551	7552	7553		7554	7555	
A063X	COMM BASED PROCESS	ALL	7530	7531	7532	7533		7534	7535	
A064X	ENVIRONMENTAL	ALL	7560	7561	7562	7563		7564	7565	
A065X	PROBLEM ID AND REFERRAL	ALL	7600	7601	7602	7603		7604	7605	
A066X	ALTERNATIVES	ALL	7510	7511	7512	7513		7514	7515	
A074X	ROOM AND BOARD	ALL	7650		7651	7652			7653	
A075X	TRANSPORTATION	ALL	7660		7661	7662			7663	
A078X	URINE DIP SCREENING	ALL	6110	6111	6112	6113	6114		6115	
A121X	MED COMM RES - HOSP SETTING	ALL	4520	4521		4522	4523			
A122X	NON-MED COMM RES TX	ALL	7040	7041	7042	7043	7044		7045	
H0009	ACUTE HOSPITAL DETOX	ALL	4500	4501		4502	4503			
H0012	SUB ACUTE DETOX	ALL	7000	7001	7002	7003	7004		7005	
H0017	BH MED COMM RES TX HOSP	ALL	4510	4511		4512	4513			
H0018	RES TREAT NON-HOSP	ALL	7010	7011	7012	7013	7014		7015	
H0019	BH NON-MED COMM RES TX	ALL	7030	7031	7032	7033	7034		7035	
H0021	TRAINING	ALL	7620	7621	7622	7623	7624		7625	
H0022	INTERVENTION	ALL	7580	7581	7582	7583	7584		7585	
H0023	BH OUTREACH	ALL				7590	7591	7592	7593	
H0030	BH HOTLINE	ALL				7520				
H0047	ALC/OTHER SUB ABUSE NOT OTHERWISE CLASSIFIED	ALL	7500	7501	7502	7503	7504		7505	
T1006	FAMILY COUNSELING	ALL	6100	6101	6102	6103	6104		6105	
T1009	CHILDCARE	ALL	7630		7631	7632			7633	
T1010	MEALS	ALL	7640		7641	7642			7643	

new AOD Medical Def matrix.xls

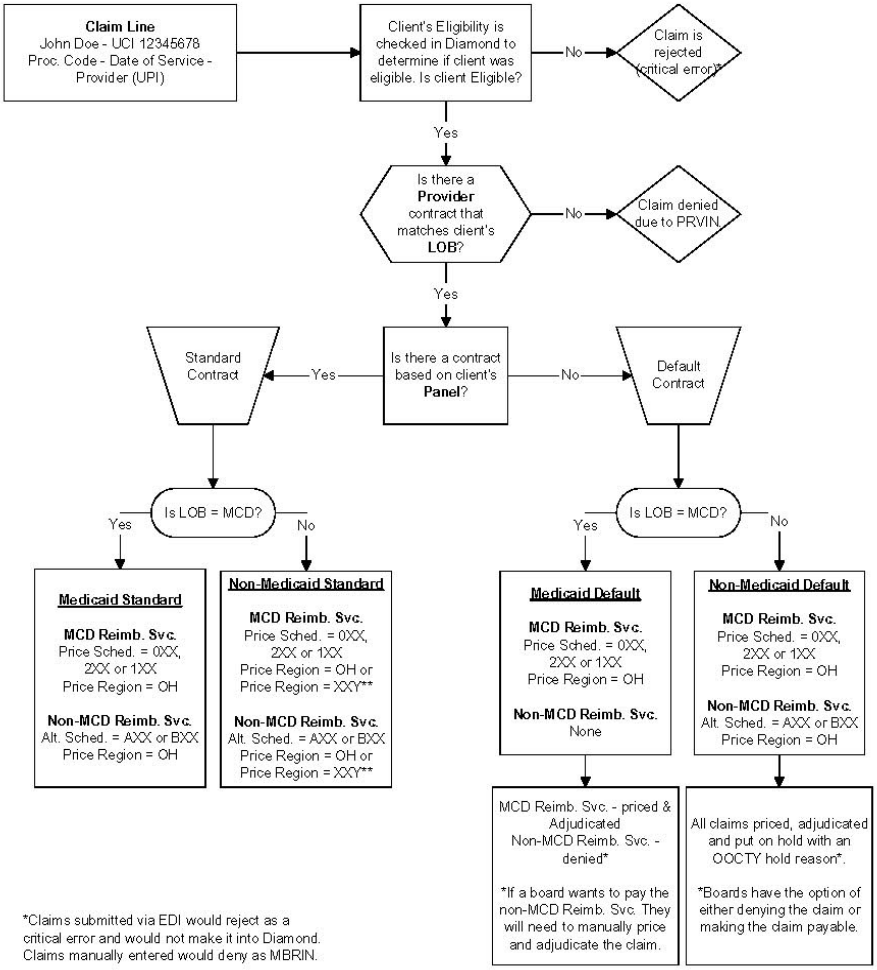
The following are non-payable AOD Medical Definitions:

AMCD	AOD MCD Fall - Through
ANON	AOD Non-MCD Fall - Through
AMOD	AOD Modifier Problem
AMPU	AOD MCD Partial Units
ANPU	AOD Non-MCD Partial Units
AMDX	AOD DX Required/MCD Service
ANDX	AOD DX Required/Non-MCD Service
DXNA	AOD Svc Requires AOD DX
ODYS	DADAS Plan/UPI not 1131

These are shared non-payable MEDEF's that will default to a MH Company Code:

MINV	BH Code/Modifier Problem
NPUA	No Partial Units Allowed - BH
NODX	Missing Diagnosis - BH
ZMCD	Medicaid BH Fall - Through
ZNON	Non-MCD BH Fall - Through

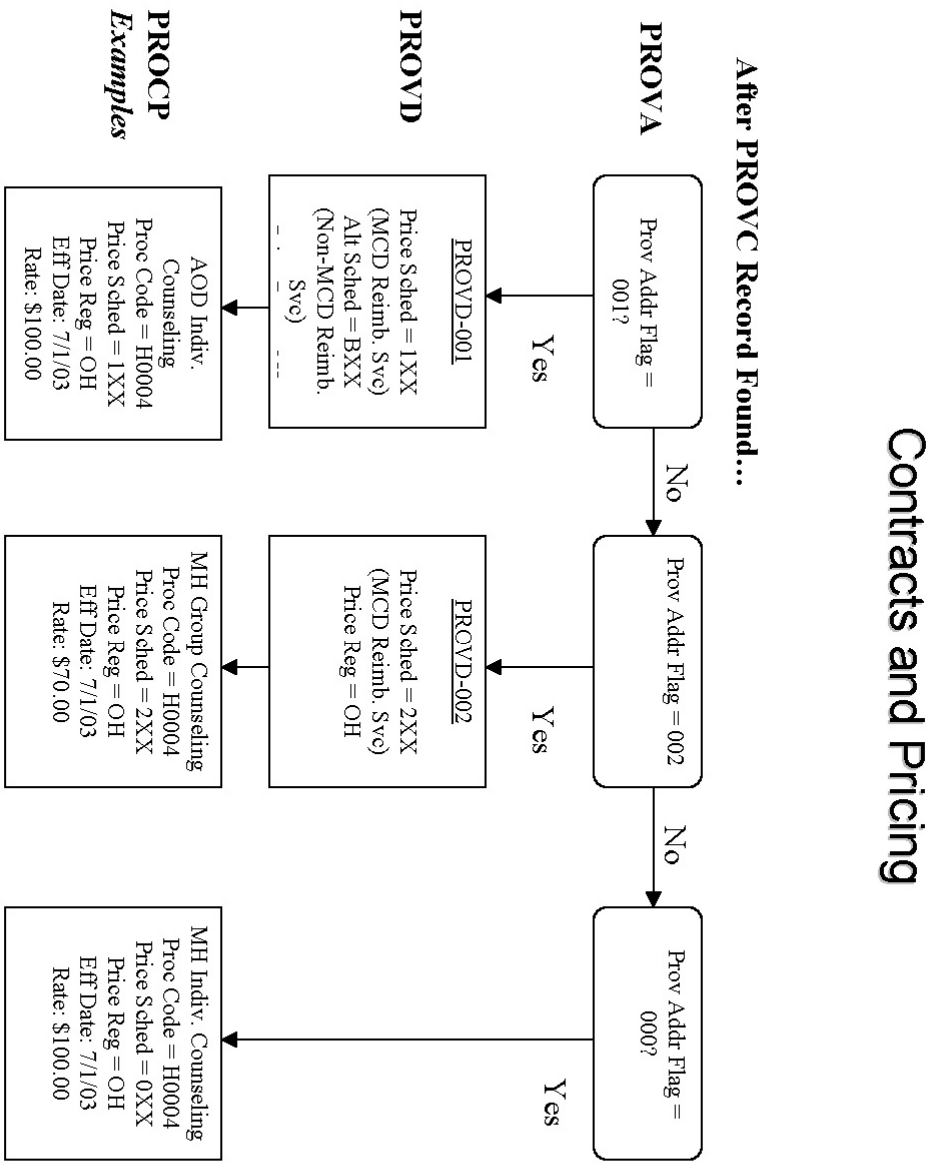
Contracts and Pricing



*Claims submitted via EDI would reject as a critical error and would not make it into Diamond. Claims manually entered would deny as MBRIN.

**If Board used different rates, withholds or services than for the Standard Medicaid contract then the Board's price region would be used.

Contracts and Pricing after PROVC Record Found



Denying Non-MCD Claims Beyond Submission Deadline

Denying non-Medicaid claims that are outside the allotted time period for submission per Board/Provider contracts.

Many boards have expressed the need to automatically deny Non-Medicaid claims that are submitted after the board's billing deadline and/or those claims that exceed the board's contractual ceiling amount for such services. Some boards wish to contractually obligate providers to submit Non-Medicaid claims no more than (for example) 90 days after the close of the fiscal year so that all claims submitted after the deadline will be denied. Another scenario involves boards that will only fund (for example) $10,000 of Non-Medicaid services during a fiscal year. In both cases, boards are now required to manually deny such claims, thus it has been requested that Diamond be configured to automatically deny any claims received after the contracted limit/designated time period.

After considerable discussion between boards and State staff, the easiest and cleanest (i.e., auditable) way to accomplish this is to remove the Alternate Price Schedule from the PROVC on the Medicaid contracts and to remove both the Primary Price Schedule and the Alternate Price Schedule from the Non-Medicaid contracts (please note that the "Default" contracts **cannot** be modified because out of county claims must continue to process normally). Boards **should not** change their rates on the PROCP in Diamond to a $0.00 allowed amount because the audit trail for previously paid claims will be lost. The important distinction is to actually DENY the claims rather than paying them at zero dollars.

Boards that decide to implement this procedure will need to email the MACSIS Support Desk so that the State can make all the necessary changes in Diamond. (All changes will be forwarded to Debbie Downs at ODADAS who will make the changes to the Diamond PROVC records, but the MACSIS Support Desk must be informed so that claims related questions can be answered for denials, etc.). The email should list all PROVC records that need adjustment along with the effective date of the change. Please include the provider's UPI, Panel, Line of Business, Contract Effective Date, Primary Price Schedule, and Alternate Price Schedule, along with the cutoff date desired. It is important that this type of change to contracts NOT be attempted during the week when Claims EDI is running. The system must be quiet so that production claims sessions do not abend, which is why the State prefers to make these changes. (If a board prefers to make the changes to the Non-Medicaid contracts, an email to the Support Desk should still be sent indicating that the board will make the necessary modifications to the Non-Medicaid contracts. Due to security codes, the State must adjust the Medicaid PROVC records. boards should only make these on-line changes when claims for their providers are not running in either Edit or Post mode.)

The steps to implement this procedure are:

(1) terminate the contract from the previous year with the term date of 6/30/yyyy (reason code will be LBCLR-Local Board Contract Limits Reached to assist in the "audit trail" of why the contract was modified),
(2) create a new contract for the current fiscal year with the appropriate price schedules, and
(3) remove the alternate price schedule from Medicaid contracts for the prior fiscal year and both the primary and alternate schedule from Non-Medicaid contracts.

This will allow all claims for Non-Medicaid services with a date of service that falls in the prior fiscal year to deny while enabling services for the current year to pay correctly. Please note that no reason code can be assigned to these claims so boards will need to explain to providers that old claims that are denied will not be flagged with a reason code. Please be aware that this methodology will result in all Non-Medicaid services being denied; this solution is not procedure code specific so boards cannot deny payment for Service A but not for Service B.

Important note: this procedure should **NOT** be used with providers receiving ODADAS grant funding (examples are ODADAS prevention service grants and the ODADAS women's grant funded programs).

OHIO DEPT OF MENTAL HEALTH
HIPAA FY2004 SERVICES

Same Day Service Reporting: Roll-up Categories for Duplicate Checking

Providers should summarize claims based on the various procedure code, modifier 1 & 2, and place of service combinations shown below. Note that each procedure code has specific allowable values for modifiers 1 and 2 and only those are payable.

Multiple encounters that occur in different places of service should be rolled up and reported with Place of Service Code=11 (Office Visit) EXCEPT for the specific procedure codes that distinguish reporting for Place of Service Codes 51 and 99 as shown below.

Modifier 1: HE=MENTAL HEALTH PROGRAM
HQ=GROUP SETTING
GT=TELEPHONE

Modifier 2: 99 or blank=FACE TO FACE WITH CLIENT, others may be present (was F0 and F1)
UK=CLIENT NOT PRESENT-SERVICE TO COLLATERAL (was F2 and F3)

HIPAA Service Name	Unit of Service	Service Modality	FY 03 PROC	FY 03 MOD	NEW PROC	NEW MOD 1	NEW MOD 2	PLACE OF SERVICE	Medical Definition MCD	Medical Definition NON
MEDICAID HEALTHCARE SERVICES										
Crisis Intervention M H Services	HOUR	Face to face with client (and others)	M1110xx	F0, F1	S9484	HE	blank or 99	not 51 or 99	1000	2000
		Face to face with others, client not present	M1110xx	F2, F3	S9484	HE	UK	not 51 or 99	1020	2020
		Face to face with client, client in jail/penal	M1110xx	F4	S9484	HE	blank or 99	99	1030	2030
		Face to face with others, client not present, client in jail/penal system	M1110xx	F5	S9484	HE	UK	99	1035	2035
		Face to face with client,client in freestanding psych hospital (private or state)	M1110xx	F6	S9484	HE	blank or 99	51	1040	2040
		Face to face with others, client not present, client in freestanding psych hospital (private or	M1110xx	F7	S9484	HE	UK	51	1045	2045
		Telephone contact with client (and others)	M1110xx	T0, T1	S9484	GT	blank or 99	not 51 or 99	not MCD billable	2050
		Telephone contact with others, client not on line	M1110xx	T2, T3	S9484	GT	UK	not 51 or 99	not MCD billable	2060
		Telephone contact with client, client in jail/penal system	M1110xx	T4	S9484	GT	blank or 99	99	not MCD billable	2070
		Telephone contact with family, client not on line, client in jail/penal system	M1110xx	T5	S9484	GT	UK	99	not MCD billable	2075
		Telephone contact with client, client in psychiatric hospital (private or state)	M1110xx	T6	S9484	GT	blank or 99	51	not MCD billable	2080
		Telephone contact with others, client not on line, client in psychiatric hospital (private or state)	M1110xx	T7	S9484	GT	UK	51	not MCD billable	2085
Psychiatric Diagnostic Interview Examination - PHYSICIAN	HOUR	Face to face with client (and others)	M1210xx	F0, F1	90801	HE	blank or 99	not 51 or 99	1200	2200
(Diagnostic Assessment)		Face to face with others, client not present (children only)	M1210xx	F2, F3	90801	HE	UK	not 51 or 99	1220	2220
		Face to face with client, client in jail/penal	M1210xx	F4	90801	HE	blank or 99	99	1230	2230
		Face to face with others, client not present, client in jail/penal system (children only)	M1210xx	F5	90801	HE	UK	99	1235	2235
		Face to face with client, client in psychiatric hospital (private or state)	M1210xx	F6	90801	HE	blank or 99	51	1240	2240
		Face to face with others, client not present, client in psychiatric hospital (private or state) (children only)	M1210xx	F7	90801	HE	UK	51	1245	2245
M H Assessment (by Non-Physician)	HOUR	Face to face with client (and others)	M1210xx	F0, F1	H0031	HE	blank or 99	not 51 or 99	1200	2200
(Diagnostic Assessment)		Face to face with others, client not present (children only)	M1210xx	F2, F3	H0031	HE	UK	not 51 or 99	1220	2220
		Face to face with client, client in jail/penal	M1210xx	F4	H0031	HE	blank or 99	99	1230	2230
		Face to face with others, client not present, client in jail/penal system (children only)	M1210xx	F5	H0031	HE	UK	99	1235	2235
		Face to face with client, client in psychiatric hospital (private or state)	M1210xx	F6	H0031	HE	blank or 99	51	1240	2240
		Face to face with others, client not present, client in psychiatric hospital (private or state) (children only)	M1210xx	F7	H0031	HE	UK	51	1245	2245
Pharmocologic Management	HOUR	Face to face with client (and others)	M131xxx	F0, F1	90862	HE	blank or 99	not 51 or 99	1300	2300
(Medication/Somatic)		Face to face with others, client not present (children only)	M131xxx	F2, F3	90862	HE	UK	not 51 or 99	1320	2320
		Face to face with client, client in jail/penal	M131xxx	F4	90862	HE	blank or 99	99	1330	2330
		Face to face with others, client not present, client in jail/penal system (children only)	M131xxx	F5	90862	HE	UK	99	1335	2335
		Face to face with client, client in psychiatric hospital (private or state)	M131xxx	F6	90862	HE	blank or 99	51	1340	2340

HIPAA Service Name	Unit of Service	Service Modality	FY 03 PROC	FY 03 MOD	NEW PROC	NEW MOD 1	NEW MOD 2	PLACE OF SERVICE	Medical Definition	
									MCD	NON
		Face to face with others, client not present, client in psychiatric hospital (private or state) (children only)	M131xxx	F7	90862	HE	UK	51	1345	2345
		Face to face with client, group setting	M131xxx	G1	90862	HQ	blank or 99	not 51 or 99	1305	2305
BH Counseling and Therapy - Individual	15 min	Face to face with client (and others)	M1410xx	F0, F1	H0004	HE	blank or 99	not 51 or 99	1400	2400
(MH Individual Counseling)		Face to face with others, client not present (children only)	M1410xx	F2, F3	H0004	HE	UK	not 51 or 99	1420	2420
		Face to face with client, client in jail/penal	M1410xx	F4	H0004	HE	blank or 99	99	1430	2430
		Face to face with others, client not present, client in jail/penal system (children only)	M1410xx	F5	H0004	HE	UK	99	1435	2435
		Face to face with client, client in psychiatric hospital (private or state)	M1410xx	F6	H0004	HE	blank or 99	51	1440	2440
		Face to face with others, client not present, client in psychiatric hospital (private or state) (children only)	M1410xx	F7	H0004	HE	UK	51	1445	2445
BH Counseling and Therapy - Group	15 min	Face to face with client (and others)	M1420xx	F0, F1	H0004	HQ	blank or 99	not 51 or 99	1500	2500
(MH Group Counseling)		Face to face with others, client not present (children only)	M1420xx	F2, F3	H0004	HQ	UK	not 51 or 99	1520	2520
		Face to face with client, client in jail/penal	M1420xx	F4	H0004	HQ	blank or 99	99	1530	2530
		Face to face with others, client not present, client in jail/penal system (children only)	M1420xx	F5	H0004	HQ	UK	99	1535	2535
		Face to face with client, client in psychiatric hospital (private or state)	M1420xx	F6	H0004	HQ	blank or 99	51	1540	2540
		Face to face with others, client not present, client in psychiatric hospital (private or state) (children only)	M1420xx	F7	H0004	HQ	UK	51	1545	2545
Community Psychiatric Supportive Therapy - Individual	15 min	Face to face with client (and others)	M1510xx	F0, F1	H0036	HE	blank or 99	not 51 or 99	1600	2600
(Individual Community Support Program <CSP>)		Face to face with others, client not present	M1510xx	F2, F3	H0036	HE	UK	not 51 or 99	1620	2620
		Face to face with client, client in jail/penal	M1510xx	F4	H0036	HE	blank or 99	99	1630	2630
		Face to face with others, client not present, client in jail/penal system	M1510xx	F5	H0036	HE	UK	99	1635	2635
		Face to face with client, client in psychiatric hospital (private or state)	M1510xx	F6	H0036	HE	blank or 99	51	1640	2640
		Face to face with others, client not present, client in psychiatric hospital (private or state)	M1510xx	F7	H0036	HE	UK	51	1645	2645
		Telephone contact with client (and others)	M1510xx	T0, T1	H0036	GT	blank or 99	not 51 or 99	1650	2650
		Telephone contact with others, client not on line	M1510xx	T2, T3	H0036	GT	UK	not 51 or 99	1660	2660
		Telephone contact with client, client in jail/penal system	M1510xx	T4	H0036	GT	blank or 99	99	1670	2670
		Telephone contact with family, client not on line, client in jail/penal system	M1510xx	T5	H0036	GT	UK	99	1675	2675
		Telephone contact with client, client in psychiatric hospital (private or state)	M1510xx	T6	H0036	GT	blank or 99	51	1680	2680
		Telephone contact with others, client not on line, client in psychiatric hospital (private or state)	M1510xx	T7	H0036	GT	UK	51	1685	2685
Community Psychiatric Supportive Therapy - Group	15 min	Face to face with client (and others)	M1520xx	F0, F1	H0036	HQ	blank or 99	not 51 or 99	1700	2700
(Group Community Support Program <CSP>)		Face to face with others, client not present	M1520xx	F2, F3	H0036	HQ	UK	not 51 or 99	1720	2720
		Face to face with client, client in jail/penal	M1520xx	F4	H0036	HQ	blank or 99	99	1730	2730
		Face to face with others, client not present, client in jail/penal system	M1520xx	F5	H0036	HQ	UK	99	1735	2735
		Face to face with client, client in psychiatric hospital (private or state)	M1520xx	F6	H0036	HQ	blank or 99	51	1740	2740
		Face to face with others, client not present, client in psychiatric hospital (private or state)	M1520xx	F7	H0036	HQ	UK	51	1745	2745
Partial Hospitalization	PGM DAY	Face to face with client (and others)	M1710xx	F0, F1	S0201	HE	blank or 99	not 51 or 99	1800 (adult) 1805 (child)	2800 (adult) 2805 (child)
NON-MEDICAID HEALTHCARE SERVICES										
B H Hotline	HOUR		M3110xx		H0030	HE	blank or 99	any valid	not MCD billable	3620
Self Help/Peer Services	15 min		M3130xx		H0038	HE	blank or 99	any valid	not MCD billable	3660
M H Services Not Otherwise Specified - Health Care (Other MH)	HOUR		M3140xx		H0046	HE	blank or 99	any valid	not MCD billable	3680
NON HEALTHCARE SERVICES										

HIPAA Service Name	Unit of Service	Service Modality	FY 03 PROC	FY 03 MOD	NEW PROC	NEW MOD 1	NEW MOD 2	PLACE OF SERVICE	Medical Definition	
									MCD	NON
Other M H Service (not Healthcare)	HOUR		M3140xx		M314x	HE	blank or 99	any valid	not MCD billable	3680
Adjunctive Therapy	HOUR		M1440xx		M144x	HE	blank or 99	any valid	not MCD billable	3120
Adult Education	HOUR		M1540xx		M154x	HE	blank or 99	any valid	not MCD billable	3160
Consumer Operated	HOUR		M3120xx		M312x	HE	blank or 99	any valid	not MCD billable	3640
Employment/Vocational	HOUR		M1610xx		M162x	HE	blank or 99	any valid	not MCD billable	3350
Occupational Therapy	HOUR		M1430xx		M143x	HE	blank or 99	any valid	not MCD billable	3100
School Psychology	HOUR		M1530xx		M153x	HE	blank or 99	any valid	not MCD billable	3140
Social Recreation	HOUR		M1550xx		M155x	HE	blank or 99	any valid	not MCD billable	3200
COMMUNITY SERVICES										
Prevention	HOUR		M4110xx		M411x	HE	blank or 99	any valid	not MCD billable	3720
Consultation	HOUR		M4120xx		M412x	HE	blank or 99	any valid	not MCD billable	3740
Info and Referral	HOUR		M4130xx		M413x	HE	blank or 99	any valid	not MCD billable	3760
Community Education	HOUR		M4140xx		M414x	HE	blank or 99	any valid	not MCD billable	3780
RESIDENTIAL SERVICES										
Residential Care (new)	DAY				M220x	HE	blank or 99	any valid	not MCD billable	3480
Community Residence	DAY		M2240xx		M224x	HE	blank or 99	any valid	not MCD billable	3460
Foster Care	DAY		M2250xx		M225x	HE	blank or 99	any valid	not MCD billable	3500
Subsidized Housing (was Housing)	DAY		M2260xx		M226x	HE	blank or 99	any valid	not MCD billable	3520
Respite Care	DAY		M2270xx		M227x	HE	blank or 99	any valid	not MCD billable	3540
Crisis Care (was Crisis Bed)	DAY		M2280xx		M228x	HE	blank or 99	any valid	not MCD billable	3560
Temporary Housing (new)	DAY				M229x	HE	blank or 99	any valid	not MCD billable	3580

NOTES: Non-Healthcare procedure codes (those that begin with the letter M) have been changed from 7 byte codes to 5 byte codes. For FY 03 and prior years, boards had the option of using the last 2 bytes of the 7 byte code to distinguish price differences at the provider level where the same procedure code was used to report activity in cifferent provider programs that had unique costs. For FY 04 and later, the 5th byte of the 5 byte code will be used to capture this information. For example, Other MH Service (M314000) had distinct codes of M314000, M314001, M314002, etc thru M314009. The new 5 byte codes to be used are M3141, M3142, etc. thru M3149. This change is necessary so that Diamond duplicate checking does not deny claims with different prices for the same service (Diamond duplicate checking uses only the first 5 bytes of the procedure code).

HEALTHCARE services do not have a locally defined 5th byte so different programs for the same service must be cost averaged.

Penal system (F4-5) and state hospital (F6-7) modifiers are replaced with place of service codes 99 and 51, respectively.

Modifiers 1 & 2 are for use by State; Modifiers 3 & 4 are for Board use. Boards that require providers to use modifiers 3 and 4 should furnish instructions outlining the appropriate codes to use when same-day claims must be summarized.

Use of any modifiers in postions 1 & 2 except for those shown above will result in a DENIED claim.

Modifiers must be in the order specified or claim will be DENIED.

Use of the telephone (GT) or group (HQ) as modifier 1 for services other than those specified will result in a DENIED claim.

Use of the telephone modifier as Modifier 3 or 4 for MH Medicaid billable services or for MH Resdiential Services will result in a DENIED claim.

For medicaid billable services, use of modifier HS as modifier 3 or modifier 4 without coding UK in modifier 2 will result in a DENIED claim.

ODADAS Rollup Categories Used for Duplicate Claim Checking

Ohio Department of Alcohol and Drug Addiction Services
Rollup Categories used for Duplicate Claim Checking

Updated 05/17/2006

HIPAA SERVICE NAME	UNIT OF SERVICE	HCPC/PROCD	Modifier 1 (used in PRULD and MEDEFs)	Modifier 2 (used in MEDEFS)	Diagnosis Required	Medicaid Med Def	Non-Medicaid Med Def
Family Counseling	15 Minutes	T1006	HA	BLANK, 99	Y	not MCD Billable	6100
		T1006	HA	H9	Y	not MCD Billable	6101
		T1006	HA	HD	Y	not MCD Billable	6102
		T1006	HF	BLANK, 99	Y	not MCD Billable	6103
		T1006	HF	H9	Y	not MCD Billable	6104
		T1006	HF	HD	Y	not MCD Billable	6105
Group Counseling	15 Minutes	H0005	HA	BLANK, 99	Y	5040	6040
		H0005	HA	H9	Y	5041	6041
		H0005	HA	HD	Y	5042	6042
		H0005	HF	BLANK, 99	Y	5043	6043
		H0005	HF	H9	Y	5044	6044
		H0005	HF	HD	Y	5045	6045
Individual Counseling	15 Minutes	H0004	HF	BLANK, 99	Y	5050	6050
		H0004	HF	H9	Y	5051	6051
		H0004	HF	HD	Y	5052	6052
23 Hour Observation Bed	Day	99236	HA	BLANK, 99	Y * Must be AoD	not MCD Billable	6120
		99236	HA	H9	Y * Must be AoD	not MCD Billable	6121
		99236	HA	HD	Y * Must be AoD	not MCD Billable	6122
		99236	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	6123
		99236	HF	H9	Y * Must be AoD	not MCD Billable	6124
		99236	HF	HD	Y * Must be AoD	not MCD Billable	6125
Acute Hospital Detoxification	Day	H0009	HA	BLANK, 99	Y * Must be AoD	not MCD Billable	4500
		H0009	HA	H9	Y * Must be AoD	not MCD Billable	4501
		H0009	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	4502
		H0009	HF	H9	Y * Must be AoD	not MCD Billable	4503
Ambulatory Detoxification	Day	H0014	HA	BLANK, 99	Y * Must be AoD	5000	6000
		H0014	HA	H9	Y * Must be AoD	5001	6001
		H0014	HA	HD	Y * Must be AoD	5002	6002
		H0014	HF	BLANK, 99	Y * Must be AoD	5003	6003
		H0014	HF	H9	Y * Must be AoD	5004	6004
		H0014	HF	HD	Y * Must be AoD	5005	6005
Behavioral Health Medical Community Residential Treatment Hospital Setting	Day	H0017	HA	BLANK, 99	Y * Must be AoD	not MCD Billable	4510
		H0017	HA	H9	Y * Must be AoD	not MCD Billable	4511
		H0017	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	4512
		H0017	HF	H9	Y * Must be AoD	not MCD Billable	4513
Residential Treatment Non-Hospital Setting	Day	H0018	HA	BLANK, 99	Y * Must be AoD	not MCD Billable	7010
		H0018	HA	H9	Y * Must be AoD	not MCD Billable	7011
		H0018	HA	HD	Y * Must be AoD	not MCD Billable	7012
		H0018	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	7013
		H0018	HF	H9	Y * Must be AoD	not MCD Billable	7014
		H0018	HF	HD	Y * Must be AoD	not MCD Billable	7015

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Ohio Department of Alcohol and Drug Addiction Services
Rollup Categories used for Duplicate Claim Checking

Updated 05/17/2006

HIPAA SERVICE NAME	UNIT OF SERVICE	HCPC/PROCD	Modifier 1 (used in PRULD and MEDEFs)	Modifier 2 (used in MEDEFS)	Diagnosis Required	Medicaid Med Def	Non-Medicaid Med Def
Behavioral Health Non-Medical Community Residential Treatment	Day	H0019	HA	BLANK,99	Y * Must be AoD	not MCD Billable	7030
		H0019	HA	H9	Y * Must be AoD	not MCD Billable	7031
		H0019	HA	HD	Y * Must be AoD	not MCD Billable	7032
		H0019	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	7033
		H0019	HF	H9	Y * Must be AoD	not MCD Billable	7034
		H0019	HF	HD	Y * Must be AoD	not MCD Billable	7035
Intensive Outpatient	Day	H0015	HA	BLANK, 99	Y	5060	6060
		H0015	HA	H9	Y	5061	6061
		H0015	HA	HD	Y	5062	6062
		H0015	HF	BLANK, 99	Y	5063	6063
		H0015	HF	H9	Y	5064	6064
		H0015	HF	HD	Y	5065	6065
Medical Community Residential: Hospital Setting	Day	A121X	HA	BLANK, 99	Y * Must be AoD	not MCD Billable	4520
		A121X	HA	H9	Y * Must be AoD	not MCD Billable	4521
		A121X	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	4522
		A121X	HF	H9	Y * Must be AoD	not MCD Billable	4523
Medical Community Residential: Non-hospital Setting	Day	A023X	HA	BLANK, 99	Y * Must be AoD	not MCD Billable	7020
		A023X	HA	H9	Y * Must be AoD	not MCD Billable	7021
		A023X	HA	HD	Y * Must be AoD	not MCD Billable	7022
		A023X	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	7023
		A023X	HF	H9	Y * Must be AoD	not MCD Billable	7024
		A023X	HF	HD	Y * Must be AoD	not MCD Billable	7025
Non-Medical Community Residential Treatment	Day	A122X	HA	BLANK, 99	Y * Must be AoD	not MCD Billable	7040
		A122X	HA	H9	Y * Must be AoD	not MCD Billable	7041
		A122X	HA	HD	Y * Must be AoD	not MCD Billable	7042
		A122X	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	7043
		A122X	HF	H9	Y * Must be AoD	not MCD Billable	7044
		A122X	HF	HD	Y * Must be AoD	not MCD Billable	7045
Room and Board	Day	A074X	HA	BLANK, 99	N	not MCD Billable	7650
		A074X	HA	HD	N	not MCD Billable	7651
		A074X	HF	BLANK, 99	N	not MCD Billable	7652
		A074X	HF	HD	N	not MCD Billable	7653
Sub Acute Detoxification	Day	H0012	HA	BLANK, 99	Y * Must be AoD	not MCD Billable	7000
		H0012	HA	H9	Y * Must be AoD	not MCD Billable	7001
		H0012	HA	HD	Y * Must be AoD	not MCD Billable	7002
		H0012	HF	BLANK, 99	Y * Must be AoD	not MCD Billable	7003
		H0012	HF	H9	Y * Must be AoD	not MCD Billable	7004
		H0012	HF	HD	Y * Must be AoD	not MCD Billable	7005

Ohio Department of Alcohol and Drug Addiction Services
Rollup Categories used for Duplicate Claim Checking

