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HIPAA EDI Policies Related to Claims and Claims Payment

40. General HIPAA EDI Policies

A. Effective Date

The HIPAA EDI policies outlined in this document shall be effective July 1, 2003 for all Boards or MACSIS Administrators¹ 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, ASC X12N Version 4010 837 Professional Transaction format will be required for submitting claims electronically via MACSIS beginning July 1, 2003, 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 implementation guide.

2. Electronic Remittance

The HIPAA-mandated, ASC X12N Version 4010 835 Health Care Claim Payment/Advice format will be provided by MACSIS to the Boards or MACSIS Administrators by agency remitted in batch mode. At least initially, 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 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 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 Reports (ARAs) will be provided via print image in the designated Board or MACSIS Administrator FTP directories as currently done.

4. ASC X12N Addenda

The HHS Secretary has adopted the X12N addenda changes (Version 004010X098A1). Therefore, MACSIS will be implementing the applicable addenda changes for both the 837P and the 835 files.

¹ MACSIS Administrators are Boards or Board Consortia who perform MACSIS-related system or administrative functions on behalf of another Board.

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C. Implementation Issues

1. Implementation Schedule

A “parallel” system implementation strategy will be used to significantly minimize the amount of downtime necessary to migrate the current MACSIS system environment to a new HIPAA-compliant environment. This “parallel” strategy entails using the existing MACSIS server to process claims for dates of service prior to July 1, 2003 and using a new server to process claims for dates of service on or after July 1, 2003.

The implementation schedule and strategy details are still being finalized and will be shared as soon as possible.

What is known is the following:

- HCFA 1500 NSF files must contain dates of service prior to July 1, 2003. They must also include the “old” code sets (e.g. State-Defined MACSIS procedure and modifier codes). Any HCFA 1500 NSF claims containing dates of service after July 1, 2003 or new code sets will be denied by MACSIS.
- ANSI 837P claim files must use the “new” HIPAA-valid code sets (e.g. for procedure and modifier codes) for any date of service on or after July 1, 2003. However, ANSI 837P files with dates of service prior to July 1, 2003, must contain the “old” State-Defined MACSIS procedure and modifier codes. Any 837P files containing new procedure codes for old dates of service will be rejected.
- After July 1, 2003, MACSIS will begin producing both the 835 Health Care Claim Payment/Advice and the existing ERA proprietary file for all remittances.

Until the implementation schedule can be finalized, it is recommended that Boards encourage their providers’ software vendors to have the flexibility for the user to select the type of file they want to create (HCFA 1500 NSF or ANSI 837P) based on a date of service range. In other words, the ANSI 837P file, if possible, should not entirely replace the HCFA 1500 NSF file creation functionality in a Production environment. This flexibility would assist the provider in preparing for the transition to HIPAA as well as provide an opportunity to validate test files created with the same source data but in two different formats.

2. Board Technical Evaluation and Modification to Support HIPAA-Mandated Transactions

Boards or MACSIS Administrators will need to evaluate their existing technical infrastructure to determine which modifications and additions are necessary to perform and support EDI functions in compliance with the Board-State 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.

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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 will 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 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

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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** 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)
 - o For Windows-based operating systems, use carriage return, line feed, hexadecimal '0D0A'x
 - o For Unix-based operating systems, use line feed, hexadecimal '0A'x
 - o For Mac-based operating systems, use carriage return, hexadecimal '0D'x

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- 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. 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.

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41. Becoming a Trading Partner

A. Getting Started

1. *Trading Partner Agreement*

An EDI Trading Partner Agreement (TPA) is a contract between parties who have chosen to become electronic business partners. The TPA stipulates the general terms and conditions under which the partners agree to exchange information electronically.

ODMH and ODADAS are in the process of developing a TPA between the State and the Boards. This document is not final at this time, but will be made available as soon as it is complete and approved. Boards will be responsible for developing TPAs between themselves and their providers.

Testing between MACSIS and a Board or MACSIS Administrator may take place prior to TPA signature approvals, but EDI production exchanges will not be initiated until all testing has been successfully completed and a Trading Partner Agreement has been agreed to and signed by all of the responsible parties.

The TPA document, once developed, should be signed by the Board Executive Director and the Directors of ODMH and ODADAS. Proof of Board resolution or existing Board policy authorizing the Board Executive Director to sign the document will be required. Further information regarding the process to obtain signatures, forward copies and related Board documentation will be forthcoming.

2. *Sender and Receiver Identification Numbers*

The ASC X12N formats require use of identification numbers assigned to both the sender and receiver of electronic claim files to identify these parties on the file being transmitted.

