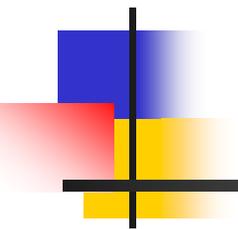
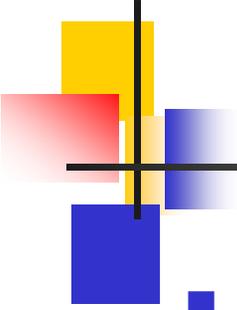


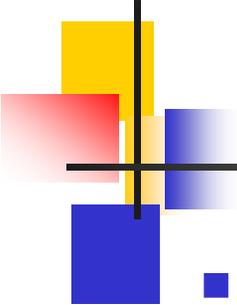
MACSIS HIPAA Claims and Payment Training





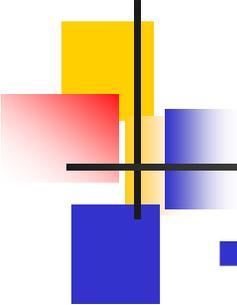
Introduction

- The primary function of MACSIS is the payment of “behavioral health” claims funded in whole or part with public funds.
- Payment of claims requires an input and an output process
 - Input is done through the 837 Professional Claim File (837P) submission
 - Output is done through the 835 Health Care Claim Payment Advice
 - State is still creating the ERA (electronic remittance advice), RA (remittance advice – printable format) and the RJ (reject/reversed claim file)



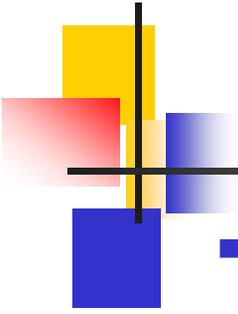
Agenda

- 837P Submission Process
- Edit Process
- Post Process
- Claims Correction Process
- Retroactive Medicaid Claims
- Accounts Payable Process/Double Loop
- OHEXT Process
- "F" Claims
- Tracking Board/Provider Files
- Claims Testing Process



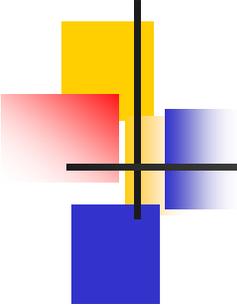
837P Submission

- Provider creates the 837P claim file and submits to Board along with a notification form (either emailed or faxed depending on board's requirement) that contains:
 - provider name and UPI
 - file submission date
 - name of the file
 - number of claim lines and total dollar amount (this must be calculated and is not a value that can be picked up from the 837P)
 - period the claims are for
 - person submitting the file



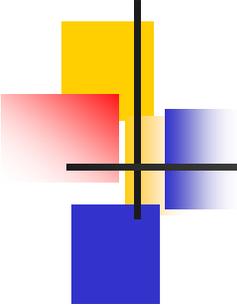
837P Submission

- File Naming Conventions
 - Incoming production UPI claim files must be named Axxxxxx#.julyy (8.5 format) while NPI claim files must be named Nxxxxxx#.julyy (8.5 format) where “xxxxxx” = the MACSIS UPI or Vendor number (right justified, zero-filled), # is a sequential number to identify separate and distinct file transmissions being sent on the same day, “jul” is the julian date the file was created and “yy” is the year the file was created.
 - Ex. **UPI**: A0010431.31402 would be the file name for the first file sent to MACSIS from provider UPI# 1043 on November 10, 2002
 - Ex. **NPI**: N0010431.19406 would be the file name for the first file sent to MACSIS from provider UPI# 1043 on July 13, 2006.
 - May 23, 2007 is the Federal deadline for NPI.
- Board verifies and logs file
- Board verifies file is not a duplicate



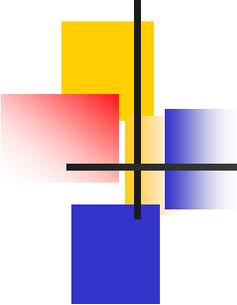
837P Submission (cont'd)

- Board FTP's 837P file to MHHUB server
 - Claim files are put into the /county/<board>/hipaa/input/ subdirectory and are FTP'd in ASCII mode
- State reviews uploaded files daily at 5 a.m. for structure and compliance
 - Accepted files are moved from MHHUB to HIPAA Production Holding directory
 - Rejected files are moved to /county/<board>/hipaa/reject
 - Board notifies provider when file is rejected
 - OVERNIGHT email sent with status of each file received and number of claims accepted for further analysis
 - Copy of OVERNIGHT report is also stored on MHHUB in /county/<board>/hipaa/reports/ subdirectory



837P Submission (cont'd)

- Whether a provider file is accepted or rejected, boards should notify their providers within 7 business days as to the status of their file
 - If file was accepted include the corresponding MACSIS batch number
 - Communication can be made via fax, email or website as long as no PHI data is disclosed.



Sample Overnight Email

From: <dhirschf@rhocl005.odn.state.oh.us>
To: <MACHIPAA@MH.STATE.OH.US>
Date: 4/7/2007 2:15:40 pm
Subject: 83B OVERNIGHT PROCESSING REPORT 1: 07APR2007
CC: <macsisupport@MH.STATE.OH.US>, <kirschr@bhg.org>; <medleyja@bhg.org>

PLEASE DO NOT REPLY TO THIS EMAIL!

Overnight Processing has analyzed the following files:

Claims	File Name	Error (If Any)
.	N0101821.09607	NO OF 2400 NE NO OF 2300
144	A0013251.09407	ACCEPTABLE
112	A0101931.09507	ACCEPTABLE
34	A0121751.09507	ACCEPTABLE
8	A0121752.09507	ACCEPTABLE
2,364	N0012901.09507	ACCEPTABLE
287	N0013221.09507	ACCEPTABLE
351	N0070951.09407	ACCEPTABLE
628	N0100611.09507	ACCEPTABLE
813	N0100612.09507	ACCEPTABLE
27	N0100613.09507	ACCEPTABLE
531	N0100651.09407	ACCEPTABLE
24	N0124671.09507	ACCEPTABLE
2	N0124671.09607	ACCEPTABLE

This action performed at 07APR07:14:14:55.

5,325 claims pass through screening of 14 files.

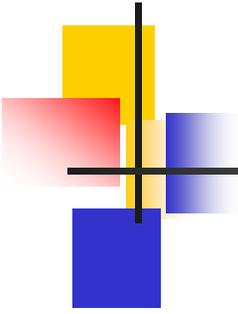
Sample Overnight on MHHUB

REPORT examining: 83B ON 07APR2007, PASS: 1, 14:13

1
14:13 Saturday, April 7, 2007

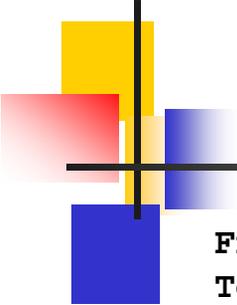
No#	File Name	Status	No of Claims	FY04-DOS	FY05-DOS	FY06-DOS	FY07-DOS	FY08+ DOS	BILLED in CLM-03
1	N0101821.09607	NO OF 2400 NE NO OF 2300	.	.	.	.	.	.	.
2	A0013251.09407	ACCEPTABLE	144	0	0	0	144	0	\$160,442.11
3	A0101931.09507	ACCEPTABLE	112	0	0	0	112	0	\$10,589.30
4	A0121751.09507	ACCEPTABLE	34	0	0	0	34	0	\$5,007.55
5	A0121752.09507	ACCEPTABLE	8	0	0	0	8	0	\$747.90
6	N0012901.09507	ACCEPTABLE	2,364	0	0	8	2356	0	\$136,947.50
7	N0013221.09507	ACCEPTABLE	287	0	0	0	287	0	\$17,801.21
8	N0070951.09407	ACCEPTABLE	351	0	0	0	351	0	\$32,497.90
9	N0100611.09507	ACCEPTABLE	628	0	0	0	628	0	\$55,986.18
10	N0100612.09507	ACCEPTABLE	813	0	0	0	813	0	\$54,482.07
11	N0100613.09507	ACCEPTABLE	27	0	0	0	27	0	\$12,455.10
12	N0100651.09407	ACCEPTABLE	531	0	0	0	531	0	\$51,870.87
13	N0124671.09507	ACCEPTABLE	24	0	0	0	24	0	\$1,235.56
14	N0124671.09607	ACCEPTABLE	2	0	0	0	2	0	\$71.06
			5,325		0	8	5317	0	\$540,134.31

Red Cell background means FY04 or before Claims Found.



837P Submission (cont'd)

- Weekly Claims Run - On your assigned run day all files in HIPAA Production Holding are processed
 - Files are read and are combined into a single XML file
 - WEEKLY PRODUCTION email is sent
 - Summary report by filename of claims read in and written out and is placed on MHHUB in /county/<board>/hipaa/reports



Sample Weekly Production Email

From: Liping Xin <lxin@rhocl005.odn.state.oh.us>
To: <macsisupport@mh.state.oh.us>
Date: Wed, Mar 10, 2004 8:17 AM
Subject: 81B -- WEEKLY PRODUCTION PRE-PROCESSING ON 10MAR2004

To Whom it May Concern: (PLEASE DO NOT REPLY TO THIS EMAIL),

The Weekly Board Pre-Processing was performed. A summary was placed in your /hipaa/reports directory.

File: A0013871.06304	CLAIMS	126
File: A0015071.06304	CLAIMS	221
File: A0070731.06304	CLAIMS	625
File: A0102771.06304	CLAIMS	822
File: A0102791.06104	CLAIMS	201
File: A0102792.06104	CLAIMS	5
File: A0103041.06304	CLAIMS	358

This action performed at 10MAR04:08:16:45.

CC: <81claims@adamhs.co.montgomery.oh.us>,
<machipaa@mh.state.oh.us>, <martinjp@mh.state.oh.us>

Sample Weekly Summary Report

*Report on Weekly GM Processing: 77B on 09APR2007
Display All Files by Processing (OVERNIGHT) Day and Provider*

1

07:31 Monday, April 9, 2007

			GM Claims	GM Billed
			Sum	Sum
Grand Total			24,653	\$1,526,963.66
FP Process Day	Provider	File		
04/06/2007	1508	A0015081.09407	6,896	\$316,080.25
		A0015082.09407	2,019	\$96,407.46
		A0015083.09407	4,923	\$128,465.24
		A0015084.09407	1,028	\$51,811.54
	All		14,866	\$592,764.49
04/07/2007	Provider	File		
	1059	N0010591.09507	3	\$285.61
		N0010592.09507	298	\$27,653.61
	1505	N0015051.09507	1,599	\$269,354.00
	1508	A0015081.09607	1,976	\$240,077.35
		A0015082.09607	1,925	\$82,363.49
	2292	A0022921.09607	69	\$8,876.54
	10028	N0100281.09607	592	\$40,744.82
	10032	A0100321.09607	504	\$44,426.06
	10033	A0100331.09507	2,587	\$205,254.19
	11239	A0112391.09607	234	\$15,163.50
	All		9,787	\$934,199.17

Sample Weekly Summary Report (cont'd)