Updated 05/17/2006

HIPAA SERVICE NAME	UNIT OF SERVICE	HCPC/PROCD	Modifier 1 (used in PRULD and MEDEFs)	Modifier 2 (used in MEDEFS)	Diagnosis Required	Medicaid Med Def	Non-Medicaid Med Def
Methadone Administration	Dose	H0020	HF	BLANK, 99	Y	5090	6090
		H0020	HF	H9	Y	5091	6091
Alcohol and/or Substance Abuse Services Not Otherwise Classified	Hour	H0047	HA	BLANK, 99	N	not MCD Billable	7500
		H0047	HA	H9	N	not MCD Billable	7501
		H0047	HA	HD	N	not MCD Billable	7502
		H0047	HF	BLANK, 99	N	not MCD Billable	7503
		H0047	HF	H9	N	not MCD Billable	7504
		H0047	HF	HD	N	not MCD Billable	7505
Alternatives	Hour	A066X	HA	BLANK, 99	N	not MCD Billable	7510
		A066X	HA	H9	N	not MCD Billable	7511
		A066X	HA	HD	N	not MCD Billable	7512
		A066X	HF	BLANK, 99	N	not MCD Billable	7513
		A066X	HF	HA	N	not MCD Billable	7514
		A066X	HF	HD	N	not MCD Billable	7515
Assessment	Hour	H0001	HA	BLANK, 99	Y	5010	6010
		H0001	HA	H9	Y	5011	6011
		H0001	HA	HD	Y	5012	6012
		H0001	HF	BLANK, 99	Y	5013	6013
		H0001	HF	H9	Y	5014	6014
		H0001	HF	HD	Y	5015	6015
Behavioral Health Hotline	Hour	H0030	HF	BLANK, 99	N	not MCD Billable	7520
Behavioral Health Outreach	Hour	H0023	HF	BLANK, 99	N	not MCD Billable	7590
		H0023	HF	H9	N	not MCD Billable	7591
		H0023	HF	HA	N	not MCD Billable	7592
		H0023	HF	HD	N	not MCD Billable	7593
Case Management	Hour	H0006	HA	BLANK, 99	Y	5020	6020
		H0006	HA	H9	Y	5021	6021
		H0006	HA	HD	Y	5022	6022
		H0006	HF	BLANK, 99	Y	5023	6023
		H0006	HF	H9	Y	5024	6024
		H0006	HF	HD	Y	5025	6025
Childcare	Hour	T1009	HA	BLANK, 99	N	not MCD Billable	7630
		T1009	HA	HD	N	not MCD Billable	7631
		T1009	HF	BLANK, 99	N	not MCD Billable	7632
		T1009	HF	HD	N	not MCD Billable	7633
Community Based Process	Hour	A063X	HA	BLANK, 99	N	not MCD Billable	7530
		A063X	HA	H9	N	not MCD Billable	7531
		A063X	HA	HD	N	not MCD Billable	7532
		A063X	HF	BLANK, 99	N	not MCD Billable	7533
		A063X	HF	HA	N	not MCD Billable	7534
		A063X	HF	HD	N	not MCD Billable	7535
Consultation	Hour	A056X	HA	BLANK, 99	N	not MCD Billable	7540
		A056X	HA	H9	N	not MCD Billable	7541
		A056X	HA	HD	N	not MCD Billable	7542
		A056X	HF	BLANK, 99	N	not MCD Billable	7543
		A056X	HF	H9	N	not MCD Billable	7544
		A056X	HF	HD	N	not MCD Billable	7545
Crisis Intervention	Hour	H0007	HA	BLANK, 99	Y	5030	6030
		H0007	HA	H9	Y	5031	6031
		H0007	HA	HD	Y	5032	6032
		H0007	HF	BLANK, 99	Y	5033	6033
		H0007	HF	H9	Y	5034	6034
		H0007	HF	HD	Y	5035	6035
Education (prevention)	Hour	A062X	HA	BLANK, 99	N	not MCD Billable	7550
		A062X	HA	H9	N	not MCD Billable	7551
		A062X	HA	HD	N	not MCD Billable	7552
		A062X	HF	BLANK, 99	N	not MCD Billable	7553
		A062X	HF	HA	N	not MCD Billable	7554
		A062X	HF	HD	N	not MCD Billable	7555
Environmental	Hour	A064X	HA	BLANK, 99	N	not MCD Billable	7560
		A064X	HA	H9	N	not MCD Billable	7561
		A064X	HA	HD	N	not MCD Billable	7562
		A064X	HF	BLANK, 99	N	not MCD Billable	7563
		A064X	HF	HA	N	not MCD Billable	7564
		A064X	HF	HD	N	not MCD Billable	7565

Ohio Department of Alcohol and Drug Addiction Services
Rollup Categories used for Duplicate Claim Checking

HIPAA SERVICE NAME	UNIT OF SERVICE	HCPC/PROCD	Modifier 1 (used in PRULD and MEDEFs)	Modifier 2 (used in MEDEFS)	Diagnosis Required	Medicaid Med Def	Non-Medicaid Med Def
Information Dissemination	Hour	A061X	HA	BLANK, 99	N	not MCD Billable	7570
		A061X	HA	H9	N	not MCD Billable	7571
		A061X	HA	HD	N	not MCD Billable	7572
		A061X	HF	BLANK, 99	N	not MCD Billable	7573
		A061X	HF	HA	N	not MCD Billable	7574
		A061X	HF	HD	N	not MCD Billable	7575
Intervention	Hour	H0022	HA	BLANK, 99	N	not MCD Billable	7580
		H0022	HA	H9	N	not MCD Billable	7581
		H0022	HA	HD	N	not MCD Billable	7582
		H0022	HF	BLANK, 99	N	not MCD Billable	7583
		H0022	HF	H9	N	not MCD Billable	7584
		H0022	HF	HD	N	not MCD Billable	7585
Medical/Somatic	Hour	H0016	HA	BLANK, 99	Y	5080	6080
		H0016	HA	H9	Y	5081	6081
		H0016	HA	HD	Y	5082	6082
		H0016	HF	BLANK, 99	Y	5083	6083
		H0016	HF	H9	Y	5084	6084
		H0016	HF	HD	Y	5085	6085
Problem Id. And Referral	Hour	A065X	HA	BLANK, 99	N	not MCD Billable	7600
		A065X	HA	H9	N	not MCD Billable	7601
		A065X	HA	HD	N	not MCD Billable	7602
		A065X	HF	BLANK, 99	N	not MCD Billable	7603
		A065X	HF	HA	N	not MCD Billable	7604
		A065X	HF	HD	N	not MCD Billable	7605
Referral and Information	Hour	A051X	HA	BLANK, 99	N	not MCD Billable	7610
		A051X	HA	H9	N	not MCD Billable	7611
		A051X	HA	HD	N	not MCD Billable	7612
		A051X	HF	BLANK, 99	N	not MCD Billable	7613
		A051X	HF	H9	N	not MCD Billable	7614
		A051X	HF	HD	N	not MCD Billable	7615
Training	Hour	H0021	HA	BLANK, 99	N	not MCD Billable	7620
		H0021	HA	H9	N	not MCD Billable	7621
		H0021	HA	HD	N	not MCD Billable	7622
		H0021	HF	BLANK, 99	N	not MCD Billable	7623
		H0021	HF	H9	N	not MCD Billable	7624
		H0021	HF	HD	N	not MCD Billable	7625
Meals	Meal	T1010	HA	BLANK, 99	N	not MCD Billable	7640
		T1010	HA	HD	N	not MCD Billable	7641
		T1010	HF	BLANK, 99	N	not MCD Billable	7642
		T1010	HF	HD	N	not MCD Billable	7643
Transportation	Month	A075X	HA	BLANK, 99	N	not MCD Billable	7660
		A075X	HA	HD	N	not MCD Billable	7661
		A075X	HF	BLANK, 99	N	not MCD Billable	7662
		A075X	HF	HD	N	not MCD Billable	7663
Laboratory Urinalysis	Screen	H0003	HA	BLANK, 99	Y	5070	6070
		H0003	HA	H9	Y	5071	6071
		H0003	HA	HD	Y	5072	6072
		H0003	HF	BLANK, 99	Y	5073	6073
		H0003	HF	H9	Y	5074	6074
		H0003	HF	HD	Y	5075	6075
Urine Dip Screening	Screen	A078X	HA	BLANK, 99	N	not MCD Billable	6110
		A078X	HA	H9	N	not MCD Billable	6111
		A078X	HA	HD	N	not MCD Billable	6112
		A078X	HF	BLANK, 99	N	not MCD Billable	6113
		A078X	HF	H9	N	not MCD Billable	6114
		A078X	HF	HD	N	not MCD Billable	6115
MARP	Year	A9999	HA	BLANK, 99	Y	5999	

Services with Medical Definitions in 5000 range will be submitted to ODJFS for Medicaid reimbursement.

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OPLST File Layout (Report 102)

Claims Post Report - New 102 File (8.2)

Field name	Data type	Data Length	Format
BATCH	TEXT	9	
UCI	TEXT	12	
PAT_CONTROL_NUM	TEXT	38	
CLAIMNO	TEXT	16	
PLAN	TEXT	10	
SERVDATE	TEXT	10	MM/DD/YYYY
RECVDATE	TEXT	10	MM/DD/YYYY
CLAIM_AGE	TEXT	3	
PROVIDER	TEXT	5	
PROV_NAME	TEXT	15	
DX1	TEXT	7	
SECURITY	TEXT	1	
PROCCODE	TEXT	8	
MODIFIER	TEXT	2	
PROC_DESCRIPTION	TEXT	28	
QUANTITY	TEXT	6	
BILLED	NUMBER	25	
ALLOWED	NUMBER	25	
ALLOW_REASON	TEXT	5	
COPAY	NUMBER	25	
OTHER_CARRIER_AMT	NUMBER	25	
COB_CODE	TEXT	5	
WITHHOLD	NUMBER	25	
NOTCOVERED_AMT	NUMBER	25	
NOTCOVER_REASON	TEXT	5	
NET_AMT	NUMBER	25	
CLAIMS_STATUS	TEXT	1	
AP_STATUS	TEXT	1	
MEDDEF	TEXT	4	
CLIENT_AGE	TEXT	4	
GLREF	TEXT	3	
HOLD_REASON	TEXT	5	
PANEL	TEXT	3	
MODIFIER2	**TEXT**	**2**	**(Second modifier)**
MODIFIER3	**TEXT**	**2**	**(Third modifier)**
MODIFIER4	**TEXT**	**2**	**(Fourth modifier)**
POS	**TEXT**	**5**	**(Place of Service)**
OFFSET_AMT	**NUMBER**	**25**	
OFFSET_REASON	**TEXT**	**5**	

Crosswalk of HIPAA 835 Reason Codes with Diamond 8+ Reason Codes

Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
AD	ADAPL	CLAIM ADJUSTED DUE TO PROVIDER APPEAL	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA91**	This determination is the result of the appeal you filed	922	CR-Correction and Reversals	Add MA91 Remark Code
AD	ADAUT	CLAIM ADJUSTED DUE TO CHANGE IN AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code	240	CR-Correction and Reversals	
AD	ADCOB	Claim Adjusted For COB	23	Payment adjusted because charges have been paid by another payer.	**MA92**	Missing/incomplete/invalid primary insurance information	554	CR-Correction and Reversals	Change to MA92 Remark Code
AD	ADCOR	Claim Adjusted	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA67	Correction to a prior claim	5,767	CR-Correction and Reversals	
AD	ADERP	CLAIM ADJUSTED DUE TO PROVIDER ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA67	Correction to a prior claim	15,352	CR-Correction and Reversals	
AD	ADERR	CLAIM ADJUSTED DUE TO PROCESSOR ERROR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA67	Correction to a prior claim	3,067	CR-Correction and Reversals	
AD	ADMBR	CLAIM ADJUSTED DUE TO CHANGE IN MEMBER ELIGIBILITY	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage			180,432	CR-Correction and Reversals	
AD	ADWSA	Alcohol/Drug Women-Set-Aside	23	Payment adjusted because charges have been paid by another payer.				CR-Correction and Reversals	
AD	CLINL	CLINICIAN INELIGIBLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			16	PR-Patient Responsibility	
AD	LMBEN	Maximum benefit for this service reached	**119**	Benefit maximum for this time period has been reached			2,888	PR-Patient Responsibility	Change to 119 Reason Code
AD	MCDBA	MEDICAID BILLED AMOUNT CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M54	Missing/incomplete/invalid total charges	2,845	CR-Correction and Reversals	
AD	MCDCR	CLAIM ADJUSTED FOLLOWING MH COMPLIANCE REVIEW	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	2,023	PI-Payor Initiated Reductions	
AD	MCDDU	CONFIRMED MEDICAID DUPLICATE CLAIM (MH ONLY)	18	Duplicate claim/service			13,963	CR-Correction and Reversals	

Bolded items – change effective 7/1/04

Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
AD	MCDIA	MEDICAID CLAIM ADJUSTED (INTERNAL AUDIT) MH ONLY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N10**	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	1,344	CR-Correction and Reversals	Add N10 Remark Code
AD	MCDMO	MEDICAID MODIFIER CORRECTION	4	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M78**	Missing/incomplete/invalid HCPCS modifier	262	CR-Correction and Reversals	Add M78 Remark Code
AD	MCDPR	MEDICAID PROCEDURE CODE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N56	Procedure Code billed is not correct/valid for the services billed or the date of service billed	3,665	CR-Correction and Reversals	
AD	MCDSC	CONFIRMED NOT COVERED DUE TO MH SERVICE CONTENT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N66**	Missing/incomplete/invalid documentation	47	CR-Correction and Reversals	Add N66 Remark Code
AD	MCDTP	MEDICAID THIRD PARTY PAYMENT	23	Payment adjusted because charges have been paid by another payer.	**MA92**	Missing/incomplete/invalid primary insurance information	2,068	CR-Correction and Reversals	Change to MA92 Remark Code
AD	MCDUN	MEDICAID UNITS OF SERVICE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M53	Missing/incomplete/invalid days or units of service	2,648	CR-Correction and Reversals	
AD	MCDWC	CONFIRMED INCORRECT UCI BILLED	**125**	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA61**	Missing/incomplete/invalid social security number or health insurance claim number	910	CR-Correction and Reversals	Current crosswalk did not match original request
AD	MCDWD	CONFIRMED INCORRECT DATE OF SERVICE BILLED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M52	Missing/incomplete/invalid "from" date(s) of service	370	CR-Correction and Reversals	
AD	MCDYO	MEDICAID CLAIM MORE THAN A YEAR OLD WHEN RECEIVED	29	The time limit for filing has expired			3,470	CO-Contractual Obligations	
AD	NEGPA	NEGATIVE PAID AMOUNT	23	Payment adjusted because charges have been paid by another payer.			9,056	CR-Correction and Reversals	
AD	NONBA	NON-MEDICAID BILLED AMOUNT CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M54	Missing/incomplete/invalid total charges	12,174	CR-Correction and Reversals	
AD	NONCR	CLAIM ADJUSTED FOLLOWING MH COMPLIANCE REVIEW	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	115	PI-Payor Initiated Reductions	
AD	NONDU	CONFIRMED NON-MEDICAID DUPLICATE CLAIM (MH ONLY)	18	Duplicate claim/service			12,259	CR-Correction and Reversals	

Bolded items = change effective 7/1/04

Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
AD	NONIA	NONMEDICAID CLAIM ADJUSTED (INTERNAL AUDIT)	**125**	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N10**	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	1,584	CR-Correction and Reversals	Current crosswalk did not match original request
AD	NONMO	NON-MEDICAID MODIFIER CORRECTION	4	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M78**	Missing/incomplete/invalid HCPCS modifier	57	CR-Correction and Reversals	Add M78 Remark Code
AD	NONON	SERVICE NOT INCLUDED IN NON-MEDICAID CONTRACT	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed			861	OA-Other Adjustments	
AD	NONPR	NON-MEDICAID PROCEDURE CODE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N56	Procedure Code billed is not correct/valid for the services billed or the date of service billed	1,725	CR-Correction and Reversals	
AD	NONSC	CONFIRMED NOT COVERED DUE TO SERVICE CONTENT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N66**	Missing/incomplete/invalid documentation	236	CR-Correction and Reversals	Add N66 Remark Code
AD	NONTP	NON-MEDICAID THIRD PARTY PAYMENT CORRECTION	23	Payment adjusted because charges have been paid by another payer.	**MA92**	Missing/incomplete/invalid primary insurance information	3,102	CR-Correction and Reversals	Change to MA92 Remark Code
AD	NONUN	NON-MEDICAID UNITS OF SERVICE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M53	Missing/incomplete/invalid days or units of service	3,797	CR-Correction and Reversals	
AD	NONWC	CONFIRMED INCORRECT UCI BILLED	**125**	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA61**	Missing/incomplete/invalid social security number or health insurance claim number	1,963	CR-Correction and Reversals	Current crosswalk did not match original request
AD	NONWD	CONFIRMED INCORRECT DATE OF SERVICE BILLED	**125**	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M52**	Missing/incomplete/invalid "from" date(s) of service	1,230	CR-Correction and Reversals	Change to 125 Reason Code; Add M52 Reason Code
AD	NONYO	NON-MEDICAID CLAIM MORE THAN A YEAR OLD WHEN REC'D	29	The time limit for filing has expired			1,224	CO-Contractual Obligations	
AD	NPR30	NO PROVIDER RESPONSE WITHIN 30 DAYS	**138**	Claim/service denied. Appeal procedures not followed or time limits not met.			903	OA-Other Adjustments	Change to 138 Reason Code
AD	RWJCF	RWJ Adjust Cap to FFS	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AD	RWJFC	RWJ Adjust FFS to Cap	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AL	DUPOP	POTENTIAL DUP O/P CLAIM	18	Duplicate claim/service				CR-Correction and Reversals	
AL	GRPIN	SYSTEM GENERATED-GROUP INELIGIBLE	**B7**	This provider was not certified/eligible to be paid for this procedure/service on this date of service.				PR-Patient Responsibility	Change to B7 Reason Code

Bolded items = change effective 7/1/04

Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
AL	HIPAA	HIPAA	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.				CR-Correction and Reversals	
AL	INFOR	INFORMATION LINE ITEM	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AL	IPCAR	INPATIENT CARVE OUT	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AL	MARP	CUYAHOGA COUNTY MARP PROJECT	**45**	Charges exceed your contracted/legislated fee arrangement			77	CO-Contractual Obligations	Change to 45 Reason Code
AL	MBDEC	Member Deceased	13	The date of death precedes the date of service			165	CR-Correction and Reversals	
AL	MBRIN	SYSTEM GENERATED - MEMBER INELIGIBLE	26	Expenses incurred prior to coverage			9,959	PR-Patient Responsibility	Critical Error in HIPAA
AL	MCDBA	MEDICAID BILLED AMOUNT CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M54	Missing/incomplete/invalid total charges	2,845	CR-Correction and Reversals	
AL	MCDUN	MEDICAID UNITS OF SERVICE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M53	Missing/incomplete/invalid days or units of service	2,648	CR-Correction and Reversals	
AL	NOAUT	NO AUTHORIZATION ON FILE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**M62**	Missing/incomplete/invalid treatment authorization code	6,096	PR-Patient Responsibility	Add M62 Remark Code
AL	NONBA	NON-MEDICAID BILLED AMOUNT CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M54	Missing/incomplete/invalid total charges	12,174	CR-Correction and Reversals	
AL	NONUN	NON-MEDICAID UNITS OF SERVICE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M53	Missing/incomplete/invalid days or units of service	3,797	CR-Correction and Reversals	
AL	PCCNV	AMOUNT ALLOWED PER CONVERSION	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AL	PCCRT	AMOUNT ALLOWED PER CASE RATE	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AL	PCFSC	Amount Allowed Per Fee Schedule	**42**	Charges exceed our fee schedule or maximum allowable amount			12,011,675	CO-Contractual Obligations	Change to 42 Reason Code
AL	PCMNR	MODIFIER NOT USED FOR THIS PROCEDURE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M78**	Missing/incomplete/invalid HCPCS modifier	2	CR-Correction and Reversals	Add M78 Remark Code
AL	PCMNV	MODIFIER NOT VALID FOR PROCEDURE CODE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M78**	Missing/incomplete/invalid HCPCS modifier	4,460	CR-Correction and Reversals	Add M78 Remark Code
AL	PCMOD	A MODIFIER IS REQUIRED FOR THIS PROCEDURE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M78**	Missing/incomplete/invalid HCPCS modifier	2,359	CR-Correction and Reversals	Add M78 Remark Code
AL	PCPDM	AMOUNT ALLOWED PER DIEM RATE	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code

Bolded items = change effective 7/1/04

Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
AL	PCTBI	SYSTEM GENERATED-PERCENT OF BILLED	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AL	PERD1	PER DIEM DAYS 1 THROUGH 3	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AL	PERD4	PER DIEM DAYS 4 PLUS	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
AL	PRE04	PRE FY04	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.				CR-Correction and Reversals	
AL	PRE2K	CLOSED AS PRE-FY2000 SPAN	B7					CO-Contractual Obligations	
AL	PRE99	SERVICE PROVIDER PRE SFY 1999	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.				CO-Contractual Obligations	
AL	PREGL	PRE GO-LIVE ALLOWED REASON	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.				CO-Contractual Obligations	
AL	PRVIN	SYSTEM GENERATED - PROVIDER INELIGIBLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			412	PI-Payor Initiated Reductions	
AL	SPLUC	SPECIAL LUCAS COUNTY	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
CP	00% SF	0% SLIDING FEE	2	Coinsurance Amount				PR-Patient Responsibility	
CP	05%SF	5% SLIDING FEE	2	Coinsurance Amount			62,037	PR-Patient Responsibility	
CP	10%SF	10% SLIDING FEE	2	Coinsurance Amount			62,623	PR-Patient Responsibility	
CP	100%F	100% CLIENT PAY	2	Coinsurance Amount			15,227	PR-Patient Responsibility	
CP	15%SF	15% SLIDING FEE	2	Coinsurance Amount			39,121	PR-Patient Responsibility	
CP	20%SF	20% SLIDING FEE	2	Coinsurance Amount			35,942	PR-Patient Responsibility	
CP	25%SF	25% SLIDING FEE	2	Coinsurance Amount			21,185	PR-Patient Responsibility	
CP	30%SF	30% SLIDING FEE	2	Coinsurance Amount			22,918	PR-Patient Responsibility	
CP	35%SF	35% SLIDING FEE	2	Coinsurance Amount			13,029	PR-Patient Responsibility	
CP	40%SF	40% SLIDING FEE	2	Coinsurance Amount			14,208	PR-Patient Responsibility	
CP	45%SF	45% SLIDING FEE	2	Coinsurance Amount			10,447	PR-Patient Responsibility	
CP	50%SF	50% SLIDING FEE	2	Coinsurance Amount			10,359	PR-Patient Responsibility	
CP	55%SF	55% SLIDING FEE	2	Coinsurance Amount			7,791	PR-Patient Responsibility	
CP	60%SF	60% SLIDING FEE	2	Coinsurance Amount			8,978	PR-Patient Responsibility	
CP	65%SF	65% SLIDING FEE	2	Coinsurance Amount			7,550	PR-Patient Responsibility	
CP	70%SF	70% SLIDING FEE	2	Coinsurance Amount			7,722	PR-Patient Responsibility	
CP	75%SF	75% SLIDING FEE	2	Coinsurance Amount			5,139	PR-Patient Responsibility	
CP	80%SF	80% SLIDING FEE	2	Coinsurance Amount			8,003	PR-Patient Responsibility	
CP	85%SF	85% SLIDING FEE	2	Coinsurance Amount			6,835	PR-Patient Responsibility	
CP	90%SF	90% SLIDING FEE	2	Coinsurance Amount			12,735	PR-Patient Responsibility	
CP	90W	FFSE FOR ODADAS WOMENS SET-ASIDE PROGRAMS	**23**	Payment adjusted because charges have been paid by another payer.			136,863	CO-Contractual Obligations	Change to 23 Reason Code
CP	95%SF	95% SLIDING FEE	2	Coinsurance Amount			11,183	PR-Patient Responsibility	
CP	CIOOP	Member Coinsurance = 0	2	Coinsurance Amount			667	PR-Patient Responsibility	
CP	COINS	Member coinsurance	2	Coinsurance Amount			59,381	PR-Patient Responsibility	
CP	COPAY	Client copayment	3	Co-payment Amount			6,226	PR-Patient Responsibility	
CP	CPPCP	Primary Care Copayment	3	Co-payment Amount			5,894	PR-Patient Responsibility	
CP	FF10	$10/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF100	$100/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	

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Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
CP	FF125	$125/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF15	$15/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF150	SUMMIT COUNTY FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF175	$175/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF200	$200/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF225	$225/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF25	$25/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF250	$250/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF5	$5/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF50	$50/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	FF75	$75/MONTH FLAT FEE SCALE	3	Co-payment Amount				PR-Patient Responsibility	
CP	MAXED	SYSTEM GENERATED - OOP LIMIT HAS BEEN SATISFIED	**127**	Coinsurance--Major Medical	**N16**	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	944	PR-Patient Responsibility	Change to 127 Reason code; Add N16 Remark Code
CP	MCDDF	NO COPAY APPLIED FOR MEDICAID	3	Co-payment Amount				CO-Contractual Obligations	Change to 3 Reason Code
CP	VERIF	100% COPAY ON NONMCD/NONEMER UNTIL INCOME	3	Co-payment Amount			1,796	PR-Patient Responsibility	
DD	MAXED	SYSTEM GENERATED - OOP LIMIT HAS BEEN SATISFIED	**127**	Coinsurance--Major Medical	**N16**	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	944	PR-Patient Responsibility	Change to 127 Reason code; Add N16 Remark Code
NC	AUTHC	SYSTEM GENERATED - AUTHORIZATION IS CLOSED	**15**	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			32	PR-Patient Responsibility	Change to 15 Reason Code
NC	AUTHD	SYSTEM GENERATED - AUTHORIZATION HAS BEEN DENIED	**15**	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			162	PR-Patient Responsibility	Change to 15 Reason Code
NC	CLINL	CLINICIAN INELIGIBLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			16	PR-Patient Responsibility	
NC	DUPLY	Duplicate Claim	18	Duplicate claim/service			5,883	CR-Correction and Reversals	
NC	DXMIS	NOT COVERED BECAUSE DIAGNOSIS IS MISSING	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid			5,038	CR-Correction and Reversals	
NC	GRANT	GRANT BASED NONMCD FUNDING (100% WITHHOLD)	**145**	Premium payment withholding				CO-Contractual Obligations	Change to 145 Reason Code
NC	INVPC	Invalid Procedure Code/Modifier Combination	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	M78	Missing/incomplete/invalid HCPCS modifier	4,014	CR-Correction and Reversals	Add M78 Remark Code

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Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
NC	LBCLR	LOCAL BOARD CONTRACT LIMITS REACHED	119	Benefit maximum for this time period has been reached			229	PR-Patient Responsibility	
NC	LMARP	LIMIT OF ONE PER ELAPSED YEAR	**119**	Benefit maximum for this time period has been reached	**M90**	Not covered more than once in a 12 month period		PR-Patient Responsibility	Add M90 remark code
NC	LMBEN	Maximum Benefit For This Service Reached	**119**	Benefit maximum for this time period has been reached			2,888	PR-Patient Responsibility	Change to 119 Reason Code
NC	LMDAY	DAY SERVS LIMIT 1 PER DAY	**119**	Benefit maximum for this time period has been reached	**MB6**	Service denied because payment already made for same/similar procedure within	7,666	PR-Patient Responsibility	M63 deactivated; MB6 substitute
NC	LMDIP	AOD DIP SERVICES LIMIT OF ONE PER	**119**	Benefit maximum for this time period has been reached	**M90**	Not covered more than once in a 12 month period		PR-Patient Responsibility	Add M90 remark code
NC	LMEAT	MEALS SERVICE LIMITED TO 3 MEALS PER DAY	119	Benefit maximum for this time period has been reached				PR-Patient Responsibility	
NC	LMMTH	LIMITS BILLING TO ONE PER ELAPSED MONTH (28 DAYS)	119	Benefit maximum for this time period has been reached				PR-Patient Responsibility	
NC	LMOUT	O/P LIMIT 24 HRS/DAY	119	Benefit maximum for this time period has been reached			221	PR-Patient Responsibility	
NC	LMPHA	Par Hosp limit one/day for adults	119	Benefit maximum for this time period has been reached	**MB6**	Service denied because payment already made for same/similar procedure within	3	PR-Patient Responsibility	M63 deactivated; MB6 substitute
NC	LMPHC	Par Hosp limit two/day for children	119	Benefit maximum for this time period has been reached	**MB6**	Service denied because payment already made for same/similar procedure within	52	PR-Patient Responsibility	Add MB6 Remark Code
NC	LMRWJ	MH RWJ CUYAHOGA WAIVER LIMIT	**45**	Charges exceed your contracted/legislated fee arrangement				CO-Contractual Obligations	Change to 45 Reason Code
NC	LMTRS	LIMITS TRANSPORTATION TO ONE PER ELAPSED M ONTH	119	Benefit maximum for this time period has been reached				PR-Patient Responsibility	
NC	MAXED	SYSTEM GENERATED - OOP LIMIT HAS BEEN SATISFIED	**127**	Coinsurance--Major Medical	**N16**	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	944	PR-Patient Responsibility	Change to 127 Reason code; Add N16 Remark Code
NC	MBDEC	Member Deceased	13	The date of death precedes the date of service			165	PR-Patient Responsibility	
NC	MCDBA	CONFIRMED MEDICAID BILLED AMOUNT CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M54	Missing/incomplete/invalid total charges	2,845	CR-Correction and Reversals	
NC	MCDCR	CLAIM NOT COVERED FOLLOWING MH COMPLIANCE REVIEW	**125**	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N10**	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	2,023	CR-Correction and Reversals	Current crosswalk did not match original request
NC	MCDDU	CONFIRMED MEDICAID DUPLICATE SERVICE	18	Duplicate claim/service			13,963	CR-Correction and Reversals	
NC	MCDEL	Member not Medicaid Eligible at time of service	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency			1,290	PR-Patient Responsibility	

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Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
NC	MCDIA	MEDICAID CLAIM ADJUSTED (INTERNAL AUDIT) MH ONLY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N10**	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	1,344	CR-Correction and Reversals	Add N10 Remark Code
NC	MCDMO	CONFIRMED MEDICAID MODIFIER CORRECTION	4	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M78**	Missing/incomplete/invalid HCPCS modifier	262	CR-Correction and Reversals	Add M78 Remark Code
NC	MCDPR	CONFIRMED MEDICAID PROCEDURE CODE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N56	Procedure Code billed is not correct/valid for the services billed or the date of service billed	3,665	CR-Correction and Reversals	
NC	MCDSC	CONFIRMED NOT COVERED DUE TO SERVICE CONTENT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N66**	Missing/incomplete/invalid documentation	47	CR-Correction and Reversals	Add N66 Remark Code
NC	MCDTP	CONFIRMED MEDICAID THIRD PARTY PAYMENT	23	Payment adjusted because charges have been paid by another payer.	**MA92**	Missing/incomplete/invalid primary insurance information	2,068	CR-Correction and Reversals	Change to MA92 Remark Code
NC	MCDUN	CONFIRMED MEDICAID UNITS OF SERVICE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M53	Missing/incomplete/invalid days or units of service	2,648	CR-Correction and Reversals	
NC	MCDWC	CONFIRMED INCORRECT UCI BILLED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA61	Missing/incomplete/invalid social security number or health insurance claim number	910	CR-Correction and Reversals	
NC	MCDWD	CONFIRMED INCORRECT DATE OF SERVICE BILLED	**125**	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M52**	Missing/incomplete/invalid "from" date(s) of service	370	CR-Correction and Reversals	Current crosswalk did not match original request
NC	MCDYO	MEDICAID CLAIM OVER 365 DAYS OLD WHEN RECEIVED	29	The time limit for filing has expired			3,470	CO-Contractual Obligations	
NC	MEDEF	DENIED FOR INVALID MEDEF	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			6,226	CR-Correction and Reversals	
NC	MODFM	MISSING OR INVALID MODIFIER CODE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing	**M78**	Missing/incomplete/invalid HCPCS modifier	118	CR-Correction and Reversals	Add M78 Remark Code
NC	NCSVC	Service/Supply Not Covered	96	Non-covered charge(s)			18,787	PR-Patient Responsibility	
NC	NEGPA	NEGATIVE PAID AMOUNT	23	Payment adjusted because charges have been paid by another payer.			9,056	OA-Other Adjustments	Auto fix in HIPAA
NC	NOAUT	NO AUTHORIZATION ON FILE	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**M62**	Missing/incomplete/invalid treatment authorization code	6,096	PR-Patient Responsibility	Add M62 Remark Code

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Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
NC	NONBA	CONFIRMED NON-MEDICAID BILLED AMOUNT CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M54	Missing/incomplete/invalid total charges	12,174	CR-Correction and Reversals	
NC	NONCR	N-M Adjustment Following MH Compliance Review	**125**	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N10**	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	115	CR-Correction and Reversals	Current crosswalk did not match original request
NC	NONDU	CONFIRMED NON-MEDICAID DUPLICATE SERVICE	18	Duplicate claim/service			12,259	CR-Correction and Reversals	
NC	NONIA	NON-MEDICAID CLAIM ADJUSTED (INTERNAL AUDIT)	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N10**	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	1,584	CR-Correction and Reversals	Add N10 Remark Code
NC	NONMO	CONFIRMED NON-MEDICAID MODIFIER CORRECTION	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M78**	Missing/incomplete/invalid HCPCS modifier	57	CR-Correction and Reversals	Add M78 Remark Code
NC	NONON	SERVICE NOT INCLUDED IN NON-MEDICAID CONTRACT	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed			861	OA-Other Adjustments	
NC	NONPR	CONFIRMED NON-MEDICAID PROCEDURE CODE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N56	Procedure Code billed is not correct/valid for the services billed or the date of service billed	1,725	CR-Correction and Reversals	
NC	NONSC	CONFIRMED NOT COVERED DUE TO SERVICE CONTENT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N66**	Missing/incomplete/invalid documentation	236	CR-Correction and Reversals	Add N66 Remark Code
NC	NONTP	CONFIRMED NON-MEDICAID THIRD PARTY AMT	23	Payment adjusted because charges have been paid by another payer.	**MA92**	Missing/incomplete/invalid primary insurance information	3,102	CR-Correction and Reversals	Change to MA92 Remark Code
NC	NONUN	CONFIRMED NON-MEDICAID UNITS OF SERVICE CORRECTION	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M53	Missing/incomplete/invalid days or units of service	3,797	CR-Correction and Reversals	
NC	NONWC	CONFIRMED INCORRECT UCI BILLED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA61	Missing/incomplete/invalid social security number or health insurance claim number	1,963	CR-Correction and Reversals	
NC	NONWD	CONFIRMED INCORRECT DATE OF SERVICE BILLED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M52	Missing/incomplete/invalid "from" date(s) of service	1,230	CR-Correction and Reversals	

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Diamond Reason
to 835 Adjustment Code Crosswalk

Diamond Reason Category	Diamond Reason Code	Diamond Description	835 Reason Code	835 Reason Code Definition	835 Remark Code	835 Remark Code Description	FY03 Frequency	835 Reason Group	Comments
NC	NONYO	NON-MEDICAID CLAIM IS OVER 365 DAYS OLD WHEN RCVD.	29	The time limit for filing has expired			1,224	CO-Contractual Obligations	
NC	NOQTY	NO UNITS OF SERVICE BILLED	17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M53**	Missing/incomplete/invalid days or units of service	102	CR-Correction and Reversals	Add M53 Remark Code
NC	NPR30	NO PROVIDER RESPONSE WITHIN 30 DAYS	**138**	Claim/service denied. Appeal procedures not followed or time limits not met.			903	OA-Other Adjustments	Change to 138 Reason Code
NC	OOCTY	OUT OF COUNTY NOT COVERED	38	Services not provided or authorized by designated (network/primary care) providers			68,659	PR-Patient Responsibility	
NC	PCINV	Procedure Code invalid or nonspecific	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N56	Procedure Code billed is not correct/valid for the services billed or the date of service billed	213	CR-Correction and Reversals	
NC	STATE	Old claim unheld/denied by State	**29**	The time limit for filing has expired			320	PR-Patient Responsibility	New, not previously mapped
OC	2	BLUE CROSS/BLUE SHIELD	**23**	Payment adjusted because charges have been paid by another payer.			12,181	OA-Other Adjustments	Change to 23 Reason Code
OC	3	OTHER PRIV INS	**23**	Payment adjusted because charges have been paid by another payer.			88,369	OA-Other Adjustments	Change to 23 Reason Code
OC	4	EMPLOYER/UNION	**23**	Payment adjusted because charges have been paid by another payer.			6,181	OA-Other Adjustments	Change to 23 Reason Code
OC	5	PUBLIC AGENCY	**23**	Payment adjusted because charges have been paid by another payer.			66,003	OA-Other Adjustments	Change to 23 Remark Code
OC	6	OTHER CARRIER	**23**	Payment adjusted because charges have been paid by another payer.			67,723	OA-Other Adjustments	Change to 23 Reason Code
OC	9	HARBOR OTHER CARIER	**23**	Payment adjusted because charges have been paid by another payer.			111	CO-Contractual Obligations	Change to 23 Reason Code
OC	E	BENEFITS EXHAUSTED	**22**	Payment adjusted because this care may be covered by another payer per coordination of benefits.			39,281	OA-Other Adjustments	Change to 22 Reason Code
OC	F	NO COVERAGE FOR ANY FAMILY MEMBER	**22**	Payment adjusted because this care may be covered by another payer per coordination of benefits.			187,552	OA-Other Adjustments	Change to 22 Reason Code
OC	L	DISPUTED	**22**	Payment adjusted because this care may be covered by another payer per coordination of benefits.			2,150	OA-Other Adjustments	Change to 22 Reason Code
OC	P	NO COVERAGE FOR THIS MEMBER	**22**	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9,014	OA-Other Adjustments	Change to 22 Reason Code
OC	R	NO RESPONSE FROM INS CO	**22**	Payment adjusted because this care may be covered by another payer per coordination of benefits.			9,118	OA-Other Adjustments	Change to 22 Reason Code
OC	S	NOT COVERED SERVICE	**22**	Payment adjusted because this care may be covered by another payer per coordination of benefits.			1,131,518	OA-Other Adjustments	Change to 22 Reason Code
OC	X	NON-COOPERATIVE MEMBER WITH INSURANCE	**22**	Payment adjusted because this care may be covered by another payer per coordination of benefits.			2,094	OA-Other Adjustments	Change to 22 Reason Code

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Reporting Third Party Insurance on the 837P

Procedures for Reporting Third Party Insurance Information on the 837P

This document is intended to clarify the reporting of third-party insurance and coordination of benefits (COB) on the 837P electronic claim files for MACSIS. These procedures apply to all claims regardless of whether a client is Medicaid eligible or not.

