

**ODADAS - ODMH**  
**Guidelines Pertaining to the Implementation of MACSIS under HIPAA**  
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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](mailto: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](mailto: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 where clients are eligible for 100% reimbursement.
- Per ORC 340.03 (9), each board will establish its own sliding fee scale.
  - o 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

1. The MACSIS Support Desk, hereinafter referred to as State, will timely process requests submitted by the board to remove client information from MACSIS.
2. 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.
3. 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).
4. State will verify client has not received services in other boards areas
5. 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)
6. 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.
7. State will take action necessary to remove client information from Outcomes database.
8. Board(s) will be responsible for notifying provider of action taken by State.
9. Provider(s) must submit a delete record to ODADAS in accordance with Behavioral Health Instruction Manual to delete client information from BH module.

10. 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  
[\(http://www.mh.state.oh.us/ois/macsis/policies/rdd/macsis001.pdf\)](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.

<b>Inmate Status</b>	<b>Non-Inmate Status</b>
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 1<sup>st</sup> 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.
- MHGROUPE 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:**

- **ADMCDAYS** (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 ([macsisupport@mh.state.oh.us](mailto:macsisupport@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](mailto:Macsis_claims@odadas.mh.state.oh.us)

MACSIS Member Users Group – [Macsis\\_members@odadas.mh.state.oh.us](mailto:Macsis_members@odadas.mh.state.oh.us)

MACSIS MIS Users Group – [Macsis\\_mis@odadas.mh.state.oh.us](mailto:Macsis_mis@odadas.mh.state.oh.us)

MACSIS Finance Users Group – [Macsis\\_finance@odadas.mh.state.oh.us](mailto:Macsis_finance@odadas.mh.state.oh.us)

MACSIS Project and Operations (POP) – [Macsis\\_pop@odadas.mh.state.oh.us](mailto: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<sup>1</sup> 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*

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<sup>1</sup> MACSIS Administrators are Boards or Board Consortia 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.

##### o 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](mailto: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 Consortia

- 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](http://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](http://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](mailto: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](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**

<b>#</b>	<b>Requirement</b>	<b>MACSIS Guideline</b>	<b>Loop/Segment /Element</b>	<b>SNIP Type</b>
	<b>FILE NAMING CONVENTION</b>			
O1	Proper file naming convention is used (Jxxxxxx#.julyy)	42A	N/a	7
	<b>CONTROL SEGMENT USAGE</b>			
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
	<b>SUBMITTER/RECEIVER IDs</b>			
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
	<b>PROVIDER INFORMATION</b>			
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
	<b>SUBSCRIBER INFORMATION</b>			
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 of 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
	<b>CLAIM INFORMATION</b>			
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
	<b>OTHER PROVIDER INFORMATION</b>			
X1	Rendering Provider Information, if provided, is properly coded. (Note: Not required for MACSIS)	N/A	Loop 2310B	7
	<b>OTHER PAYER INFORMATION (IF APPLICABLE)</b>			
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
	<b>SERVICE INFORMATION</b>			
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**

#	<i>Test Scenario</i>	<i>Used to Verify</i>
1	<ul style="list-style-type: none"> <li>○ Other payer is involved with the claim</li> <li>○ Client is Medicaid Eligible</li> <li>○ Service is Medicaid Eligible</li> </ul>	<ul style="list-style-type: none"> <li>○ Provider system can properly generate the Loops related to Other Payer Information (2320, 2330A and 2330B)</li> </ul>
2	<ul style="list-style-type: none"> <li>○ Other payer is involved with the claim</li> <li>○ Service is not Medicaid Eligible</li> </ul>	<ul style="list-style-type: none"> <li>○ Provider system can properly generate the Loops related to Other Payer Information (2320 and 2330B)</li> </ul>
3	<ul style="list-style-type: none"> <li>○ Date of service is after July 1, 2003</li> <li>○ Billed service uses “new” MACSIS procedure, modifier codes and place of service codes</li> </ul>	<ul style="list-style-type: none"> <li>○ Provider system is using “new” MACSIS procedure, modifier and place of service codes for dates of service on or after July 1, 2003.</li> </ul>
4	<ul style="list-style-type: none"> <li>○ Same-day services (for dates of service on or after July 1, 2003) are “summed” per the MACSIS same-day service policies under HIPAA.</li> </ul>	<ul style="list-style-type: none"> <li>○ Provider system is “summing” same-day services appropriately.</li> <li>○ Refer to MH Duplicate Claim Check Roll-Up Category Matrix for more information.</li> </ul>