Simple File Listing -- Alphabetic Order

07:31 Monday, April 9, 2007 2

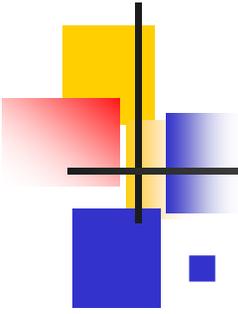
No	File	Over Night Date	FY04 and less	FY05 DOS	FY06 DOS	FY07 DOS	FY08 and more	Numb of claims	Billed Amount	File Lines
1	A0015081.09407	06APR	0	0	0	6,896	0	6,896	\$316,080.25	41,598
2	A0015081.09607	07APR	0	0	3	1,973	0	1,976	\$240,077.35	15,263
3	A0015082.09407	06APR	0	0	3	2,016	0	2,019	\$96,407.46	17,482
4	A0015082.09607	07APR	0	0	2	1,923	0	1,925	\$82,363.49	17,112
5	A0015083.09407	06APR	0	0	0	4,923	0	4,923	\$128,465.24	27,291
6	A0015084.09407	06APR	0	0	0	1,028	0	1,028	\$51,811.54	7,682
7	A0022921.09607	07APR	0	0	0	69	0	69	\$8,876.54	550
8	A0100321.09607	07APR	0	0	0	504	0	504	\$44,426.06	4,553
9	A0100331.09507	07APR	0	0	1	2,586	0	2,587	\$205,254.19	46,000
10	A0112391.09607	07APR	0	0	16	218	0	234	\$15,163.50	2,593
11	N0010591.09507	07APR	0	0	0	3	0	3	\$285.61	44
12	N0010592.09507	07APR	0	0	0	298	0	298	\$27,653.61	2,278
13	N0015051.09507	07APR	0	0	0	1,599	0	1,599	\$269,354.00	10,147
14	N0100281.09607	07APR	0	0	2	590	0	592	\$40,744.82	15,442
								24,653	\$1,526,963.66	

Sample Weekly Summary Report (cont'd)

File List by Provider in Order of Overnight Processing

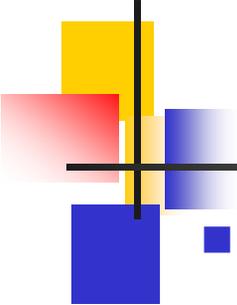
07:31 Monday, April 9, 2007 3

Provider	File	Over Night Date	FY04 and less	FY05 DOS	FY06 DOS	FY07 DOS	FY08 and more	Numb of claims	Billed Amount	File Lines
1059	N0010591.09507	07APR	0	0	0	3	0	3	\$285.61	44
	N0010592.09507	07APR	0	0	0	298	0	298	\$27,653.61	2,278
<i>1059</i>								<i>301</i>	<i>\$27,939.22</i>	
1505	N0015051.09507	07APR	0	0	0	1,599	0	1,599	\$269,354.00	10,147
<i>1505</i>								<i>1,599</i>	<i>\$269,354.00</i>	
1508	A0015081.09407	06APR	0	0	0	6,896	0	6,896	\$316,080.25	41,598
	A0015082.09407	06APR	0	0	3	2,016	0	2,019	\$96,407.46	17,482
	A0015083.09407	06APR	0	0	0	4,923	0	4,923	\$128,465.24	27,291
	A0015084.09407	06APR	0	0	0	1,028	0	1,028	\$51,811.54	7,682
	A0015081.09607	07APR	0	0	3	1,973	0	1,976	\$240,077.35	15,263
	A0015082.09607	07APR	0	0	2	1,923	0	1,925	\$82,363.49	17,112
<i>1508</i>								<i>18,767</i>	<i>\$915,205.33</i>	
2292	A0022921.09607	07APR	0	0	0	69	0	69	\$8,876.54	550
<i>2292</i>								<i>69</i>	<i>\$8,876.54</i>	
10028	N0100281.09607	07APR	0	0	2	590	0	592	\$40,744.82	15,442
<i>10028</i>								<i>592</i>	<i>\$40,744.82</i>	
10032	A0100321.09607	07APR	0	0	0	504	0	504	\$44,426.06	4,553
<i>10032</i>								<i>504</i>	<i>\$44,426.06</i>	
10033	A0100331.09507	07APR	0	0	1	2,586	0	2,587	\$205,254.19	46,000
<i>10033</i>								<i>2,587</i>	<i>\$205,254.19</i>	
11239	A0112391.09607	07APR	0	0	16	218	0	234	\$15,163.50	2,593
<i>11239</i>								<i>234</i>	<i>\$15,163.50</i>	



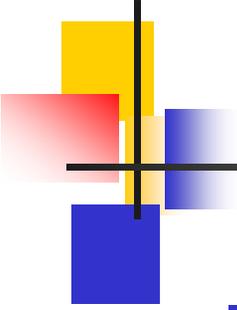
837P Submission (cont'd)

- MOM runs claims EDI – Edit Mode
 - 6 reports (numbered 000-005) are generated and put in your /county/<board>/hipaa/reports/subdirectory.
 - You will be notified by email when edit is complete and your reports are available.
 - Board staff FTP's reports to their local machine.
 - Review your edit reports
 - Update your log and determine if batch should be posted.
 - Notify MacHipaa@mh.state.oh.us whether to post or cancel the run.



837P Submission (cont'd)

- Board decides to cancel the run
 - Run is cancelled
- Board decides to post the run
 - MOM runs claims EDI – Post Mode
 - The POST and OPLST reports (numbered 101 and 102) are created and the board is notified by email when the post reports are ready.
- Board reviews and works claims reports
 - Reconcile submitted vs. processed
- Board deletes report files from the MHHUB server.



Edit Reports

- The six edit reports created by MOM during PREDI-Edit are:
 - **000 PREDI-J** – Claims EDI Job Log
 - Provides time stamped detail of the various EDI functions performed on the batch
 - Summarizes: critical & non-critical errors, number of claims read, accepted and rejected and total claim charges.
 - **These totals should be checked with your logbook* to make sure they agree.**

*The logbook could be an Excel spreadsheet, Access database or other form of documentation.

Sample 000 PREDI-J

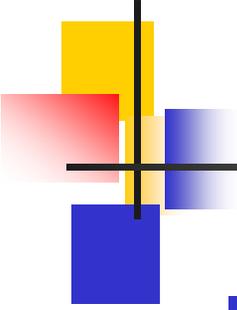
CLMVD-J 3/4/04
ECLMED02.PUB
Run on 3/4/04 @ 2:48 PM

ADTEST SYSTEM
DIAMOND Solutions
Claims EDI
Claims EDI Job Log

Page 1

Batch ID : FIVECLMSJ
Trading Partner ID : 00000000NOPOST
Claim Record Type : Professional
Action : Edit
Comments : LLD

Time	Type	MsgNo.	Message Text
2:47 PM	INFO	OPE032	Pricing is turned ON for this transaction set.
2:47 PM	INFO	OPE035	Adjudication is turned ON for this transaction set.
2:47 PM	INFO	OPE052	Duplicate check is turned ON for this transaction.
2:47 PM	INFO	OPE119	Bill Type/POS Check is turned OFF for this transaction set.
2:47 PM	INFO	OPE054	Auth-claim link is turned OFF for this transaction set.
2:47 PM	INFO	OPE120	Revenue Code/HCPSC Check is turned OFF for this transaction set.
2:47 PM	INFO	OPE101	Processing Information: Validate=YES, Post=NO, Partial Post=NO, Re-workable=YES, Process by Batch=YES
2:47 PM	INFO	OPE030	DIAMOND Claims EDI Summary Statistics: Number of Critical Errors: 7 Number of Non-Critical Errors: 1 Number of Claim Headers Read: 5 Number of Claim Details Read: 5 Number of Claim Details Accepted: 1 Number of Claim Details Rejected: 4 Total Claim Charges: \$926.13



Edit Reports (cont'd)

- **001 PREDI-D** – Detail Claims Report
 - Summary of each claim that was submitted and whether it was accepted/rejected. (The claims rejected due to critical errors will also show up on your PREDI-C.)
 - This report could be imported into a spreadsheet/database in order to summarize accepted/rejected claims by provider. NOTE: Accepted claims can be payable, held, denied (not paid).

Sample 001 PREDI-D

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

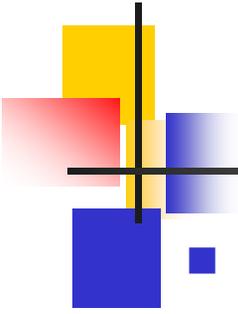
ADTEST SYSTEM
 DIAMOND Solutions
 Claims EDI
 Detail Claims Report

Page 1

 Batch ID : FIVECLMSJ
 Trading Partner ID : 00000000NOPOST
 Claim Record Type : Professional
 Action : Edit
 Comments : LLD

Patient Control Number	DIAMOND Claim Number	DIAMOND Provider ID	DIAMOND Member ID	Service Date	Ln #	Proc Code	Mod	Billed Charges
R 00000933002400		000000001365	4444444	- 07/11/03	001	H0001	HF	88.76
R 00000933002401		000000001365	7777777	- 07/11/03	001	H0003	HF	222.32
00000933002402	0000000646519880	000000001365	7777777	-00 07/11/03	001	H0004	HF	222.32
R 00000933002403		000000001365	7777777	-00 07/11/03	001	H0005		222.32
R 00000933002404		000000001365	7777777	- 07/11/03	001	H0015	HF	170.41

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



Edit Reports (cont'd)

- **002 PREDI-C – Critical Errors Report**
 - Shows all records with missing or invalid data.
 - These are the same claims that showed as rejected claims on the PREDI-D report.
 - **This is the only report which shows all of the rejected claims that need to be resubmitted by the provider (all meaning in and out-of-county).**
 - These should be reviewed to determine the corrections needed and notification sent to the provider so they can resubmit.
 - **THESE CLAIMS NEVER MAKE IT INTO DIAMOND.**
 - Claims with critical errors involving procedure codes and modifiers cause orphan headers that must manually be deleted by state staff.
 - Many of the errors on this report come in pairs and in some cases can have 3 or 4 messages (especially not priced), i.e., OPE010 and OPE015.

Sample 002 PREDI-C

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

ADTEST SYSTEM
DIAMOND Solutions
Claims EDI
Critical Errors Report

Page 1

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

Ref. No. SSN Last Name First Name M Gndr Birth Date

4444444 123-45-6789 LASTNAME FIRSTNAME D F 01/01/50
FATAL OPE006 Subscriber not found in DIAMOND system.

Patient Control Number DIAMOND Claim DIAMOND Prov DIAMOND Member Serv Dt LN# Proc cd Mod Billed Charges

000000933002400 000000001365 4444444 - 07/11/03 001 H0001 HF 88.76
FATAL OPE015 Claim Line Rejected!! Subscriber not found in DIAMOND system.

Ref. No. SSN Last Name First Name M Gndr Birth Date

7777777 123-45-6789 LASTNAME XXXXXNAME F 01/01/50
FATAL OPE010 Patient Person Number cannot be determined.

Patient Control Number DIAMOND Claim DIAMOND Prov DIAMOND Member Serv Dt LN# Proc cd Mod Billed Charges

000000933002401 000000001365 7777777 - 07/11/03 001 H0003 HF 222.32
FATAL OPE015 Claim Line Rejected!! Patient Person Number cannot be determined.

Patient Control Number DIAMOND Claim DIAMOND Prov DIAMOND Member Serv Dt LN# Proc cd Mod Billed Charges

000000933002403 000000001365 7777777 -00 07/11/03 001 H0005 222.32
FATAL OPE015 Claim Line Rejected!! Modifier 1 'XX' Not Found.

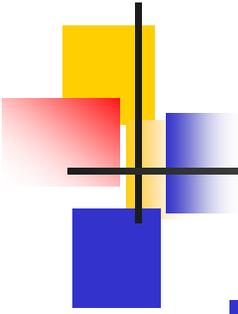
Ref. No. SSN Last Name First Name M Gndr Birth Date

7777777 123-45-6789 LASTNAME XXXXXNAME F 01/01/50
FATAL OPE010 Patient Person Number cannot be determined.