All claims submitted to MACSIS where the client has a third-party insurer are required to contain **Loop 2320** "Other Subscriber Information", **2330A** "Other Subscriber Name" and **2330B** "Other Payer Name".

All required data elements noted in the MACSIS 837 Professional Claim Informational Guide must be valued. For **Loop 2320**, the amount paid by a third-party insurer is reported in **AMT02**. If a third-party insurer denies a claim, does not respond within 90 days or adjudicates the claim payment as zero, then value **AMT02** at zero. No first party (patient) payments should be included in this amount per HIPAA guidelines. If more than one other payer made a payment on the claim, then the amounts should be summed and placed in the first occurrence of **Loop 2320**. Report the most appropriate COB indicator for the summed third-party insurers. Ex., client has a payment of $10.00 with a COB indicator of "2" and a payment of $15.00 with a COB indicator of "3" – sum the amounts ($25.00) and then choose either 2 or 3 as the COB indicator (Loop 2330A). Ex. Client has a payment of $10.00 with a COB indicator of "2" and a $0.00 payment with a COB indicator of "S" – sum the amounts ($10.00) with a COB indicator of "2".

For **Loop 2330A**, the "Other Insured Additional Identifier" (**REF02**) is required if an amount is reported in **Loop 2320**, **AMT02** and vice versa. This identifier equates to the ODJFS third party COB indicators used prior to HIPAA.

Valid values for the third party COB indicator are:

2 – Blue Cross/Blue Shield
3 – A Private Carrier
4 – Employer or Union
5 – Public Agency (Medicare, Worker's Comp)
6 – Other Carrier
R – No Response from Carrier
P – No Coverage for this Recipient Number
F – No Coverage for all Recipient Numbers
L – Disputed or Contest Liability
S – Non-Covered Service
E – Insurance Benefits Exhausted
X – Non-Cooperative Member.

For COB Indicators 2, 3, 4, 5, or 6 Loop 2320, AMT02 must be greater than zero. For COB Indicators R, P, F, L, S, E, or X Loop 2320, AMT02 must equal zero.

EXAMPLES OF THIRD-PARTY INSURER INFORMATION REPORTING USING THE ELECTRONIC 837P

The following segments are required when the member has insurance and a payment has been received.

LOOP 2320 OTHER SUBSCRIBER INFORMATION

SBR*P*18***C1****ZZ
AMT*D*30.00
DMG*D8*19520804*F
OI***Y***Y

S. 79 – Other Payer Paid Amount

LOOP 2330A OTHER SUBSCRIBER NAME

NM1*IL*1*KRACOTO*MITZY****MI*555656666
REF*IG***2**

S. 81 – ODJFS COB Indicator (2 = Blue Cross/Blue

LOOP 2330B OTHER PAYER NAME

NM1*PR*2*BLUE CROSS*****PI*BLUE CROSS

The following segments are required for a member who has third-party insurance but no payment has been received.

LOOP 2320 OTHER SUBSCRIBER INFORMATION

SBR*P*18***C1****ZZ
AMT*D*0.00
DMG*D8*19520804*F
OI***Y***Y

S. 79 – Other Payer Paid Amount

LOOP 2330A OTHER SUBSCRIBER NAME

NM1*IL*1*KRACOTO*MITZY****MI*555656666
REF*IG***S**

S. 81 – ODJFS COB Indicator (S = Non-Covered

LOOP 2330B OTHER PAYER NAME

NM1*PR*2*ANTHEM*****PI*ANTHEM

ODADAS - ODMH
Guidelines Pertaining to the Implementation of MACSIS under HIPAA
Effective July 1, 2003
Last Updated January 27, 2005

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INTRODUCTION

These Guidelines contain information related to the Multi-Agency Community Services Information System (MACSIS) and should be used in conjunction with the detailed information found in the Claims and Member manuals. Boards and providers should review this information carefully so that timely and accurate reimbursement can be made.

If there are questions about these guidelines, please contact the MACSIS Support Desk at: 614-466-1562 or 1-877-462-2747.

GUIDELINE UPDATING

These guidelines may require periodic additions and changes as a result of policy development, and or changes in State and Federal laws. All policy communication should be reviewed by the originator to determine if there are any impacts to these guidelines. If there are implications, the originator should email changes to the guidelines by completing information required in the Revision History and any supporting documentation to be included in the guidelines to MacsisSupport@mh.state.oh.us concurrent with distribution of the policy communication. These updates will be recorded in the Revision History portion at the back of these Guidelines and will include the Change, Section Revised, Date of Revision and the person or entity authorizing the change.

GENERAL

1. Topic: Change Control Procedures

This topic documents the steps needed for requesting or initiating system changes and the procedures for initiating the changes.

A. General Information

The MACSIS Operations Management (MOM) Team will be used as the primary gatekeeper for approving and monitoring system build changes and related procedures to ensure compliance with Medicaid and other State and Federal rules and requirements. Such changes fall into categories relating to member and benefits within Diamond, as well as changes to existing schedules and policies for claims electronic data interchange (EDI), accounts payable update (APUPD), and data extracts/reports.

All change requests must be submitted via email to MacsisSupport@mh.state.oh.us.

Requests received by close of business on Friday afternoons will be discussed at the next MOM meeting, typically held every Tuesday from 8-10 am. The email request must contain all requisite information needed to evaluate and implement the changes as outlined below **in bold typeface** for each type of change. For the most part, changes to the Diamond build will be entered into the system by State staff based on information received from the requesting board.

Most changes can be accommodated with a 30-day notification; unless the change impacts other boards or is so complex that additional time is needed (e.g. adding a new plan or changes to benefits). Those keywords that boards can change without prior notification are also listed under the appropriate change category.

Requests for types of changes not listed below should be sent to MACSIS Support for evaluation.

B. Changes to Diamond Files

1. *Membership*

- Adding a New Panel: Boards may add new panels without prior notification to the State. Panel naming conventions can be found in the MACSIS Naming Conventions document. Boards will need to add the new panel code to Diamond Keyword PANEL, and also create a new group/panel affiliation (GRUPP) record for each group and panel. **Boards should notify MACSIS Support of changes made since member reports are distributed by PANEL and State staff will need to add the new panel to the distribution list. Additionally, boards will need to build new Non-Medicaid provider contracts (PROVC) for the new panel(s) and must supply the necessary documentation for the State to build the Medicaid contracts.**
- Adding a New Affiliation Code: Boards need to request the addition of a new code. Use of affiliation codes must comply with HIPAA regulations and can only be used when the information is essential to paying a claim. **The request should list the business reason for adding a new code and a recommended 5-character code.**
- Adding a new Plan Code: Boards need to request the addition of a new plan code (PLANC) code. This type of addition is a very complex build change and should be requested only after all other possible avenues have been explored to meet the business need. Changes and additions to general ledger assignments (GLASS), general ledger references (GLREF), benefit packages and rules (BENEF, BRULE) and group detail (GRUPD) are required when a new plan is added, and extensive claims testing must also occur to ensure that claims adjudicate properly. **Boards will need to submit comprehensive documentation outlining the business need for such a substantial change, and will also need to work with State staff in determining the changes needed for the ancillary keywords mentioned above.** Adding a new plan actually requires two new plan codes, one for Medicaid and one for Non-Medicaid. This type of change requires 90 days notice, and will be implemented only twice per year for the following January 1 or July 1 start date. No retroactive changes can be made. Please refer to the Benefit Packages section below for additional information and requirements. Once the build is complete, boards will be required to manually move and enter clients into the new plan; the State cannot move clients electronically into a new plan due to limitations in the nightly member update programs.

2. *Implementing Rider Codes*

Boards that need to implement the use of rider (RIDER) codes to control benefits can do so by creating the necessary group premium detail (GRUPD) records. Please note that actually

triggering the rider codes is accomplished through the use of Benefit Rules thus **boards will also need to follow the procedures outlined below for BRULEs**. The new rider codes must be manually added to the member record. There is no need to terminate the old span and open a new span with the new rider code since the rider will be effective as of the date entered into the BENEF package.

3. ***Diamond Reason Codes***

Boards need to request the addition of a new code. The request should indicate the reason code type, recommended 5 character codes, the business reason for the change, and the recommended corresponding 835 Health Care Claim/Payment Advice claim adjustment reason category and code.

4. ***Diagnosis Codes***

Diamond contains the 647 ICD-9-CM (International Classification of Diseases, Version 9, Clinical Modification) diagnosis codes approved by Ohio Department of Job and Family Services (ODJFS) for Medicaid billing. These codes can only be changed by State staff when notified by ODJFS of adjustments made at the State or Federal level. See the list of MACSIS Behavioral Health ICD-9-CM Codes Considered for Payment under HIPAA, Health Insurance Portability and Accountability Act of 1996, (http://www.mh.state.oh.us/ois/macsis/codes/bhcare.icd9cm.codes.payment.hipaa.pdf) for a complete list.

5. ***Benefits***

- Adding/Changing Benefit Rules: Boards need to request additions and changes to benefit rules (BRULE). Typical changes include adding a rider code, applying or removing a copay or coinsurance, denying services, holding claims for some services, and limiting the quantity or dollar amount of services. **Boards should submit a request that describes the intent of the rule and provide a name for the rule that follows the naming conventions found in the MACSIS Naming Conventions document. A comprehensive list of all the medical definitions and appropriate rider codes that will be covered by the rule must also be submitted, along with the effective date of the new rule and the termination date of any old rules if applicable**. Adding a new rule requires 30 days notice due to the extensive testing needed, and will be implemented only twice per year for the following January 1 or July 1 start date. No retroactive additions or changes can be made.
- Terminating a Benefit Rule: Boards need to request the termination of a rule. This process is less complex than adding or changing rules so **the email only needs to include the rule name and the termination date, which cannot be retroactive**. Rules can be terminated without 30 days prior notice and such a change is not restricted to January or July.

C. Changes to Claims EDI

1. *Changes in Provider Software:*

Boards must follow the MACSIS HIPAA EDI Claims File Testing and Approval Policy and Procedure, Tier 1 and Tier 2 testing (http://www.mh.state.oh.us/ois/macsis/claims/hipaa.edi.claims.file.test.policy.pdf and http://www.mh.state.oh.us/ois/macsis/claims/procedure.submit.macsis.hipaa.edi.claim.file.pdf), for any providers who upgrade or change claims processing software before submitting production claims files. The test file submitted should contain sufficient claims to ensure that all contracted procedure codes are pricing and adjudicating correctly.

2. *Changes to Production Claims Reports:*

With the exception of the Outpatient List Report (OPLST, 102), all Edit and Post reports are Diamond proprietary formats and cannot be changed. For changes to the 102 report, please refer to Section D below.

3. *Changes to Production Claims Schedule:*

To request a second production run during the week, or permanently change the scheduled date or time, **a request should be sent to MACSIS Support indicating the adjustment needed. Requests for claims runs outside of the normal time period will be accommodated based on volume for the week.** Every attempt will be made to reschedule a run, however high volume weeks may preclude a second run due to system resource limitations.

D. Changes to Extracts and Reports

All change requests should be submitted to MACSIS Support. **Include the file/report name and specify in detail the proposed changes.** Since any adjustments to file structures will affect all boards, MOM will evaluate the change and determine which user groups must be involved in the decision to accommodate the requested change. Typically, volunteers from the appropriate committees will be solicited to meet or confer via phone in order to evaluate the impact and efficacy of the change being requested.

CLIENTS

2. Topic: Clients Enrolled and Services Reported in MACSIS

MACSIS is a Client Centered information system. Only those clients receiving behavioral health services funded **in whole** or **in part** with public funds administered through the boards will be enrolled in MACSIS.

Boards are responsible for assigning clients enrolled in MACSIS a Unique Client Identifier (UCI). Providers must have a valid UCI for public clients to receive payment or credit for services provided.

Pseudo Client Identifiers are available for non-client specific services and are addressed in Topic 44 of this document. MACSIS can ONLY receive data for clients that have been enrolled.

3. Topic: New Member Enrollment/UCI Request Process

A standard Member Enrollment Form can be used to initiate enrollment for a client in MACSIS. This statewide standard form (http://www.mh.state.oh.us/ois/macsis/forms/new.member.enrollment.pdf) includes the maximum number of data elements which can be collected at enrollment.

Boards may choose to design their own enrollment forms but must adhere to the following guidelines:

- No data element beyond what is stored in the MACSIS Member Data File can be collected on any MACSIS enrollment form, with the exception of questions designed to prompt the provider to ensure the proper procedures are being followed in their office.
- Boards must accept the State standard form or any other board's form from any provider (in-county or out-of-county) as long as the required data elements are completed on the form, the data has been verified by the provider for accuracy, the data elements are in the standard form order and the form is legible. This includes accepting forms which are system-generated and meet the preceding criteria. See Member Enrollment Form Completion Instructions for further details about what data elements are required and when (http://www.mh.state.oh.us/ois/macsis/forms/mbrfrmin.pdf)
- Boards may refuse to process an enrollment form where a required data element is not labeled or valued on the form (i.e., null or blank value). Simply leaving a data element off a system-generated form or leaving a value blank will not be interpreted as a "no" or completed response. Providers must label and value every required field. If the enrollment form indicates that the client is in crisis (i.e., the "In crisis at enrollment?" is marked "Yes"), then the provider must at a minimum provide the client's last name, first name, gender (best guess) and real or "default" date of birth. Every attempt should be made by the provider to subsequently obtain the required information.
- Boards cannot require a provider to mail an enrollment form, if a faxed copy is legible. However, they can require the provider fax the enrollment form to a confidential fax number, if the number is made available to the provider in advance.
- Providers must complete the physical address where the client is residing on the enrollment form, but the "county" should be the legal county of residence. The Residency Verification Form (http://www.mh.state.oh.us/ois/macsis/policies/rdd/macsis001.pdf) should be used to communicate further legal county of residency information, if different.
- Required data elements will be flagged with an "asterisk" on the Standard MACSIS Enrollment Form and will appear in the required order. Boards are encouraged to similarly flag the standard required data elements on their forms with an "asterisk" for clarity and consistency. Please note that some data elements are only required if specifically stated in the board/provider contractual agreement. The latter data elements will not be marked with an "asterisk".

4. Topic: Confidentiality

The following state and federal laws address confidentiality and related notice requirements imposed upon Providers, Boards, ODADAS and ODMH in conjunction with their roles in the public community mental health system:

- Ohio Revised Code (ORC) Chapter 1347 applies to State and local agencies that deposit personally identifying information into a database. The statute mandates notice to persons whose data is input into the system, and adoption of measures to protect the confidentiality and integrity of information input into the system.
- ORC 5122.31 (see also Ohio Administrative Code, OAC 5122-27-08), imposes limitations on the disclosure of personally identifying information relating to a recipient of mental health care or treatment.
- 42 Code of Federal Regulations (CFR) Part 2 (Re: Alcohol or Drug (AOD) Confidentiality)

  AOD Policy – Consent for Release of Information

  - Federal law (42 CFR 2.12 (d)(2)) requires releases of information relating to AOD treatment (with limited exceptions)
  - Notice regarding prohibition on re-release of information also required
  - **Requires client signature**
  - Applicable to AOD treatment/services

- 45 CFR Part 164 (HIPAA) imposes limitations on the use and disclosure of protected health information. HIPAA applies to health plans, clearinghouses and health care providers, and, through mandated contracts, their business associates.

5. Topic: Sliding Fee Scales and Co-Payments

The purpose of this guideline is to establish business rules and specify procedures for the assessment of consumer fees and appropriate billing for services to members whose adjusted annual income and number of dependents fall within the fee scale established by the local Board. With the implementation of MACSIS, sliding fee scale is referred to as co-insurance. Co-payments refer to flat-rate minimum fees and residential fees.

A. Sliding Fee (Co-Insurance)

- MACSIS will be used to capture the patient sliding fee percentage (referred to in MACSIS business rules as co-insurance). When claims are processed through MACSIS, the percentage share to be paid by the member will be calculated based on the allowed amount, deducted from the total billed amount and the net amount will be paid by the board. It is the provider's responsibility to collect the balance from the client. Sixteen (16) rider codes (A - S) have been set aside for sliding fee. These rider codes correspond to 5% increments beginning with five (5%) and ending with 95%. A single rider code (A – S) will be attached to the client and to a benefit rule for each **non-Medicaid reimbursable service**. An additional rider code (Z) has been created when a client is responsible for 0% (i.e. Board pays 100%).

- If/when a client's status changes, such that it changes the appropriate sliding fee scale percent, the rider code will need to be updated. This must be done manually by the Board with a new effective and termination date.
- All enrolled clients should have a sliding fee percentage (i.e., rider code) assigned (e.g. data collected includes family size and income). Not only is there the possibility of a client's eligibility moving from Medicaid to non-Medicaid but Medicaid does not pay for all services. Therefore, by design, a Medicaid client can receive non-Medicaid eligible services. The sliding fee can be applied to any non-Medicaid eligible service although there are many cases were clients are eligible for 100% reimbursement.
- Per ORC 340.03 (9), each board will establish its own sliding fee scale.
    - Since a client can only have one effective rider code associated with a sliding fee or copayment, a board must implement a uniform fee schedule with all contract agencies.
- Processes should be developed to update clients' sliding fee percentages routinely. Untimely processing may result in clients' rights issues.
- Sliding fee amounts and/or copayments (see below) should not be deducted from the claim billed amount. Since the client amounts due are calculated in MACSIS, deducting the amount in advance could result in a double deduction.

B. Co-payments (minimum fee)

MACSIS could be used to compute co-payments. When claims are processed through MACSIS, the flat-rate amount to be paid by the member will be deducted from the total billed amount, and the net amount will be paid by the Board. It is the provider's responsibility to collect the balance from the client. MACSIS can compute monthly co-pay fees through the use of up to 16 rider codes. *For example: a Board could determine that it wants the increments to begin with $10 and end with $550.* The appropriate rider code (1 - 9 and T - Z) will be attached to the client and to a benefit rule (BRULE) for each **non-Medicaid reimbursable service**.

6. Topic: Removal of Client Data from MACSIS

The purpose of these guidelines is to establish the criteria and process for removing protected health information (PHI) from MACSIS, Mental Health (MH) Outcomes and the Behavioral Health Module and to establish ODMH, ODADAS and board responsibilities.

A. Conditions

The following matrix illustrates various scenarios of when it is and is not permissible under applicable federal and state statutes and policies for the State to delete protected health information (PHI) from the ODMH and ODADAS systems.

Scenario	Delete	Comments
Client enrolled but has no claims	Yes	Follow process below
Client has received services(s) paid in whole or part with public funds	No	Information needs to be maintained in accordance with Business Records retention schedule
Client has received services but they have NOT been paid in whole or part with public funds.	Yes	MACSIS Guidelines – Topic 2 indicates that only those clients receiving services funded in whole or in part with public funds administered through the boards will be enrolled in MACSIS.

B. Process

The MACSIS Support Desk, hereinafter referred to as State, will timely process requests submitted by the board to remove client information from MACSIS.

Documentation to substantiate request to remove client information should be maintained at the local level (board and/or provider) and not routinely submitted to the State. The State reserves the right to request information as necessary to timely process the request.

Boards or providers can initiate a request on behalf of the client by completing the Request to Remove Client from MACSIS form. Reason for request must be documented and approved by board prior to submission to the State. Board approval process should include but not be limited to the following:

- Exploration to assure client has not received services paid in whole or part with funds administered through requesting board. Board should verify this by checking to make sure that a net amount of zero is not the result of benefit rules, rider codes or 100% withhold (i.e. clients served in Women's Set-Aside Grant Program shall not be submitted for deletion).

State will verify client has not received services in other boards areas

If MACSIS has claims paid by a board other than from the requesting board then the State will work with those board(s) prior to removing client from database to assure services were not funded in whole or part with public funds (i.e. even if netted to zero)

State will take action to remove member and claims information from the MACSIS on-line system. Information archived (on-line) or on back-up tapes will not be modified.

State will take action necessary to remove client information from Outcomes database.

Board(s) will be responsible for notifying provider of action taken by State.

Provider(s) must submit a delete record to ODADAS in accordance with Behavioral Health Instruction Manual to delete client information from BH module.

Boards and providers should take necessary action to remove client information from local databases and files.

7. Topic: County of Residence

Residency issues will be governed by the ODMH and ODADAS definitions as incorporated in the Guidelines and Operating Principles for Residency Determinations Among CMH/ADAS/ADAMHS Boards (http://www.mh.state.oh.us/ois/macsis/mac.pol.rdd.html).

8. Topic: Residency Guidelines

1. The purpose of these guidelines and operating principles is to clarify what is to take place, in terms of Board responsibilities and residency determinations, when clients seek services outside their service district of residence.
   a. Nothing contained in this document should be interpreted to reduce in any way the obligation of Boards set forth in ORC Section 5122.01(S) to deal with crisis/emergency situations which occur within their service districts and to respond to essential client service needs while residency questions are being resolved.
   b. Regardless of residency determination, nothing contained in this document should be interpreted to constrain the freedom of clients to seek services wherever they wish. Rather, it is intended to clarify which Board is to deal with such requests and under the auspices of which Board's Mutual Systems Performance Agreement – M-SPA (i.e., the Community Mental Health Plan) they are to be considered.
2. For the purposes of MACSIS, the county of assigned residency determines into which Board's service system (i.e. group and plan) an individual is to be enrolled. In special circumstances, a client may live in a Board area which differs from that to which residency/enrollment has been legitimately and appropriately assigned.
3. A fundamental tenet that is to guide residency policy and its interpretation is that continuity-of-care is paramount and that responsibility to ensure this in instances of out-of-district placement or referral should rest ultimately with the "home" Board from which the client came. A Board should not be in a position to shift this responsibility by facilitating the relocation of clients to facilities or services which lie outside its service district. The "home" Board to which a client's residency is assigned should carry the following responsibilities (some of which may be delegated to another entity):
   a. Assuring reasonable client access to the services called for in the Board's M-SPA in a fair and equitable manner.
   b. Enrolling eligible persons in its benefit plans in accordance with the applicable business rules and providing for the provision and management of these benefits.
   c. Serving as the local authority for funding, contracting, coordinating, monitoring, and evaluating services. These responsibilities include clinical oversight and utilization review responsibilities as authorized by Chapters 340 and 5122 of the Ohio Revised Code.

d. Providing the necessary financial resources (to the extent such resources are available to the Board).

e. Taking the initiative to negotiate and implement workable solutions when problems involving residency arise.

4. Residency determinations are to be based upon the following:

   a. For mental health clients, the statutory provisions contained in ORC 5122.01(S), which read as follows:

      "Residence" means a person's physical presence in a county with intent to remain there, except that if a person (1) is receiving a mental health service at a facility that includes nighttime sleeping accommodations, residence means that county in which a person maintained his primary place of residence at the time he entered the facility, or (2) is committed pursuant to section 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residence means the county where the criminal charges were filed.

   b. For alcohol/drug clients, the definition of residency established by ODADAS, which reads as follows:

      "Residence means a person's physical presence in a county with intent to remain there, except that, if a person is receiving alcohol or other drug addiction services from a program that includes nighttime sleeping accommodations, residence means that county in which the person maintained his/her primary place of residence at the time he/she entered the program."

5. All policies involving residency-related issues are to be consistent, whether mental health or alcohol/drug issues are involved. There are not to be differing residency determinations/assignments depending upon the nature of the diagnosis, type of service, or sources of financial support. Accordingly, ODMH and ODADAS shall adhere to a policy of reciprocity, wherein each shall defer to the other in the determination of when residency remains with a "home" Board because of a client's placement in a special residential program or facility or because of other unusual circumstances.

6. The provisions of ORC Section 5122.01(S) and the ODADAS definition of residency shall be construed to apply to all specialized residential programs or facilities in which clients are placed because of their need for treatment, supervision/support, or other specialized services, with this principle to be defined and operationalized as follows:

   a. A primary criterion for what constitutes a specialized residential program or facility shall be that it is subject to licensure (or some comparable certification).

   b. The type of facilities encompassed includes hospitals, nursing homes, ODMH-licensed and ODADAS certified residential facilities, Ohio Department of Health (ODH) licensed Adult Care Facilities, mental retardation group homes, Intermediate Care Facilities for the Mentally Retarded (ICF/MR's), rest homes, drug/alcohol residential programs, crisis shelters, foster-care homes, etc.

   c. The term "mental health services" is to be construed broadly to encompass all those items contained in OAC 5122-25-02(B) and ORC Section 340.09 and the term "alcohol or other

drug addiction services" shall include all those alcohol/drug services identified in OAC 3793:2-1-08 through 17.

d. The phrase "receiving (MH or AOD) services at a program/facility" is to be understood to mean "while on the rolls of the program/facility." It is not necessary either for the services to be provided "on the premises of the program/facility" or "by an employee of the program/facility." Likewise, it is not necessary for said services to be officially certified for the purposes of residency determination.

e. There is to be no "statute of limitations" on designated residency remaining with the "home" Board for persons placed in specialized residential programs/facilities that lie outside its service district.

f. Designated residency shall remain with the "home" Board regardless of whether it was directly involved in facilitating placement in an out-of-district specialized program/facility.

g. Residency shall not remain with the "home" Board in those situations where a client is placed for an indefinite period in a facility for reasons having nothing to do with mental health or alcohol/drug needs and then develops such problems subsequent to placement. However, no discharge directly from a state hospital to a facility shall cause a change in residency, regardless of the reasons for the discharge.

7. The interpretation of the provisions of ORC Section 5122.01(S) and the ODADAS definition of residency in regard to "intent to remain" shall be guided by the following:

a. "Intent to remain" is to be interpreted to mean a person's expressed intent, **as documented by completing and signing the Residency Verification Form,** to remain in the county, with the exception of persons in specialized treatment facilities. There can be no intent to remain when a person is visiting, transient or present in a county for only a time-limited specific purpose. The Residency Verification Form should be completed when:

1) The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county)

2) The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (ex. domestic violence shelter case, client temporarily living with relatives, etc., child or adult, out-of-county)

3) The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county)

b. Boards may request from in-county, contracting providers one of the following forms of documentation that is current to assess whether a person's actions demonstrate intent to be a resident. The contract between a provider and board may dictate the form of documentation required for cases not outlined in section 7.a. above.

1. mailing address
2. voting
3. car registration
4. job or other vocational efforts

5. payment of taxes
6. location of family
7. general conduct.
8. signed Residency Verification Form (http://www.mh.state.oh.us/ois/macsis/policies/rdd/macsis001.pdf)

- Where a client lacks the capacity to communicate clearly or is unwilling to state an intent (and there is no compelling evidence to think otherwise), it shall be assumed that the client intends to remain in the service district he/she is currently located.
- Boards and their agents are not to be involved in efforts to coerce or unduly influence client intent vis-à-vis residency.
- For out-of-county, non-contracting providers, a signed Residency Verification Form shall suffice as proof of residency.

8. Residency for children is to be determined by the residency of the parents (or guardian) and should change when the parents move (even when this occurs in the middle of a hospitalization or residential placement). When temporary or permanent legal custody of a child has been awarded to some other official entity (such as a Children Services Board (CSB), Ohio Department of Youth Services (ODYS), etc.), residency should remain with the "home" Board of the county where the court which ruled maintains jurisdiction. **Completion and signing of the Residency Verification Form shall provide residency documentation for children.**
   a. This guideline is not intended to resolve boundary issues between the responsibilities of Boards versus those of CSB's, juvenile courts, ODYS, etc.. Rather, it is intended to clarify that it is the responsibility of the "home" Board to work through such matters for its clients.
   b. Persons with handicapping conditions who consequently may remain in the custody of a CSB, etc., through their 21st year shall be considered to be children for the purposes of these guidelines.
9. The interpretation of these residency provisions for children is to be guided by the provisions of ORC Sections 3313.64(A)(1 and 4), 3313.64 (C)(2), and 2151.35, which deal with the determination of local responsibility within the educational system.
10. For clients committed pursuant to ORC Sections 2945.38, 2945.39, 2945.40 2945.401 [2945.40.1], or 2945.402 [2945.40.2] of the Revised code, residency shall remain with the Board of the service district in which the charges were filed only for as long as the client remains in a forensic status. If and when the client's status reverts to a civil commitment, at that point the client's residency shall be changed to that to which it would be for non-forensic clients (i.e. the "home" Board from which the client originally came). For those clients who may be in a non-hospital setting when their commitment status changes, residency should be determined by type of facility and/or intent, depending upon the circumstances. When residency shifts because of a change in forensic status, the Board from which residency is being shifted is to give timely notice to the new Board of residency.
11. Where special circumstances, such as result from unusual geographic boundaries, create situations where the applicability of the residency criteria in the law may be especially

problematic, the Boards involved may negotiate a "Memorandum of Understanding" as to how various issues will be addressed, rather than repeatedly disputing individual cases.

12. A Board (directly or through its contract agencies) may receive requests for services from a client whose residency rests with the Board of another service district (with this encompassing clients involved in emergencies while away from home, clients wishing to travel to receive non-emergency services from a provider in another district, and clients placed in a specialized residential facility who seek additional services beyond that which the facility itself may provide). Such requests for services from non-residents should be dealt with as follows:

    a. Emergency/crisis situations are to be addressed by the Board and/or designated agency where the crisis occurs, regardless of the client's official residency assignment.

        1. To the extent that commitment/probate matters may be involved in addressing the crisis, the Boards involved shall be guided by item #10 (page 14) of this guideline.

        2. For mental health, non-Medicaid services, the board providing the service is responsible for crisis intervention services up to three days.

           For ODADAS, non-Medicaid services out of county/ emergency/ clinically appropriate services are the Level I services (Assessment, Individual Counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Urinalysis; (Lab analysis of specimens for presence of alcohol and/or drugs), Medical/Somatic, Methadone Administration and Intensive Outpatient services) plus Level III and Level IV ambulatory detoxification services provided for three days or until linkage to treatment is established in the "home county". If out of county treatment is to extend beyond three days, the out of county placement must be approved by the home board. It is essential collaborative efforts be made between providers and Boards to establish arrangements for a client's continued care.

        3. When an enrollee of a Board receives crisis services [as defined above in paragraph (2)] outside his/her service district and under the auspices of another Board's service system, financial responsibility for these crisis services shall be borne by the Board in which the client is enrolled. The rate for said services shall be that contained in the contract of the local Board under whose auspices the services are being provided.

        4. A Board which is providing crisis/emergency services for an individual who is enrolled in another Board's plan shall contact that other Board (or its designee) within one business day, to notify it that one of its members is involved in a crisis situation and to consult on the disposition of the case.

            a. The Board in which a client is enrolled shall have no financial responsibility for the provision of out-of-district crisis services beyond three days without its concurrence. In the event it is anticipated that the three-day limit shall be exceeded, the Board/agency involved in the provision of crisis services to an out-of-district party shall be responsible for contacting the Board of residency/enrollment to establish appropriate arrangements for payment or to provide for the orderly transfer of the client to a provider selected by the home Board.

            b. Services other than emergency/crisis services and Medicaid-billable services should remain the sole responsibility of the "home" Board of residency, with this

responsibility understood to encompass the items listed in section #2 of this document.

c. The Chief Clinical Officer (or designee) of the "home" Board should be responsible for determining what services may be clinically necessary and appropriate for an individual seeking services outside of his/her "home" district. The "home" Board should bear ultimate responsibility for overseeing and supporting the provision of appropriate out-of-district services (to the extent they are approved as being consistent with the Board's M-SPA and sufficient financial resources are available).

d. For non-Medicaid services, a Board may have "preferred providers" (i.e. its contract agencies) and expect residents seeking Board-subsidized services to use these organizations.

e. Non-emergency services may be provided to out-of-district clients by either the "home" Board of residence or the Board from which the client is seeking services. However, no Board should be expected or assumed to provide ongoing, non-emergency services to out-of-district clients without its explicit consent and without a mutually agreeable reimbursement mechanism having been negotiated. All Boards should adopt official policies and procedures which layout how it will respond to requests of its residents who seek services outside the Board's service district.

f. Anytime a severely mentally disabled (SMD) client is placed in an out-of-district residential facility with the involvement of the public community mental health system, the "home" Board should notify the Board where the facility is located and work out matters of service coordination and continuity-of-care.

g. Contract agencies are free to serve whomever they wish with funds other than those provided pursuant to a contract with a Board.