Since the receiver of the 837 professional claims file (ex., home Board) may be different than the entity ultimately identified as responsible for adjudicating a claim (ex. out-of-county Board), the sender and receiver identification numbers for the 837 will not necessarily match the sender and receiver identification numbers for the 835 Health Care Claim Payment/Advice files.

- **837 Professional Claim File**

- a. **Sender Identification Numbers**

- For providers, the MACSIS-assigned UPI, Vendor or MACSIS 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

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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 the next section 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 834 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

This process is dependent upon further information from HSD/Perot and will be documented as soon as that information is available.

B. EDI Testing Policies

Boards will need to ensure that each of their contracting providers are approved to submit production electronic claims to the MACSIS system, whether sent directly or via a clearinghouse on their behalf. Please note that it will not be necessary to approve a “provider software vendor” or “clearinghouse” per se. Each provider will be approved individually regardless of the similarity in software or clearinghouse used.

The testing policies under MACSIS will closely adhere to the recommendations made by the Strategic National Implementation Process (SNIP) Transaction Set Testing Sub/Workgroup as outlined in the white paper, “Transaction Compliance and Certification”
www.wedi.org/snip/public/articles/testing_whitepaper082602.pdf

Please note that the testing “levels” as discussed in the original SNIP white paper have changed and are now referred to as “types”. For this reason, the details about MACSIS’ testing process will be published in a separate testing policy and procedure document. These guidelines have been updated to remove details about the testing policy accordingly.

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Boards or MACSIS Administrators will be responsible for initiating the testing and approval process for each contracting provider through MACSIS. The MACSIS Team will communicate with the Board or MACSIS Administrator representative any testing or approval status related to a provider using the MACSIS Claims Testing Form(s). It is the Board's or MACSIS Administrator's responsibility to share the status with the provider. If approved, the Board will receive a faxed copy of the MACSIS Claims Testing Form approving the provider to submit live claim data. If rejected, the Board will be notified of the reason for the rejection via the same form, which could be one of the following:

- 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
- 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

Please note subsequent approval for production claim submission will be required if the provider or their respective software vendor or clearinghouse changes their file creation program.

42. 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

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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 HIPAA implementation guide compliance. Only files passing HIPAA compliance validation will be processed into MACSIS.

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

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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 50 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.

Since Diamond Version 8.0 has not been fully tested in the MACSIS test environment at this time, it is unclear how much the steps involved in editing and posting claims into MACSIS will change from current practice. More information on the processing steps involved and the effect on the schedule will be forthcoming as it becomes available.

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 www.mh.state.oh.us/ois/macsis/claims/837.prof.claim.guide.pdf for a copy of the 837 Informational Guide.

43. ASC X12N 835 Health Claim/Payment Advice Return Policies

A. File Compliance

1. 100% Payment for Medicaid Services (formerly Topic 27)

Please reference ODMH/ODADAS memorandum of March 31, 1999 (C-3-99-05) that contains the FY 2000 and FY 2001 Community Mental Health Medicaid Agreements. In part, the memorandum reflects the following:

- **Beginning in FY 2000, State and local public fund match verification will no longer occur at the 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 FFP.** The sole exception is

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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 (formerly Topic 25)

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

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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 www.mh.state.oh.us/initiatives/macsis/ra/macsis.remit.info.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 the Cash Management Improvement Act (CMIA), 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 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. If not, federal interest penalties of the CMIA may be applicable.

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 Abbbxxxxx.julyy. An example is A25B001043.31402, where:

- "A" is a constant used to identify the file as an ANSI-compliant file.
- "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")

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- “jul” equals the julian date the file was created (ex. 314 for November 10th)
- “yy” equals the year the file was created (ex. 02 for 2002)

The supplemental, existing proprietary ERA format naming convention will remain the same (ex. 25B01043.314). If test 835 files are disbursed during the testing process, then the test 835 files will be 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)
- 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

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there is scheduled or unscheduled system downtime or other system issues prohibiting production.

Boards and providers can monitor the number and amount of claims finalized by “AP Date” by Board responsible for payment via the Remittance Tracking Reports accessible on the web <http://www.mh.state.oh.us/ois/macsis/mac.rpts.index.html>.

Since Diamond Version 8.0 has not been fully tested in the MACSIS test environment at this time, it is unclear how the production schedule will need to be altered to accommodate differences in processing speed that might occur with the new version. For this reason, this schedule is tentative pending further testing.

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 www.mh.state.oh.us/macsis/claims/835.claim.pay.advice.pdf for a copy of the 835 Informational Guide.