Patient Control Number DIAMOND Claim DIAMOND Prov DIAMOND Member Serv Dt LN# Proc cd Mod Billed Charges

000000933002404 000000001365 7777777 - 07/11/03 001 H0015 HF 170.41
FATAL OPE015 Claim Line Rejected!! Patient Person Number cannot be determined.

Number of Critical Errors : 7



Edit Reports (cont'd)

- **003 PREDI-N** – Non-critical Errors Report
 - Shows errors that do not keep the claim from making it into Diamond, but may cause the claim to be held or denied. These are mostly name/DOB mismatches.
 - Providers should be notified of their non-critical errors. As with the critical error report, multiple errors can appear for the same claim line because of one invalid data field.

Sample 003 PREDI-N

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

ADTEST SYSTEM
DIAMOND Solutions
Claims EDI
Non-Critical Errors Report

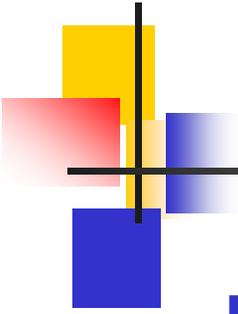
Page 1

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

Patient Control Number	DIAMOND Claim	DIAMOND Prov	DIAMOND Member	Serv Dt	LN#	Proc cd	Mod	Billed Charges
00000933002403	000000646519890	00000001365	7777777	-00	07/11/03	001 H0005		222.32

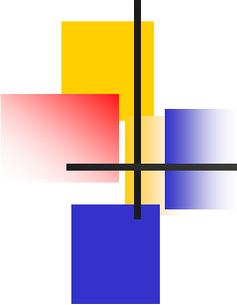
WARN DTL630 MODIFIER 1 IS REQUIRED

Number of Non-critical Errors : 1



Edit Reports (cont'd)

- **004 PREDI-A** – Auth Link Report
 - Authorizations are turned off in Diamond. This report is always empty.



Sample 004 PREDI-A

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

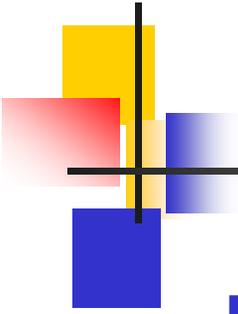
ADTEST SYSTEM
DIAMOND Solutions
Claims EDI
Auth Link Report

Page 1

Batch ID : FIVECLMSJ
Trading Partner ID : 00000000NOPOST
Claim Record Type : Professional
Action : Edit
Comments : LLD

Patient Control Number DIAMOND Provider DIAMOND Member ID Service Date Submitter Auth No. DIAMOND Auth No.

No messages for this report



Edit Reports (cont'd)

- **005 PREDI-P – Pricing/Adjudication**
 - Identifies the logic used for pricing and adjudication of each claim.
 - This report will tell you what benefit package, benefit rules, price schedules, price regions, etc. were used to price and adjudicate each claim.
 - This report is too long to print, but can be used if you have questions about specific claims.
 - You can also regenerate the Pricing/Adjudication decision on non-finalized claims by re-adjudicating (F6-B) the claim in OPCLM and then viewing the pricing and adjudication decision (F6-D).

Sample 005 PREDI-P

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

ADTEST SYSTEM
 DIAMOND Solutions
 Claims EDI
 Pricing and Adjudication Rpt

Page 1

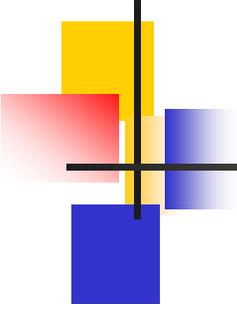
 Batch ID : FIVECLMSJ
 Trading Partner ID : 000000000NOPOST
 Claim Record Type : Professional
 Action : Edit
 Comments : LLD

Patient Control Number	DIAMOND Claim Number	DIAMOND Provider ID	DIAMOND Member ID	Service Date	Ln #	Proc Code	Mod	Billed Charges
------------------------	-------------------------	------------------------	----------------------	-----------------	---------	--------------	-----	-------------------

000000933002402	0000000646519880	000000001365	7777777	-00 07/11/03	001	H0004	HF	222.32
-----------------	------------------	--------------	---------	--------------	-----	-------	----	--------

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

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



Post Reports

- **101 Post Report**

- Lists all claims with changes in pricing/adjudication between edit and post due to benefit rules and duplicate rules.
- Lists claims denied as duplicates either within a file or against the database.
- It is recommended that this report be saved as an ASCII file and then read into an editor or word processor to search for records that contain "warning" and "held" messages.
 - **These warning messages will not appear in any other reports.**

Sample 101 Post Report

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

ADTEST SYSTEM
DIAMOND Solutions
Claims EDI
Post Transaction Set Job Log

Page 1

Batch ID : FIVECLMSJ
Trading Partner ID : 00000000NOPOST
Claim Record Type : Professional
Action : Post
Comments : LLD

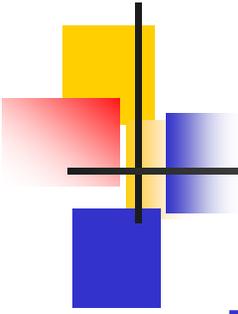
Billed Allowed Not Cov Copay Deduct Oth Carr Withhold Net Offset

11:18 AM WARN 07/01/2003-0000000655699740: Duplicate of claim no:0000000605898260 Action:Denied

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

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

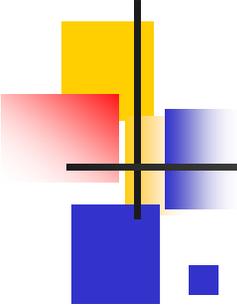
Claim header records read: 1
Claim header records written: 1
Claim detail records read: 1
Claim detail records written: 1
Accounts Payable records written: 1



Post Reports (cont'd)

- **102 OPLST**

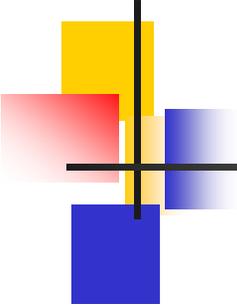
- This report lists all accepted claims in the batch.
- This report is an ASCII file that could be imported into other software (Access or Excel) to generate “held”, “denied” and “payable” claims reports by provider.
 - These reports should then be distributed to the providers
- This report also includes the out-of-county claims (out-of-county will not be in your extract files).



Denied Claims

■ Denied Claims

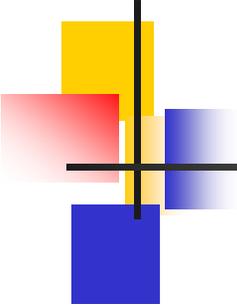
- Each Provider should get a copy of their denied claims.
 - There are 3 scenarios for denied claims:
 - The claim was correctly denied and has a processing status of "U" (un-posted) – no further action is required in Diamond.
 - The claim was correctly denied and has a processing status of "H" (held) – board must take the claim off hold.
 - The claim was denied incorrectly and should be changed to a payable claim.



Held Claims

■ Held Claims

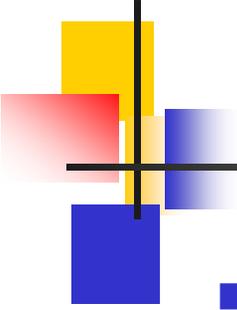
- Board should review all held claims and the reason for the claim being placed on hold.
- After researching the claims the board can do one of 3 things:
 - Fix the claim
 - Deny the claim
 - Make the claim payable



Payable Claims

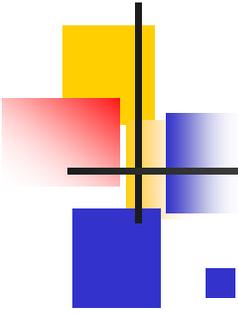
■ Payable Claims

- These claims, if left untouched, will process through the system and be paid and finalized.
- Board staff should reconcile the number of claim lines/dollar amount submitted against what was received, accepted, rejected, etc.



Claims Corrections

- The claims correction policy establishes the guidelines and specific procedures for when and how boards may make claims corrections.
 - This policy is Topic 45 in the “ODADAS-ODMH Guidelines Pertaining to the Implementation of MACSIS under HIPAA”
- The “Procedure for Claim Corrections within MACSIS” outlines which claims can be corrected, the proper correction procedure and the documentation required.



Claims Corrections (cont'd)

- Potential erroneously billed claims can be identified in one of the following ways:
 - Board discovers it when reviewing claims data, edit reports, post reports, etc.
 - Provider brings the erroneously billed service to the attention of the board
- The claims correction process differs depending on whether it is a finalized or un-finalized claim

Claims Corrections (cont'd)

MACSIS CLAIMS CORRECTION FORM

For reporting erroneous claims

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

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

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

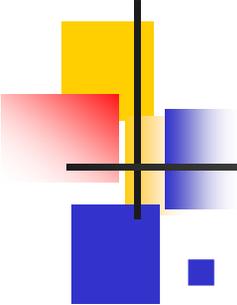
¹ Must use one of the allowable ODJFS COB Indicator values: 2-6, R, P, F, L, S, E, X

² Denote reason for error: wrong patient, date of service, units, procedure, modifier, 3rd party pmt/indicator, etc. or MACSIS Reason Code

Provider Representative Signature (required): _____

Date (required): _____

If submitting via electronic media, type name above; add electronic signature: (check box)