13. A person incarcerated in an out-of district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support Board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary re-assignment of a jail inmate to a plan of the local Board may be effected. Upon release from the jail facility, the plan assignment shall revert to the original Board of residence.

14. Residency disputes are to be addressed as follows:

a. Ultimate responsibility for resolving residency disputes shall rest with ODMH and ODADAS, whose decisions shall be binding.

b. ODMH and ODADAS shall officially adopt and distribute these "Guidelines and Operating Principles" (along with any subsequent modifications), with the explicit understanding that they are to be followed in the determination of residency.

c. Boards are expected to work out routine questions of residency among themselves without resorting to an official dispute resolution process.

d. As the initial step in the formal dispute resolution process, the Board which believes that an individual's residency has been inappropriately determined is to contact the Board it believes is the proper Board to which residency should be assigned. This is to be done in writing and,

unless there are extenuating circumstances, is to take place within ten working days of the time a Board first becomes aware that a residency assignment may need to be questioned.

e. After receipt of the written statement initiating the residency dispute process, the two Boards shall have five additional working days to agree upon the appropriate residency designation. If the matter remains unresolved, either Board may refer the matter to ODMH or ODADAS (depending upon the circumstances) for final resolution. This shall be done in writing and shall occur immediately upon expiration of the five working days during which the Boards are to attempt to resolve the matter between themselves. The Director of ODMH/ODADAS (or his/her designee) shall make a final determination about residency within ten additional working days, during which time the Boards involved in the dispute and other relevant parties (including, where appropriate, the client) are to be contacted. A written determination, including the rationale for the decision, is to be provided to both Boards.

15. While residency questions are being resolved, essential client services are to be maintained, with the primary responsibility for this to rest with the Board from whose system an individual is receiving services. As part of the resolution of a residency dispute, it shall be determined which Board shall be responsible for the costs of treatment services provided during the period of the dispute. In cases where the appropriate state agency determines that a Board other than the Board which paid for the services is the appropriate Board of residence then the Board which paid for the cost of service will invoice the Board of residence. The Board of residence will be expected to pay the Board of service within a reasonable amount of time.

    [For Medicaid purposes only, while the residency dispute process is taking place, the automatic contracting and payment of Medicaid reimbursable services is not to be interrupted or delayed in any way. This is to say that no changes are to be made to the MACSIS "plan" the client is enrolled in, Medicaid reimbursable services are to be continued to be provided and paid for and, if necessary, the "Secondary" Medicaid Contract is to be established within the 30-day limit. For MACSIS purposes, ODMH/ODADAS reserve the right to take any action deemed necessary to assure this process is strictly adhered to.]

16. No Board is to alter an individual's residency/plan assignment within MACSIS without the explicit approval of the other affected Board or a formal ODMH/ODADAS resolution of a residency dispute. (Normal practice should be for the receiving Board to effect a residency change in MACSIS.)

17. Nothing in this document should be interpreted as precluding two Boards from effecting a transfer of residency responsibilities when they mutually determine this to be in the best interest of a client.

    a. These guidelines deal only with inter-Board residency issues and are not intended to address situations where individuals may be placed or seek services across state lines. It is felt that the issues involved are enough different to warrant separate consideration.

A. Guidelines to be used in determining the county of residency for College Students, Homeless Clients, Migrant Workers and Out-of-State Clients.

Please note: these guidelines address county of residency determinations for MACSIS enrollment/plan/panel assignment and not State Hospital county of residency issues.

1. ***College Student Guideline***

As referenced in item #8 (page 14) the residency for children is to be determined by the residency of the parent(s)/or guardian(s) and should change when the parent(s)/guardian(s) move (even when the move occurs in the middle of a hospitalization or residential placement).

The primary question to use in determining whether or not this guideline is applicable is: "Is the student an IRS (Internal Revenue Service) Tax Dependent?" If the student is, then the board area in which the parent(s)/guardian(s) reside is the child's county of residence. The student is to be enrolled in one of that county's plan(s)/panel(s).

If the student is not considered an IRS Tax Dependent, then the following is to be taken into consideration for county of residency determination:

Is the student emancipated?
Is this a graduate level student?
Does this student have dependent children?

Students who fall within these criteria should have further screening to determine actual county of residency. Please reference item # 4 (page 11-12). Has the client/student established residency or expressed the intent to remain? If the client has, then the Board must enroll that student as a resident of their county.

If it is an out of state college student, enrollment criteria should be developed and implemented by the local Board. These students should be enrolled using the address of the parent(s)/guardian(s) and using "OUTSTATE" in the Sales Rep field.

2. ***Homeless Client Guideline***

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Example:

The client was originally enrolled in a plan/panel of the Franklin County Alcohol, Drug and Mental Health (ADAMH) Board. This client subsequently presents in Montgomery county for services and claims to be homeless (please note that this client can claim an address of homeless or an address of a homeless shelter). The Montgomery County ADAMH Board should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. If this client continues their journey and presents for services in Butler county two months later and again claims to be homeless, the Butler County Boards should assume responsibility for the client's services by transferring enrollment into one of their plan/panel combinations. Please note, it is intended for MACSIS to track this type of client to assist in identifying such populations and their need for continuity of care.

How to process enrollments/transfers in MACSIS:

a. Client not previously enrolled. Board area in which the client presents as homeless should enroll immediately for benefits. Note: A client in this situation should NEVER be terminated for benefits prior to another board assuming responsibility.

b. Client previously enrolled. If the client is already enrolled in another Board's plan/panel, then the Board in which client has presented for services and stated homelessness MUST immediately transfer the client into one of their plan/panel combinations. As previously noted above, a client in this situation should NEVER be terminated for benefits prior to another board assuming responsibility.

3. ***Migrant Worker Guideline***

The following guideline is applicable to Legal Migrant Workers. (Illegal Migrant workers are still under discussion, however, it was noted that boards should be utilizing the "Out of County Service Matrix" (page 24) when dealing with these clients.)

These clients are to be enrolled in a plan/panel of the board in which they present for services (a type of rolling enrollment).

Please reference the "Homeless Client Guideline" above.

4. ***Out of State Client Guideline***

How to handle the enrollments within MACSIS:

a. If the client has a valid Ohio Medicaid card, then the Board in which the client has presented for service should enroll the client in one of their plan/panel combinations or if the client has previously been enrolled, immediately transfer the client to one of their plan/panel combinations.

b. If the client does NOT have a valid Ohio Medicaid card, then the Board could exercise their local option to enroll these clients for service. (Please reference the enrollment guideline for out of state college students.)

B. Criminal Justice System and Residence Determinations

As part of the Multi-Agency Community Services Information System (MACSIS) implementation by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH), many questions have arisen concerning how to determine the "county of residence" for a client who has recently been under the auspices of the Ohio Department of Rehabilitation and Correction (ODRC) system and is in need of alcohol and other drug or mental health services.

A workgroup, consisting of representatives from ODADAS, ODMH, ODRC, and Alcohol and Drug Addiction Services (ADAS) Boards, Community Mental Health Boards (CMHB), Alcohol, Drug Addiction and Mental Health (ADAMH) Boards and in conjunction with provider input, believes the basic residency guidelines outlined on pages 11-17 are adequate for determining county of residence in this situation. Former offenders should be treated, for residence determination purposes, in the same manner as any other individual in the State of Ohio. Primacy for determining county of residence shall be upon the individual's statement (i.e.,

expressed intent to remain) and/or upon the individual's county of residence prior to becoming a charge of the ODRC system.

The applicable section of the residency determination guidelines can be found on page 12, item #6. a. and b. ODRC will bear the financial responsibility for necessary drug and alcohol and/or mental health services provided to Transitional Control inmates housed in halfway houses contracted with ODRC. When a person transitions from an inmate status to a non-inmate status, eligibility for and the financial responsibility for alcohol and other drug and/or mental health services should be determined as it would be for any other Ohioan. The attached documents, including an inmate versus non-inmate status matrix developed by ODRC and shared and reviewed by the workgroup, should be used in determining when an individual's services are the responsibility of ODRC and when the individual's services become the responsibility of the community alcohol and drug and/or mental health system.

Inmate Status	Non-Inmate Status
Halfway House Population: Transitional Control Offender (ODRC Jurisdiction) Prison (ODRC Jurisdiction)	Halfway House Population: Parole/Post-Release Control/Probation/Community Control
CBCF (County/Court Jurisdiction) Jail (County/Sheriff Jurisdiction)	Non-Halfway House Population: Parole/Post Release Control

A. Jails and CBCF's (Community-Based Correctional Facilities)

- A person in a jail is considered an inmate.
- ODRC does not provide MH or AoD funding for jails but does set standards by which jails are to provide substance abuse and/or mental health treatment services.
- A person in a CBCF is considered an inmate of a correctional institution and is under the jurisdiction of a common pleas court.
- Either of these persons is still a resident of his/her home county.
- In many communities the local ADAS/ADAMHS/CMH Board has traditionally, through a voluntary collaborative arrangement with the local Judicial Corrections Board, made arrangements for the CBCF to utilize local AoD and MH agencies for the provision of needed services.
- These scenarios are covered by item 10 (page 14).
- A person incarcerated in an out-of-district jail facility shall remain a resident of the district from which he/she came. However, to facilitate and support Board-sponsored programs for the provision of services to a local jail facility, by mutual agreement a temporary re-assignment of a jail inmate to a plan of the local Board may be effected.

Upon release from the jail facility, the plan assignment shall revert to the original Board of residence.

B. Halfway House

ODRC currently contracts with 24 halfway houses throughout the state. All of these facilities house individuals who are considered non-inmates, with the exception of those facilities which serve Transitional Control offenders. Transitional Control (or furlough) clients are considered inmates and their services are the responsibility of ODRC. At which time an offender is no longer under Transitional Control status and is transferred to another status, such as parole or post-release control, and expresses an "intent to remain" in the county, the offender may be referred to community agencies and is eligible for services as any other resident of that county.

C. Normal Out of County Enrollment Process

Step 1 Provider determines client's county of residence.
It is the Provider's responsibility to obtain sufficient documentation to determine the client's county (Board) of residence. It is in everyone's best interest for the provider to obtain as much information as possible to assist in the residency determination process. This information is essential to quickly and correctly identifying a client's correct residence.

Step 2 Provider completes enrollment form

Step 3 Provider submits form to enrollment center for the board where the client resides.
Once the Provider has determined the residency of the client, the Provider must submit the enrollment form to that Board's enrollment center per the Board's submission requirements to begin the enrollment process. The Provider must indicate on the enrollment form that releases have been obtained for that specific Board area.

Step 4 Board enrolls the client or works with the provider to clarify questions.
Upon receipt of an enrollment form from a Provider that is treating a client who is a resident of that Board area, the Board's enrollment center should look up the client, enroll the client if not already in MACSIS, and then return to the provider the client's UCI, plan assignment and rider information. If there are points of clarification, the Board is responsible for making contact with the Provider to resolve any questions.

Step 5 Board returns UCI to provider.
It is recommended that no more than 5 business days (1) should separate the submission of the enrollment form from the provider to the board and the receipt of the UCI by the provider. The provider will then use the UCI to bill for services. Medicaid clients receiving Medicaid certified services will be paid and non-Medicaid clients and non-Medicaid services will be subject to the Out of County guidelines.

D. Disputed Enrollment Process (for Providers)

Step 1 Provider follows Normal Enrollment Process
In all cases, the Provider should follow the process established for a normal out of county enrollment. It is in everyone's best interest for the provider to obtain as much information as

possible to assist in the residency determination process. This information is essential to quickly and correctly identifying a client's correct residence. Examples of documentation that can be used to establish a client's residency include:

Driver License
State ID Card
Lease agreement
Adoption or custody papers
Statement from Client (Signed and Witnessed) Indicating Residency

Step 2 Board of Residency Refuses to Enroll an Out of County Client
If the Board (where the Provider determines the client resides) refuses to enroll the client or fails to provide a UCI within ten business days, the provider should contact the MACSIS Support line.

Step 3 MACSIS Support Line Enrolls Client
The Provider will provide the MACSIS Support line with copies of the enrollment form and all supporting information that was provided to the Board. As soon as the proper documentation has been received, the MACSIS Support Line staff will send an email to the affected board and wait 1 working day before doing the enrollment. This is to provide time for the affected board to become aware of the issue. (2)

The MACSIS Support Line staff will enroll the client in a generic plan of the Board where the client resides. The MACSIS Support Line will follow the rules as outlined in the Summary Matrix outline on page 24.

Note: Providers should be aware that non-Medicaid clients that are not in Crisis WILL NOT be enrolled per the Summary Matrix included in this notice.

The MACSIS Support line Staff will then electronically notify both the Board where the client has been enrolled and the provider that is treating the client, with the enrollment information.

Step 4 Residency Dispute Claim Submitted
If the board where the client is enrolled disputes the residency determination and action taken by the MACSIS Support Line, the Board may file a formal residency dispute following the established residency dispute determination (RDD) Guidelines.

(1) The expectation remains that the majority of enrollments will occur within two (2) to five (5) days. It is understood, however, that exceptional circumstances will occur, particularly with out-of-county enrollments. In no event, however, should any enrollment, in-county or out-of-county, take longer than ten (10) days.

(2) The MACSIS Support Line is not responsible for settling residency disputes and therefore, should not be expected to respond to board disputes which might result from the e-mail notification. They will continue, as outlined in this procedure (i.e., enrolling the client) and the disputing board must then file the appropriate dispute as noted in the RDD guidelines.

E. Clarification of Requirements for Out-of-County MACSIS Enrollment

Mental Health Services

1. **Enrollment of Medicaid eligible persons who seek services from provider organizations outside their Board service district in either emergency or non-emergency situations.**

   In these circumstances, such persons must be enrolled with the appropriate Board of residence per the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying Medicaid claims, even in out-of-county non-emergency situations.

2. **Enrollment of non-Medicaid eligible persons who seek services from provider organizations outside their Board service district in emergency situations.**

   In these circumstances, such persons must be enrolled with the appropriate Board of residence pursuant to the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying non-Medicaid claims for Crisis Intervention services in emergency situations for a period up to 72 hours.

3. **Enrollment of non-Medicaid eligible persons who seek services from provider organizations outside their Board service district in non-emergency situations.**

   In these circumstances the provider organization is not required to enroll such persons. However, the provider organization should refer such persons to the Enrollment Center for the person's Board of residence in order to be linked with the appropriate provider organization. The out-of-county provider organization should offer the person assistance in contacting the Enrollment Center for the person's Board of residence. Such assistance in referral will better ensure appropriate continuity of care.

Alcohol and Drug Addiction Services

Medicaid

1. **Enrollment of Medicaid eligible persons who seek services from provider organizations outside their Board service district in either emergency or non-emergency situations.**

   In these circumstances such persons must be enrolled with the appropriate Board residence of pursuant to the MACSIS enrollment guidelines. The reason enrollment is required is the Board of residence is responsible for paying Medicaid claims, even in out-of-county non-emergency situations.

Non-Medicaid

1. **ODADAS recognizes non-Medicaid services, out-of-county services, emergency services or clinically appropriate services as:**

- Level I Services (Assessment, Individual counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Urinalysis (Lab analysis of specimens for presence of alcohol and/or drugs), Medical/Somatic, Methadone Administration and Intensive Outpatient Services, plus)

- Levels III and IV Ambulatory Detoxification Services

Non-Medicaid clients who present for services out-of-county are eligible for Board funding under the same considerations as if the clients presented for services in their home county. Level I services and Levels III and IV ambulatory detoxification services may be provided for three days or until linkage to treatment is established in the "home county." If out-of-county treatment is to extend beyond three days, the out-of-county placement must be approved by the home board. It is essential that collaborative efforts occur between providers and Boards to establish arrangements for a client's continued care.

Out-of-County MACSIS Enrollment Summary Matrix

Circumstances	MH	AOD
Medicaid eligible person - emergency or non-emergency	Enrollment: Must enroll. Services: Any Medicaid covered service.	Enrollment: Must enroll. Services: Any ODADAS Medicaid covered service.
Non-Medicaid eligible person - emergency	Enrollment: Must enroll. Services: Crisis Intervention services for up to three days (72 hours).	Enrollment: Must enroll Services: Level I Services:(assessment, individual counseling, group counseling, crisis intervention, case management, alcohol/drug urinalysis (lab analysis of specimens for presence of alcohol and/or drugs), medical /somatic, intensive outpatient and methadone administration) plus Levels III and IV ambulatory detoxification services for three days or until linkage to treatment is established in the "home county".
Non-Medicaid eligible person - non-emergency	Enrollment: Not required. Services: Not required to pay for services.	Enrollment: Must enroll Services: Level I services plus Levels III and IV ambulatory detoxification services for three days or until linkage to treatment is established in the "home county"

9. Topic: Spend Down

The client's eligibility status will be updated when the client's spend down amount has been met according to ODJFS eligibility files. The revised Medicaid eligibility status will be transmitted to MACSIS during the nightly update process. If a client is Medicaid eligible the McareSt field (on the MACSIS Member screen) will contain a spend down indicator. The codes and meanings are as follows:

R for Recurring (eligible 1st day of month); D for Delayed (Medicaid eligible because they have met their spend down), and N for Not eligible have not met spend down).

The Spend Down information for people not Medicaid eligible is not maintained in the MACSIS MEDELIG (nightly Medicaid eligibility update) file (subset of the ODJFS Recipient Master file).

10. Topic: Retroactive Medicaid Eligibility

For MACSIS purposes, retroactive eligibility occurs when the initial coverage changes at a later point in time.

A client will be assigned a UCI number at the point when the agency expects payment in part or in whole from a Board, whether Medicaid eligible or not. When a client subsequently gains or loses his/her Medicaid eligibility status, the UCI will remain the same, but his/her affiliated benefit plan in MACSIS will be updated to reflect CURRENT Medicaid eligibility status.

The problem is that if a change occurs that affects an eligibility period that is not the current eligibility period there is no automated means of making the correction. The system is set up to identify changes that affect today. If a change affects today (and previous days in the same span) the change can be automatically updated in MACSIS.

The following instances will require the board to make manual adjustments:

- Changes to the retroactive MACSIS member eligibility period from a previous point in time (as described in above paragraph)
- Claims adjudicated before retroactive eligibility changes are processed must be manually adjusted by the Board and then resubmitted by the Departments to ODJFS as long as it is within 365 days.

FINANCIAL

11. Topic: Use of Company Codes in Diamond

Company code will be used to identify a board or group of boards in MACSIS (Diamond).This policy will allow each board to operate as a separate company (in Diamond terms) or as a board consortium, depending on accounts payable and general ledger assignment needs.

While this procedure will allow for multiple companies to be formed, it is imperative that this policy not be confused with the use of security codes. If a board elects to become a part of a consortium or break away from a consortium, a separate discussion regarding use of security codes will need to take place and will require approval by the State MACSIS Team.

12. Topic: MACSIS Unique Provider Identifier (UPI) and Vendor Numbers

All AOD and MH service providers who intend to submit claims through the MACSIS system must be assigned a MACSIS UPI and VENDR number as defined below.

Definition of MACSIS VENDR Number:

MACSIS Vendor Number. It is a five digit number assigned to the legal owner of a provider as identified by the tax identification number on the MACSIS Provider Registration Form and as verified against the provider's AOD and MH certification records. Please note the following:

- The number will be assigned by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) in cooperation with the Ohio Department of Mental Health (ODMH).
- For non-governmental entities the long name linked to the MACSIS VENDR number will be the name associated to owner's charter number as registered and verified with the Ohio Secretary of State, Business Services Division.
- The address associated with the MACSIS VENDR number is where the provider wants remittance information distributed.
- There can only be one MACSIS VENDR Number per Tax-ID.

Definition of MACSIS UPI:

Unique Provider Identifier. It is a five digit number assigned to the entity providing AOD or MH services at a physical location within the State of Ohio. The UPI number is linked to the legal owner via the MACSIS Vendor Number. Please note the following:

- The number will be assigned by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) in cooperation with the Ohio Department of Mental Health (ODMH).
- The long name associated with the UPI will be the name of the provider as recorded in the AOD and MH certification records.
- All AOD entities will be registered by the Ohio Department Alcohol and Drug Addiction Services (ODADAS) with the Substance Abuse and Mental Health Services Administration (SAMHSA) federal agency.
- There can be multiple UPI's assigned to a MACSIS VENDR Number if services are provided at distinct, certified physical locations.

Exceptions:

To attach a UPI to a VENDR number other than the legal owner, the board and provider must submit legal documentation to MACSIS (TPA/BAA) indicating that the proposed VENDR accepts complete financial responsibility for the attached provider.

Transferring UPI Numbers:

A UPI will only be transferred from one MACSIS VENDR number (i.e., legal owner) to another MACSIS VENDR number if the owner submits documentation via the board attesting to the legal and financial obligation transferring from one owner to another. It shall be the policy of MACSIS to not reassign UPIs of entities no longer submitting claims to MACSIS.

- It should be noted that an entire board-combined weekly claim file could reject, if an existing UPI number for a provider in the file is transferred from one VENDR number to another and

the file contains claims for prior dates of service. This is because both the VENDR and the Tax ID information are not date sensitive in Diamond.

Please use the MACSIS Provider Request/Modification Form to add or change information regarding a provider.

13. Topic: Medicaid Pricing

In the MACSIS system, Medicaid pricing (rates) will be:

- State maintained as fully described in the MACSIS procedural manual.
- The contracted rate for Medicaid will be applicable to all Medicaid clients served by a provider regardless of county of residence.
- Providers will be reimbursed at 100% of the Medicaid contracted rate.
- If a providers' rates are not revised at the beginning of a new state fiscal year, the most recent rates will be used to pay claims until rates are revised.

14. Topic: Diamond Contract Process

The original MACSIS Finance and Contracts Team initially created an overall approach to how contracts are built and administered in Diamond that address the Medicaid Contract issue and the Default Contracts for both Medicaid and Non-Medicaid. This basic conceptual approach was expanded for contracts beginning July 1, 2003, to accommodate changes due to HIPAA EDI requirements and in the Diamond HIPAA compliant software.

A. Standard Diamond Contracts

Standard Diamond Contracts (PROVC) will be built for each Provider + Line of Business (LOB) + Panel combination that reflects contracts between the Boards and Providers. The pricing of actual claims is affected by the price schedules, regions and contract details associated with each contract. The standard contracts include:

1. *Medicaid Standard Contracts*

   Medicaid Standard contracts (LOB=MCD) are used to control pricing for services provided by certified Medicaid providers to Medicaid eligible clients in MACSIS. A separate Medicaid Standard contract (PROVC) will be created and maintained by the State for each Provider + MCD + panel combination. The price region on these contracts will always be "OH".

   - The primary price schedule(s) associated with the Medicaid Standard Contract will control pricing for the Medicaid eligible services provided to Medicaid eligible clients The alternate price schedule(s) associated with the Medicaid Standard Control will control pricing for the Non-Medicaid eligible services provided to Medicaid eligible clients. The "home" board, defined as the Board that holds the primary Medicaid contract with the provider, will dictate the services included in the alternate price

schedule. If any other board wishes to contract with the same provider, the State will assign the next available alternate price schedule for use by the other board.

2. *Non-Medicaid Standard Contracts*

   Non-Medicaid Standard contracts (LOB=NON) are used to control pricing for services provided to Non-Medicaid eligible clients in MACSIS. A separate Non-Medicaid Standard contract (PROVC) will be created by the State but maintained by the Board for each Provider + NON + panel combination. The price region on these contracts will either be "OH" or the Board's price region.

   - If the Board that is contracting with this provider chooses to use the same prices as linked to the Medicaid Standard contracts, then the price region "OH" would be used. If the Board has negotiated different rates or a different range of services for their Non-Medicaid clients, the price region must be changed to the Board's.

3. *Medicaid Default Contracts*

   Medicaid Default contracts are used to control pricing for services provided by out-of-county Medicaid providers to Medicaid eligible clients. Medicaid Default contracts will be created and maintained by the State for each Provider + MCD combination. The price region on these contracts will always be "OH".

   - The decision was made to not use any Alternate Price Schedule for Medicaid Default Contracts. The affect of this configuration is that no Non-Medicaid eligible services will be priced and in fact all Non-Medicaid eligible services claims that reach this contract will be denied. Boards that choose to pay for these services have the option to override Diamond on a one by one basis or to create a Standard Contract and re-adjudicate these claim lines.

4. *Non-Medicaid Default Contracts*

   Non-Medicaid Default contracts are used to control pricing for services provided by out-of-county providers to Non-Medicaid eligible clients. Non-Medicaid Default contracts will be created and maintained by the State for each Provider + NON combination. The price region on these contracts will always be "OH".

   - The primary price schedules associated with the Non-Medicaid Default Contracts will price and place on hold all Medicaid eligible services provided to Non-Medicaid clients in an out-of-county setting. However, the Boards' will only be liable for up to three days of crisis services per current policy. The alternate price schedules associated with the Non-Medicaid Default Contracts will price and place on hold services which are being contracted with the home Board. Boards will then choose which services to pay and will have the option to override each claim on a one by one basis.

B. Price Schedules

Each provider will be assigned five price schedules as follows:

- **Primary Price Schedule P0 (0xx)** – This price schedule will control pricing for Medicaid eligible services with the exception of MH group services and/or AOD individual counseling.
- **Primary Price Schedule P1 (1xx)** – This price schedule will control pricing for AOD individual counseling services.
- **Primary Price Schedule P2 (2xx)** – This price schedule will control pricing for MH Group Counseling and/or Community Support (CSP) services.
- **Alternate Price Schedule A0 (Axx)** – This price schedule will control pricing for Non-Medicaid eligible services with the exception of AOD Hotline services. Note: If any other board wishes to contract with the same provider, the State will assign the next available alternate price schedule for use by the other board.
- **Alternate Price Schedule A1 (Bxx)** – This price schedule will control pricing for AOD Hotline services.

C. Provider Contract Detail

In addition to the assigned price schedules above, each provider will be assigned three provider address records which control the pricing for "shared" procedure codes under HIPAA.

- Main Address (000) – This address record will control pricing for all services except AOD individual counseling, AOD Hotline and MH Group Counseling and/or CSP services.
- AODINDIV Address (001) – This address record will control pricing for AOD individual counseling and AOD Hotline services.
- MHGROUP Address (002) – This address record will control pricing for MH Group and/or CSP services.

15. Topic: Title XX of the Social Security Act (Block Grants to States for Social Services)

MACSIS is developed to capture all publicly funded behavioral healthcare services. However, it is only designed to distinguish Medicaid funded services and non-Medicaid funded services (General Revenue Fund (GRF), Title XX, local levy, etc.). As a result, Title XX claims can be billed thru MACSIS as a non-Medicaid funded service, but they will not be uniquely identified in MACSIS. Consistent with current reporting requirements, Boards and Providers will need to continue to report Title XX funds for the total expenditures and total recipients, (adult, children/adolescents, total) by service, by eligibility category outside of MACSIS.

As a reminder, when clients receive services paid for with Title XX funds, in most cases, it is considered payment in full and the client should not be required to pay a co-pay or sliding fee amount. To conform with this Federal requirement, it is recommended that the amount or percentage share that MACSIS automatically deducts be set to zero (see Topic 5 of this document). Any copayment that is charged must be consistent with the Title XX eligibility criteria established by the county Job and Family Services

Department. In no instance should a copayment be collected for Title XX recipients eligible for free services.

16. Topic: Out-of-County Provider Reimbursement

Definition of Residency: Residency issues will be governed by the ODMH and ODADAS definitions as incorporated in: Topic 8: Residency Guidelines.

- **For ODMH and ODADAS Medicaid reimbursable services provided to Medicaid eligible clients**, Boards will be responsible for paying Medicaid services from any agency in Ohio, which has a Medicaid Agreement in effect with another Board.
- **For ODADAS Medicaid reimbursable services provided to non-Medicaid clients,** boards are responsible for out-of-county, emergency, clinically appropriate Level I services plus Level III and Level IV Ambulatory Detoxification services provided for three days or until linkage to treatment is established in the "home county". If out of county treatment is to extend beyond three days, the out of county placement must be approved by the home board. It is essential collaborative efforts be made between providers and Boards to establish arrangements for a client's continued care.
    - Level I services include Assessment, Individual Counseling, Group Counseling, Case Management, Crisis Intervention, Alcohol/Drug Urinalysis (Lab Analysis of Specimens for Presence of Alcohol and/or Drugs), Medical/Somatic, Methadone Administration including levomethadyl acetate (LAAM) and Intensive Outpatient services
- **For out-of-county, non-Medicaid eligible services,** boards may pay or deny claims per their own business rules except in emergency situations, in which case emergency/crisis services should be covered for 72 hours.

17. Topic: ODADAS Women's Set Aside Programs

A. Purpose

This guideline is intended to provide uniform directions and assistance for ADAMH/ADAS Boards regarding grants to women's set-aside programs.

B. Basic Assumptions

1. Grants to women's set-aside providers are to be paid in full on a regular monthly basis.
2. Services provided by these programs must be recorded in MACSIS in a consistent manner. The current inability to consistently report such services places Ohio at a significant disadvantage. Reports lack credibility as both dollars and services are not counted correctly or uniformly across board areas. Also, it is consistent that Boards are to pay from the 835 Health Care Claim Payment Advice/Electronic Remittance Advice (ERA) and it is acceptable for Boards to compare the actual value of the Women's Program (HD) modified claims against the award amount for monitoring purposes. Finally, Boards are also reminded

that MACSIS is not designed to be an accounting system. It is recommended that Boards separate the patient accounting function from the fund accounting function of reconciling funds. ODADAS hopes to create a mutually beneficial situation: providers continue their ability to receive all the grant dollars awarded and the Boards and State obtain the ability to document adequately and account for services to these programs.

C. Background

Initially the State established a "90W" plan and/or panel in an attempt to meet the requirements above. Lack of uniformity in implementation left some services being denied when paid by grant funds, others being valued at zero dollars and other combinations that did not allow for any reasonable analysis of the data. The implementation of HIPAA uniform procedure coding and the ability to add modifiers to the new 837 Professional Version 4010 Claim File format provide an opportunity for a solution to this issue.

D. Implementation Plan

Provider requirements for billing Women's Set Aside Services each Women's Set-Aside grant award will include a requirement stating that all women's services will be billed through MACSIS and that these services will have "HD" modifier in the modifier two position. The "HD" modifier identifies services provided under a "Women's Program."

Board Requirements for Adjudicating Women's Set-Aside Services in MACSIS

1. *For Services Provided by Contracting Providers*

   The net paid amount for Women's Set-Aside services covered under the grant must be equal to the contracting provider's Medicaid or Non-Medicaid rate for those services. Boards cannot deny these claims in Diamond and/or use a 100% copay to force the net paid amount to zero.

2. *For Services Provided by Out-of-County Providers*

   For services provided under the Women's Set-Aside Program by a non-contracting, out-of-county provider to a Non-Medicaid client, these claims will automatically go on hold in MACSIS. When correcting or adjusting claims, Boards need to correct these claims by making the "withhold amount" equal to the "allowed amount" and by adding the adjustment reason code of "**ADWSA**" (Alcohol/Drug Women-Set-Aside) to the claim in Diamond.

   - Please note that Diamond Reason Codes do not appear on the 835 Health Care Claim Payment Advice, only the national standard claim adjustment reason codes will appear. However, the modifier 2 will be included on the 835 and it will be an obvious indicator as to why these services were withheld.

Board Requirements for Disbursing Funds for Women's Set-Aside Services

Whatever the value of the claims, the provider must still be paid the 1/12 value of the grant, assuming the board provides the funds in twelve monthly installments. To be consistent with the directive that Boards are to pay from the 835/ERA, boards should remit payment for services at

the time the 835/ERA is produced and then reconcile to the grant funds on a monthly basis. Examples on how to do this are provided below.

To facilitate this process for smaller boards which do not have the systems in place to analyze the 835/ERA, ODADAS modified the printed remittance advice (RA) to show Modifier 2 and developed a subtotal reflecting the net pay amount for all eligible services with a non-Medicaid medicaid definition (MCD Flg = N) and the HD modifier on the RA. Since the printed RA is a busy document, ODADAS removed the first four positions (currently all zeros) of the MACSIS Claim Number to make room for the placement of modifier 2.

Example: Provider A has a annual Women's Set Aside Award for $120,000 starting July 1, 2003. Provider also has a board contract for $50,000 for services budgeted from State GRF and Federal Block Grant dollars under the board control. Provider submits claims totaling $15,000 for month of July. Weekly 835/RA's for the month shows subtotal of HD claims at $8,000 and other non-Medicaid at $5,000.

Outside Diamond, the board monitors the transfer of dollars to its providers. Board voucher request shows a draw of $8,000 for HD claims value and $2,000 for grant value (subtotal of $10,000 which is 1/12 of the grant award) and $5,000 from levy, Block Grants or whichever source the board has identified for that provider. Whether the Board provides the Women's Set-Aside program their offsetting grant value weekly or monthly is the board's option.

If the provider outperforms its monthly Women's dollars amount, the board may choose to reimburse more than the 1/12 in any given month but the provider must understand that the total of the Women's Grant Award will not exceed 12/12 or whatever the provider's Women's Set-Aside Award equals.

CLAIMS PROCESSING

18. Topic: Benefit Plans, Medical Definitions, and Default BRULES

Benefit Rules (BRULE) in Diamond are used to automatically adjudicate claims according to a Board's funding policies. In general, benefit rules and benefit packages (BENEF) are used to automatically hold or deny certain claims, deduct copayments and coinsurance based on client income and family size, and limit selected services to a maximum number of units or dollars in a specified time period. Please refer to Topic 1: Change Control Procedures for additional information on procedures for adding, changing, and terminating benefit packages.