**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	<ul style="list-style-type: none"> <li>• HIPAA Service Rate Forms (Medicaid and Non-Medicaid) have been faxed along with the Tier 2 Test form.</li> <li>• 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<sup>2</sup> must not be less than the rates on the HIPAA Service Rate Form and in Diamond.</li> </ul>	N/A
4	The number of claims on the file represents a typical weekly submission for the provider, but does not exceed 500 claims <sup>3</sup> .	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 <sup>4</sup> .	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 <sup>4</sup> .	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

<sup>2</sup> 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.

<sup>3</sup> See [http://www.mh.state.oh.us/ois/macsis/claims/prov\\_fy03\\_clms.XLS](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.

<sup>4</sup> 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 10<sup>th</sup>)
- “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:

<u>TIME SERVICE PROVIDED</u>	<u>UNITS TO BILL</u>
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	---	---
<b>TOTAL BILLED as one line item</b>	<b>7/5/03</b>	<b>Joe Client</b>	<b>33 min</b>	<b>----</b>	<b>H0036</b>	<b>2</b>	<b>\$100</b>

**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:

<i>Time Service Provided</i>	<i>Units to Bill</i>
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)**

<b>Service Date</b>	<b>Actual Time</b>	<b>Service name</b>	<b>Service Time</b>	<b>Units of Service</b>
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	--
	<b>Total Billed as one line item</b>		<b>30</b>	<b>.5</b>
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	--
	<b>Total Billed as one line item</b>		<b>37</b>	<b>.6</b>

**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 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:

<b>Scenario</b>	<b>Procedure Code</b>	<b>Mod 1</b>	<b>Mod 2</b>	<b>POS</b>	<b>Units</b>
<u>Service in School</u> <ul style="list-style-type: none"> <li>○ BH Counsel. &amp; Therapy</li> <li>○ 20-min at School</li> <li>○ Family/ client Present</li> </ul>	Round minutes to whole units per table <i>H0004</i>	HE		03	1
<u>Service w/probation officer</u> <ul style="list-style-type: none"> <li>○ BH Counsel. &amp; Therapy</li> <li>○ 20-min at office</li> <li>○ client NOT Present</li> </ul>	Round minutes to whole units per table <i>H0004</i>	HE	UK	03	1
<u>Service in School and at home</u> <ul style="list-style-type: none"> <li>○ BH Counsel. &amp; Therapy</li> <li>○ 30-min at School with teacher, client NOT present</li> <li>○ 60-min at client’s home with Family/ client Present in p.m.</li> </ul>	Round minutes to whole units per table  <i>Submit 2 claims:</i>  <i>H0004</i>  <i>H0004</i>	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, 9<sup>th</sup> 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
<u>Same-Day Inpatient Psych Facility</u> <ul style="list-style-type: none"> <li>MH Assessment</li> <li>Non-Physician</li> <li>20-min at CMHC in a.m.</li> <li>30-min at State Hospital in evening</li> </ul>	Submit two separate claims <i>H0031</i>	HE		53	.3
	<i>H0031</i>	HE		51	.5
<u>Same-Day Nurse/Physician MedSomatic</u> <ul style="list-style-type: none"> <li>Pharmacologic Mgmt</li> <li>7-min at CMHC by physician in a.m.</li> <li>7-min at CMHC by nurse in p.m.</li> </ul>	Submit one claim. "Sum" then round minutes to partial units per table <i>90862</i>	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.
  - o 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.
  - o 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

<b>Acronym</b>	<b>Definition</b>
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)