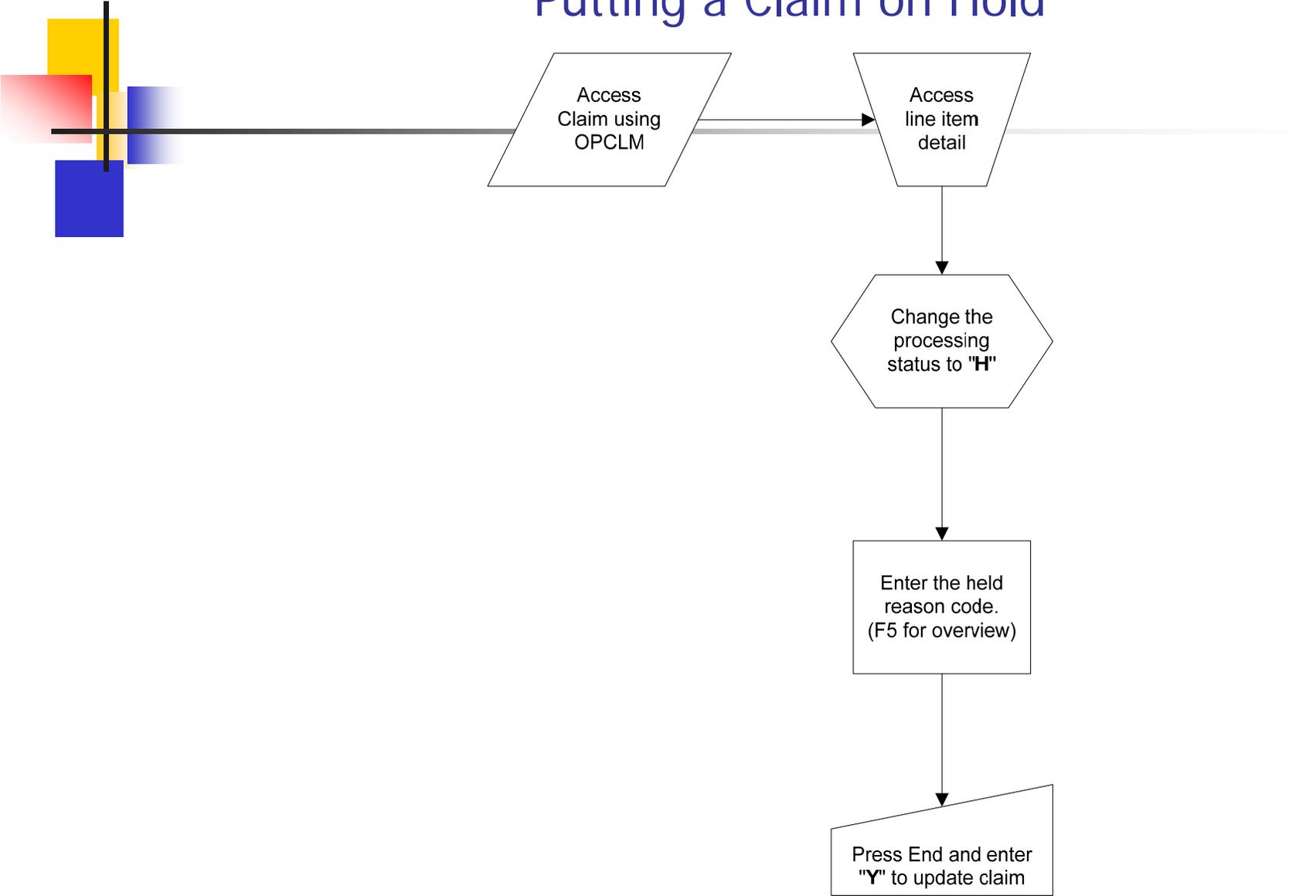


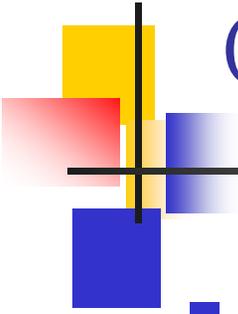
Correcting Un-finalized Claims

- The procedure for correcting un-finalized claims is the same for both MH and AOD
 - Board identified claims
 - When suspected erroneously billed claims are identified by the board they should be placed on hold with the appropriate “held” reason code and the Claims Correction Form¹ should be completed and sent to the provider for written confirmation that the claim was or was not erroneously billed.
 - Board can keep these claims on hold for 30 days from the date the form/report was mailed to provider.

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

Putting a Claim on Hold

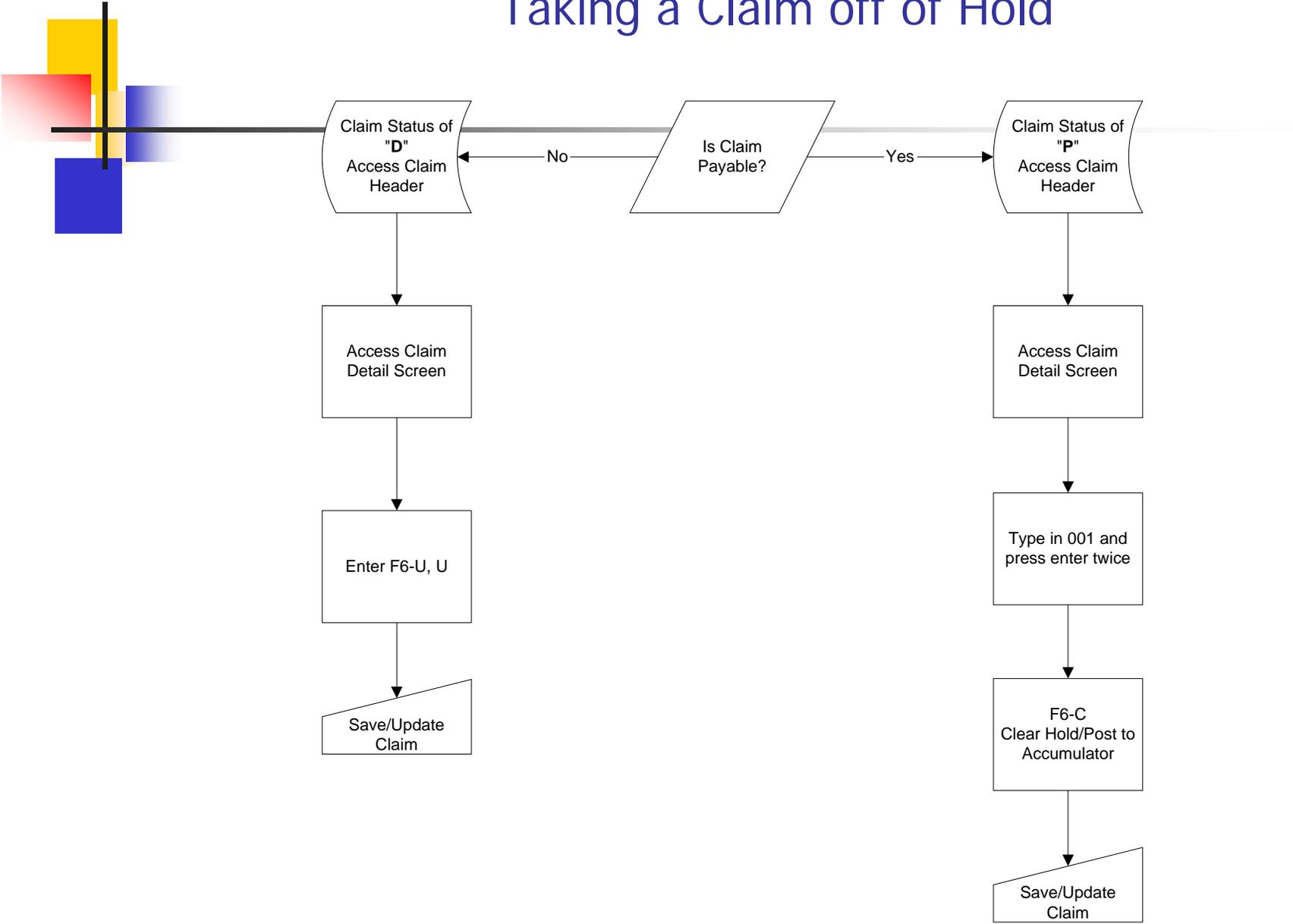


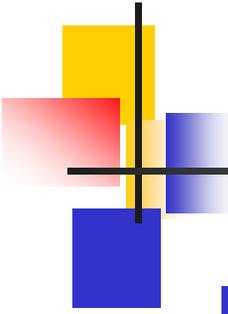


Correcting Un-finalized Claims (cont'd)

- Once written confirmation has been received from provider that:
 - Claim was not billed in error
 - Take the claim off of hold and remove the held reason
 - Update (save) the claim

Taking a Claim off of Hold

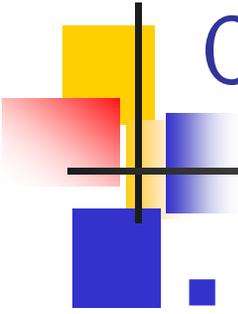




Correcting Un-finalized Claims (cont'd)

- Claim is already denied as duplicate
 - These claims have already been denied as a duplicate. No action is to be taken on these claims.
 - If this is a “straggler¹” claim, the original claim is the one that needs to be corrected.

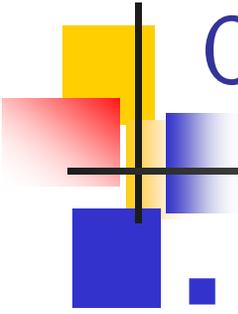
¹ With the roll-up of claims, when a same-day service comes in after the initial claim was submitted, these claims are known as “Straggler” claims. These claims will be denied as a duplicate.



Correcting Un-finalized Claims (cont'd)

- Billed amount, units of service, procedure code, modifier, place of service¹ or third party amounts are incorrect.
 - Correct the incorrect value
 - Re-adjudicate the claim by pressing F6-B (this will remove the held reason code and change the PROC STAT to "U")
 - Enter the appropriate adjustment reason code
 - Update (save) the claim

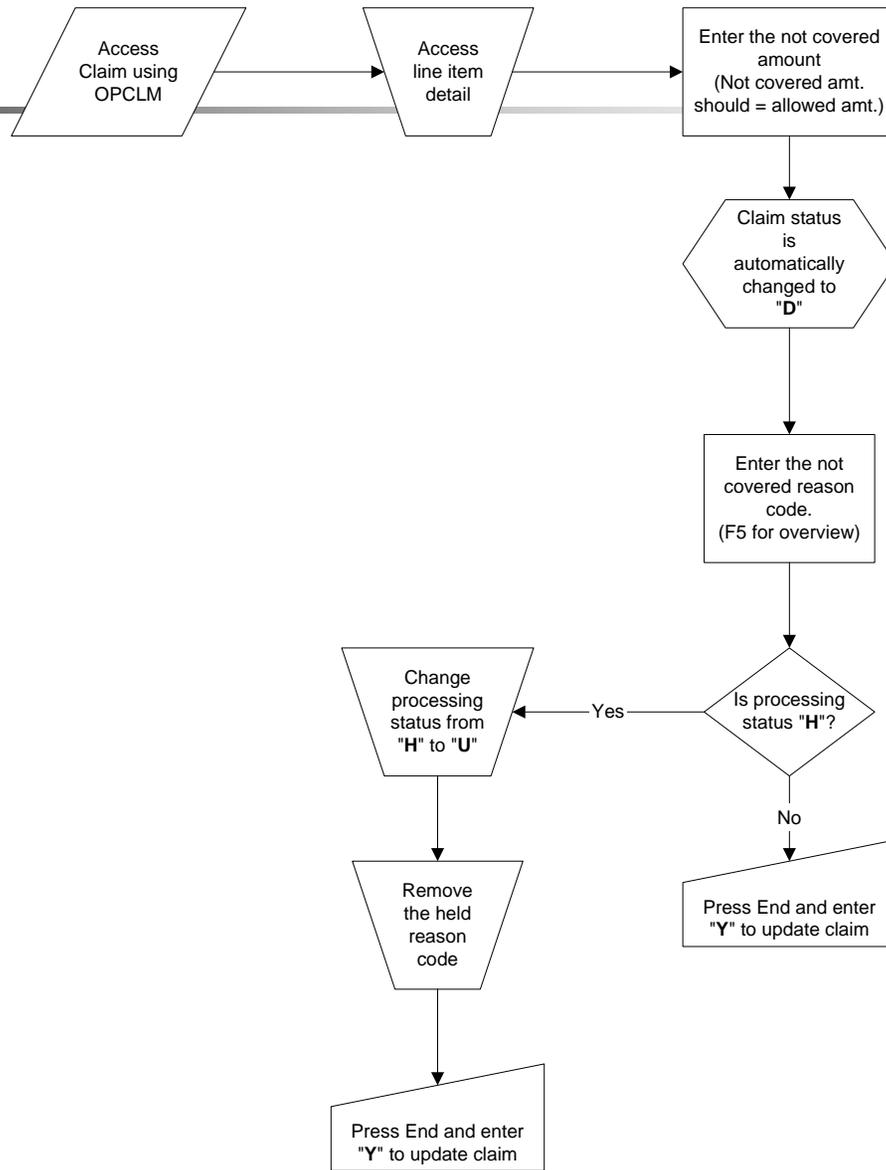
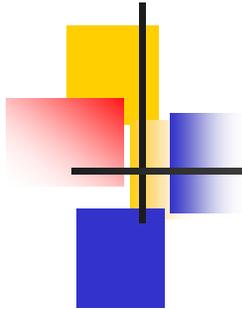
¹ Note: Only correct the place of service code if it is changing from 51 or 99/09, or to 51 or 99/09. Effective 7/1/2007 place of service code 99 will no longer be used to report clients in the penal system.