Benefit rules are based on Medical Definitions (MEDEF) that are determined by combinations of procedure code , modifier 1, modifier 2, and place of service (for MH only) codes. Medical Definitions are an essential component in claims adjudication and are used to determine (1) which claims will be submitted to Medicaid, (2) which claims are subject to copayments, limits, exclusions, out-of-pocket maximums, etc., (3) G/L payment source (MH Mcd, AoD Mcd, MH non-Mcd, AoD non-Mcd, etc.) and (4) which claims should be denied as duplicates. Invalid claims (missing critical information or plan-procedure mismatches for split MH/AoD boards) are assigned non-billable medical definitions and denied automatically during adjudication.

Each board must create at least one benefit package and must include, at a minimum, the statewide rules that restrict service utilization for selected services discussed below. Boards can use the statewide default rules for non-billable medical definitions or construct their own if their policies are not fully covered by the statewide rules.

Statewide rules that MUST be attached to all benefit packages are as follows:

- **ADMCDDAYS** (AOD MCD DAY SVC LIMIT): This rule limits AOD Medicaid eligible services, such as ambulatory detoxification (H0014) and intensive outpatient (H0015), to one per day.
- **ADMCDOUTP1** (AOD MCD OUTPAT 15MIN): This rule limits AOD Medicaid eligible 15-minute services, such as individual counseling (H0004) and group counseling (H0005), to 96 units per day.
- **ADMCDOUTP2** (AOD MCD OUTPAT 24 HRS): This rule limits AOD Medicaid eligible 60-minute services to 24 units per day.
- **OHINVALID**: This rule will cause claims with invalid medical definitions to deny (ex. invalid procedure and modifier code combination).
- **MHPARHOSPA:** This rule limits MH partial hospitalization services (S0201) for adults to 1 unit per day.
- **MHPARHOSPC:** This rule limits MH Partial Hospitalization (S0201) for children to two units per day.

19. Topic: MACSIS System Access

A. Board Notification Responsibilities

In accordance with the HIPAA Security Regulations regarding Information Access Management (42 CFR Part 164.308 (a4)), boards are responsible for monitoring system access requirements to minimize risks for unauthorized access to protected health information (PHI). In addition, since MACSIS is a system supported by ODMH staff, it is subject to the ODMH Administration Services Information System policy in regards to passwords and User IDs. The latter policy dictates requirements around notification of changes in system access due to termination or job function.

Therefore, boards are required to notify the MACSIS team of changes in system access as follows:

- For involuntary termination – must notify prior to termination or within one hour
- For retirement or resignation – must notify at effective date
- For changes of responsibility (affecting system access) – must notify at effective date

The process by which boards should notify the MACSIS team of changes is outlined below.

B. Obtaining MACSIS On-Line Access

1. To obtain access for employees to the MACSIS on-line system, the Board/Consortium MACSIS Administrator must complete and submit a MACSIS Account Request Form, a TCP/IP Access Form and a Disclosure of Information Notice to the following location:

   Ohio Department of Mental Health
   C/O MACSIS Account Coordinator
   Suite 1010
   30 East Broad Street
   Columbus, OH 43266-0414
   Or fax to: 614-752-6474

2. All forms must be completed in full, dated and signed by responsible authorizer (CEO, CIO, supervisor, etc.). Incomplete forms will be returned to requesting board without MACSIS on-line access being granted. All completed forms which have been processed will be filed by the MACSIS Account Coordinator and the OIS Billing Supervisor.

C. Modifying MACSIS On-Line Access

To modify access, the Board/Consortium MACSIS Administrator must re-submit a MACSIS Account Request Form to the above location indicating a change in access. Once the change is complete, the Board/Consortium MACSIS Administrator will be notified accordingly and a copy of the form will be filed by the MACSIS Account Coordinator.

D. Terminating MACSIS On-Line Access

1. To terminate access, the Board/Consortium MACSIS Administrator must re-submit a MACSIS Account Request Form indicating termination

2. Once received, the following steps will be taken:

   a. The user's access to Diamond will be terminated within four hours.

   b. DAS will be notified to terminate the user's TCP/IP Access.

   c. The Disclosure of Information Notice will be discarded by the OIS Billing Reimbursement Supervisor.

   d. The related forms will be stored on file by Board/Consortium and a copy retained by the MACSIS Account Coordinator.

   e. The MACSIS Support Desk will and Board MACSIS Administrator will be notified.

E. Routine Review of Employee Access

To encourage routine review of user system access, the MACSIS Technical Team will distribute of list of all active MACSIS Accounts on a semi-annual basis to the Board MACSIS Administrator. Accounts which have been inactive for over 90 days will be marked for removal. Boards are required to review and respond with changes within 30 days.

F. E-Mail Group Distribution Lists

If an employee needs to be added, updated or removed from a MACSIS-related email distribution list, the Board MACSIS Administrator should send an email to the MACSIS Support Desk (macsissupport@mh.state.oh.us) and indicate exactly which e-mail distribution lists need to be updated. This list includes but is not limited to the following:

MACSIS Claims Users Group – Macsis_claims@odadas.mh.state.oh.us
MACSIS Member Users Group – Macsis_members@odadas.mh.state.oh.us
MACSIS MIS Users Group – Macsis_mis@odadas.mh.state.oh.us
MACSIS Finance Users Group – Macsis_finance@odadas.mh.state.oh.us
MACSIS Project and Operations (POP) – Macsis_pop@odadas.mh.state.oh.us
MACSIS HIPAA Production Claims Reports – MACHIPAA GroupWise List

⇒ Note: Boards can self-subscribe or unsubscribe to the HIPAA Community List Service via http://www.mh.state.oh.us/ois/macsis/mac.join.html . To unsubscribe, type "unsubscribe" in place of subscribe.

It is the Board's responsibility to ensure changes or deletions in e-mail addresses are reported in a timely manner.

CLAIMS EDI (Electronic Data Interchange)

40. Topic: General EDI Policies

A. Effective Date

The HIPAA EDI policies outlined in this document are effective July 1, 2003 for all Boards or MACSIS Administrators[1] submitting claims via MACSIS. Please refer to Topic 2, "Clients Enrolled and Services Reported in MACSIS" for further explanation of the scope of claims to be submitted.

B. Formats and Versions Supported

1. *Electronic Claims Submission*

   The HIPAA-mandated, Accredited Standards Committee (ASC X12N) 837 Professional Claim (837P) Transaction Version 4010 is required for submitting claims electronically via MACSIS , except as noted in Section C1 below. These files will only be supported in a batch, not real-time mode, as recommended in the standard HIPAA implementation guide.

2. *Electronic Remittance*

[1] MACSIS Administrators are Boards or Board Consortiums who perform MACSIS-related system or administrative functions on behalf of another Board.

The HIPAA-mandated, ASC X12N 835 Health Care Claim Payment/Advice Version 4010 format is provided by MACSIS to the Boards or MACSIS Administrators by agency remitted in batch mode. MACSIS will continue to provide the existing MACSIS Electronic Remittance Advice (ERA) file by agency and by Board to supplement the new 835 files, until its continued need and use can be further evaluated.

Due to the operational efficiency issues surrounding disbursement of electronic remittance information to non-contracting providers, MACSIS will provide print-image files of the existing MACSIS Remittance Advice Report and MACSIS/ODJFS Reject Report to the Boards or MACSIS Administrators. It would be the Board's or MACSIS Administrator's responsibility to determine which file types (835, print-image, etc.) should be initially disbursed to non-contracting providers within HIPAA guidelines and on what medium. If, however, a non-contracting provider requests an electronic 835 file, the Board or MACSIS Administrator must comply with that request regardless of file size per HIPAA regulations.

3. *Electronic Reimbursement to Boards via ODJFS and MACSIS*

   Agency Reimbursement Accounting Reports (ARAs) are provided via print image in the designated Board or MACSIS Administrator file transfer protocol (FTP) directories as currently done.

4. *ASC X12N Addenda*

   The Health and Human Services (HHS) Secretary adopted the X12N addenda changes (Version 004010X098A1) proposed in October 2002. Therefore, MACSIS has implemented the applicable addenda changes for both the 837P and the 835 files.

C. Implementation Issues

Board Technical Evaluation and Modification to Support HIPAA-Mandated Transactions

Boards or MACSIS Administrators must evaluate their technical infrastructure to determine which modifications and additions are necessary to perform and support EDI functions in compliance with the Board-State Business Associate/Trading Partner Agreement. The evaluation should include analysis of telecommunication hardware and software, EDI translation software if needed, any business system applications used to support claims processing, including pre-scrubbing, reporting (electronic, paper or via web), general accounting interface or remittance update programs.

D. General File Transfer Policies

1. *File Transfer Overview*

   Boards or MACSIS Administrators are provided a special "FTP" account on a designated "FTP" server also referred to as the MHHUB AIX server. Each Board's account is provided with its own unique password and secure, distinct storage area.

   Once FTP account access is established, Boards have access to an assigned set of directories for file drop-off and/or pick-up. The list of available directories is not static, depending on the evolving needs of the Boards or MACSIS Administrators.

For more information about the "FTP" server directories and process, please refer to the MACSIS Technical Support Documentation, FTP Accounts (http://www.mh.state.oh.us/ois/macsis/technical/macsis.ftp.and.dir.updated.2.pdf)

When a Board or MACSIS Administrator "drops off" files anywhere into their designated sub-directories, these files are available to the Board or MACSIS Administrator FTP account (as owner) and the "staff" (or MACSIS) group. There are no world or other access rights enabled.

2. *Board Technical Account/Security Liaison*

Each Board or MACSIS Administrator must designate a MACSIS Technical Account/Security Contact person to be responsible for the following:

- File Transfers to/from MACSIS
- EDI Security Issues
- Resolving FTP/Unix Account access issues

This person must be familiar with basic Unix commands and the file transfer (FTP) process.

3. *File Transfer Protocol Accounts (FTP)*

Once designated, the MACSIS Technical Account/Security Contact must have on file or submit a "Request for TCP/IP" form that can be found at http://www.mh.state.oh.us/ois/macsis/forms/tcpip.form.pdf for the MACSIS Account Coordinator to gain FTP access to the MACSIS server where electronic files may be dropped off or retrieved. The contact should indicate on the form that they are responsible for the "FTP" account for their Board or MACSIS Administrator.

TCP/IP (Transmission Control Protocol/Internet Protocol) Request Forms can be mailed or faxed to the following location:

Ohio Department of Mental Health
C/O MACSIS Account Coordinator
Suite 1010
30 East Broad Street
Columbus, Ohio 43266-0414
Or fax to: 614-752-6474

Upon receipt of the form, the MACSIS Technical Support Team will assign an FTP account and password and will notify the Board MACSIS Technical/Security Contact accordingly.

FTP account passwords are in a standard AIX style and will change every 57 days. When the passwords are changed, the Board's Technical Account/Security Contact is informed. If you have questions about the current password on your account, contact the MACSIS Technical Support Team.

4. *File Transfer Account Termination Policy*

The Board's or MACSIS Administrator's MACSIS Technical Account/Security Contact or Privacy Officer must notify the MACSIS Technical Team of any changes in staffing or responsibilities related to TCP/IP access within one business day.

5. *Required File Transfer Process*

Boards or MACSIS Administrators may use their FTP software of choice, but must adhere to the following file transfer process.

For "raw" data files, such as non-compressed 837 claim files, transfer or retrieve files in the **ASCII mode** (American Standard Code for Information Interchange) of FTP.

- Please note Boards or MACSIS Administrators must transfer 837 claim files as non-compressed (i.e., non-zipped) files to MACSIS. Compressed or "zipped" 837 files will not be processed.

For compressed ("zipped"), word processing or spreadsheet files, transfer or retrieve files in **BINARY mode of FTP**. An example of a compressed file is the Board's weekly extract files.

There are many software programs on the market that make file transferring as easy as "drag and drop". MACSIS supports Ipswitch's WS_FTP Pro software. Electronic claim files submitted via portable media (diskette, CD-ROM, tape, etc.) will not be processed by MACSIS.

6. *Required File Characteristics*

MACSIS requires consistent use of segment, element and component delimiters to ensure proper adjudication of electronic claims data. The delimiters are defined as follows:

- Segment Delimiter (i.e., End of Line Marker)
  - For Windows-based operating systems, use carriage return, line feed, hexadecimal '0D0A'x
  - For Unix-based operating systems, use line feed, hexadecimal '0A'x
  - For Mac-based operating systems, use carriage return, hexadecimal '0D'x
- Element Delimiter – Use * (asterisk)
- Component Delimiter – Use : (colon)

Additionally, any of the delimiters noted above should not be used in the content of a text/alphanumeric data element within an ASC X12N transaction sent to MACSIS. It is also recommended that other special characters such as "&" or "/" not be used in text/alphanumeric data elements. Please note that the delimiter values are also defined in the Interchange Acknowledgement Envelope (ISA) of the ASC X12N transactions.

7. *"FTP" Server Purge Policy*

The MACSIS Team reserves the right to erase any file on the "FTP" server that is more than thirty days old. If a Board or MACSIS Administrator has a strong business need for storage on the server of over thirty days, the designated Board Technical Account/Security Contact

must contact the MACSIS Technical Support Team for special permission. If space is available, this may be granted on a short-term basis.

41. Topic: Becoming a Business Associate/Trading Partner

A. Getting Started

1. Business Associate/Trading Partner Agreement

   Each board must have a signed MACSIS Business Associate/Trading Partner agreement (http://www.mh.state.oh.us/ois/macsis/policies/final.macsis.baa-tpa.pdf) on file with ODMH and ODADAS before HIPAA-compliant claim files can be processed in a Production environment on behalf of a board. Testing between MACSIS and a Board can begin prior to receiving a signed BAA/TPA agreement; however, no production claims will be processed until a signed agreement is on file. Boards will be responsible for negotiating TPAs between themselves and their providers.

   The Board-State BAA/TPA document, should be signed by the Board Executive Director and the Directors of ODMH and ODADAS. Signed BAA/TPA agreements should be returned to the Legal Counsel Department at ODMH.

2. Sender and Receiver Identification Numbers

   The ASC X12N formats require use of identification numbers assigned to both the sender and receiver of electronic claim files to identify these parties on the file being transmitted.

   Since the receiver of the 837 professional claims file (ex., home Board) may be different than the entity ultimately identified as responsible for adjudicating a claim (ex. out-of-county Board), the sender and receiver identification numbers for the 837 will not necessarily match the sender and receiver identification numbers for the 835 Health Care Claim Payment/Advice files.

   - 837 Professional Claim File

     a. Sender Identification Numbers

        For providers, the MACSIS-assigned Unique Provider Identifier (UPI), Vendor or MACSIS Value Added Network (VAN) ID's will serve as the sender's respective identification number. For example, if Agency "X" with UPI number 10045 is submitting a claim file to their contracting Board, their sender identification number is "10045" and will remain that number when the file is forwarded to MACSIS.

        There are several possible scenarios where the sender may be a vendor submitting on the behalf of multiple agencies with different UPI numbers or the sender may be a clearinghouse. The following information clarifies how the sender identification numbers should be valued:

- If the MACSIS Provider UPI and MACSIS Vendor Number are the same and the provider is the creator of the file, the sender identification number is the MACSIS UPI number.
- If the MACSIS Provider UPI and MACSIS Vendor Number are different, the sender identification number is either the MACSIS UPI number or the MACSIS Vendor Number depending on who created the file.
- If a clearinghouse is the creator of the file, the sender identification number is the MACSIS-assigned VAN ID. See section 3 below for more information.

- 835 Health Care Claim Payment/Advice File

  a. Sender Identification Numbers

     The sender identification number will be the five character MACSIS-assigned Board company code. This code identifies the Board responsible for the adjudicated claim(s).

  b. Receiver Identification Numbers

     The receiver identification number will be the five digit MACSIS Unique Provider Identifier (UPI) assigned to the agency being remitted. Refer to section 43-D (ASC X12N 835 Health Care Claim Payment/Advice Return Policies, File Content) for more information as to why this number will be used as the receiver identification number.

3. Obtaining MACSIS VAN (Clearinghouse) ID

   Providers who intend to use a clearinghouse or Value Added Network (VAN) to submit HIPAA-compliant claim files must notify their contracting board to obtain a MACSIS-assigned VAN ID for their clearinghouse or VAN. . The board should then email the MACSIS Support Desk at macsissupport@mh.state.oh.us. to obtain the assigned number. The e-mail must include the full name, address, contact name, phone and fax number for the Clearinghouse or VAN as well as a list of the MACSIS-assigned UPI numbers the VAN will be supporting.

B. EDI Testing Policies

1. 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)

2. ***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 4010) 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 .

3. **Constituent Responsibilities***:*

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.

> 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 Tier 1 and 2 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 for both Tiers, 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 Tier 2 File Analysis Report returned to the provider will indicate if they have approval to submit claims in the production environment.

Although we encourage software vendors to work through their providers to submit test files via the boards, it is possible for software vendors to submit an initial test file directly to the MACSIS staff to determine how close their file formats fit the basic MACSIS requirements. The latter will be managed by the MACSIS Support Desk (macsissupport@mh.state.oh.us) via an independent process and the test file must contain no real client data. However, approval for production submission will not be granted at a software vendor level, only at a provider level.

Providers are required to be re-approved through Tier 1 and Tier 2 testing, if they change software vendors and/or apply a significant upgrade to their existing system. Although not required, it is recommended that Tier 2 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 4010 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, **Appendix A** outlines examples of what to test and verify as it pertains to MACSIS-specific requirements.

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.

C. Submitting Initial Test Files To Board for MACSIS Testing and Approval (Tier 1)

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 EDI Claim 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:

- A maximum of 100 claims per initial test file
- The test file must contain at least one scenario of each of the required testing scenarios noted in **Appendix B,** if the scenario could at all apply (even in the future) to the provider
- The test file may or may not use actual client or service data
- 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 "J" instead of "A", so they can easily be distinguished.

When submitting test files to the board, providers must initiate the "MACSIS Claims Tier 1 Testing 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.

D. Submitting Final Test Files to Board for MACSIS Testing and Approval (Tier 2)

Once the initial test file(s) has been approved, providers will need to prepare their final test file for submission to their main contracting board to complete the MACSIS Testing and Approval Process. Final test files should include:

- The volume of claims representative of a typical production file submission for that agency up to a maximum of 500 claims in the file. If you are not sure what your average weekly claim volume is for MACSIS, see SFY03 (State Fiscal Year 2003) data available at http://www.mh.state.oh.us/ois/macsis/claims/prov_fy03_clms.XLS .
- All funded procedure codes are represented
- Real client data
- Claims for dates of service on or after July 1, 2003, must be demonstrated on the test file. Fictitious service data may be used, as long as all currently funded procedure codes and corresponding rates are represented. HIPAA-compliant procedure, modifier and place of service codes must be used.
- 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.
- As in Tier 1, 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.
- 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 the final test file for approval, providers must initiate the "MACSIS Claims Tier 2 Testing Form" (http://www.mh.state.oh.us/ois/macsis/claims/tier2.test.form.rev.pdf). 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.

Clearinghouses

Clearinghouses will be responsible for ensuring their contracting provider's outbound claim files (i.e., ASC X12N 837P Version 4010 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.

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 Claims Testing Forms and faxing them to the State
- Verifying test files comply with HIPAA-mandated and MACSIS-specific EDI requirements under Tier 1
- Evaluating Error Reports resulting from Tier 1 and 2 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.
- Notifying the MACSIS staff via the Tier 2 form that a new copy of Production is necessary before re-testing, when applicable.
- 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 with Tier 2 Test File Forms
- Initiating Medicaid Contract Agreements or Amendments per ODMH and/or ODADAS Medicaid Policy.
- Maintaining Non-Medicaid rates in MACSIS.

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 Tiers 1 and 2 of 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

Cross-Constituent Shared Responsibilities:

All constituents will be responsible for:

- 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.
- Ensuring file handling protocols are followed to ensure the proper translation of file end of line markers. See http://www.mh.state.oh.us/ois/macsis/mac.tech.revisited.EOL.issues.html for more information.

MACSIS Testing and Approval Methodology:

MACSIS will be using a two-tiered approach to test files received from providers via the boards. This approach allows the staff to identify simple, basic file problems in the first tier and then focus on more complex problems which may only manifest themselves in a large, production-simulation environment in the second tier.

Tier 1 – Basic Form, Structure, Syntax Testing

The primary purpose of **Tier 1 testing** *is to evaluate the form, structure and syntax of the claims EDI test file as it pertains to MACSIS-specific guidelines. The type of review includes but is not limited to:*

- Conformance to file naming conventions
- Envelope Structure and Control Numbers
- Appropriate End-of-Line (EOL) marker and other delimiter definitions
- Appropriate use of sender and receiver identification numbers
- Appropriate use of provider identification numbers
- One-To-One Correspondence of Loops 2300 and 2400 (i.e., one service line per claim)
- Appropriate Segment Usage For MACSIS Adjudication Purposes as outlined in the MACSIS 837P Technical Information Guide

Tier 1 testing does not require information related to "real" clients, although the latter is preferable. These files can contain fictitious names, dates of birth, Unique Client Identifiers (UCI), etc. Segment, field and component usage will be examined, but no comparisons will

be made between the EDI file and the MACSIS database content at this point in the testing process. Appendix A provides a list of the types of items examined in Tier 1 Testing by the MACSIS staff.

Tier 2 – Production Simulation Testing

Tier 2 testing is the final stage before approval is granted to submit claims into the HIPAA-compliant Diamond Production Environment.

This level of 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. Since Tier 2 testing is the first time the data in the test files is compared to the data in the Diamond environment, issues such as discrepancies in Tax-ID and/or provider addresses will become apparent in Tier 2 testing. Appendix C provides a list of the types of items examined in Tier 2 Testing by the MACSIS staff.

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 Tier 2 test files containing just one UPI per file. Once the Tier 2 test files are approved on a per-UPI basis, then a final combined Tier 2 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 4010 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 Tier 2 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 before Tier 2 approval will be granted.

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.

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.

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.

APPENDIX A
MACSIS HIPAA EDI TESTING CHECKLIST FOR TIER 1

#	*Requirement*	*MACSIS Guideline*	*Loop/Segment /Element*	*SNIP Type*
	FILE NAMING CONVENTION			
O1	Proper file naming convention is used (Jxxxxxx#.julyy)	42A	N/a	7
	CONTROL SEGMENT USAGE			
C1	Expected segment, field and component delimiters used as outlined in Guidelines	40D6	ISA	7
C2	ISA envelope is a fixed length of 105 bytes	N/A	ISA	7
C3	ISA-06 and ISA-08 are properly coded	41A2	ISA	7
C4	ISA-13 matches IEA-02 (Interchange Control Numbers)	N/A	ISA and IEA	7
C5	GS-02 and GS-03 (Application Sender and Receiver Codes) are properly coded	N/A	GS	7
C5	SE02 (Trans Set Control #) equals the total number of lines in the file minus four	N/A	SE	7
	SUBMITTER/RECEIVER Ids			
S1	Submitter ID equals valid MACSIS UPI number, MACSIS Vendor number or MACSIS-Assigned VAN ID	41A2	1000A/NM109	7
S2	Receiver ID is valid Board Number and Type	41A2	1000B/NM109	7
S3	Receiver Name is valid Board Name	41A2	1000B/NM103	7
	PROVIDER INFORMATION			
P1	Agency Tax-ID is valued and is in the correct format (ex., with hyphen is present)	N/A	2010AA/NM109	7
P2	Agency UPI number is present; 12 bytes, leading zeros	N/A	2010AA/REF02	7
P3	If Pay-To Provider information is applicable, tax-id is provided with hyphen	N/A	2010AB/NM109	7
P4	If Pay-To Provider information is applicable, the MACSIS-assigned vendor number is provided in a 15-byte, leading zero format.	N/A	2010AB/REF02	7
P5	If rendering provider information is sent (i.e., not used for MACSIS adjudication purposes), then it is coded correctly	N/A	Loop 2310B	7
	SUBSCRIBER INFORMATION			
B1	Claim Filing Indicator Code equals "ZZ"	N/A	2000B/SBR09	7
B2	Client First and Last Name are provided	N/A	2010BA/NM103 and NM104	7
B3	Client suffix is provided in EITHER NM107 or NM103	N/A	2010BA/NM107 or NM103	7
B4	Valid date or birth and gender code is provided		2010BA/DMG02 and DMG03	7
B6	Client SSN is provided (without hyphens)	N/A	2010BA/ REF02	7
B7	Destination Payer Name and ID is MACSIS	N/A	2010BB/NM103 and NM109	7
	CLAIM INFORMATION			
M1	Patient Control Number contains expected value per provider's system needs (see Guidelines for specific AOD prevention requirements).	44B	2300/CLM01	7
M2	Total claim charge amount and corresponding	N/A	2300/CLM02	7

#	*Requirement*	*MACSIS Guideline*	*Loop/Segment /Element*	*SNIP Type*
	decimal point usage (implied or explicit) is correct			
M3	ICD-9-CM diagnosis code is present when required for procedure, billable under MACSIS and does not contain a period	44E	2300/HI segment	7
	OTHER PROVIDER INFORMATION			
X1	Rendering Provider Information, if provided, is properly coded. (Note: Not required for MACSIS)	N/A	Loop 2310B	7
	OTHER PAYER INFORMATION (IF APPLICABLE)			
R1	If other payer involved with claim, other payer paid amount is provided and logically corresponds to the ODJFS Coordination of Benefits (COB) Indicator value in Loop 2330A/REF02. The amount is correct given decimal point usage (implied or explicit).	44F	2320/AMT02	7
R2	For Medicaid eligible services to Medicaid eligible clients, Other Subscriber Secondary ID is valued to ODJFS COB Indicator.	N/A	2330A/REF02	7
R3	For Medicaid eligible services to Medicaid eligible clients, other payer paid amount is valued correctly when ODJFS COB indicator is present	N/A	2320/AMT02	7
	SERVICE INFORMATION			
L1	One service loop per claim loop is provided	44A1	2400 Loop	7
L2	Proper "product/service qualifier" is used for the procedure being billed (i.e., HC for HCPCS and ZZ for non-healthcare procedure codes)	N/A	2400/SV101-1	7
L3	Service code is valid for date of service	N/A	2400/SV101-2	7
L4	Modifier 1 is always present	N/A	2400/SV101-3	7
L5	Unit or Basis for Measurement Code is valued to "UN"	N/A	2400/SV103	7
L6	Units of service were accurately calculated per rounding tables and do not exceed a one-tenth decimal place.	44C1	2400/SV104	7
L6	Emergency Indicator is "null" or "N"	N/A	2400/SV109	7
L7	Date/Time Qualifier is "472" for Service Date	N/A	2400/DTP01	7

Certain items beyond those noted above may be reported in the Tier 1 Test results as "Notes". These are items which will not prevent Tier 1 approval, however, offer further explanation or clarification so the submitter can assess if/how the data should be provided. Examples of "notes" are below:

- Loop 2010BB (Payer Name), N3 and N4 (Payer Address) are not required; however, if sent, the values should be "30 E. Broad Street, Columbus, OH 43215-3430".
- All PRV segments are no longer required per the October 2002 addenda.
- If both Loop 2300, CLM01 and Loop 2400, REF02 (where REF01 = 6R) are provided, MACSIS will only return Loop 2400, REF02 on the 835 remittance file.

APPENDIX B
MACSIS HIPAA EDI SCENARIOS FOR TIER 1 TESTING

#	*Test Scenario*	*Used to Verify*
1	○ Other payer is involved with the claim ○ Client is Medicaid Eligible ○ Service is Medicaid Eligible	○ Provider system can properly generate the Loops related to Other Payer Information (2320, 2330A and 2330B)
2	○ Other payer is involved with the claim ○ Service is not Medicaid Eligible	○ Provider system can properly generate the Loops related to Other Payer Information (2320 and 2330B)
3	○ Date of service is after July 1, 2003 ○ Billed service uses "new" MACSIS procedure, modifier codes and place of service codes	○ Provider system is using "new" MACSIS procedure, modifier and place of service codes for dates of service on or after July 1, 2003.
4	○ Same-day services (for dates of service on or after July 1, 2003) are "summed" per the MACSIS same-day service policies under HIPAA.	○ Provider system is "summing" same-day services appropriately. ○ Refer to MH Duplicate Claim Check Roll-Up Category Matrix for more information.

APPENDIX C
MACSIS HIPAA EDI TESTING CHECKLIST FOR TIER 2

#	Requirement	Loop/Segment/Element
1	Non-Medicaid rate changes have been updated by the board.	N/A
2	Current Medicaid Agreements have been submitted to Medicaid Policy Staff (ODMH and/or ODADAS).	N/A
3	• HIPAA Service Rate Forms (Medicaid and Non-Medicaid) have been faxed along with the Tier 2 Test form. • The rates as represented on the HIPAA Service Rate Form must match the rates as stored in Diamond (MHHIPAA). Additionally, the rates as provided on the Tier 2 Test file[2] must not be less than the rates on the HIPAA Service Rate Form and in Diamond.	N/A
4	The number of claims on the file represents a typical weekly submission for the provider, but does not exceed 500 claims[3].	N/A
5	Real Tax-ID is used on the test file	Loop 2010AA and/or Loop 2010AB, NM109
6	Although not required, it is highly recommended that the Billing Provider address match the address associated with the "UPI" number in MACSIS[4].	Loop 2010AA, N3/N4 segments
7	Although not required, it is highly recommended that the Pay-To Provider address match the address associated with the MACSIS Vendor Number.	Loop 2010AB, N3/N4 segments
8	Real client data is used on the test file for all services.	Loop 2010BA
9	Valid place of services under HIPAA are used	Loop 2300, CLM05-1 and Loop 2400, SV105
10	At least one claim includes ODJFS COB (coordination of benefits) information, if provider submitted COB information in SFY03	Loop 2320, AMT02 and Loop 2330A, REF02
11	All current contracted services are represented on file with correct HIPAA procedure, modifier and place of service code combinations as well as the correct rate.	Loop 2400/Segment SV1

[2] Once approved, it is not required that providers submit billed amounts that do not exceed their contracted Medicaid or Non-Medicaid rate in the production environment. It is only necessary during the testing phase so that it is clear that the provider and board have the same understanding about what the contracted rate is.
[3] See http://www.mh.state.oh.us/ois/macsis/claims/prov_fy03_clms.XLS for information about your average weekly volume of claim submission in FY03.
[4] See http://www.mh.state.oh.us/ois/macsis/mac.provf.top.html to verify address information as stored in MACSIS.

42. Topic: ASC X12N 837 Professional Claim File Submission Policies

A. File Naming Conventions

Incoming production claim files should be named Axxxxxx#.julyy, where "xxxxxx" = the MACSIS UPI or Vendor number on behalf of whom the claims are being sent (right-justified, zero-filled), "#" is a sequential number to identify separate and distinct file transmissions being sent on the same day, "jul" is the julian date the file was created and "yy" is the year the file was created.

> Ex. A0010431.31402 would be the file name for the first file sent to MACSIS from provider UPI # 001043 on November 10, 2002.

Incoming test claim files should be named similar to the production files, only the first character should be a "J" instead of an "A".

B. File Data Change Policy

Boards or MACSIS Administrators will not be permitted to change the contents of claims data submitted by a provider before forwarding the file to MACSIS. This is a State Auditor requirement.

C. File Transaction Limits

Boards or MACSIS Administrators must submit a provider-combined minimum of 100 service lines (2400 loops) per week to ensure processing of claims in a particular claim run. If the provider-combined claim volume for a given Board continues to be less than 100 service lines for a month, those claims will be processed in a special run. A provider-combined maximum of 50,000 service lines (2400 loops) per weekly claim run per Board will be processed.

D. File Acknowledgement

MACSIS will not be returning a 997 Functional Acknowledgement Transaction upon receipt of a file or files from a Board or MACSIS Administrator. Boards or MACSIS Administrators, however, may choose to return a 997 functional acknowledgement transaction to their respective providers if they can and want to create the transaction themselves.

E. File Validation Edits

Incoming claim files will be checked for basic MACSIS 837 Professional Claim Implementation Guide compliance, including but not limited to:

- Correct File Naming Convention Used
- Non-Duplicate File Name Submitted
- Basic 837P v4010 File Format Compliance
- Proper Use of Delimiters
- Proper Use of Loops and Segments
- One Service Line Per Claim Present
- Provider Approved to Submit Services via 837P

Only files passing basic MACSIS HIPAA compliance validation will be processed into MACSIS. Boards must not reject an entire claim file for reasons other than the specific criteria applied at the State level (examples noted above) unless the provider and board mutually agree it is in the provider's best interest to resubmit the file.

F. Processing Schedule

1. Timeliness of Billing File Posting By Board or MACSIS Administrator

If a provider specifically requests an acknowledgement that their home Board received their claim file(s), the Board or MACSIS Administrator must honor that request within two business days of the request for acknowledgement. The Board and provider must mutually agree via their trading partner agreement (TPA) how file acknowledgement will be provided. For example, it can be provided via the recommended HIPAA-standard 997 functional acknowledgement transaction as supported by the Board/MACSIS Administrator or via another method such as e-mail.

If acknowledgement is handled via the 997 Functional Acknowledgement transaction, the standard data elements on that transaction will dictate the information exchanged between the Board and provider.

If acknowledgement communication is handled via email or fax, the provider must specify in their request to the Board or MACSIS Administrator the submitted file(s) name, total billed amount, number of claims and the date submitted. The Board or MACSIS Administrator should reply with the submitted information attached, indicate if the file was received and provide an estimated date of when the file will be loaded into MACSIS. Providers must understand the date provided is only an estimate and may change if the file is later found to reject from MACSIS due to format or content errors and/or unforeseen problems with the MACSIS system.

All Boards or MACSIS Administrators are required to notify their providers within seven business days of receiving a claim file if the file was accepted and processed into MACSIS and the corresponding MACSIS batch number under which it was processed or if the file was rejected. If the file was rejected, the Board or MACSIS Administrator must indicate the generic reason why and what action the provider is expected to take accordingly.

Boards or MACSIS Administrators may choose to communicate status of received and/or processed files via a website accessible to their providers. The return of standard reports to

the provider, such as the Claim Error Report, Claim Processing Reports or other Board-produced reports clearly indicating that the file was processed into MACSIS and/or rejected and why would suffice as acknowledgment to the provider, if sent to the provider within seven business days of submission of the file.

Boards or MACSIS Administrators may not choose to process files only monthly or semi-monthly. If files have been submitted, they must be processed weekly unless there are MACSIS system problems preventing the State or Board/MACSIS Administrator from processing files. If the latter occurs, the Boards or MACSIS Administrator will notify their submitting providers of the problem and status. (Please note that the posting of a provider's file may be delayed, if the total number of claims received by a Board for a particular week is under 100 claims.) Boards or MACSIS Administrators are also required to ensure a tracking system is in place to ensure provider files are submitted timely and accurately to MACSIS.

Providers are encouraged to submit claim files on a routine, timely basis and to not submit claim files less frequently than once a month. This will help to ensure the timely adjudication of provider claims.