44. 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. It is required that the current practice of retrospective clinical and financial audits continue.

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)

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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

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

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

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 (Topic 16)*

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

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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	---	---
<i>TOTAL BILLED as one line item</i>	<i>7/5/03</i>	<i>Joe Client</i>	<i>33 min</i>	<i>----</i>	<i>H0036</i>	<i>2</i>	<i>\$100</i>

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)

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Alcohol and/or Other Drug Service Intervention (H0022)
 Alcohol and/or Other Drug Service Referral and Information (A0510)
 Alcohol and/or Other Drug Service Training (H0021)
 BH Outreach (H0023)
 Alcohol and/or Other Drug Svc Prevention Environmental Svcs (A0640)
 Alcohol and/or Other Drug Prevention Problem Id & Referral (A0650)
 Child Sitting services for children of the individual receiving alcohol and/or
 substance abuse services (T1009)
 Alcohol and/or Substance Abuse Services, Not Otherwise Classified (T1011)

- If the same service is legitimately provided on the same day to the same client, the service minutes must be summed for the date of service, then rounded according to the table below and submitted as one service line on the claim.
- All hourly based services require the following rounding conventions to be used when reporting service units. Hourly-based services should be rounded to the nearest tenth as follows:

Time Service Provided	Units to Bill
0 minutes to 7 minutes	Not Billable
8 minutes	.1 Units
9 minutes to 14 minutes	.2 Units
15 minutes to 20 minutes	.3 Units
21 minutes to 26 minutes	.4 Units
27 minutes to 32 minutes	.5 Units
33 minutes to 38 minutes	.6 Units
39 minutes to 44 minutes	.7 Units
45 minutes to 50 minutes	.8 Units
51 minutes to 56 minutes	.9 Units
57 minutes to 62 minutes	1.0 Units
63 minutes to 68 minutes	1.1 Units

- Actual minutes must be accurately reflected in the clinical records. Each encounter for the day should be recorded separately in the clinical record. You must either a) record the start and end time of each encounter or b) record the start time and duration (in minutes) of each encounter.

Progress Note (and implication for billing)

Service Date	Actual Time	Service name	Service Time	Units of Service
7/27/03	8:05 – 8:15	Crisis Intervention	10	--
7/27/03	12:00–12:05	Crisis Intervention	5	--
7/27/03	3:45 – 4:00	Crisis Intervention	15	.--
	Total Billed as one line item		30	.5
7/31/03	9:00 – 9:27	Pharmacologic Mgt	27	--
7/31/03	11:15 – 11:20	Pharmacologic Mgt	5	--
7/31/03	2:00 – 2:05	Pharmacologic Mgt	5	--
	Total Billed as one line item		37	.6

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c. Day- Based Services

- APPLIES TO THE FOLLOWING SERVICES:

MH - Partial Hospitalization (S0201)

MH Residential services that do include Room and Board:

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. Please refer to the October 5, 2001 communication from Don Anderson for additional information.
- 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.

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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 five 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 or CPT codes used to capture nationally recognized healthcare services. Please refer to the procedure code table for additional clarity.

*For example: If an 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

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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 www.mh.state.oh.us/ois/macsis/codes/mh.hipaa.modifier.code.table.pdf and for ODADAS at 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 for MH Medicaid covered services or for Housing and Residential services in modifier 3 or 4 will result in a denied claim.
- For MH services the use of UK in modifier 3 or 4 will result in a denied claim.
- Some Vendors Require Values in Consecutive Positions
 - If required, place “99” which means Multiple Modifiers in position “2” or “3” as needed
 - If not required, Modifier 2 may be left blank

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.

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- 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 or Loop 2400, Field SV105, Place of Service Code.
- 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 the allowable MH services, regardless of whether the client was present or not present. 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.

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 the client is NOT present .

Examples:

Scenario	Procedure Code	Mod 1	Mod 2	POS	Units
<u>Service in School</u> <ul style="list-style-type: none"> • BH Counsel. & Therapy • 20-min at School • Family/ client Present 	Round minutes to whole units per table <ul style="list-style-type: none"> • H0004 	HE		11	1
<u>Service w/probation officer</u> <ul style="list-style-type: none"> • BH Counsel. & Therapy • 20-min at office • client NOT Present 	Round minutes to whole units per table <ul style="list-style-type: none"> • H0004 	HE	UK	11	1
<u>Service in School and at home</u> <ul style="list-style-type: none"> • BH Counsel. & Therapy • 30-min at School with teacher, client NOT present • 60-min at client’s home with Family/ client Present in p.m. 	Round minutes to whole units per table Submit 2 claims: <ol style="list-style-type: none"> 1. H0004 2. H0004 	HE	UK	11	2
		HE		12	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 (like currently done) and can be found at www.mh.state.oh.us/ois/macsis/mac.codes.macsis.pos.codes.html

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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 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 place of service code can be any acceptable value, since it will not be used in the adjudication process.