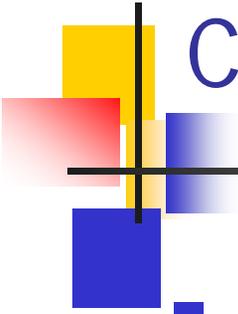


Correcting Un-finalized Claims (cont'd)

- Incorrect date of service or incorrect UCI
 - If the claim is on hold, take the claim off hold
 - Deny the claim by entering the not covered amount (should be equal to the allowed amount)
 - Do not split the claim because it will carry the incorrect UCI and/or incorrect date of service
 - Board should manually re-enter the claim with the correct information or have the provider resubmit
 - Enter the appropriate not covered reason codes
 - Update (save) the claim

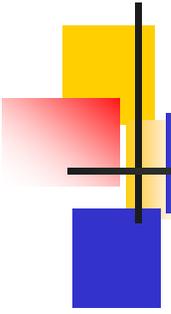
Denying a Claim





Correcting Un-finalized Claims (cont'd)

- Claim is over 365 days
 - Board may **deny** the claim without putting it on hold first
 - Deny the claim by entering the not covered amount (should be equal to the allowed amount)
 - Enter MCDYO or NONYO as the reason code
 - Update (save) the claim

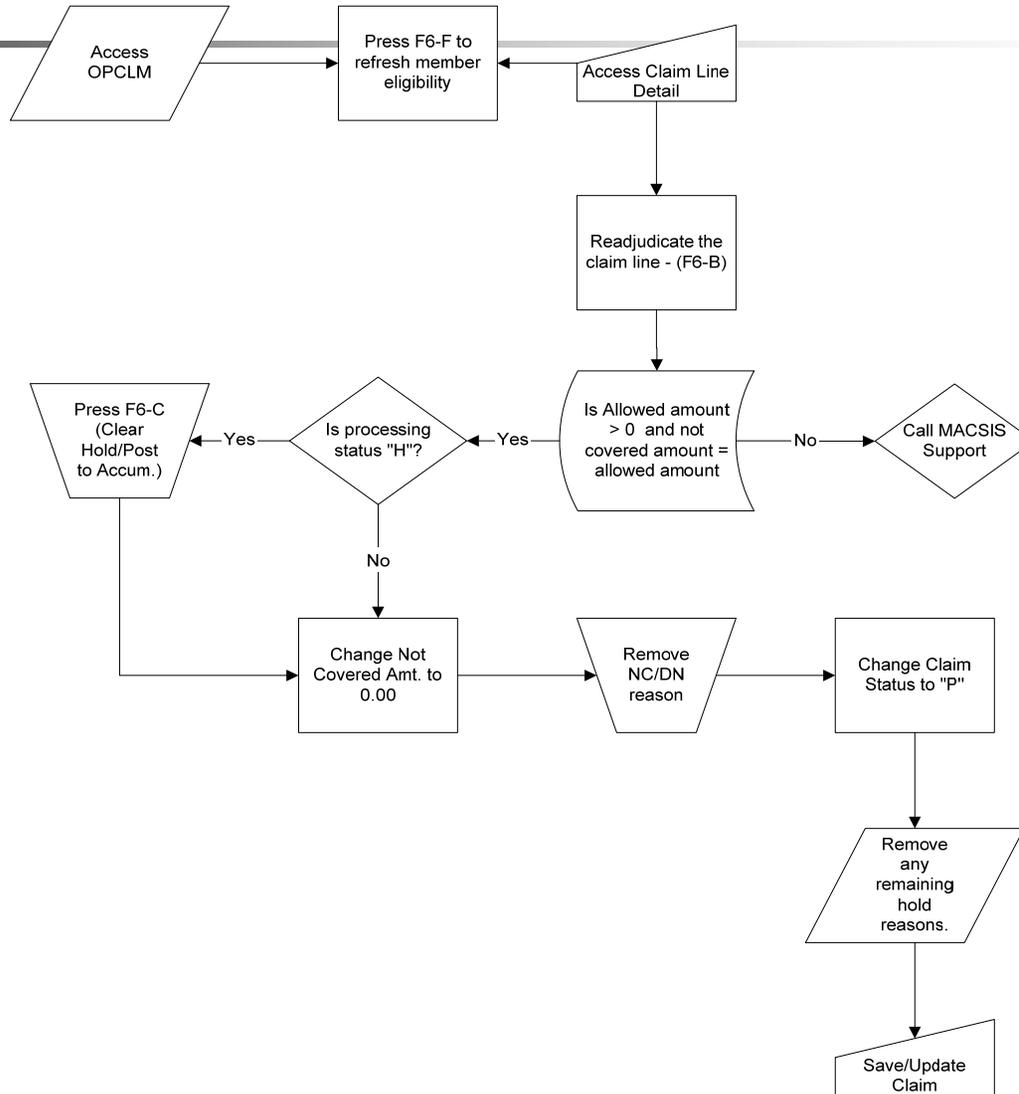


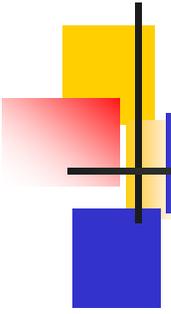
Correcting Un-finalized Claims (cont'd)

- Original claim is denied
 - If the original claim was denied due to missing or invalid modifier or diagnosis code:
 - Boards can correct the claim manually
 - Boards can let original claim deny and have the provider resubmit the claim electronically
 - If original claim was denied due to board error (missing PROCP)
 - Boards can not require the provider to resubmit the claim electronically, unless mutually agreed to.

Note: No other claims may be corrected by resubmission.

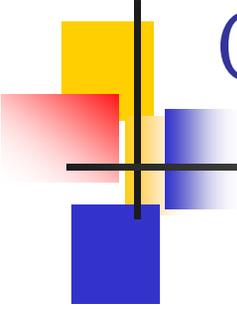
Making a Denied Claim Payable





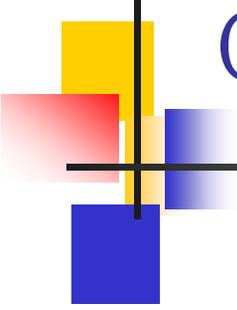
Correcting Un-finalized Claims (cont'd)

- No written confirmation from provider within 30 days
 - Board can deny the claim with the not covered reason code of NPR30 (no provider response within 30 days)
- OHIO claims
 - Claims in Diamond that were denied and do not have a valid payable company code or G/L Ref code do not finalize through the normal APUPD cycle. In order to notify providers that the claims were denied, these claims must be corrected so that they finalize with the appropriate company code so they will appear on the remittance advice for the board and provider.



Correcting Un-finalized Claims (cont'd)

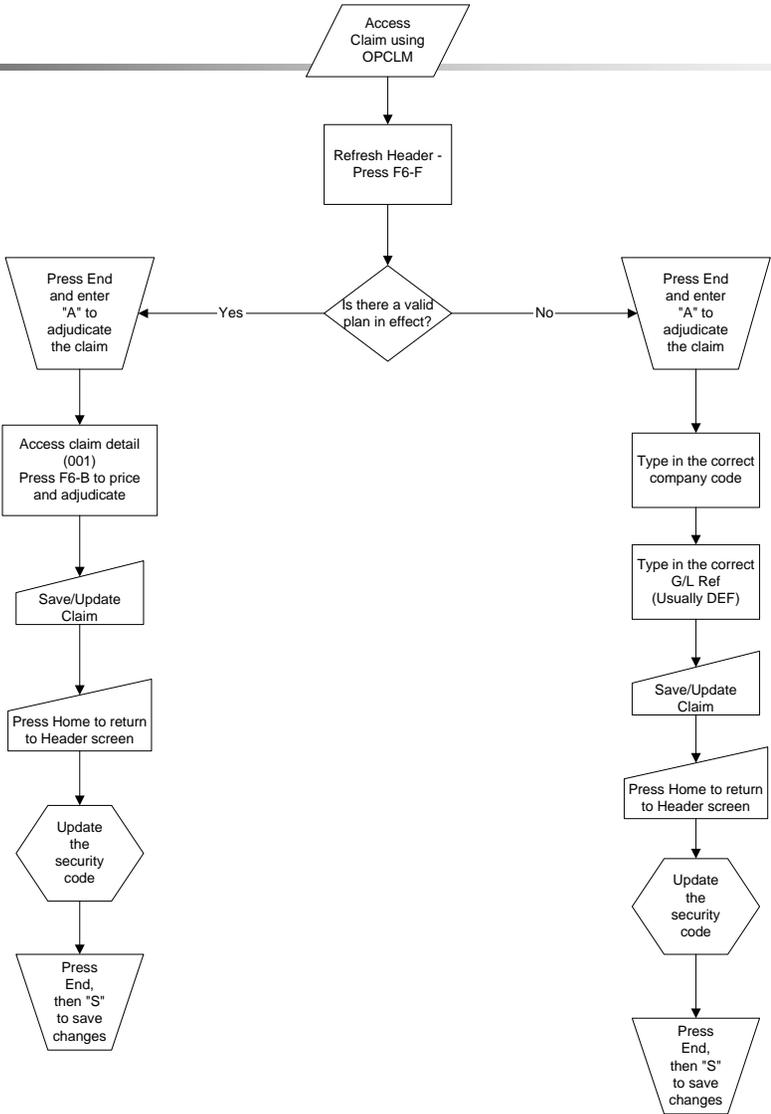
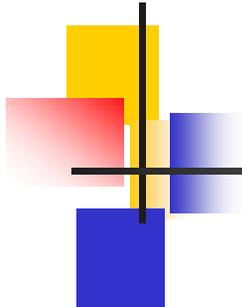
- Claims where the member is ineligible or the provider was ineligible used to become OHIO claims with a denied reason of MBRIN or PRVIN.
- EDI claims where the member is ineligible (MBRIN) will now receive a critical error and do not make it into Diamond.
- EDI claims where the provider is ineligible will deny with a reason of PRVIN.
 - Note: Diamond will not allow you to enter a claim manually where the provider is ineligible.



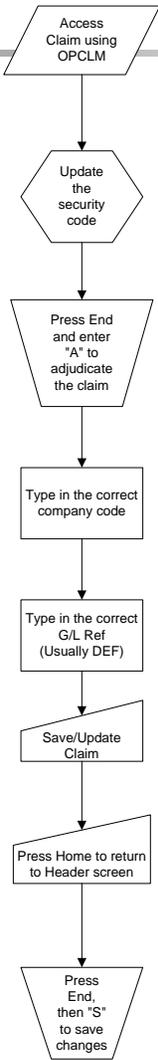
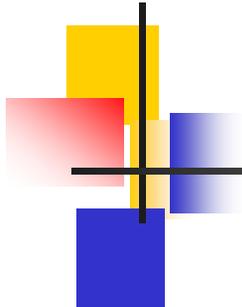
Correcting Un-finalized Claims (cont'd)

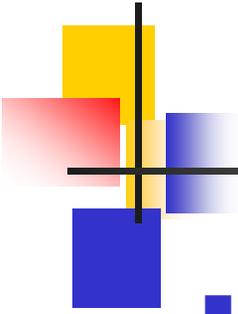
- Some MBRIN - OHIO claims may occur if the member's eligibility has been changed by board staff to make the member ineligible and the claim is re-adjudicated, or if a claim is entered manually with a date of service prior to a valid eligibility span in Diamond.
- OHIO claims show up on a report that is created every Monday for State staff. The MACSIS Support Desk fixes any OHIO claims that show up on this report.
 - To find OHIO claims – search your extract for claims with Company = OHIO

OHIO Claims – MBRIN



OHIO Claims – PRVIN

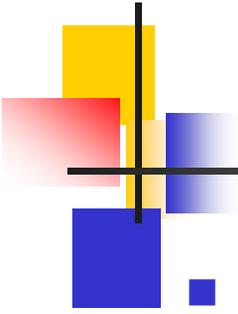




Correcting Un-finalized Claims (cont'd)

■ Mismatch Claims

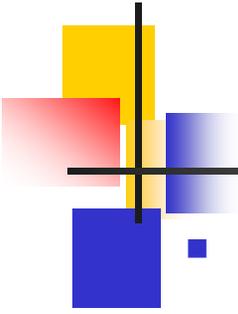
- Mismatch claims occur when the EPLAN (eligibility plan in member for the date of service), CPLAN (the plan on the claim header), company (company on the claim detail) or security code do not match each other.
- A mismatch claim file is created weekly and can be found in your /county/ra subdirectory.
 - MM.XXXXX.julyy.gz (ex.: MM.BUTLB.07107.gz)
 - This file is placed in your subdirectory at the same time as your payment files.
- How you correct these claims depends on the type of mismatch.