2. *MACSIS Processing Schedule*

Boards or MACSIS Administrators will be assigned a designated day per business week when their claims will be processed into the MACSIS system. The assigned day may shift due to holidays, mutual agreement between the Board/MACSIS Administrator and MACSIS staff, scheduled or unscheduled system downtime. To view current monthly MACSIS schedules, see http://www.mh.state.oh.us/ois/macsis/mac.sched.index.html.

G. MACSIS 837 Professional Claim Informational Guide

A technical information guide is available to provide further information on recommended values for specific loop, segment and data elements on the 837 Professional Claim transaction to ensure proper adjudication of claims in MACSIS. This is only a guide and not intended to instruct the submitter as to what *must* or *must not* be provided on the transaction. The guide includes further information for required fields and only those situational fields which MACSIS will use for adjudication purposes. All other data elements are not included, but can be submitted by the provider within HIPAA guidelines. Refer to http://www.mh.state.oh.us/ois/macsis/claims/837.prof.claim.guide.pdf for a copy of the 837 Informational Guide.

43. Topic: ASC X12N 835 Health Claim/Payment Advice Return Policies

A. File Compliance

1. 100% Payment for Medicaid Services

Per the ODJFS/ODMH interagency agreement and the Board's M-SPA, please note the following:

- **Beginning in FY 2000, State and local public fund match verification will no longer occur at the community mental health (CMH) agency level. Rather, the Board now must be able to verify that each valid Medicaid claim is fully paid from State or Local public funds prior to claiming federal financial participation payments (FFP).** The sole exception is where a governmental entity is the CMH agency. The Board will need to be able to document the expenditure of eligible public matching funds prior to claiming FFP.

- There is agreement within the departments that when a Board goes live on MACSIS, providers will receive 100% of the Medicaid contracted rate by a Board when the service is billed minus amounts of ACTUAL payments received from other carriers as reported in Loop 2320 (Other Subscriber Information), COB Amount Segment.

- Payment will be made at the time of adjudication in MACSIS, contingent upon the interface/interactions between the Board and the County Auditor.

- Medicaid claims that meet criteria to submit to ODJFS will be extracted from MACSIS and submitted to ODJFS for adjudication. This process is more informally known as the double loop process where the first loop represents the Board provider contract relationship and the second loop represents the State to ODJFS to Board relationship. If a Board has paid a claim and then the claim is denied by ODJFS, the double loop process automatically reverses the claim and recovers the payment the next time claims are adjudicated by the Board. If a claim is submitted with Medicaid as a secondary payor, then the following process will be used to ensure the proper amount is submitted to ODJFS.

- The ASC X12N 837 Professional Claim Format contains two data elements used to reflect the liability of the primary carrier for coordination of Benefits (Loop 2320, Field AMT02 (COB Amount) and Loop 2330A, Field REF02, Other Insured Additional Identifier). Using this data, MACSIS will automatically deduct the amount paid from the Allowed amount. If the claim is Medicaid reimbursable then this Net Amount will be extracted from MACSIS and submitted to ODJFS through the Double Loop process.

- Payment to the provider must be disbursed no later than 30 calendar days from the claim being included on a State-Produced ASC X12N 835 Health Care Claim/Payment Advice. A copy of the electronic remittance advice file must accompany payment and/or be disbursed prior to receipt of the payment.

2. *Disbursement of Remittance Advice*

At least initially, the State will create both a standard ASC X12N 835 Health Care Claim/Payment Advice as well as the existing Electronic Remittance Advice (ERA) proprietary format. Boards or MACSIS Administrators may add additional information to the proprietary ERA format only in the designated Board area. Boards or MACSIS

Administrators may not modify the ASC X12N 835 Health Care Claim/Payment Advice file as provided by MACSIS prior to disbursing it to the provider.

Due to the operational efficiency issues surrounding disbursement of electronic remittance information to non-contracting providers, MACSIS will continue to provide print-image files of the existing MACSIS Remittance Advice Report and MACSIS/ODJFS Reject Report to the Boards or MACSIS Administrators. It would be the Board's responsibility to determine which file types (835, print-image, etc.) should be initially disbursed to non-contracting providers within HIPAA guidelines and on what medium. If, however, a non-contracting provider requests an electronic 835 file, the Board or MACSIS Administrator must comply with that request regardless of file size per HIPAA regulations. Boards are not required to provide both a paper remittance advice and an electronic remittance advice file. Only the latter is required per HIPAA regulations.

Further information regarding the format of the existing Electronic Remittance Advice (ERA) proprietary format and any print-image remittance advice reports can be found at http://www.mh.state.oh.us/ois/macsis/mac.pay.paper.remit.reports.index.html .

3. *Timeliness of Payment*

Boards must remit 100% payment from non-Federal funds to the provider for Medicaid services within 30 calendar days of the claim being included on a State-produced ASC X12N 835 Health Care Claim/Payment Advice. Remitting payment means actually disbursing the check and the 835 file within the 30-day timeframe. The 835 file may precede the check or accompany the check, but cannot be disbursed after the check. This federal requirement applies to both in-county and out-of-county provider payments.

The 30-day timeframe is based on OAC 5101:3-1-19.7, which requires providers to be paid prior to the FFP reimbursement from ODJFS being received by the Departments. Thirty calendar days is the estimated timeframe by which the FFP will be received by the Departments. Many Boards or MACSIS Administrators disburse HIPAA-compliant remittance data much sooner than 30 calendar days after the creation of the State-produced ASC X12N 835 Health Care Claim/Payment Advice, which is acceptable and, in fact, encouraged. However, a 30-day timeframe has been established to also permit paper disbursements of remittance advices as requested by providers, which requires more time than electronic disbursements, and to accommodate, when possible, some provider's requests to receive the remittance advice and checks at the same time rather than separately.

Boards must also disburse an ASC X12N 835 Health Care Claim/Payment transaction to their providers for non-Medicaid services within 30 calendar days of the distribution of the State-produced ASC X12N 835 Health Care Claim/Payment Advice which includes the claim. If a Board has contractually agreed to pay a provider for non-Medicaid services on a fee-for-service (FFS) basis and/or the Board is using federal funds to pay for the non-Medicaid services, a check must also be disbursed in this timeframe.

Boards or MACSIS Administrators must disburse an ASC X12N 835 Health Care Claim/Payment file to a provider, even if all of the claims on the file are denied. Boards or MACSIS Administrators should check every Monday for 835 files in their Unix directory because they may have claims they are responsible for paying which came into the system via another Board.

B. File Naming Conventions

ASC X12N 835 Health Care Claim Payment/Advice files will be named according to the format Abbbxxxxxx.julyy. An example is A25B001043.31402, where:

- "A" is a constant used to identify the file as an ANSI-compliant file. (Note: ANSI is American National Standards Institute.)
- "bbb" equals the remitting Board's number and type code (ex. 25B for Franklin ADAMH).
- "xxxxxx" equals the provider's MACSIS-assigned UPI number (ex. "001043")
- "jul" equals the julian date the file was created (ex. 314 for November 10th)
- "yy" equals the year the file was created (ex. 02 for 2002)

The supplemental, existing proprietary ERA format naming convention will remain the same (ex. 25B01043.314). If test 835 files are disbursed during the testing process, then the test 835 files will named according to the convention noted above, except the first character will be a "J" instead of an "A".

- A weekly 835 Summary File will be made available to Boards to audit and balance to the individual 835 Health Care Claim Payment/Advice files created. These files will be named Sbbb835Summary.julyy (ex. S25B835Summary.31402)

- If an ERA or 835 file needs to be recreated at the request of a Board or due to a system problem, the naming convention for the recreated file will be the same as noted above, except "R" will be added to the end of the file extension (ex., A25B001043.31402R or 25B01043.314R). The julian date of the recreated file will remain the date the file was originally created.

- Please note that ARA files returned to the Boards via the Double Loop process will be named PRbbb351.ASC (MH) and PRbbb451.ASC (AOD) for claims processed in the new HIPAA environment (ex. PR25B351.ASC).

C. File Transaction Limits

There are no applicable file transaction limits at this time.

D. File Content

The ASC X12N 835 Health Care Claim/Payment Advice will encompass the following:

- The 835 Health Care Claim Payment/Advice file will be produced as a "notification only" file (see Segment BPR01, Transaction Handling Code for more information). The reason for this decision is because the actual payment funding method associated with claim payment transactions on an 835 file are determined individually by Board outside of the MACSIS system process. For this reason and the fact that some providers sharing the same MACSIS vendor information use disparate computer systems, the State will be producing one 835 file per provider (i.e., UPI), not MACSIS Vendor. The 835 file will, however, contain both provider and MACSIS vendor information in the appropriate loops and segments.

- Only paid or denied claims will be included on the ASC X12N 835 Health Care Claim/Payment Advice, not held or pended claims.

- "Negative Balance Due" claims (i.e., claims where the net total due back from the provider is a negative or debit balance) will be included on the ASC X12N 835 Health Care Claim/Payment Advice. This information is provided on the existing supplemental MACSIS electronic remittance advice (ERA) files as preferred by the majority of Boards and providers.

E. MACSIS Processing Schedule

The State-produced ASC X12N 835 Health Care Claim/Payment Advice files and supplemental proprietary ERA files are estimated to be produced approximately one week following the date the claim is finalized in the MACSIS system (also referred to as the "AP Date"). Files are generally produced over the weekend and made available to the Boards or MACSIS Administrators by Monday afternoons, unless there is scheduled or unscheduled system downtime or other system issues prohibiting production. To view current monthly MACSIS schedules, see http://www.mh.state.oh.us/ois/macsis/mac.sched.index.html.

Boards and providers can monitor the amount of claims finalized by week, month or fiscal year using the reports available on the MACSIS webpage. (See http://www.mh.state.oh.us/ois/macsis/mac.rpts.index.html).

F. MACSIS 835 Health Care Claim Payment/Advice Informational Guide

A technical information guide is available to provide further information regarding the anticipated values for specific loop, segment and data elements on the 835 Health Care Claim Payment/Advice transaction as claims are adjudicated in MACSIS. This is only a guide and not intended to limit the values which may or may not be provided on the transaction. The guide includes further information for required fields and only those situational fields which MACSIS will use for adjudication purposes. All other data elements conditionally available for use under HIPAA but not intended for use under MACSIS are not included. Refer to http://www.mh.state.oh.us/ois/macsis/claims/835.claim.pay.advice.pdf for a copy of the 835 Informational Guide.

44. Topic: Data Content Policies

A. One Service Line per Claim

For claims submitted on an 837P file, there can only be one service line per claim to ensure proper adjudication within MACSIS. It will be necessary to repeat the claim information for each service line in the claim file.

1. *Medicaid Implications*

   To maximize potential Medicaid revenue, only one detail service line can be submitted per claim. The MACSIS program used to extract Medicaid services for further adjudication by ODJFS only reads the first line of service on the claim. Additionally, MACSIS adjudicates all service lines associated with a claim based on the eligibility status of the member as determined by the primary date on the claim. For example, if a client has not previously been Medicaid eligible, all claim lines may adjudicate as non-Medicaid when in fact eligibility may have changed during the time period covered by the detail service lines. For these reasons, any 837P file that contains more than one detail service line per claim will be rejected.

2. *MACSIS Definition of a Medicaid claim*

   When a Medicaid covered service is provided, MACSIS will automatically determine if a service unit(s) is billable to Medicaid by checking the service code, service date, modifier(s), place of service, and client's Medicaid eligibility on that day of service.

B. Non-Client Specific Services

(Examples: BH Hotline – H0030, MH Prevention – M4110, MH Education – M4140, AOD Training- H0021, AOD Prevention – A0610/A0660, AOD Transportation – A0750)

The MACSIS Member team has developed a recommendation to track non-client specific services that is fully documented in the Member User Documentation (http://www.mh.state.oh.us/ois/macsis/manuals/hipaa.member.manual.pdf). In short, this will be accomplished by creating a pseudo-client number that can be used to capture services that are not limited to a single identified member at a time. Services such as MH - Community Education or Alcohol and other Drug Addiction Prevention fall into this category. AoD Services designated as "non-client specific" must use a pseudo UCI and are marked with an "*" on the ODADAS Procedure Code Table at http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf . MH services are not designated as "non-client specific" but do allow pseudo UCIs to be used when appropriate and in accordance with parameters established in the Member Manual.

All pseudo-clients must be entered manually by the Board staff and meet format requirements. Please note that claims pertaining to non-client specific services, if submitted electronically, must still be submitted via the ASC X12N 837 Professional claim format as outlined in this document.

For AOD prevention services (Information Dissemination: A0610, Education: A0620, Community-Based process: A0630, Environment: A0640, Problem Identification and Referral: A0650, and Alternatives: A0660) providers should pass service delivery information in the control number fields on the 837 professional claims file (Loop 2300, CLM01 or Loop 2400, REF02). The service delivery information identifies the population characteristics of those who received the prevention service and should be formatted as follows:

- Delimited, not fixed-length format
- Delimiters are letters which identify the values immediately following the letters
- Order of delimiters is:
  - U, S or I to indicate "universal, selected or indicated" statistics, M = # of Males, F = # of Females, S = # under the age of 21, T = # between ages of 21 and 44, U = # between ages of 45 and 64, V = # 65 and over, W = # of Whites, Not Hispanic, B = # of Blacks, Not Hispanic, N = # of Native Americans, A = # of Asian or Pacific Islander, H = # of Hispanic/Latino
- Examples:
  - Universal, 20 males, 100 Females, 75 under 21, 45 age 24-44, 65 White, 40 Black, 15 Mexican would be sent as : UM20F100S75T45W65B40H15
  - Selected, 25 males, 0 Females, 25 65 and Over, 25 White would be sent as: SM25V25W25
- As a matter of explanation, one can apply the IOM framework to an adolescent population:

  Universal - all students at Smith High School
  Selected - survey results show that the transition from 8th-9th grade is often accompanied by increased ATOD use, so the program targets all freshmen (at risk).
  Indicated - freshmen who have violated school ATOD policies.
- If one were to apply the IOM framework to an adult population:

  Universal - all senior citizens living in Smith City
  Selected - all senior citizens living in Smith City who take prescription medications
  Indicated - all senior citizens living in Smith City who drink alcohol and take prescription medications

If prevention services are provided, for example, to two elementary classes, once in the morning and once in the afternoon, the control number should be calculated with the number of attendees totaled. Please note that the submission of service data delivery via the 837P file replaces the requirement to submit minimum data set (MDS) data separately.

NOTE: To accommodate the use of the 837P control number fields for both service delivery data and provider-assigned control numbers, prevention providers have the option of placing a "Z" between the service delivery data and their provider-assigned control number. For example in the above case, the program would report:

UM20F100S75T45W65B40H15Z##### where ##### provides uniqueness to the provider-assigned control number. This information will be returned to the provider on the 835 Health Care Claim/Payment Advice file in the appropriate control number data elements.

C. Procedure Codes

To assure proper adjudication, claims must include the procedure codes contained in the MACSIS Procedure Code table for ODMH at http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.code.table.pdf or ODADAS at http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf.

1. Service Units Rounding Conventions

ODMH and ODADAS require the following rounding conventions to be used when reporting service units. The appropriate OAC will be modified to reflect proposed changes in the billable unit policy. Please refer to the procedure code taxonomy for definition of appropriate billing units.

a. 15 Minute Service Unit (1 unit = 15 minutes)

- APPLIES TO THE FOLLOWING SERVICES:

  BH Counseling and Therapy (H0004, MH and AOD)
  Community Psychiatric Supportive Treatment (H0036)
  MH Self-Help/Peer Services (H0038)
  Alcohol and/or Other Drug Service Group Counseling (H0005)
  Alcohol and/or Substance Abuse Service Family/Couple Counseling (T1006)

- Services that are measured in 15 minute increments should be billed in whole units. If these claims are submitted with less than one unit of service or for partial units, they will be denied.

- Services exceeding seven minutes must be rounded to the nearest whole unit in accordance with the following table:

TIME SERVICE PROVIDED	UNITS TO BILL
0 minutes to 7 minutes	Not billable
8 minutes to 22 minutes	1
23 minutes to 37 minutes	2
38 minutes to 52 minutes	3
53 minutes to 67 minutes	4
68 minutes to 82 minutes	5
83 minutes to 97 minutes	6

- If the same service is legitimately provided on the same day to the same client, the service minutes must be summed for the date of service, then rounded according to the table as noted above and submitted as one service line on the claim.

- Actual minutes must be accurately reflected in the clinical records. Each encounter for the day should be recorded separately in the clinical record. You must either a) record the start and end time of each encounter or b) record the start time and duration (in minutes) of each encounter.

Scenario:

MH Community Psychiatric Supportive Treatment (H0036) is provided face-to-face by the same agency three times during a single day to the same client. This provider bills MH Community Psychiatric Supportive Treatment at $50 per unit of 15-min. service. When the "sum and round" methodology is used, the units of service on the bill would be calculated as follows:

Clinician (Staff)	Date of Service	Client	Duration	Start Time	Billable Service	Billable Units	Billable Rate
Clinician A	7/5/03	Joe Client	7 min.	9:00 am	H0036	---	---
Clinician B	7/5/03	Joe Client	23 min.	11:00 am	H0036	---	---
Clinician C	7/5/03	Joe Client	3 min.	4:00 pm	H0036	---	---
TOTAL BILLED as one line item	***7/5/03***	***Joe Client***	***33 min***	----	***H0036***	***2***	***$100***

b. Hourly Based Service Units

- APPLIES TO THE FOLLOWING SERVICES

  BH Hotline (H0030)
  Crisis Intervention – MH services (S9484)
  MH Assessment, Non-physician (H0031)
  Psychiatric Diagnostic interview – Physician (90801)
  Pharmacologic Mgt (90862)
  Occupational Therapy (M1430)
  Adjunctive Therapy (M1440)
  School Psychology (M1530)
  Adult Education (M1540)
  Social & Recreational (M1550)
  Employment/Vocational (M1620)
  Consumer Operated Service (M3120)
  MH Svcs, Not otherwise specified - Healthcare (H0046)
  Other MH Svcs – Non healthcare (M3140)
  Prevention (M4110)
  Consultation (M4120)
  MH Education (M4140)
  Information and Referral (M4130)

  Alcohol and/or Other Drug Service Assessment (H0001)
  Alcohol and/or Other Drug Service Case mgt (H0006)
  Alcohol and/or Other Drug Service Crisis Intervention (H0007)
  Alcohol and/or Other Drug Service Medical/Somatic (H0016)

Alcohol and/or Other Drug Service Consultation (A0560)
Alcohol and/or Other Drug Service Intervention (H0022)
Alcohol and/or Other Drug Service Referral and Information (A0510)
Alcohol and/or Other Drug Service Training (H0021)
BH Outreach (H0023)
Alcohol and/or Other Drug Svc Prevention Environmental Svcs (A0640)
Alcohol and/or Other Drug Prevention Problem Id & Referral (A0650)
Child Sitting services for children of the individual receiving alcohol and/or substance abuse services (T1009)
Alcohol and/or Substance Abuse Services, Not Otherwise Classified (T1011)

- If the same service is legitimately provided on the same day to the same client, the service minutes must be summed for the date of service, then rounded according to the table below and submitted as one service line on the claim.

- All hourly based services require the following rounding conventions to be used when reporting service units. Hourly-based services should be rounded to the nearest tenth as follows:

Time Service Provided	*Units to Bill*
0 minutes to 7 minutes	Not Billable
8 minutes	.1 Units
9 minutes to 14 minutes	.2 Units
15 minutes to 20 minutes	.3 Units
21 minutes to 26 minutes	.4 Units
27 minutes to 32 minutes	.5 Units
33 minutes to 38 minutes	.6 Units
39 minutes to 44 minutes	.7 Units
45 minutes to 50 minutes	.8 Units
51 minutes to 56 minutes	.9 Units
57 minutes to 62 minutes	1.0 Units
63 minutes to 68 minutes	1.1 Units

- Actual minutes must be accurately reflected in the clinical records. Each encounter for the day should be recorded separately in the clinical record. You must either a) record the start and end time of each encounter or b) record the start time and duration (in minutes) of each encounter.

Progress Note (and implication for billing)

Service Date	Actual Time	Service name	Service Time	Units of Service
7/27/03	8:05 – 8:15	Crisis Intervention	10	--
7/27/03	12:00–12:05	Crisis Intervention	5	--
7/27/03	3:45 – 4:00	Crisis Intervention	15	.--
	Total Billed as one line item		**30**	**.5**
7/31/03	9:00 – 9:27	Pharmacologic Mgt	27	--
7/31/03	11:15 – 11:20	Pharmacologic Mgt	5	--
7/31/03	2:00 – 2:05	Pharmacologic Mgt	5	--
	Total Billed as one line item		**37**	**.6**

c. Day- Based Services

- APPLIES TO THE FOLLOWING SERVICES:

  MH - Partial Hospitalization (S0201)
  MH Residential services that do include Room and Board: (See http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.housing.table.pdf for more information about MH Residential service code definitions and examples.)

  Crisis Care (M2280)
  Temporary Housing (M2290)
  Residential Care(M2200)
  Foster Care (M2250)
  Respite Care (M2270)
  Subsidized Housing (M2260 – Daily or Monthly)
  Community Residence (M2240 – Daily or Monthly)
  Temporary Housing (M2290)

  Alcohol and/or Other Drug Service Intensive Outpatient (H0015)
  Alcohol and/or Other Drug Service Ambulatory Detox (H0014)
  Alcohol and/or Other Drug Medical Cmty Res Treatment Hosp Setting (A1210)
  BH Medical Cmty Res Treatment (H0017)
  Alcohol and/or Other Drug Service Medical Cmty Res Treatment
  Non-Hospital setting - includes Room & Board (A0230)
  BH Alcohol and/or Other Drug Service Medical Cmty Res Treatment
  Non-Hospital setting - without Room & board (H0018)

Alcohol and/or Other Drug Service Non-Medical Cmty Res Treatment includes Room & Board (A1220)
BH Non-medical Cmty Res Treatment -without Room & Board (H0019)
Alcohol and/or Other Drug Service Observation or inpatient hospital care for a patient who is admitted and discharged on the same date with a presenting problem of high severity (99236)
Alcohol and/or Other Drug Service Sub-Acute Detox (H0012)
Alcohol and/or Other Drug Service Acute Detox – Hosp inpatient (H0009)
Room and Board (A0740)

- Effective July 1, 2001, a client no longer has to be in the MH - partial hospitalization program (S0201) at least three hours in order to bill for the service. However, agencies must bill fractional units of a partial hospitalization program day if the client is not in the program for the entire program day. The agency must bill the percentage of the program day that the client attends the program for a given day. For example, if the client is in the program two out of three hours of the agency's partial hospitalization program day, the agency can bill 2/3's of a unit (.67 of a unit). However, the agency will need to round to the nearest tenth of a percent of a unit (.7) to bill through MACSIS. All of the fractional units of partial hospitalization should be rounded to the nearest tenth of a unit. Please remember, however, that the edits are still in place in MACSIS to allow a maximum of one unit of partial hospitalization a day for adults and two for children.
- Actual time must be accurately reflected in case records
- MACSIS will only accept a maximum of 1.0 unit per day for all day based services EXCEPT Children's Partial Hospitalization where MACSIS will accept 2 units.

2. ***Multiple Rates/Sites For Same Service***

If a provider offers different programs that fall under the same procedure code and these different programs have different rates or unit costs or are provided at different sites, the Board has the option of requiring the provider to use one of the following solutions:

The rates may be blended based on the expected volume and cost of each service;

If the programs are provided at different CERTIFIED sites, a second Unique Provider Identifier (UPI) could be issued, and the two separate programs would be billed under the same procedure code, but separate UPIs or;

If the programs are in the same physical location, the Board will assign one of the nine alternate procedure codes where the 5th position of the **MACSIS-DEFINED** procedure code would be used to distinguish multiple rates/sites for **same NON-HEALTHCARE service**. This distinction is not permitted with HCPCS (Healthcare Common Procedure Coding System) or CPT (Current Procedural Terminology) codes used to capture nationally recognized healthcare services. Please refer to the procedure code table for additional clarity.

For example: If a MH provider offers two **EMPLOYMENT** programs with different rates, that provider would have a single UPI and bill using two separate procedure codes: where M1620 is the standard code and could be used for one program and the second program could use **M1621.**

3. ***Other Mental Health Services***

Board and agencies may determine the exact procedure code used to capture certified Other Mental Health services. There is an option to identify services as other healthcare versus other non-healthcare services based on whether the specific certified service falls into a healthcare versus a non-healthcare category as determined by the boards and agencies.

- **MH Services, not otherwise specified – Health care (H0046)**: is to be used for healthcare services that have been certified by ODMH as "Other". It is important to recognize if the national standard code is used, the rate for the service would have to be a blended rate for all healthcare services falling under the "other mental health" category.

- **Other Mental Health - non health care (M3140)**: is to be used for non-healthcare services that have been certified as "Other" by ODMH. If this option is used, position 5 in the procedure code could be used to identify specific programs and bill by program cost instead of a blended rate.

4. ***Rates for Shared Procedure Codes***

Separate rates will be possible under MACSIS for services that share the same procedure code (ex., H0004 for BH Counseling and Therapy, Individual or Group for MH and Individual BH Counseling and Therapy for AOD). Modifier 1 will be used to distinguish which type of service is provided and will the drive the rate accordingly.

D. Modifier Codes

When a modifier is applicable to a claim, the code must be one of the nationally defined modifier codes contained in the modifier code table available for ODMH at http://www.mh.state.oh.us/ois/macsis/codes/mh.hipaa.modifier.code.table.pdf and for ODADAS at http://www.mh.state.oh.us/ois/macsis/codes/aod.hipaa.modifier.code.table.pdf and valued in the order outlined in that same table to assure proper adjudication.

1. ***Modifier Coding Guidelines***

It is essential Modifiers be valued in accordance with ODMH and/or ODADAS Modifier tables noted above. Please note the following:

- Modifier 1 will be required to ensure proper pricing in MACSIS
- Modifier 2 may be necessary to ensure proper adjudication in MACSIS
- Modifiers 1 and 2 will be used for duplicate claim checking
- Modifier positions 3 and 4 do not affect pricing and adjudication but are reserved for board use.
- For MH services, the use of "GT" (Telephone) for MH Medicaid covered services or for Housing and Residential services in modifier 3 or 4 will result in a denied claim.

- For MH Medicaid covered services, if "HS" (Family/couple without client present) is in modifier 3 or 4, and "UK" is not in modifier 2, the claim will be denied.
- Some vendors require modifier values in consecutive positions
  - If required, place "99", which means "Multiple Modifiers", in modifier 2 or 3 as needed.
  - If not required, modifier 2 may be left blank
  - A blank or "99" modifier are treated the same within MACSIS and must be summed for same-day services (see Section 44I for more details about the same day service reporting policies).

2. ***Identifying Other Fund Sources For Non-Healthcare Services***

   Board(s) may determine the exact procedure code used to capture service information that is paid for with public dollars from other fund sources for Non-Healthcare Services. Each Board has the option to identify other payer sources via national standard modifiers for health care services. For non-healthcare services, it is recommended that the Board instruct their providers to value the third or fourth modifier to the appropriate national standard value to identify funding sources if necessary and as available.

3. ***Clients Treated in an Institution For Mental Disease- IMD (POS = 51) or Treated While in the Penal System (POS = 99)***

   Services provided while the client is in an IMD or while the patient is in the penal system will no longer be identified via the use of modifier codes. This is because national standard modifier codes do not exist to identify these instances.

   For clients treated in an IMD, services should be submitted with a place of service code of "51 – Inpatient Psychiatric Facility" on the claim. For more information about what constitutes an IMD, refer to 42CFR 435.1009. For clients treated while in the penal system, services should be submitted with a place of service code of "99 – Other Unlisted Facility" on the claim.

   Please note the following:

   - Even though Medicaid eligible services provided to Medicaid eligible clients in the penal system (based on eligibility reflected in MACSIS at the time the claim is processed) will be identifiable via the place of service code "99", these services will be adjudicated as "paid" in MACSIS and forwarded to ODJFS to make the final determination about the client's eligibility at the time of service.
   - Medicaid eligible services to Medicaid eligible clients 21 or under or 65 and older with Place of service code 51 (Inpatient Psychiatric Facility) will be sent to ODJFS for final adjudication.
   - There are two locations on the 837 Professional Claim Transaction where place of service information can be provided. Loop 2300, Field CLM05-1, Facility Code Value (required) or Loop 2400, Field SV105, Place of Service Code (situational). Since there should be one Loop 2300 for each Loop 2400, if both are valued, technically, both place of service codes should match. However, if both are valued and they do not match, the

place of service code in Loop 2400 will be used for adjudication purposes. If Loop 2400 is not valued, the place of service code in Loop 2300 will be used.

- Through the use of benefit rules, Boards will have the flexibility to pay, hold or deny these services provided to non-Medicaid eligible clients

4. ***Clients Treated Via the Telephone***

If clients are treated via the telephone, providers should specify modifier "GT –Interactive Telecommunications" in Modifier 1 for MH Individual Community Psychiatric Supportive Therapy (H0036) and MH Crisis Intervention (S9484). Please note that only MH Individual Community Psychiatric Supportive Therapy (H0036) is permissible via the telephone under Medicaid Policy and will be forwarded to ODJFS for adjudication. Although this modifier may also be used for MH Crisis Intervention, it is not a Medicaid reimbursable service when done via telephone. The "GT" modifier should not be used with other procedure codes, including MH Hotline.

5. ***Services Provided to Significant Others, Other Professionals or Family When the Client is NOT Present***

Modifier "UK" (services provided on behalf of the client to someone other than the client) should be used to capture services provided to Significant Others, Other Professionals or Family when the client is NOT present. The use of modifier UK should only occur when Medicaid covered services are provided when the client is NOT present . Do not use "UK" with other MH services.

Examples:

Scenario	**Procedure Code**	**Mod 1**	**Mod 2**	**POS**	**Units**
Service in School o BH Counsel. & Therapy o 20-min at School o Family/ client Present	Round minutes to whole units per table *H0004*	HE		03	1
Service w/probation officer o BH Counsel. & Therapy o 20-min at office o client NOT Present	Round minutes to whole units per table *H0004*	HE	UK	03	1
Service in School and at home o BH Counsel. & Therapy o 30-min at School with teacher, client NOT present o 60-min at client's home with Family/ client Present in p.m.	Round minutes to whole units per table *Submit 2 claims:* *H0004* *H0004*	HE HE	UK	03 12	2 4

E. Place of Services Codes (a.k.a. Facility Value Codes)

1. *General Provisions*

The place of service codes are nationally defined as opposed to locally defined (as previously done) and can be found at http://www.mh.state.oh.us/ois/macsis/mac.codes.macsis.pos.codes.html. Under the ANSI standards, they are referred to both as Place of Service codes or Facility Value codes. The codes are similar to those used today, but not exactly the same. MACSIS will only refer to the place of service code for MH Medicaid reimbursable service adjudication purposes when valued to "51 – Inpatient Psychiatric Facility" (for IMD) or for clients treated while in the penal system, when valued as place of service code of "99 – Other Unlisted Facility".

2. *Clients Treated in an Institution For Mental Disease - IMD (POS = 51) or Treated While in the Penal System (POS = 99)*

Please refer to Section D. Modifier Codes part 3.

3. *Recommendations*

- If the actual Place of Service (POS) does not have a defined code use "11 – Office".
- For same-day services, if there are multiple POS and they are not POS – 51 or POS – 99, the services must be summed and linked to one of the acceptable place of service codes. If the same-day services are all provided in the penal system or IMD (ex. all "99"), then the same-day services must still be summed with POS code "99" or "51" accordingly.

F. Diagnosis Codes

1. *General Provisions*

HIPAA requires use of the most current published version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes for professional claims submission. Although providers may submit any current ICD-9-CM code, MACSIS will consider for payment claims containing only those diagnosis codes outlined in the Behavioral Health ICD-9-CM-Code Table at http://www.mh.state.oh.us/ois/macsis/codes/bhcare.icd9cm.codes.payment.hipaa.pdf.

- Not all services require diagnosis codes to be considered for payment. To determine if a service requires a diagnosis code, refer to the MH and/or AOD procedure code tables (http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.code.table.pdf and http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf
- Claims submitted with diagnosis codes not included in the table noted above will be denied in MACSIS.
- One of the AOD diagnosis codes listed in the diagnosis table must be provided when reporting AOD residential or AOD Detox services.

- Several diagnoses codes can be submitted at the claim level in Loop 2300, Segment HI – Health Care Diagnosis Codes, but MACSIS will only adjudicate a specific service based on the primary billing diagnosis code associated with the service line as indicated by Loop 2400, Field SV107-1 (Diagnosis Code Pointer = 1). Please note that if a claim is submitted with out a diagnosis code indicated in Loop 2300, Segment HI, but the diagnosis code pointer in Loop 2400, Field SV107-1 is valued, the claim will deny.

G. Reporting Other Carrier Information

Other carrier (i.e., payer) information is required on the 837P format, if other payers are known to potentially be involved in the paying of the claim. Please refer to the national standard HIPAA 837P implementation guide for further information regarding all of the other payer data that is required. MACSIS will only retrieve certain data elements from the required data set for adjudication purposes as noted in the MACSIS 837 Professional Claim Informational Guide http://www.mh.state.oh.us/ois/macsis/claims/837.prof.claim.guide.pdf.

For MACSIS purposes, it is important to note the following:

- All third party payers must be billed before MACSIS.
- If no response is received from a third party payer after 90 days from the date of service, a claim can be billed to MACSIS.
- Other payer paid amounts must be reported in Loop 2320, Other Subscriber Information, AMT segment with Amount Qualifier Code "D". The payer paid amount can be valued to zero.
- MACSIS uses only the first iteration of other payer information (Loops 2320 and 2330A) for adjudication purposes. This is due vendor system limitations and limitations within the current interface to ODJFS.
- If another payer paid amount is reported in Loop 2320, the total claim charge amount (Loop 2300, CLM02) and the line item charge amount (Loop 2400, SV102) should still reflect the provider's total billed amount. MACSIS will subtract the other payer paid amount and other system-derived deductions from the billed amount to determine the net paid amount..
- Other payer paid amounts cannot include patient paid amounts per HIPAA EDI regulations. Patient paid amounts must be reported separately on the 837P file and will not be used by MACSIS for adjudication purposes.
- The ODJFS COB Indicator will be required if a payer paid amount is reported in Loop 2320. The ODJFS COB Indicator must be submitted on the 837P file in Loop 2330A, Other Subscriber Name in field REF02, Other Insured Additional ID per ODJFS guidelines. The allowable values for the COB indicator remain the same:

  2 – Blue Cross/Blue Shield
  3 – A private carrier
  4 – Employer or Union
  5 – Public Agency (Medicare, Worker's Comp)

6 – Other carrier
R – No response from carrier
P – No coverage for this recipient number
F – No coverage for all recipient numbers
L – Disputed or contest liability
S – Non-covered service
E – Insurance benefits exhausted
X – Non-cooperative member.