F. Diagnosis Codes (formerly Topic 14)

1. General Provisions

HIPAA requires use of the most current published version of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes for professional claims submission. Although providers may submit any current ICD-9-CM code, MACSIS will consider for payment claims containing only those diagnosis codes outlined in the Behavioral Health ICD-9-CM-Code Table at <http://www.mh.state.oh.us/ois/macsis/codes/bhcare.icd9cm.codes.payment.hipaa.pdf>.

- Claims submitted with diagnosis codes not included in the table noted above will be denied in MACSIS.
- Several diagnoses codes can be submitted at the claim level in Loop 2400, Segment HI – Health Care Diagnosis Codes, but MACSIS will only adjudicate a specific service based on the first billing diagnosis code associated with the service line as indicated by Loop 2400, Field SV107-1 (Diagnosis Code Pointer).

2. Diagnosis Coding Adjudication Requirements

To be considered for payment, claims for all Medicaid covered services (regardless of whether the client is Medicaid eligible) must point to one of the 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>

Additionally, one of the AOD diagnosis codes listed in the table must be provided when reporting AOD residential or AOD Detox services. All other services do not require a diagnosis code for adjudication purposes. However, if one is provided, it should be one of the codes noted in the table to assure correct adjudication of the claim. Please note that the MACSIS MH and AOD Procedure Code Tables now include a column indicating which procedures will require a diagnosis code for adjudication purposes.

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

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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.
- 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 (currently submitted on the HCFA 1500 NSF file on the FA0 Record, Field 21) 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. Correction and Resubmitting Claims

1. ***Claim Corrections in MACSIS*** - *This section will be developed and shared at a later date*
2. **Resubmitting corrected claims on EDI File** - If a previously denied or rejected claim is resubmitted it will be treated as a new claim and initially denied as a “duplicate” claim. MACSIS will not be able to distinguish between original and resubmitted claim.

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. ODJFS removed the duplicate claim edits from their system and, therefore, duplicate checking is no longer being performed in the manner it was pre-MACSIS. ODADAS and ODMH have made assurances to ODJFS that duplicate claim checking will be carried out locally by providers and also centrally within MACSIS. Failure of the MACSIS system to perform this checking may result in ODJFS re-implementing their duplicate checks. Duplicate checking for claims and EDI transactions will be treated in the same manner as described below.

Guidelines Pertaining to MACSIS HIPAA EDI Topics

1. Same Day Service Reporting

New procedures will be 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 will be reconfigured to automatically adjudicate, deny and not hold a non-rolled up “duplicate” service. (Note: MACSIS currently creates a “warning” and holds these services, so the Boards may or may 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. Exception: Same-day services with the place of service codes of “99” or “51” should not be summed. Please refer to the Roll-Up Category Matrix for ODMH at www.mh.state.oh.us/macsis/hipaa/macsis.mh.hipaa.rollup.xls and for ODADAS at www.mh.state.oh.us/macsis/hipaa/macsis.aod.hipaa.rollup.xls which include healthcare and non-healthcare procedures.

<u>Same-Day Inpatient Psych Facility</u> <ul style="list-style-type: none"> • MH Assessment non-phys. • Non-Physician • 20-min at CMHC in a.m. • 30-min at State Hospital in evening 	Submit two separate claims 1. H0031 2. H0031	HE HE		53 51	.3 .5
<u>Same-Day Nurse/Physician MedSomatic</u> <ul style="list-style-type: none"> • Pharmacologic Mgmt • 7-min at CMHC by physician in a.m. • 7-min at CMHC by nurse in p.m. 	Submit one claim. “Sum” then round minutes to partial units per table 1. 90862	HE		53	.2

2. Service Rounding Conventions

Rounding conventions outlined in Section 44C of this document should be applied to episodes of treatment occurring on the same day after summing the total number of service minutes. Refer to the example provided in Section 44C for Individual MH Community Support (CSP) for more information.

3. Claims Correction Policy

A sub-committee of board and provider representatives is currently in the process of updating the Claims Correction Policy and Procedure for use under HIPAA. The policy and procedure will be published once available. It is important to note a corrected claim that is re-submitted electronically will result in an automatic “duplicate” denial.

4. 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.