Correcting Un-finalized Claims (cont'd)

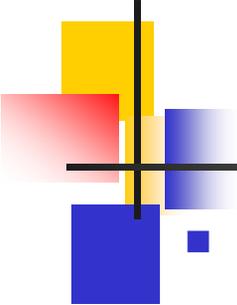
■ Types of Mismatch Claims

- Company code on the claim detail, the CPLAN on the claim header and the EPLAN (eligibility plan in the member record) all match, but the security code does not match
 - Enter the correct security code and save changes
- CPLAN on the claim header matches the EPLAN on the member record, but the company code on the claim detail does not match
 - Access the claim detail line, re-adjudicate the claim (F6-B) then enter "S" to save the changes
 - Return to the header screen and add/correct the security code if necessary



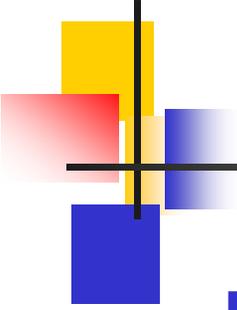
Correcting Un-finalized Claims (cont'd)

- EPLAN on the member record matches the company code on the claim detail, but the CPLAN on the claim header does not match
 - Refresh the claim header by pressing F6-F
 - Add/correct the security code if necessary
 - Update (save) the changes
- CPLAN on the claim header, security code and company code on the claim detail all match, but do not match the EPLAN on the member record
 - Investigate to find out if this was intentional (for example, a client may have been Medicaid, the claim was reversed by ODJFS and the board wants to pay the claim as non-MCD. In order to do this the board may have changed the plan to non-MCD, re-adjudicated the claim and then changed the plan back to MCD).
 - If there was a retro-eligibility change made to the member record and the claim should be adjudicated based on that eligibility:
 - Refresh the claim header
 - Re-adjudicate the claim
 - Add/change the security if necessary



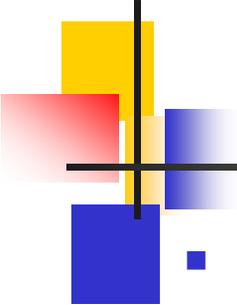
Correcting Finalized Claims

- The procedure for correcting finalized claims is the same for both MH and AOD
 - The correction procedure is the same whether the board identifies the service as possibly being billed incorrectly (Claims Correction Form sent to provider) or the correction is initiated by the provider (Claims Correction Form submitted to board).
 - Providers are permitted 30 days from the date of notification of a potential error to respond to the board. If no response is received, the claim may be reversed by the board.
 - No action is to be taken on erroneously billed Medicaid claims that will be too old by the time they get extracted and sent to ODJFS for adjudication. Adjustments will be handled in accordance with each department's ODJFS approved Medicaid Reconciliation Process.



Correcting Finalized Claims (cont'd)

- Once the board is notified in writing that the service was billed in error they will then need to verify that the claim has come back from ODJFS before making any corrections.
 - Check the claims extract file and look for a date in the ODHSEXTD and a date in the HSDTPAID field (this means the claim has been extracted and come back from ODJFS).
 - Do not reverse a finalized Medicaid claim that has not come back from ODJFS. If you do and ODJFS reverses the claim you will have two reversal ACPAY records and the monies will be deducted from the provider twice.

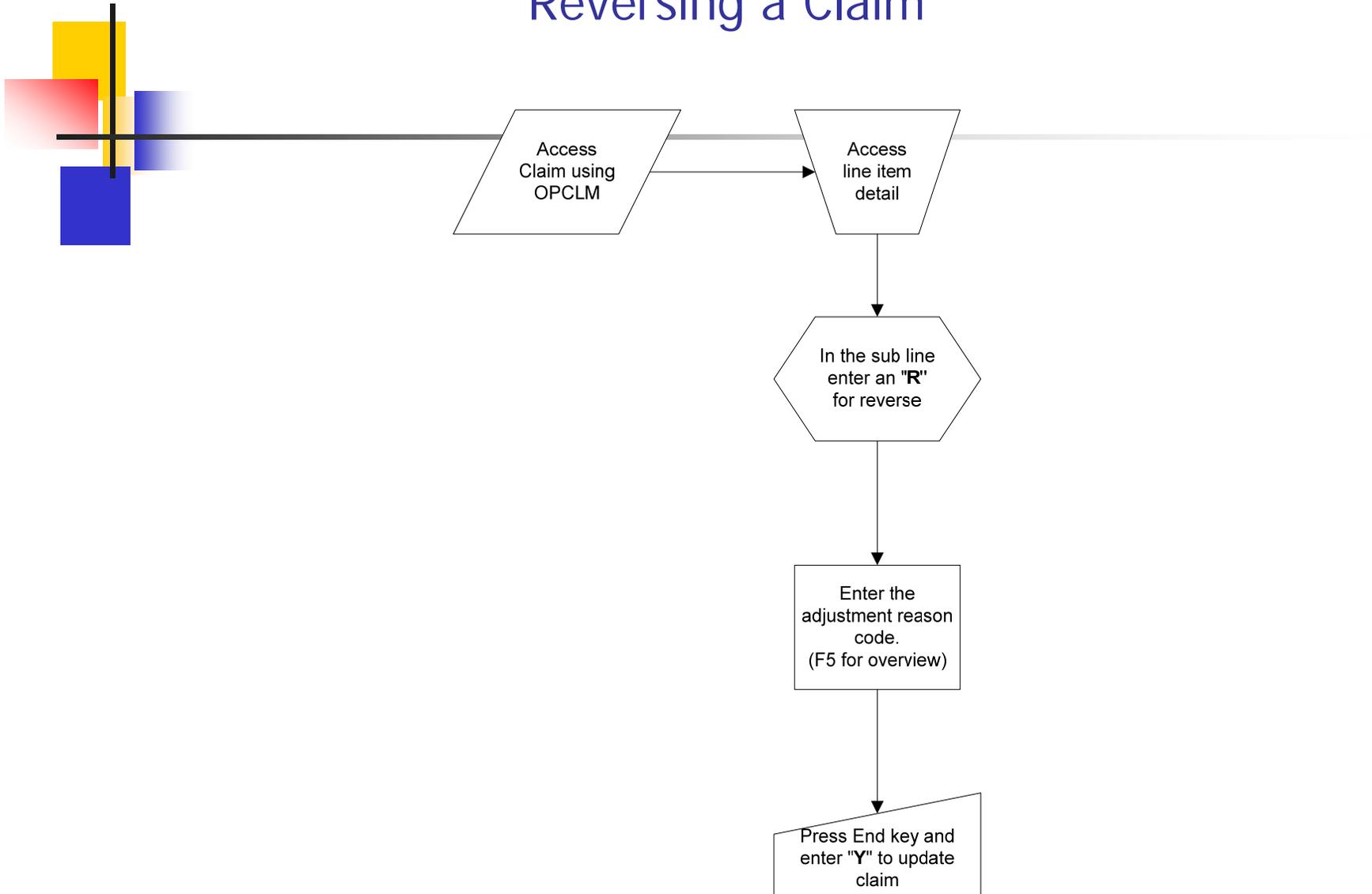


Correcting Finalized Claims (cont'd)

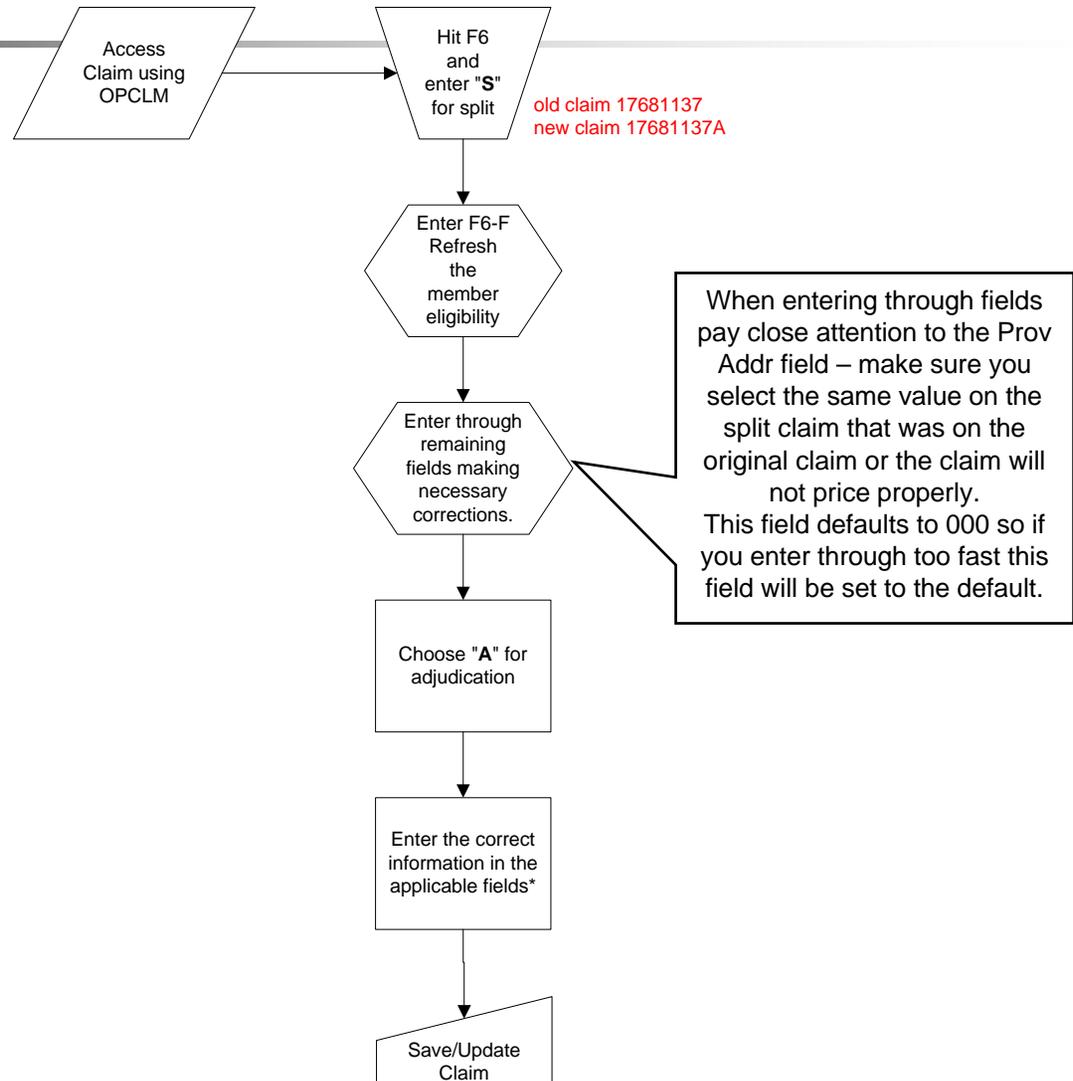
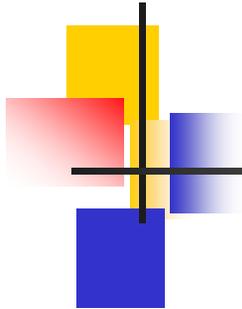
- Claim is a duplicate
 - Claim has already been denied – no correction is to be done to a finalized denied duplicate claim.
 - You can not un-deny a claim.
 - If this was a “straggler” claim, the original claim is the one that will need to be corrected (see Units of Service are Incorrect)
- Billed amount, units of service, procedure code, modifier, place of service or third party amount are incorrect
 - Reverse the original claim line
 - Enter the appropriate adjustment reason code¹
 - Split the claim and enter the correct amounts (no adjustment reason code should be entered on the split claim)
 - Update (save) the claim detail