H. Resubmitting Claims

1. **Resubmitting corrected claims on EDI File** - If a previously denied or rejected claim is resubmitted it will not be denied as a "duplicate" claim, although the claim may deny for other reasons. Boards and providers should refer to Topic 45: Claim Corrections within MACSIS and the "Procedure for Claim Correction within MACSIS" (http://www.mh.state.oh.us/ois/macsis/claims/macsis.hipaa.claim.correction.proc.pdf) to determine when resubmission of claims is appropriate.

I. Duplicate Claims Policies

Consistent with pre-MACSIS Community Medicaid rules and to assure ODJFS that providers are not billing for the same service episode twice, MACSIS has been configured to check for duplicate claims as described below. Duplicate checking for manual claims and EDI transactions will be treated in the same manner as described below.

1. Same-Day Service Reporting

Procedures have been implemented that require valid "same-day" services (i.e., same services provided to the same client on the same day by the same provider) to be rolled up to one service line on the claim before submitting to MACSIS. Consequently, MACSIS has been configured to automatically adjudicate, deny and not hold a non-rolled up "duplicate" service. (Note: MACSIS previously created a "warning" and held these services, so the Boards could or could not deny the service on a line-by-line basis.)

"Same service" means the combination of UPI, UCI, date of service, procedure code, and modifier codes 1 and 2. These combinations result in the same medical definition (i.e., adjudication category) in MACSIS.

- Same-day MH Medicaid reimbursable services with the place of service codes of "99" or "51" should not be summed with other place of service codes.
  - Note: If the same-day MH Medicaid reimbursable services are all provided in the penal system or IMD (ex. all "99"), then the same-day services should be summed with POS code "99" or "51" accordingly.
- Modifier codes "99" and blank are treated the same within MACSIS. Therefore, same-day services with modifier codes "99" or blank in modifier position 2 should be summed.
- For more information, please refer to the Roll-Up Category Matrix for ODMH at http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.rollup.pdf and for

ODADAS at http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.rollup.pdf which includes healthcare and non-healthcare procedures.

Scenario	Procedure Code	Mod 1	Mod 2	POS	Units
Same-Day Inpatient Psych Facility • MH Assessment • Non-Physician • 20-min at CMHC in a.m. • 30-min at State Hospital in evening	Submit two separate claims *H0031* *H0031*	 HE HE		 53 51	 .3 .5
Same-Day Nurse/Physician MedSomatic • Pharmacologic Mgmt • 7-min at CMHC by physician in a.m. • 7-min at CMHC by nurse in p.m.	Submit one claim. "Sum" then round minutes to partial units per table *90862*	 HE		 53	 .2

2. *Service Rounding Conventions*

   Rounding conventions outlined in Section 44C of this document should be applied to episodes of treatment occurring on the same day after summing the total number of service minutes. Refer to the example provided in Section 44C for Individual MH Community Support (CSP) for more information.

3. *Pre-Checking Policy*

   Boards or MACSIS Administrators will no longer be required to perform various levels of duplicate claim checking prior to the submission of a provider claim file to MACSIS. However, they should make every effort to ensure whole claim files are not submitted twice inadvertently to MACSIS.

45. Topic: Claim Corrections in MACSIS

Purpose:

To establish guidelines and specific procedures for when and how Boards may make claim corrections within MACSIS for erroneously billed services. All corrections must be made in accordance with the "Procedure for Claim Corrections within MACSIS".

Policies:

Only the following claim errors may be corrected in MACSIS:

- Finalized MH Medicaid and non-Medicaid claims

- Un-finalized MH Medicaid and non-Medicaid claims
- Finalized AOD Medicaid and non-Medicaid claims
- Un-finalized AOD Medicaid and non-Medicaid claims
- The wrong number of units were billed (i.e., straggler claim, incorrect units)
- The billed amount was incorrect
- Incorrect procedure code
- Incorrect modifier
- Incorrect third party amounts
- Wrong date of service
- Incorrect UCI
- Date of service on claim is over 365 days old when received in MACSIS
- OHIO claims (i.e., Company Code = OHIO)
- Mismatch claims
- Claims that have been reported on the OHEXT (Ohio Medicaid Extract) Error Report
- Client has retroactive Medicaid eligibility
- Denied claims with missing information

Note: "Denying" a claim for payment within MACSIS because it had been billed twice is not the same as "denying" a client treatment. The term "denial" in this document refers to the denial of payment, not the denial of treatment.

1. This guideline is not to be used to reverse claims paid before a resolution to a residency dispute. This is because the Provider is not responsible for creating a residency dispute and therefore their funds should not be retracted accordingly. As noted in the "ODADAS - ODMH Guidelines Pertaining to the Implementation of MACSIS", Topic 8, section 16. Boards are to resolve monies owed due to residency dispute resolutions outside of MACSIS.
2. All claims adjusted/reversed/denied/etc. **MUST** have a reason code.
3. This Guideline is **NOT** to be used to adjust Medicaid rates. Medicaid rate changes are assigned an effective date based on the day they are input into Diamond by ODMH/ODADAS. Therefore, neither Boards nor Providers are to use the claims correction procedure to retroactively update Medicaid rate(s). In instances where Boards maintain separate rates for non-Medicaid, the claims correction procedure may be used to correct non-Medicaid claims due to an incorrect or retroactive rate change.
4. To ensure consistency across provider and board areas, both ODMH and ODADAS will allow correcting of Medicaid claims and non-Medicaid claims regardless of claim status.
5. All claims (whether AOD or MH) will be corrected following the "Procedure for Claim Corrections within MACSIS" (http://www.mh.state.oh.us/ois/macsis/claims/macsis.hipaa.claim.correction.proc.pdf).
   - Boards may require claims that were originally denied in Diamond (missing/invalid modifier/diagnosis code) due to provider error to be resubmitted electronically.
   - Boards cannot require Providers to resubmit claims electronically if the claims were originally denied in Diamond due to Board error, unless mutually agreed to.

6. **DO NOT** reverse Medicaid claims which have not come back from the Ohio Department of Job and Family Services (ODJFS).

   If ODJFS rejects the claim and a Board has already reversed the claim line in Diamond, the claim will have two reversal accounts payable (ACPAY) records and the monies will be deducted from the Provider twice. The only way to check if claims have been extracted and sent to ODJFS is to use the claims extract file. If there is a date in the ODHSEXTD field, the claim has been extracted and sent to ODJFS. When there is a date in the DTPAID field and in the ODHSEXTD field, the claim has been extracted, sent to, and returned by ODJFS.

7. Boards **MUST** pay claims when they have been finalized and documented on the 835(s) (even if corrections are going to be made). The erroneous claims must then be "worked" following the "Procedure for Claim Corrections Within MACSIS".

8. Currently ODJFS' adjudication deadline is 365 days from the date of service. If the date of service on the Medicaid claim is 366 days or older when it is received in MACSIS (based on the received date in Diamond), the Board may deny the claim or may allow the claim to be submitted to ODJFS for adjudication.

9. Boards and Providers are responsible for identifying claims billed in error to ODJFS in a timely manner.

10. Boards and Providers must use the **Claims Correction Form** (http://www.mh.state.oh.us/ois/macsis/claims/macsis.hipaa.claim.correction.form.pdf) to identify erroneously billed claims. See http://www.mh.state.oh.us/ois/macsis/claims/macsis.hipaa.claim.correction.form.instruct.pdf for detailed instructions on how to complete the form.

    - Exception: For large batches of erroneous claims, boards and providers may mutually agree to another method to identify/report errors. The key is it must be a mutual agreement; otherwise, Boards and Providers must accept the standard **Claims Correction Form**. Boards and Providers **MUST** maintain a copy of this form (or mutually agreed upon report) to serve as written documentation that a service was or was not erroneously billed.

11. Boards are permitted to place claims in question on hold for no more than 30 days after entered into Diamond.

12. Providers are permitted 30 days from the date of notification of the potential error to respond to the Board regarding the claim.

    - If no response is received from the Provider within 30 days, Boards may reverse a finalized claim or deny an un-finalized claim.

13. Boards are required to process corrections with little delay after receipt of a **Claims Correction Form** or a Provider response to a **Claims Correction Form**.

14. The actual, year-end Medicaid cost reconciliation will be handled according to ODADAS' or ODMH's Medicaid Reconciliation Guidelines.

15. Boards **MUST** "work" the OHEXT Error Report and correct Member eligibility spans to resolve claims which are being paid as Medicaid but are not being extracted and sent to ODJFS.

16. Boards **MUST** "work" the OHIO claims, the Mismatch claims, and the Retroactive Medicaid claims in a timely manner.

***The MACSIS Claim Correction Policy is adopted as phase I of ODADAS' re-engineering of Medicaid reconciliation. Phase I represents movement toward alignment of current Medicaid reconciliation processes with MACSIS technology.**

History of Document Revision

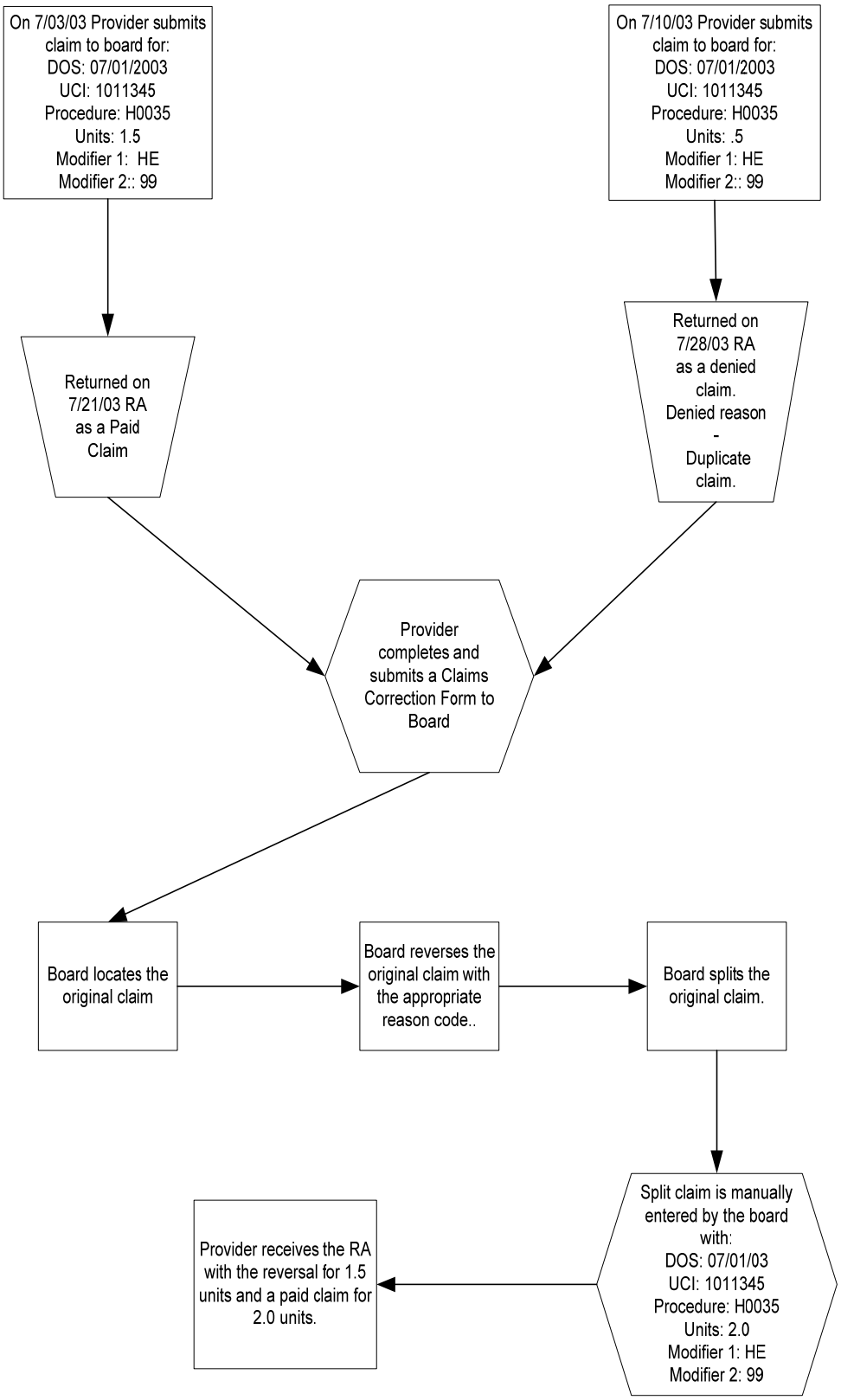
Change	Topic Revised or added	Date of Revision	Originator of Change
1. Added Topic 12.	MACSIS Unique Provider Identifier (UPI) and Vendor Numbers	4/20/04	P. Eichner
2. Removed Topic 19.	Claims in "Held" Status	4/20/04	P. Eichner
3. Updated Topic 43 to include file naming conventions for recreated files.	ASC X12N 835 Health Care Claim/Payment Advice Return Policies	5/19/04	P. Eichner
4. Added New Topic 19.	MACSIS System Access	1/27/05	P. Eichner
5. Updated Topics 40-43 to removed pre-HIPAA references.	Claims EDI	1/27/05	P. Eichner
6. Updated Topic 9	Spend Down – removed invalid references to spend down amount on member record.	08/31/05	K. Cluggish

Glossary of Acronyms

Acronym	Definition
835	Health Care Claim Payment Advice (Electronic HIPAA Format)
837P	Professional Claim Transaction (Electronic HIPAA Format)
ACPAY	Accounts Payable Records (Diamond Term)
ADAMH	Alcohol, Drug and Mental Health Board
AOD	Alcohol or Drug
APUPD	Accounts Payable Update (Diamond Term)
ASC	Accredited Standards Committee, X12N - Insurance Sub-Committee
ASCII	American Standard Code for Information Interchange
ANSI	American National Standards Institute
BENEF	Benefit Package Records (Diamond Term)
BRULE	Benefit Rule Records (Diamond Term)
CBCF	Community Based Correctional Facility
CFR	Code of Federal Regulations
CMH	Community Mental Health
CMHB	Community Mental Health Board
CMIA	Cash Management Improvement Act
COB	Coordination of Benefits
CPT	Common Procedural Terminology
CSB	Children Services Board
CSP	Community Support
EDI	Electronic Data Interchange
ERA	Electronic Remittance Advice (Pre-HIPAA Format)
FFP	Federal Fund Participation Payment
FFS	Fee-For-Service
FTP	File Transfer Protocol
GLASS	General Ledger Assignment Records (Diamond Term)
GLREF	General Ledger Reference Records (Diamond Term)
GRF	General Revenue Fund
GRUPD	Group Detail Records (Diamond Term)
GRUPP	Group/Plan Affiliation Records (Diamond Term)
HCFA	Health Care Financing Administration renamed Centers for Medicare and Medicaid Services (CMS)
HCPCS	Healthcare Common Procedure Coding System
HD	Women's Program Modifier under HIPAA
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD-9-CM	International Classification of Disease, Version 9, Clinical Modification
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IMD	Institution for Mental Disease
IRS	Internal Revenue Services
LAAM	Levomethadyl Acetate

Acronym	Definition
LOB	Line of Business (Diamond Term)
MACSIS	Multi-Agency Community Services Information System
MDS	Minimum Data Set
MEDEF	Medical Definition (Diamond Term)
MEDELIG	Nightly Medicaid Eligibility File
MH	Mental Health
MOM	MACSIS Operations Management Team
M-SPA	Mutual Systems Performance Agreement (Board/State Agreement)
OAC	Ohio Administrative Code
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODRC	Ohio Department of Rehabilitation and Corrections
ODYS	Ohio Department of Youth Services
OHEXT	Ohio Medicaid Extract
OHIO	Claims adjudicating under the Company Code of OHIO (Diamond Reference)
ORC	Ohio Revised Code
PHI	Protected Health Information
PLANC	Plan Codes (Diamond Term)
POS	Place of Service Code
PROVC	Provider Contract Records (Diamond Term)
RA	Remittance Advice (Hard-copy, Pre-HIPAA Format)
RDD	Residency Dispute Determination
RIDER	Rider Codes (Diamond Term)
SFY	State Fiscal Year (for Ohio July 1 through June 30)
SMD	Severely Mentally Disabled
SNIP	Strategic National Implementation Planning Committee (HIPAA EDI)
TCP/IP	Transmission Control Protocol/Internet Protocol
Title XX	Title XX of the Social Security Act (Block Grants to States for Social Services)
UCI	Unique Client Identifier
UPI	Unique Provider Identifier
VAN	Value Added Network (e.g., clearinghouse)

Correcting Straggler Claims



MACSIS Sample 837P NPI File

ISA*00* *00* *ZZ***000000000012345***ZZ***25B** *030707*0812*U*00401*000000257*0*T*:
GS*HC***12345****25B***20030715*0812*1*X*004010X098A1

Appl Sender ID (UPI)

Appl Receiver ID

Interchange Sender ID (UPI)

Interchange Receiver ID

TRANSACTION SET HEADER
ST*837*000000001
BHT*0019*00*258*20030715*0812*CH
REF*87***004010X098DA1**

Trans Type: Test File

LOOP 1000A SUBMITTER NAME
NM1*41*2*DO GOOD THINGS*****46***12345**
PER*IC*PETE MARAVICH*TE*6142222222

MACSIS Submitter ID (UPI)

LOOP 1000B RECEIVER NAME
NM1*40*2*FRANKLIN ADAMH*****46***25B**

Receiver Primary ID

LOOP 2000A BILLING/PAY-TO-PROVIDER HL
HL*1**20*1

LOOP 2010AA BILLING PROVIDER NAME
NM1*85*2*DO GOOD THINGS*****XX*1000000003**
N3*405 WEST SOUTH AVENUE
N4*COLUMBUS*OH*43231
REF***1G*000000012345**
REF*EI*31-12345678
PER*IC*AGENCY ADMINIS DESK*TE*6145772104

Billing Provider NPI

MACSIS Legacy Provider Identifier (UPI)

Billing Provider Tax ID

LOOP 2010AB PAY-TO-PROVIDER NAME
NM1*87*2*XYZ CORPORATION*****XX*1000000014**
N3*400 EAST WEST STREET
N4*COLUMBUS*OH*43313
REF*1G*000000000022345

Pay-To Provider NPI

*Delete Pay-To REF*1G*

LOOP 2000B SUBSCRIBER HL
HL*2*1*22*0
SBR*P*18*******ZZ

LOOP 2010BA SUBSCRIBER NAME
NM1*IL*1*KRACOTO*KILE*A****JR***MI***3445555**
N3*1928 EAST 56TH ST
N4*LORAIN*OH*44254
DMG*D8*19510127*M
REF*SY*268445400

Subscriber Suffix and UCI

LOOP 2010BB PAYER NAME

NM1*PR*2*MACSIS*****PI*MACSIS

Payer Name and ID

N3*SUITE 1001*30 E. BROAD STREET

N4*COLUMBUS*OH*43266-0414

LOOP 2300

CLM*1156478910*40.00***11::1*Y*A*Y*Y*C

HI*BK:3050

Patient Control Number Claim Level

Facility Code Claim Level

LOOP 2320 OTHER SUBSCRIBER INFORMATION

SBR*S*18***C1****ZZ

AMT*D*30.00

Other Payer Paid Amount

DMG*D8*19520804*F

OI***Y***Y

LOOP 2330A OTHER SUBSCRIBER NAME

NM1*IL*1*KRACOTO*MITZY****MI*555656666

REF*IG*S

ODJFS COB Indicator (S = Non-Covered Service)

LOOP 2330B OTHER PAYER NAME

NM1*PR*2*AETNA HMO*****PI*AETNA HMO

LOOP 2400 SERVICE LINE

LX*1

Product/Service Qualifier and Procedure Code

SV1*HC:H0004:HE:HR::HX*40.00*UN*1*53**1**N

Modifiers

Line Item Charge Amt and Place of Service

DTP*472*D8*20030702

REF*6R*BB973AF65341F8B5AA862CEB23B0B1

Line Item Control Number

TRAILER SEGMENTS

SE*40*000000001

GE*1*1

MACSIS 837 Professional Claim Informational Guide - Updated for NPI

837 FILE SPECIFICATIONS									
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
B.3	ISA	**Interchange Control Header**				**Please note that the ISA control segment is a fixed length segment. It is the only fixed length segment in the 837P v4010 file.**			
	ISA01	Auth Information Qualifier	**00**-No autho info present	ID 2/2	R				
	ISA02	Auth Information	SPACES	AN 10/10	R				
	ISA03	Security Info Qualifier	**00**-No Security info present	ID 2/2	R				
	ISA04	Security Information	SPACES	AN 10/10	R				
	ISA05	Interchange ID Qualifier	**ZZ**- Mutually defined	ID 2/2	R				
	ISA06	Interchange Sender ID	MACSIS Submitter ID Right Justified, zero fill	AN 15/15	R	**- For providers who do not use a value-added network (VAN), the submitter ID will be the provider's original MACSIS UPI. '- For providers who do use a VAN, the submitter ID will be a MACSIS-assigned VAN ID.**	41A2	Value and Comments Changed	The NPI final rule does not require trading partner IDs (such as sender/submitter IDs) change to equal the NPI. Palmetto and others will be retaining their existing trading partner IDs accordingly. MACSIS chose to retain the UPI as the submitter ID to be consistent with existing file naming lengths and to address concerns about potential inappropriate disclosure of NPI information.
	ISA07	Interchange ID Qualifier	**ZZ**- Mutually defined	ID 2/2	R				
	ISA08	Interchange Receiver ID	BOARD NUMBER and TYPE Left-justified, blank-fill	AN 15/15	R	This field should identify the board receiving the file (ex. 25B for Franklin County).	41A2		
	ISA09	Interchange Date	YYMMDD	DT 6/6	R				
	ISA10	Interchange Time	HHMM	TM 4/4	R				
	ISA11	Interchange Control Standards ID	**U**	ID 1/1	R				
	ISA12	Interchange Control Version Number	**00401**	ID 5/5	R				
	ISA13	Interchange Control Number	same as in IEA02	N0 9/9	R	The interchange sender determines this value. Per the standard implementation guide, this field must match IEA02 or the file will fail ANSI validation edits.			
	ISA14	Acknowledgement Requested	**0** - No Acknowledgement requested	ID 1/1	R	**The receipt of an interchange acknowledgement is determined by the TPA. Per this document, the State will not be providing an acknowledgement transaction to the Boards. However, Boards may choose to negotiate this item in the TPAs with their providers if the board can and wants to create the acknowledgement transaction themselves.**	42D		
	ISA15	Usage Indicator	**P**-Production **T**-Test	ID 1/1	R	This field will be referenced by MACSIS to determine if the file is a production or test file.			
	ISA16	Component Element Separator	:	ID 1/1	R	To guarantee accurate evaluation and processing of the file, this field should be valued to :	40D6		
B.8	GS	**Functional Group Header**							
	GS01	Functional Identifier Code	**HC**	ID 2/2	R				

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	GS02	Application Sender Code	MACSIS Submitter ID	AN 2/15	R	This field should equal the value in ISA06; however, since this segment is not required to be fixed-length, the leading zeros are not required. (Note: It is not a problem if they are provided.)		Value and Comments Changed	MACSIS' pre-NPI 837P companion guide states this element will be different than ISA06 IF the submitter is a VAN and that, if the latter is the case, the element identifies the provider (i.e., UPI). This has changed such that ISA06 will match GS02 in value (excluding leading zeros if necessary).
	GS03	Application Receiver Code	BOARD NUMBER and TYPE	AN 2/15	R	This field should identify the entity receiving the claims contained in the functional group. This field should equal ISA08.			
	GS04	Date	CCYYMMDD	DT 8/8	R				
	GS05	Time	HHMM	TM 4/8	R				
	GS06	Group Control Number	Same as GE02	N0 1/9	R	The application sender determines this value. Per the standard implementation guide, this field must match GE02 or the file will fail ANSI validation edits.			
	GS07	Responsible Agency Code	**X**	ID 1/2	R				
	GS08	Version/Release Code	004010X098A1	AN 1/12	R	Addenda changes were adopted by the HHS Secretary on 2/13/03.	40B4		
	TABLE 1 - HEADER								
62	**ST**	**Transaction Set Header**			**R**				
	ST01	TS ID Code	**837**	ID 3/3	R				
	ST02	TS Control Number	Transaction Set Control Number	AN 4/9	R	It must match the value in SE02, but it will not be stored in MACSIS.			
63	**BHT**	**Beginning of Hierarchical Transaction**			**R**				
	BHT01	Hierarchical Structure Code	**0019**	ID 4/4	R				
	BHT02	TS Purpose Code	**00**-Original	ID 2/2	R				
	BHT03	Originator Application Transaction Identifier	Batch number assigned by application sender	AN 1/30	R	This number is determined by the application sender. It will not be stored in MACSIS.			
	BHT04	TS Creation Date	CCYYMMDD	DT 8/8	R				
	BHT05	TS Creation Time	HHMM	TM 4/8	R				
	BHT06	TS Type Code	**CH**-chargeable	ID 2/2	R	MACSIS will consider for payment "CH" transaction types only.			
66	**REF**	**Transmission Type Identification**			**R**				
	REF01	Reference Identification Qualifier	**87**	ID 2/3	R				
	REF02	Transmission Type Code	**004010X098A1 (Prod)** **004010X098DA1 (Test)**	AN 1/30	R	Addenda changes were adopted by the HHS Secretary on 2/13/03.		Note	Test files should contain the appropriate transmission type code.
	-- LOOP ID 1000A SUBMITTER NAME								
67	**NM1**	**Submitter Name**			**R**				
	NM101	Entity Identifier Code	**41**	ID 2/3	R				
	NM102	Entity Type Qualifier	**2** - non-person entity	ID 1/1	R				
	NM103	Submitter Name	Submitter Name	AN 1/35	R	This should be the organization name associated with the MACSIS Submitter ID provided in ISA06 and GS02. Do not use "&" in the name.		Value and Comments Changed	
	NM108	Identification Code Qualifier	**46**-ETIN	ID 1/2	R				
	NM109	Identification Code	MACSIS Submitter ID	AN 2/80	R	This field should equal the value in ISA06; however, since this segment is not required to be fixed-length, the leading zeros are not required. (Note: It is not a problem if they are provided.)		Value and Comments Changed	
71	**PER**	**Submitter EDI contact Information**			**R**				
	PER01	Contact Function Code	**IC**	ID 2/2	R				

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	PER02	Submitter Contact Name	Contact Person	AN 1/60	R	This field should contain the name of the person who should be contacted if there is a technical problem with the file.		Value and Comments Changed	For most providers, this value will remain the same as pre-NPI; however, the explanation was changed to provide more clarity.
	PER03	Communication Number Qualifier	**TE**-Telephone	ID 2/2	R				
	PER04	Communication Number	Format: AAABBBCCCC, where AAA is the area code, BBB is the telephone number pre-fix and CCCC is the telephone number.	AN 1/80	R	The extension, when applicable, should be included immediately after the telephone number.			
	-- LOOP ID 1000B RECEIVER NAME								
74	**NM1**	**Individual or Organizational Name**			**R**				
	NM101	Receiver Code	**40**	ID 2/3	R				
	NM102	Entity Type Qualifier	**2** - non-person Entity	ID 1/1	R				
	NM103	Receiver Name	Board Name	AN 1/35	R	It is recommended this field contain the name of the board corresponding to the value in ISA08			
	NM108	Identification Code Qualifier (ETIN)	**46**	ID 1/2	R				
	NM109	Receiver Primary Identifier	BOARD NUMBER and TYPE	AN 2/80	R	It is recommended this field contain the same value as noted in ISA08.			
	TABLE 2 - BILLING/PAY-TO PROVIDER DETAIL								
	-- LOOP ID 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL					Implied max of 5000			
77	**HL**	**Hierarchical Level**			**R**				
	HL01	Hierarchical ID Number	start with 1, increment by 1	AN 1/12	R				
	HL03	Hierarchical Level Code	**20**	ID 1/2	R				
	HL04	Hierarchical Child Code	**1**	ID 1/1	R				
	-- LOOP ID 2010AA BILLING PROVIDER NAME								
84	**NM1**	**Individual or Organizational Name**			**R**				
	NM101	Billing Provider	**85**	ID 2/3	R				
	NM102	Entity Type Qualifier	**2** - Non-Person Entity	ID 1/1	R				
	NM103	Billing Provider Name	Billing Provider Name D/B/A	AN 1/35	R	**This field should contain the billing provider name under which the provider is doing business as noted on the provider's type-2 NPI application. If the provider applied for a subpart, this identifier must reflect the subpart who is billing for the service. Do not use & in the name.**		Value and comments changed	The MACSIS NPI Workgroup felt it would be important for providers to be consistent in the business name used for MACSIS and the name on file with the NPI enumerator (Fox Systems). However, MACSIS will not be rejecting files where the provider's organization name is inconsistent.
	NM108	Identification Code Qualifier	**XX**- National Provider Identifier	ID 1/2	R	The value in this field must be "XX" or the file will be rejected.		Value and comments changed	
	NM109	Billing Provider Identifier	Provider National Provider Identifier	AN 2/80	R	**This field must contain the type-2 national provider identifier assigned to the organization or subpart who is billing for the service.** **All 10 digits of the NPI number are required. The claim file will be rejected for the following:** **- It is not a valid NPI number on file with MACSIS** **- The NPI provided does not match the UPI and Tax ID provided in the Loop 2010AA, REF segments according to MACSIS provider enrollment records.** **- The calculated self-check digit for the NPI number does not match the last digit of the NPI.**		Value and comments changed	
88	**N3**	**Billing Provider Address**			**R**				

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	N301	Billing Provider Address 1	Provider Primary Practice Location Address Line 1	AN 1/55	R	This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.		Value and comments changed	MACSIS will not be validating the provider's location information against the information on file in MACSIS.
	N302	Billing Provider Address 2	Provider Primary Practice Location Address Line 2	AN 1/55	S	This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.		Value and comments changed	MACSIS will not be validating the provider's location information against the information on file in MACSIS.
89	N4	**Billing Provider Geographic Location**			R				
	N401	Billing Provider's City	Provider Primary Practice City	AN 2/30	R	This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.		Value and comments changed	MACSIS will not be validating the provider's location information against the information on file in MACSIS.
	N402	Billing Provider's State	Provider Primary Practice State	ID 2/2	R	This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.		Value and comments changed	MACSIS will not be validating the provider's location information against the information on file in MACSIS; however, this field must contain a valid State value.
	N403	Billing Provider's Zip Code	Provider Primary Practice Zip Code	ID 3/15	R	This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.		Value and comments changed	MACSIS will not be validating the provider's location information against the information on file in MACSIS; however, this field must contain a valid zip code.
91	REF	**Billing Provider Secondary Identification**			S	This segment will be required to ensure proper adjudication of the claim in MACSIS.			
	REF01	Reference Identification Qualifier	**1G** - Provider UPIN Number	ID 2/3	R	Submitters will be required to provide a "1G" reference qualifier and corresponding UPI value during the transition phase (i.e., until May 23, 2007).		Comments changed	MACSIS will be adopting a transition strategy similar to CMS and OCUFS, where files using either the pre-NPI or NPI format will be accepted until the May 23, 2007 deadline. Those which follow the NPI format must provide both the NPI information and the legacy identifier (UPI) until May 23, 2007.
	REF02	Billing Provider Secondary Identification	MACSIS-Assigned UPI Number 12 bytes with leading zeros	AN 1/30	R	**This field must contain the MACSIS-Assigned UPI number. Please note the value must be 12 bytes in length and containing leading zeros.** **The claim file will reject if the UPI number provided does not match the NPI or Tax ID numbers provided in Loop 2010AA according to MACSIS provider enrollment records.**		Comments changed	
	REF01	Reference Identification Qualifier	**EI** - Employer's Identification Number	ID 2/3	R			Added	Under the NPI rule, payers may request the provider's tax ID as a secondary identifier, if it is necessary to identify the entity.

837 FILE SPECIFICATIONS									
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	REF02	Billing Provider Secondary Identification	Provider Tax ID Number Hyphen included	AN 1/30	R	**This field must contain the Tax ID number associated with the provider's type-2 National Provider Identifier. A hyphen is required between the second and third digits only.** **The claim file will reject if the Tax ID number provided does not match the NPI or UPI numbers provided in Loop 2010AA according to MACSIS provider enrollment records.**		Added	
96	PER	**Billing Provider contact Information**			S	This segment is required if different than the submitter contact information in Loop 1000A, segment PER, but the information will not be used by MACSIS.			
	PER01	Contact Function Code	**IC**	ID 2/2	R				
	PER02	Billing Provider Contact Name	Provider Contact Person	AN 1/60	R	This field should contain the name of the provider contact person who should receive questions regarding the provider's NPI.		Value and Comments changed	This information should match the information provided in Section 5 of the NPI Application.
	PER03	Comm Number Qualifier	**TE**-Telephone	ID 2/2	R				
	PER04	Comm Number	Provider Contact Telephone Number	AN 1/80	R			Value changed	This information should match the information provided in Section 5 of the NPI Application.
	-- LOOP ID 2010AB PAY-TO PROVIDER NAME					**This loop is only required if the pay-to provider information is different than the billing provider information. It will not be used by MACSIS for payment purposes.**			
99	**NM1**	**Individual or Organizational Name**			**R**				
	NM101	Billing Provider	**87**	ID 2/3	R				
	NM102	Entity Type Qualifier	**2** - Non-Person Entity	ID 1/1	R				
	NM103	Pay-To Provider Name	Pay-To Provider Name D/B/A	AN 1/35	R	**This field should contain the name under which the provider is doing business as noted on their type-2 NPI application. If the provider applied for a subpart, this name should reflect the NPI or subpart where payments should be sent. It will not be used by MACSIS for payment purposes.**		Comment changed	
	NM108	Identification Code Qualifier	**XX**- National Provider Identifier	ID 1/2	R	The value in this field must be "XX" or the file will be rejected.		Value and Comment changed	
	NM109	Pay-To Provider Identifier	Pay-To Provider's National Provider Identifier	AN 2/80	R	This field must contain the type-2 national provider identifier assigned to the organization or subpart who should receive payment. It will not be used by MACSIS for payment purposes.		Value and comment changed	
103	**N3**	**Pay-To Provider Address**			**R**				

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	N301	Pay-To Provider Address 1	Pay-To Provider Address Line 1	AN 1/55	R	**This field should contain the mailing address information associated with the NPI who should receive payment. It will not be used by MACSIS for payment purposes.** **Since Boards disburse payments, providers should verify with their main Board that they have the correct address for remittance information.**		Comment changed	
	N302	Pay-To Provider Address 2	Pay-To Provider Address Line 2	AN 1/55	S	This field should contain the mailing address information associated with the NPI who should receive payment. It will not be used by MACSIS for payment purposes.		Comment changed	
104	**N4**	**Vendor Geographic Location**			**R**				
	N401	Pay-To Provider's City	Pay-To Provider City	AN 2/30	R				
	N402	Pay-To Provider's State	Pay-To Provider State	ID 2/2	R				
	N403	Pay-To Provider's Zip Code	Pay-To Provider Zip Code	ID 3/15	R				
106	**REF**	**Pay-to Provider Secondary Identification**						Delete	With NPI, the additional identifiers associated with the pay-to provider are optional, not required. Since MACSIS does not use this information to determine where remittance information should be sent, it is no longer necessary to provide these additional pay-to provider identifiers.
	REF01	Reference Identification Qualifier	**1G** - Provider UPIN Number	ID 2/3	R			Delete	
	REF02	Pay-to Provider Additional Identifier	MACSIS-Assigned Vendor Number 15 bytes, leading zeros	AN 1/30	R			Delete	
	REF01	Reference Identification Qualifier	**EI** - Employer's Identification Number	ID 2/3	R			Delete	
	REF02	Pay-to Provider Additional Identifier	Pay-To Provider Tax ID Number	AN 1/30	R			Delete	
	TABLE 2 - SUBSCRIBER DETAIL								
	-- LOOP ID 2000B SUBSCRIBER HIERARCHICAL LEVEL					Implied max of 5000			
108	**HL**	**Hierarchical Level**			**R**				
	HL01	Hierarchical ID Number	start with 1, increment by 1	AN 1/12	R				
	HL02	Hierarchical Parent Id Number	**1**-Subscribe self	AN 1/12	R				
	HL03	Subscriber Level Code	**22**-Subscriber	ID 1/2	R				
	HL04	Hierarchical Child Code	**0**- No subordinate HL segment	ID 1/1	R				
110	**SBR**	**Subscriber Information**			**R**				
	SBR01	Payer Responsibility Seq # Code	**P** - Primary **S** - Secondary **T** - Tertiary	ID 1/1	R				
	SBR02	Relationship Code	**18** - Self	AN 1/30	S				
	SBR09	Claim Filing Indicator Code	**ZZ- Mutually defined**	ID 1/2	S	This code is required prior to the mandated use of a national plan ID code. It will not be used by MACSIS for adjudication purposes.			

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	-- LOOP ID 2010BA SUBSCRIBER NAME								
117	NM1	**Subscriber Name Information**			R				
	NM101	Insured or Subscriber	**IL**-Insured	ID 2/3	R				
	NM102	Entity Type Qualifier	**1**-Person	ID 1/1	R				
	NM103	Subscriber Last Name	MACSIS Client Last Name	AN 1/35	R		44B		
	NM104	Subscriber First Name	MACSIS Client First Name	AN 1/25	S	Since all MACSIS clients are "person's", not "entities", first name should always be provided, even for pseudo-UCIs.	44B		
	NM105	Subscriber Middle Name	MACSIS Client Middle Initial	AN 1/25	S				
	NM107	Subscriber Name Suffix	MACSIS Client Suffix	AN 1/10	S	This field should contain the suffix of the client (ex. Jr, Sr, I, II, III). Do not value the suffix here and in NM103.			
	NM108	ID Code Qualifier	**MI** - Member ID Number	ID 1/2	R				
	NM109	Subscriber Primary Identifier	MACSIS UCI Number	AN 2/80	R		44B		
121	N3	**Subscriber Address**			R	This segment data is required, but will not be validated by MACSIS.			
	N301	Subscriber address 1	MACSIS Client/Enrollment Address 1	AN 1/55	R				
	N302	Subscriber address 2	MACSIS Client/Enrollment Address 2	AN 1/55	S				
122	N4	**Subscriber City/State/Zip Code**			R	This segment data is required, but will not be validated by MACSIS.			
	N401	Subscriber City Name	MACSIS Client City Name	AN 2/30	R				
	N402	Subscriber or Province Code	MACSIS Client State	ID 2/2	R				
	N403	Subscriber zip code	MACSIS Client Zip Code	ID 3/15	R				
124	DMG	**Subscriber Demographic Info**			R	This segment will likely be used by MACSIS for matching the claim to an existing client.			
	DMG01	Date Time Period Format Qualifier	**D8**	ID 2/3	R				
	DMG02	Subscriber Birth Date	MACSIS Client Date of Birth CCYYMMDD	AN 1/35	R				
	DMG03	Subscriber Gender	**F,M,U**	ID 1/1	R				
126	REF	**Subscriber Secondary Identification**			S				
	REF01	Reference Identification Qualifier	**SY**-Social Security Number	ID 2/3	R	To ensure proper adjudication of the claim in MACSIS, the social security number of the client should be provided. It will be used to help link the incoming claim to the appropriate client's records in MACSIS.			
	REF02	Subscriber Supplemental Identifier	MACSIS Client SSN	AN 1/30	R	Do not include dashes.			
	-- LOOP ID 2010BB PAYER NAME								
130	NM1	**Payer Name Information**			R				
	NM101	Entity Identifier Code	**PR**	ID 2/3	R				
	NM102	Entity Type Qualifier	**2** - Non-Person Entity	ID 1/1	R				
	NM103	Payer Name	**MACSIS**	AN 1/35	R				
	NM108	Identification Code Qualifier	**PI**-Payer ID	ID 1/2	R				
	NM109	Payer Primary Identifier	**MACSIS**	AN 2/80	R				
	-- LOOP ID 2300 CLAIM INFORMATION						44A and 44H		
170	CLM	**Claim Information**			R				

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	CLM01	Patient Control Number	Provider-assigned claim-level control number	AN 1/38	R	**If this element is valued and Loop 2400, field REF02 (Line Item Control Number) is not, this field will be returned on the 835 in Loop 2100, field CLP01. Alphanumeric values are permissible, but not special characters.** **Please note this field is longer in length (up to 38 characters) than the Loop 2400/REF02 field. It is also longer in length than the 15-character control number returned on the ERA/RA.** **See guidelines for specific requirements for AOD prevention services.**	44B	Comment changed to remove pre-HIPAA DOS references.	The content of this element has not changed from pre-NPI requirements.
	CLM02	Total Claim Charge Amount		R 1/18	R	**This amount should match the amount in Loop 2400, SV102.** **The addenda further clarified how decimal points should be used for Type "R" fields. If there are no "cents" involved in the amount (ex., $100), then the value should not include the decimal point or subsequent decimal positions (ex., 100). If however, there are "cents" involved in the amount (ex., $100.50), then the value must include the decimal point and subsequent decimal positions (ex. 100.50)**		Comment changed	The content of this element has not changed from pre-NPI requirements. The comment was changed to provide additional information about editing (i.e., The amount should match the amount in Loop 2400, SV102.)
	CLM05	Health Care Service Location Info		ID 1/2	R				
	CLM05 - 1	Facility Code Value	See http://www.cms.gov/states/posdata.pdf for a complete list of codes.	AN 1/2	R	**This information will be stored at the claim header level in MACSIS. If no information is provided in Loop 2400, SV105, then this code will default to the service location on the associated claim detail record(s) and will be used for adjudication purposes.**	44E	Comment changed to remove pre-HIPAA DOS references.	The content of this element has not changed from pre-NPI requirements.
	CLM05 - 3	Claim Frequency Code		ID 1/1	R	MACSIS will not use this information for adjudication purposes.			
	CLM06	Provider Signature on File	Y-Yes	ID 1/1	R				
	CLM07	Medicare Assignment Code	**A**-Assigned **B**-Assignment Accepted on Clinical Lab Services Only **C**-Not Assigned **P**-Patient Refuses to Assign Benefits	ID 1/1	R	This information will not be used by MACSIS for adjudication purposes.			
	CLM08	Assignment of Benefits Indicator	**N**-No **Y**- Yes	ID 1/1	R	This information will not be used by MACSIS for adjudication purposes.			
	CLM09	Release of Information Code	**A**-Appropriate Release of Info on File **I**-Informed Consent to Release Medical Info **M**-Limited or restricted ability release data **N**-Not allowed to release data **O**-On file at Payer or plan sponsor **Y**-Signed statement permitting release of data	ID 1/1	R	This information will not be used by MACSIS for adjudication purposes. Existing policies regarding obtaining appropriate release information still apply.	4		

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	CLM10	Patient Signature Source Code	**B**-Signed on HCFA-1500, block 12 and block 13 **C**-Signed on HCFA-1500 **M**-Signed on HCFA-1500 block 13 **P**-Physician signed due to patient not present **S**-Signed on HCFA-1500 block 12	ID 1/1	S	Although this information is required (except if CLM09=N), it will not be used by MACSIS for adjudication purposes.			
	CLM11	Related Causes Info	Composite field - see below	O	S	Although this information is required if the cause of the client's condition is related to other factors, it will not be used for adjudication purposes in MACSIS.			
	CLM11-1	Related Causes Code	**AA** - Auto Accident **AP** - Another Party Responsible **EM** - Employment **OA** - Other Accident	ID 2/3	R	The value of "AB" for abuse was deleted in the October 2002 Addenda. MACSIS does not use this information for adjudication purposes.			
	CLM11-2	Related Causes Code	**AA** - Auto Accident **AP** - Another Party Responsible **EM** - Employment **OA** - Other Accident	ID 2/3	S	The value of "AB" for abuse was deleted in the October 2002 Addenda. MACSIS does not use this information for adjudication purposes.			
	CLM11-3	Related Causes Code	**AA** - Auto Accident **AP** - Another Party Responsible **EM** - Employment **OA** - Other Accident	ID 2/3	S	The value of "AB" for abuse was deleted in the October 2002 Addenda. MACSIS does not use this information for adjudication purposes.			
	CLM11-4	Auto Accident State or Province Code	State where accident occurred	ID 2/2	S				
	CLM11-5	Country Code	Country where accident occurred	ID 2/3	S				
	CLM12	Special Program Indicator	**01** - Early & Periodic Screening **02** - Physically Handicapped Childrens' program **03** - Special Federal Funding **05** - Disability etc.	ID 2/3	S	This information will not be used by MACSIS for adjudication purposes.			
265	**HI**	**Health Care Diagnosis Code**			**S**	**As with current MACSIS billing policy, not all procedure codes require a diagnosis code. Please refer to MH and AOD Procedure Code Matrices to determine which procedures require a diagnosis code.**	44F		
	HI01	Health Care Code Information		AN 1/30	R				
	HI01-1	Diagnosis Type Code	**BK**-Principle Diagnosis ICD-9 Codes	ID 1/3	R				
	HI01-2	Diagnosis Code	ICD-9 Code	AN 1/30	R	Only the principal diagnosis code will be sent to ODJFS for Medicaid eligible services to Medicaid eligible clients. Do not include decimal point.			No new 2006 ICD-9 codes have been added to the list of diagnoses considered for payment under MACSIS.
	HI02	Health Care Code Information	R if additional Diagnosis	AN 1/30	S				
	HI02-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/3	R				
	HI02-2	Diagnosis Code	ICD-9 Code	AN 1/30	R				
	HI03	Health Care Code Information	R if additional Diagnosis	AN 1/31	S				
	HI03-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/4	R				
	HI03-2	Diagnosis Code	ICD-9 Code	AN 1/31	R				
	HI04	Health Care Code Information	R if additional Diagnosis	AN 1/32	S				
	HI04-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/5	R				
	HI04-2	Diagnosis Code	ICD-9 Code	AN 1/32	R				
	HI05	Health Care Code Information	R if additional Diagnosis	AN 1/33	S				

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	HI05-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/6	R				
	HI05-2	Diagnosis Code	ICD-9 Code	AN 1/33	R				
	HI06	Health Care Code Information	R if additional Diagnosis	AN 1/34	S				
	HI06-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/7	R				
	HI06-2	Diagnosis Code	ICD-9 Code	AN 1/34	R				
	HI07	Health Care Code Information	R if additional Diagnosis	AN 1/35	S				
	HI07-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/8	R				
	HI07-2	Diagnosis Code	ICD-9 Code	AN 1/35	R				
	HI08	Health Care Code Information	R if additional Diagnosis	AN 1/36	S				
	HI08-1	Diagnosis Type Code	**BF**-Diagnosis ICD-9 Codes	ID 1/9	R				
	HI08-2	Diagnosis Code	ICD-9 Code	AN 1/36	R				
	-- LOOP ID 2310B RENDERING PROVIDER NAME					Required if different than billing provider noted in Loop 2010AA. However, this segment will not be used by MACSIS for adjudication purposes.		Delete	Although the rendering provider loop is required if different than the billing provider (Loop 2010AA), this loop description will be removed since it is not used for adjudication purposes in MACSIS.
290	**NM1**	**Rendering Provider Name Info**			**S**			Delete	
	NM101	Entity Identifier Code	**82** - Rendering Provider		R			Delete	
	NM102	Entity Type Qualifier	**2**-Non-Person Entity	ID 1/1	R			Delete	
	NM103	Rendering Provider Last Name	Rendering Provider Organization Name	AN 1/35	R	Do not use "&" in the name.		Delete	
	NM108	Identification Code Qualifier	**24**-Employer's ID Number	ID 1/2	R			Delete	
	NM109	Rendering Provider ID	Rendering Provider ID	AN 2/80	R			Delete	
	-- LOOP ID 2320 OTHER SUBSCRIBER INFORMATION (CLAIM LEVEL ADJUSTMENTS)					**This loop is required to be sent by the provider when another payer has adjudicated the claim. MACSIS plans on using only the first iteration of the segments noted below for adjudication purposes.**	44G		
318	**SBR**	**Other Subscriber Information**			S				
	SBR01	Payer Responsibility Sequence Number Code	**P** - Primary **S** - Secondary **T** - Tertiary	ID 1/1	R				
	SBR02	Individual Relationship Code	See guide for valid values	ID 2/2	R				
	SBR05	Insurance Type Code	See guide for valid values	ID 1/3	R				
	SBR09	Claim Filing Indicator Code	**ZZ** - Mutually Defined	ID 1/2	S	This code is required prior to the mandated use of a national plan ID code. It will not be used by MACSIS for adjudication purposes.			
332	**AMT**	**COB Amount**			**S**	Payments from another payer should be reported in this segment. MACSIS will reference this segment for adjudication purposes. Please note MACSIS will not use prior payor paid amounts reported in Loop 2430, SVD Segment for adjudication purposes.			
	AMT01	Amount Qualifier Code	**D**- Payer Amount Paid	ID 1/3	R	MACSIS plans to only use COB amount reported as "D" - Payer Amount Paid for adjudication purposes.			

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	AMT02	Amount	Payer Amount Paid	R 1/18	R	Report the amount paid by the prior payer in this field. Do not include any amounts paid or due from the patient including provider-determined sliding fee amounts here. If the payer denied the claim or adjudicated the claim payment as zero, enter zero. If the provider determines the patient copayment at the time of service and therefore must reflect patient paid amounts,they can reduce the amount billed rather than report patient paid amounts here. Please see clarification in addenda as to how Type "R" amount fields should be reported in terms of including or excluding the decimal point.			
342	**DMG**	**Subscriber Demographic Info**			**R**	This information will not be used by MACSIS for adjudication purposes.			
	DMG01	Date Time Period Format Qualifier	**D8**	ID 2/3	R				
	DMG02	Date of Birth - Subscriber	CCYYMMDD	AN 1/35	R				
	DMG03	Gender - Subscriber	**F**-Female **M**-Male **U**-Unknown	ID 1/1	R				
344	**OI**	**Other Insurance Coverage Information**			**R**	This information will not be used by MACSIS for adjudication purposes.			
	OI03	Assignment of Benefits Indicator	**N**-No **Y**-Yes	ID 1/1	R				
	OI06	Release of Information Code	**A**-Appropriate Release of Info on File **I**-Informed Consent to Release Medical Info **M**-Limited or Restricted Ability to Release Info **N**-Not Allowed to Release info **O**-On file **Y**-Yes, signed release form	ID 1/1	R				
	-- LOOP ID 2330A OTHER SUBSCRIBER NAME					This loop is required when Loop 2320 is used.			
350	**NM1**	**Other subscriber name**			**R**				
	NM101	Entity Identifier Code	**IL**	ID 2/3	R				
	NM102	Entity Type Qualifier	**1**-Person	ID 1/1	R				
	NM103	Subscriber Last Name	Other Subscriber Last Name	AN 1/35	R				
	NM104	Subscriber First Name	Other Subscriber First Name	AN 1/25	R				
	NM108	Identification Code Qualifier	**MI**-Member ID Number	ID 1/2	R				
	NM109	Other subscriber primary identifier	Other Subscriber Member ID Number	AN 2/80	R				
357	**REF**	**Other Subscriber Secondary Identification**							
	REF01	Reference Identification Qualifier	**IG** - Insurance Policy Number	ID 2/3	S				

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	REF02	Other Insured Additional Identifier	**2** – Blue Cross/Blue Shield 3 – A private carrier **4** – Employer or Union **5** – Public Agency (Medicare, Worker's Comp) **6** – Other carrier **R** – No response from carrier **P** – No coverage for this recipient number **F** – No coverage for all recipient numbers **L** – Disputed or contest liability **S** – Non-covered service **E** – Insurance benefits exhausted **X** – Non-cooperative member.	AN 1/30	R	If this field is valued, an amount must be provided in Loop 2320, Field AMT02 (COB Amount) and AMT01 must equal "D" (Payer Amount Paid).			
	-- LOOP ID 2330B OTHER PAYER NAME					Although required when Loop 2320 is used, this loop will not be used for adjudication purposes in MACSIS.			
359	**NM1**	**Other Payer Name**			**R**				
	NM101	Entity Identifier Code	**PR**-Payer	ID 2/3	R				
	NM102	Entity Type Qualifier	**2**-Non-Person Entity	ID 1/1	R				
	NM103	Payer Name	Other Payer Name	AN 1/35	R				
	NM108	Identification Code Qualifier	**PI**-Payer ID	ID 1/2	R				
	NM109	Other payer primary id number	Other Payer ID Number	AN 2/80	R				
366	**DTP**	**Claim Adjudication Date**			**S**	Although required if claim was previously adjudicated and a service level adjudication date is not reported in Loop 2430, this information will not be used by MACSIS for adjudication purposes.			
	DTP01	Date/Time Qualifier	**573**-Date Claim Paid	ID 3/3	R				
	DTP02	Date Time Period Format Qualifier	**D8**	ID 2/3	R				
	DTP03	Adjudication or Payment Date	Date claim adjudicated by other payer	AN 1/35	R				
	-- LOOP ID 2400 - SERVICE LINE						44A and 44I		
398	**LX**	**Service Line - repeat >=1**			**R**				
	LX01	Line Counter	Incremented by 1 for each service line	N0 1/6	R				
400	**SV1**	**Professional Service**			**R**				
	SV101	**Composite Medical Procedure Identifier**							
	SV101-1	Product/Service ID Qualifier	**HC**-HCPCS (incl. CPT, for Healthcare) **ZZ** -Mutually Defined (Non-Healthcare)	ID 2/2	R				
	SV101-2	Procedure Code	HCPCS/CPT/Non-Healthcare Procedure Code	AN 1/48	R	See http://www.mh.state.oh.us/ois/macsis/mac.codes.index.html for a list of valid procedure codes which will be considered for payment in MACSIS.	40A, 40C, 44C	Comment changed to remove pre-HIPAA DOS references.	The content of this element has not changed from pre-NPI requirements.
	SV101-3 thru SV101 - 6	Procedure Modifier	HCPCS/CPT Modifiers	AN 2/2	S	See http://www.mh.state.oh.us/ois/macsis/mac.codes.index.html for a list of valid modifier codes which will be considered for payment in MACSIS.	40A, 40C, 44D	Comment changed to remove pre-HIPAA DOS references.	The content of this element has not changed from pre-NPI requirements.

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
	SV102	Line Item Charge Amount	Amount billed for service	R 1/18	R	This amount should match the amount in Loop 2300, CLM02. The addenda clarifies how decimal points should be used for Type "R" fields. If there are no "cents" involved in the amount (ex., $100), then the value should not include the decimal point or subsequent decimal positions (ex., 100). If however, there are "cents" involved in the amount (ex., $100.50), then the value must include the decimal point and subsequent decimal positions (ex. 100.50)		Comment changed	The content of this element has not changed from pre-NPI requirements. Comment was changed to provide additional information about editing (i.e, This amount should match the amount in Loop 2300, CLM02).
	SV103	Unit or Basis for Measurement Code	**UN**-Unit	ID 2/2	R				
	SV104	Quantity	Units of Service	R 1/15	R	Must be greater than 0. To report partial units, include the decimal and only one tenth decimal position to assure proper adjudication in MACSIS (ex., 15.6). Refer to addenda for clarification as to how Type "R" fields should be reported (in terms of including or excluding the decimal point). Services must be "summed and rounded" according to the MACSIS guidelines and reported as one service line.	44C and 44I	Comment changed to remove pre-HIPAA DOS references.	The content of this element has not changed from pre-NPI requirements.
	SV105	Place of Service Code	See http://www.cms.gov/states/posdata.pdf for a complete list of codes.	AN 1/2	S	Required if different than facility code value reported in Loop 2300, CLM05-1. It will be stored in MACSIS at the claim detail level for only the associated service being reported.	44E	Comment changed to remove pre-HIPAA DOS references.	The content of this element has not changed from pre-NPI requirements.
	SV107	Composite Diagnosis Code Pointer			S	This segment is required if the diagnosis is reported in the HI segment of Loop 2300.			
	SV107-1 thru SV107-4	Diagnosis Code Pointer		N0 1/2	R	This value can be repeated up to four times, but only the first value will be used by MACSIS for adjudication purposes.			
	SV109	Emergency Indicator	Y	ID 1/1	S	This field was changed to "situational" usage per the Oct 2002 addenda. The allowable values also changed from "Y or N" to just "Y". Do not value the data element if it does not apply. Even if valued, MACSIS will not use it for adjudication purposes.			
435	**DTP**	**Service Date**			**R**				
	DTP01	Date/Time Qualifier	**472**-Service	ID 3/3	R				
	DTP02	Date Time Period Format Qualifier	**D8**	ID 2/3	R	Per Medicaid Policy, a range of dates of service (i.e., RD8) is not permissible for behavioral health services. For services administered over range of dates, only a single start date of service should be provided.			
	DTP03	Service Date	CCYYMMDD	AN 1/35	R		40A and 40C		

	837 FILE SPECIFICATIONS								
IG PAGE	REF. DES	NAME	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	MACSIS Guide-Line	Changed?	Explanation
472	REF	**Line Item Control Number**			S				
	REF01	Provider Control Number	6R	ID 2/3	R				
	REF02	Line Item Control Number	Provider-assigned line item control number	AN 1/30	R	If this field is valued, MACSIS will store this number as the control number, not the value sent in Loop 2300, CLM01. It will be returned on the 835 file in Loop 2100, CLP01. Alphanumeric values are permissible, but not special characters. Please note this field is shorter in length (up to 30 characters) than the CLM01 field. It is longer in length than the 15-character control number on the ERA/RA. Therefore, MACSIS will return all 30 characters if provided on the 835. For the ERA/RA, the maximum returned will be 15-characters. See guidelines for specific requirements for ACD prevention services.	44B	Comment changed to remove pre-HIPAA DOS references.	The content of this element has not changed from pre-NPI requirements.
572	SE	**TRANSACTION SET TRAILER**			R				
	SE01	Segment Count	Total number of segments including SE and ST	N0 1/10	R				
	SE02	Transaction Set Control Number	Same as in ST02	AN 4/9	R	This value must equal the value in ST02, but it will not be stored in MACSIS.			
B.10	GE	**Functional Group Trailer**			R				
	GE01	# of Transaction Sets included	# of STs	N0 1/6	R				
	GE02	Group Control Number	Save as in GS06	N0 1/9	R	The application sender determines this value. Per the standard implementation guide, this field must match GS06 or the file will fail ANSI validation edits.			
B.7	IEA	**Interchange Control Trailer**			R				
	IEA01	# of Included functional Groups	# of GS	N0 1/5	R				
	IEA02	Interchange Control Number	same as in ISA13	N0 9/9	R	The interchange sender determines this value. Per the standard implementation guide, this field must match ISA13 or the file will fail ANSI validation edits.			

MACSIS EDI Claims Testing Request Form

Boards: Please verify the form is complete and email to the Office of Information Services, Ohio Department of Mental Health at macsistesting@mh.state.oh.us, after the test file has been placed in the appropriate FTP directory. **All information is required to process request.** ***DO NOT FAX THIS VERSION OF THE FORM.***

FILE SUBMISSION INFORMATION			
Test File Name	**Date File FTP'd to State**	**Submitter ID (UPI)**	**NPI**
Billing Provider Name		**Provider Bills Other Payers (COB)?**	
Provider Software Vendor		**Provider Software Product/Version**	
Board Name	**Board Contact Name**	**Board Phone #**	
Board Email	**Board Fax #**	**Test File FTP Directory**	
		/county/ /hipaa/test **(Tier 1)** /county/ /hipaa/tier2test **(Tier 2)**	
Comments			

TYPE OF TEST (CHECK ONE)		
Scenario	**File Name Format** **Board FTP Directory**	**Comments** **(One test file per UPI/NPI required for all scenarios)**
☐ Tier 1 – UPI format	J0xxxxx#.julyy /county/(board)/hipaa/test *e.x. /county/02B/hipaa/test*	Required for providers who are not ready to submit NPI-compliant files, but who are new to MACSIS, have new software, undergoing major system upgrade and/or adding new UPIs.
☐ Tier 2 – UPI format	J0xxxxx#.julyy /county/(board)/hipaa/tier2test *e.x. /county/02B/hipaa/tier2test*	Required for providers who are not ready to submit NPI-compliant files, but who have passed Tier 1, are new to MACSIS, have new software, undergoing major system upgrade and/or adding new UPIs
☐ Tier 1 – NPI format	X0xxxxx#.julyy /county/(board)/hipaa/test *e.x. /county/02B/hipaa/test*	Required for providers who are ready to submit NPI-compliant files and who are new to MACSIS, have new software, undergoing major system upgrade, added new NPIs or significantly failed Tier 2 NPI testing.
☐ Tier 2 – NPI format	X0xxxxx#.julyy /county/(board)/hipaa/tier2test *e.x. /county/02B/hipaa/tier2test*	Required for previously approved providers who are ready to submit NPI-compliant files for previously approved UPIs and/or for providers who passed Tier 1 NPI testing for the reasons noted above.

TESTING STATUS (COMPLETED BY STATE STAFF)			
Date Tested	**Tested By**	**File Passed?**	**Results Attached?**

File Requirements by Tier

Tier	File Size	Data Requirements	Test Checks
1	Max 100 claims per test file	• May be real or test data • Other payer scenario is included for both Medicaid eligible and non-Medicaid eligible services if appl. • "Summed" same day service scenario is included	File Syntax and Basic Content Compliance
2	Volume represents typical file submission up to 500 claims	• Must be real client data but service data can be test or real data • All contracted procedure codes are present • All lines of business are present (Medicaid and Non) • Other payer scenario is included for both Medicaid eligible and non-Medicaid eligible services if appl.	MACSIS pricing and adjudication

Sample EDI Weekly Report

Report on Weekly GM Processing: 22B on 28JUN2006 1
Display All Files by Processing (OVERNIGHT) Day and Provider
07:33 Wednesday, June 28, 2006

			GM Claims	GM Billed
			Sum	Sum
Grand Total			4,541	$317,274.56
FP Process Day	Provider	File		
06/22/2006	6689	A0066891.17106	381	$22,978.60
	All		381	$22,978.60
06/24/2006	Provider	File		
	1168	A0011681.16506	3,614	$251,690.06
		A0011682.16506	179	$15,290.00
	All		3,793	$266,980.06
06/28/2006	Provider	File		
	6689	A0066891.17806	367	$27,315.90
	All		367	$27,315.90

GM V3(7)

No	File	Over Night Date	FY04 and less	FY05 DOS	FY06 DOS	FY07 DOS	FY08 and more	Numb of claims	Billed Amount	File Lines
1	A0011681.16506	24JUN	0	0	3,614	0	0	3,614	$251,690.06	55,121
2	A0011682.16506	24JUN	0	0	179	0	0	179	$15,290.00	2,705
3	A0066891.17106	22JUN	0	0	381	0	0	381	$22,978.60	4,770
4	A0066891.17806	28JUN	0	0	367	0	0	367	$27,315.90	4,694
								4,541	*$317,274.56*	

Provider	File	Over Night Date	FY04 and less	FY05 DOS	FY06 DOS	FY07 DOS	FY08 and more	Numb of claims	Billed Amount	File Lines
1168	A0011681.16506	24JUN	0	0	3,614	0	0	3,614	$251,690.06	55,121
	A0011682.16506	24JUN	0	0	179	0	0	179	$15,290.00	2,705
1168								*3,793*	*$266,980.06*	
6689	A0066891.17106	22JUN	0	0	381	0	0	381	$22,978.60	4,770
	A0066891.17806	28JUN	0	0	367	0	0	367	$27,315.90	4,694
6689								*748*	*$50,294.50*	

Overnight Program Errors

Overnight File Handling and SAS© First Pass File Examination
Release 3.4

Version 3 of the first step of the HIPAA Front--End Processing -- commonly referred to as "Overnight" Processing or "First Pass (FP SAS©)" processing -- provides tests related to the following 28 possible error messages. Please note that while a single such reported error rejects a file for further processing and only one such error will be reported per file, it is entirely possible for a file to have multiple such errors. Rejected files are noted on your "Overnight" report, a copy of which is emailed to your contact list and an additional copy placed in your reports sub--directory on the mhhub server. Rejected files are also placed in the reject directory on that server as well.

ERROR MESSAGE	Simple Description
1 ZERO BYTES IN FILE	A unix "ls" command shows zero bytes in the file.
2 FILENAME WRONG LENGTH	The file length must be 14 bytes (including the dot). Anything else will be rejected with this error message.
3 FILENAME FIRST LETTER	The filename must begin with either an "A" or an "N".
4 FRONT WRONG LENGTH	The filename must have an "8.5" format. If the first "word" (i.e., before the dot) is not 8 bytes, the file will be rejected.
5 BACK WRONG LENGTH	The back or second word (i.e., after the dot) must be 5 bytes.
6 TOO MANY FILENAME DOTS!	The file name can contain only 1 dot.
7 BAD FILE SEQ NUMBER	The 8th byte is required to be a number from 1 to 9 representing the number of files submitted by this provider this day. Zero cannot be used as a sequence number.
8 ILLEGAL CHAR IN FNAME	Special characters and other ASCII oddities are not allowed in filenames -- like underline or ampersand, etc.
9 DUP FROM | | PROCESS_DATE	A Board may submit a filename only once -- any subsequent submissions by the board will be rejected as duplicates. Note: It does not matter if the original submission was accepted or rejected; a filename may be submitted only once.

10 EOL PROBLEM: || STATUS	Problems with the EOL marker -- this segment delimiter must be a “0A” hexadecimal characters as unix expects. A tilde, or ‘0D0A’x, or ‘0D’x end of line marker will be rejected. The unix EOL marker must be found -- using ASCII for “look-ahead” mode of FTP file transfer is the best method in normal circumstances to see this accomplished.
11 NO OF 2400 NE NO OF 2300	The number of “CLM” and “SV1” segments must agree – MACSIS has a 1:1 demand relationship for the number of Claims Headers (Loop 2300) and Claims Detail Lines 2400 Loops.
12 PAT LOOPS: || PAT_COUNT	In the MACSIS system, the client is always the patient. The X12 4010-837P Implementation Guide (IG) then specified that you cannot code Loop 2000C, Loop 2010CA, etc. If you see this error, you have the number of such Patient Loops coded as is shown.
13 SE COUNT NE LINES READ	The SE-02 number must match the number of data lines and envelopes read -- this is our only check the file transfer process has been complete and we have received all that was expected. Note: You are allowed one blank line after the ISA trailer -- too many vendors proved incapable of making a claim file without an “extra” blank line.
14 MULTIPLE BLANK LINES	More than 1 blank line, or an “inside the file blank line” are not acceptable.
15 NO CLAIMS FOUND IN FILE	A surprise to us in our original programming -- we have seen perfectly good 4010-837P envelopes submitted with no accompanying claims information whatsoever.
16 NUMB ST NE SE SEGMENTS	Multiple ST-SE sets are acceptable, but there does need to be a transaction set closing segment for every opening one.
17 NEG/MISS CLM-02 VALUES	One cannot present negative or missing claim level billed amounts.
18 NEG/MISS SV1-02 VALUES	One cannot present negative or missing service line level billed amounts.

19 NEGATIVE COB VALUES	Nor can you have negative Coordination of Benefits amounts. These edits were added as a function of some truly creative submission files.
20 NPI: BAD FORMAT	The Provider NPI, NM1-09 in Loop 2010AA of an "N" file must be 10 bytes long. All NPI analyses are performed only on "N" files.
21 NPI: UNKNOWN	The Provider NPI was not found in the master copy of PROVF information.
22 NPI: UPI NOMATCH	The Provider NPI matched PROVF, but the accompanying UPI did not match PROVF.
23 NPI: UNAUTH.	Provider NPI found which matches PROVF but that Provider is not listed as having passed Tier 2 testing i.e., "not live".
24 REF1G: MISSING OR BAD	UPI as provided in Loop 2010AA*REF*1G-02 of an "A" file does not have required 12 byte format.
25 REF1G: UNKNOWN	UPI as provided in "A" file is not found in master copy of PROVF information.
26 REF1G: UNAUTHORIZED	UPI as correctly defined is not listed in "live" category, i.e., is not shown as having passed Tier 2 testing.
27 UPI: XX MISSING	The file declares an NPI file but the NM1-08 value in 2010AA is not "XX" – this suggests to us that a Pre-NPI file has been submitted with an improper name. This would cause improper handling in XML construction and EDI processing.
28 UPI: 24 MISSING	The file name declares this to be Pre-NPI file, but the NM108 value in 2010AA is not "24" as required suggesting this is a min-named NPI file. Such causes considerable problems in EDI and many, many critical errors.
29 NPI: NPI/UPI MISMATCH	According to our records, the NPI and UPI in this file do not go together.
30 NPI: TAXID MISSING	REF*EI-02 is blank or cannot be found in an "N" file.

31 UPI: TAXID MISSING

NM1-09 is blank or missing in Loop 2010AA of an "A" file.