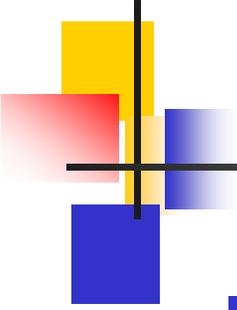
¹ A list of all appropriate reason codes are in the Procedure for Claim Corrections within MACSIS

Reversing a Claim



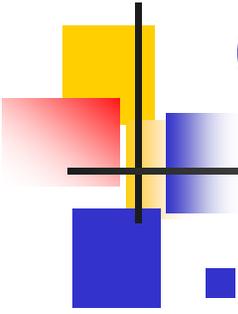
Splitting a Claim





Correcting Finalized Claims (cont'd)

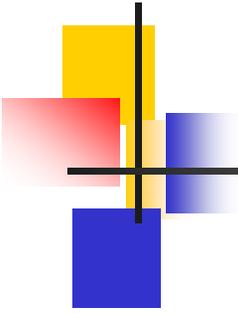
- UCI or date of service are incorrect
 - Reverse the original claim
 - Enter the appropriate adjustment reason code
 - Board will enter a new claim with the correct date of service/UCI or have the provider resubmit the claim
 - Do not split these claims because the split claim will carry the wrong UCI or date of service that is on the original claim.



Correcting Finalized Claims (cont'd)

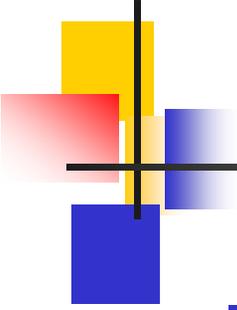
- Original Claim is Denied
 - If the original claim(s) was denied due to missing or invalid modifier or diagnosis code, boards may require that the provider resubmit the claim(s) electronically or may choose to correct the claim manually.
 - If the original claim(s) was denied due to board error (i.e. missing PROCP's), boards cannot require the provider to resubmit the claim(s) electronically, unless mutually agreed to.

Note: No other claims may be corrected by resubmission.



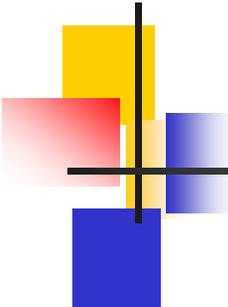
Correcting Finalized Claims (cont'd)

- No response from the provider within 30 days of notification
 - Reverse the claim
 - Enter an adjustment reason code of NPR30
 - no provider response within 30 days
 - Update (save) the claim



Misc. Claim Corrections

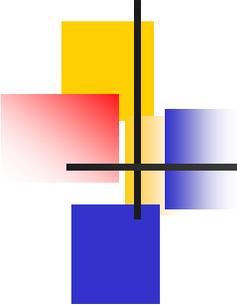
- Outlier/Caution Reports
 - Reports are created on a weekly basis from the claim extract that list claims that have a large number of service units or the allowed amount is greater than \$400.
 - These reports are placed in your /county/<board>/extract/ subdirectory
 - There are two sets of reports created; one set for the boards and the second set to be distributed to the providers



Misc. Claim Corrections (cont'd)

- Board Reports

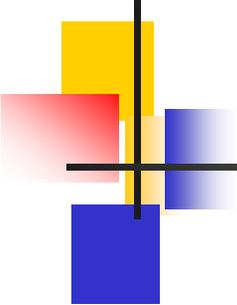
- XXX.HIPAA.BD.CAUTION.MCD.DDMONYY.PDF (ex.: 76B.HIPAA.BD.CAUTION.MCD.13MAR04.PDF) – contains Medicaid claims with a PROC STAT of “U”
- XXX.HIPAA.BD.CAUTION.NON.DDMONYY.PDF (ex.: 76B.HIPAA.BD.CAUTION.NON.13MAR04.PDF) – Non-Medicaid claims with a PROC STAT of “U”
- XXX.HIPAA.BD.HOLD.MCD.DDMONYY.PDF (ex.: 76B.HIPAA.BD.HOLD.MCD.13MAR04.PDF) – Medicaid claims that were placed on hold (PROC STAT of “H”)
- XXX.HIPAA.BD.HOLD.NON.DDMONYY.PDF (ex.: 76B.HIPAA.BD.HOLD.NON.13MAR04.PDF) – Non-Medicaid claims that were placed on hold (PROC STAT of “H”)



Misc. Claim Corrections (cont'd)

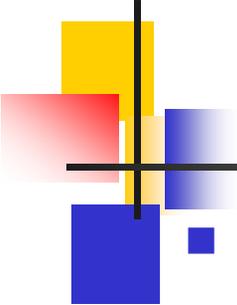
- Provider Reports

- XXX.UPI.HIPAA.PROV.CAUTION.MCD.DDMONYY.PDF (ex.: 76B.1548.PROV.CAUTION.MCD.13MAR04.PDF) – contains Medicaid claims with a PROC STAT of “U”
- XXX.UPI.HIPAA.PROV.CAUTION.NON.DDMONYY.PDF (ex.: 76B.1548.PROV.CAUTION.NON.13MAR04.PDF) – Non-Medicaid claims with a PROC STAT of “U”
- XXX.UPI.HIPAA.PROV.HOLD.MCD.DDMONYY.PDF (ex.: 76B.1548.HIPAA.PROV.HOLD.MCD.13MAR04.PDF) – Medicaid claims that were placed on hold (PROC STAT of “H”)
- XXX.UPI.HIPAA.PROV.HOLD.NON.DDMONYY.PDF (ex.: 76B.1548.HIPAA.PROV.HOLD.NON.13MAR04.PDF) – Non-Medicaid claims that were placed on hold (PROC STAT of “H”)



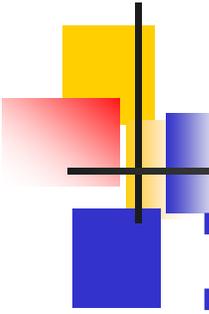
Misc. Claim Corrections (cont'd)

- These claims should be verified before they are finalized in APUPD.
- Follow the claim correction procedures outlined above for putting claims on hold, correcting the incorrect units if applicable and taking claims off hold.



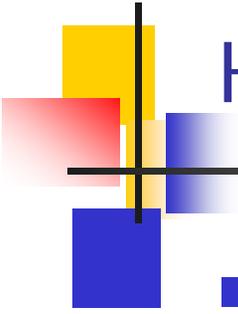
Retroactive Medicaid Claims

- What are retroactive Medicaid claims?
 - These are claims that were originally adjudicated as non-Medicaid, but due to a retroactive eligibility change to the member by ODJFS, these claims, if adjudicated now, would be Medicaid reimbursable.
 - Correcting these claims and submitting them to ODJFS for payment will result in additional money for the Board (FFP).
 - Correcting these claims could also mean more money for the provider:
 - Medicaid only providers: claims for MCD reimbursable services that had originally been denied due to client being non-MCD would now be payable.
 - Out-of-County providers: MCD reimbursable services that had been denied due to the client not being MCD eligible, not being in crisis or crisis services that extended beyond 72 hours would now be payable.



How do I find retroactive Medicaid claims?

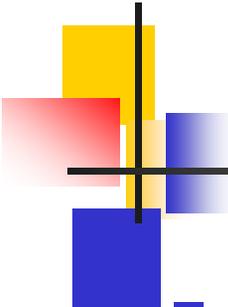
- State runs Medicaid retroactive program bi-weekly
- Three files will be created and placed in your /county/extract directory
 - The files you receive will be all inclusive. Anything you did not complete from the prior set of files will be included on the next run. So once you receive your new files, disregard the old files, otherwise you will find some of the same claims listed on the new files.
 - hmondd.ret.clm.group_bd
 - Claims that can be fixed immediately
 - hmondd.ret.mbr.group_bd
 - This file contains member records that have eligibility spans that need corrected before correcting the claims in the next file
 - hmondd.ret.clmfxmbr.group_bd
 - Claims to correct after the member eligibility spans in the above file have been corrected.
- You **must** pay previously denied claims if client is now Medicaid eligible.



How do I fix retroactive Medicaid claims?

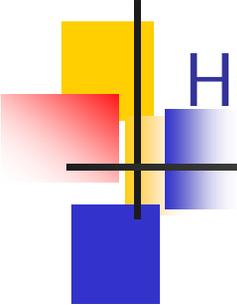
- Correct member eligibility (hmondd.ret.mbr.group_bd)
 - Access member record
 - F6-E to access the eligibility maintenance screen
 - Select "C" (change) then press enter
 - Select the appropriate span
 - Change the member's plan to Medicaid
 - Enter Medicaid ID in the USERDEF field

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



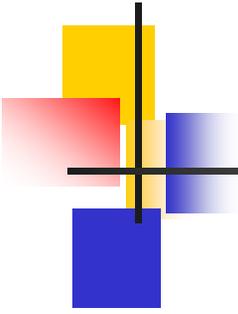
How do I fix retroactive Medicaid claims? (cont'd)

- Correct the claims paid as non-Medicaid
 - Un-finalized claims (Claim Stat "P" or "D" and Proc Stat "U" or "H")
 - Using OPCLM access the claim header and do an F6-F to refresh the member's eligibility
 - Access the claim detail by hitting "End", then "A" to adjudicate.
 - Enter 001 to access the detail line and press F6-B to price and adjudicate the claim
 - Update (save) the claim detail



How do I fix retroactive Medicaid claims? (cont'd)

- Finalized Payable claims (Claim Stat "P" and Proc Stat "P" or "F")
 - Reverse the claim using an adjustment reason of ADMBR (Claim adjusted due to member eligibility change)
 - Return to the claim header and split the claim
 - Refresh the member's eligibility (F6-F)
 - Access the claim detail screen and enter all the information from the original claim
 - Update (save) the claim detail



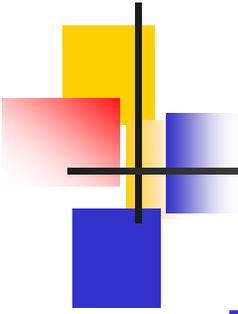
How do I fix retroactive Medicaid claims? (cont'd)

- Finalized Denied claims (Claim Stat "D" and Proc Stat is "P" or "F")

- Split the original claim
- Refresh the member's eligibility
- Access the claim detail screen and enter all the information from the original claim
- Update (save) the claim detail

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

- Once the corrected retroactive Medicaid claims are finalized, they will be extracted and submitted to ODJFS for payment.

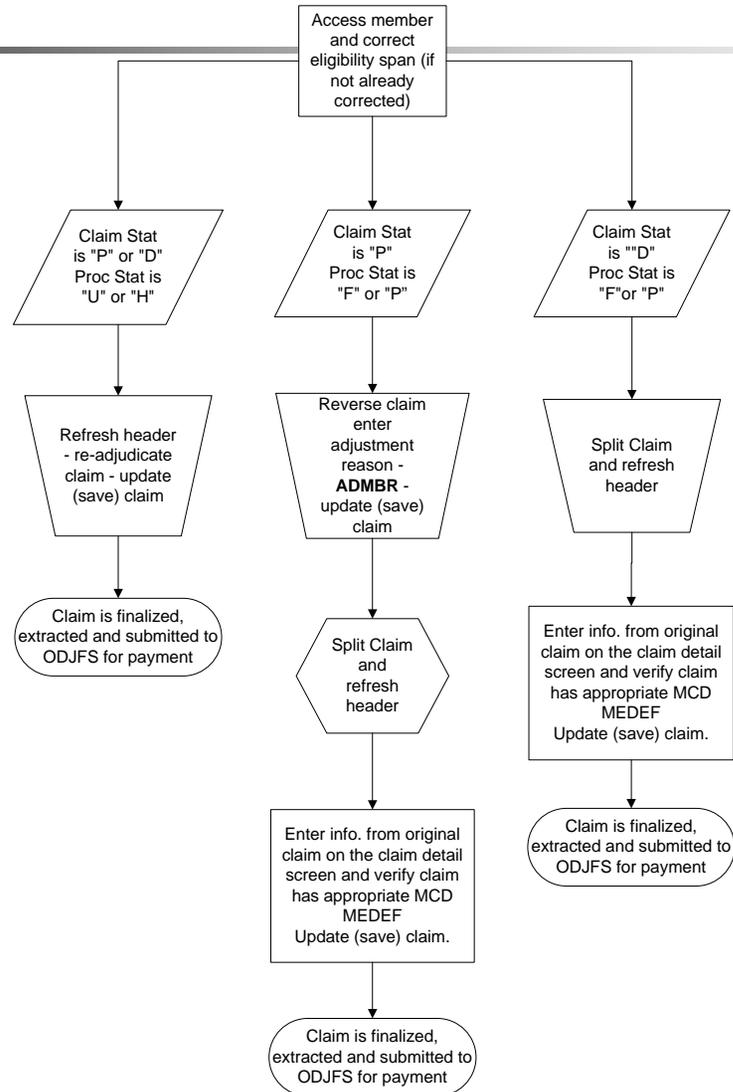


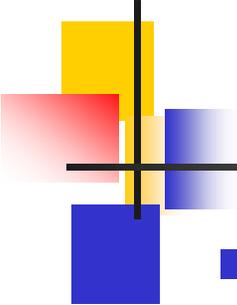
How do I fix retroactive Medicaid claims? (cont'd)

- Mismatch retroactive Medicaid claims are fixed by the State.
 - These are claims that were originally adjudicated under one board's group and plan and now belong to another board's group and plan.

Fixing Retroactive Medicaid Claims

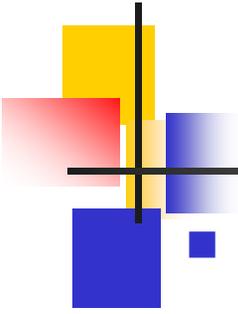
These claims were originally adjudicated as non-Medicaid.





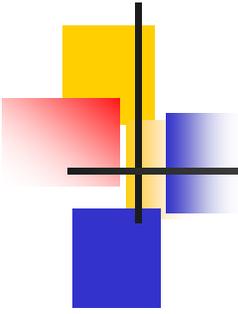
Double Loop

- The payment process in MACSIS is commonly referred to as the Double Loop.
 - The first part of the double loop pays the provider via the 835 Remittance Advice.
 - All payment files are created after APUPD is complete (835/RA/ERA/RJ).
 - The second part of the double loop pays the FFP to the board via the ARA's.
 - ARA's are created after completion of the OHEXT process.



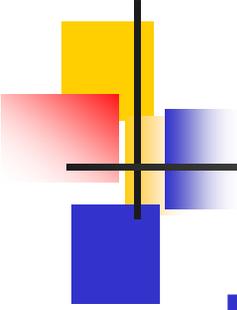
Accounts Payable Process

- APUPD is the first step in the accounts payable process and finalizes the claim.
 - Changes the PROC STAT from “U” (un-finalized) to “F” (finalized) and assigns a Post Date to the claim.
 - This process is run Monday, Tuesday & Wednesday mornings.
 - Criteria for APUPD selection is: Company Code, Entered Date (from the ACPAY record) and a thru date which is based on the board’s lag time.
 - **Finalized claims can not be modified.**
 - There is a bug in Diamond that allows the header to be refreshed on a finalized claim. Ex.: If a member’s eligibility has been changed from NON to MCD and you refresh the header, the header will have a LOB of MCD, but the detail will have a LOB of NON. **THIS CAN NOT BE CORRECTED.**



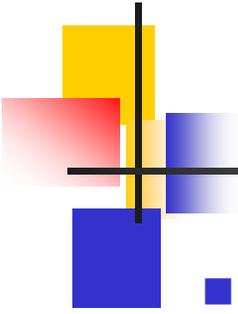
Accounts Payable Process (cont'd)

- **CKPRT** is the second step in the accounts payable process which creates a work file for the CKPST process.
- The date this process is run is the date used to assign a Check Date to the claim.



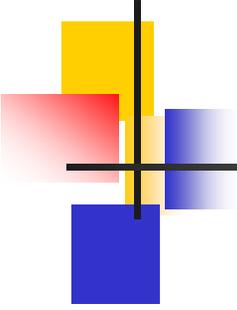
Accounts Payable Process (cont'd)

- **CKPST** is the third and final step in the accounts payable process. This step changes the PROC STAT from an "F" (finalized claim) to a "P" (paid claim) and assigns the Check Date based on the date CKPRT was run.
 - This date is not reported on the 835, but is reported on the ERA files.
- The accounts payable process runs every week
 - The claims finalized each week depends on the boards' lag time. The longer the lag/delay, the longer you have to make corrections to claims, check for duplicates, etc.



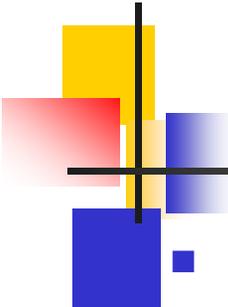
Payment Files Created

- Claims that completed the first two steps of the accounts payable process (APUPD, CKPRT) will appear on the next week's payment files.
- The 835 is the HIPAA compliant remittance file that is created for providers.
 - UPI Naming Convention (AXXXUPI.julyy.gz)
 - Ex.: A45B010182.08207.gz
 - NPI Naming Convention (NXXXUPI.julyy.gz)
 - Ex.: N45B010182.08207.gz



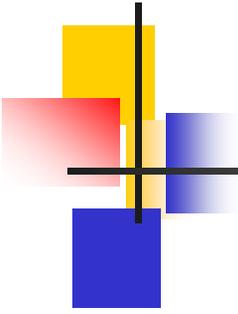
Payment Files Created

- The State also creates an 835 summary file for boards which is a summary of all 835 payment files created for the current week (Sxxx835Summary.julyy.gz).
 - Ex.: S45BSUMMARY.08204.gz



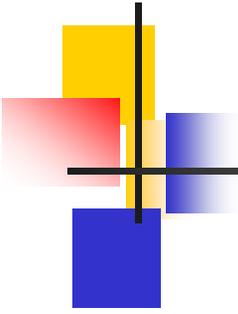
Payment Files Created (cont'd)

- The State is continuing to create the ERA (electronic remittance advice), RA (remittance advice – printable format) and the RJ (reject/reversed claims) files for board and provider convenience
 - ERA Naming Convention
 - Provider: XXXUPI.jul.gz (ex. 25B01043.314.gz)
 - Board: XXXXX.jul.gz (ex. FRANB.314.gz)
 - RA Naming Convention
 - Provider: RA.XXXUPI.julyy.gz (ex. RA.45B06755.26207.gz)
 - Board: RA.XXXXX.julyy.gz (ex. RA.LICKB.26207.gz)
 - RJ Naming Convention
 - Provider: RJ.XXXUPI.julyy.gz (ex. RJ45B06755.26207.gz)
 - Board: RJ.XXXXX.julyy.gz (ex. RJ.LICKB.26207.gz)
- All remittance files are Ftp'd to the boards' RA directory every Monday.



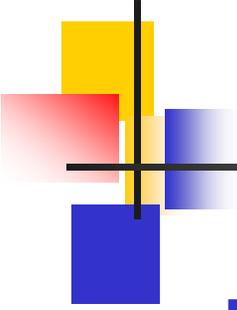
Disbursement of Payment Files

- Per HIPAA the 835 Health Care Claim Payment Advice is disbursed to providers.
 - If the provider software cannot handle the 835, boards and providers can mutually agree which file types (835, ERA, RA, RJ) to disburse to a provider.
 - Boards must provide the 835 format if requested by provider.



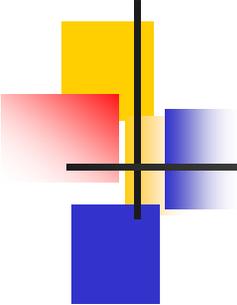
Timeliness of Payment

- Payment to the provider should be disbursed within 30 days from the date the claim was 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.



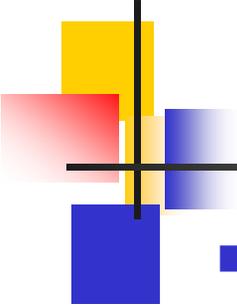
Timeliness of Payment (cont'd)

- Vendors are viewed as the administrative concern for a provider and would be the recipient of reimbursement or payment.
 - In many cases the Provider number and Vendor number are the same and have the same address
 - Where there are multiple sites, each site will have a different UPID number but share the same Vendor number
 - To find a vendor's address go to:
(<http://www.mh.state.oh.us/ois/macsis/provf/provf.top.html>)



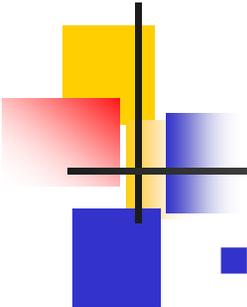
Reconciliation

- Boards should reconcile the claims that were accepted into Diamond against those that have been paid or denied and reported on the 835's.
 - The batch number that is reported on the REF02 line for each claim is assigned during the XML file creation. This batch number can be used to tie claims back to the provider file via the 835 Summary file.



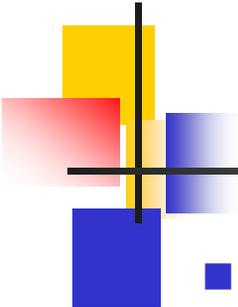
OHEXT Process

- The OHEXT process results in reimbursement to boards for the FFP that has already been paid to providers.
 - MH runs this process every other week
 - ODADAS runs this process weekly
- Claims with a Medicaid MEDEF are:
 - Extracted from Diamond
 - Submitted to ODJFS for reimbursement of the FFP
 - Payment files are returned from ODJFS and ARA's are created
 - ARA files are created bi-weekly and these are the files that give the FFP back to the board



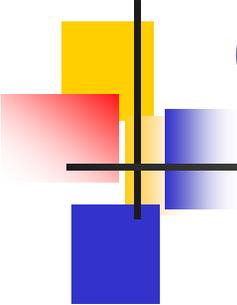
OHEXT Process (cont'd)

- **ARA** stands for agency reimbursement amount and actually reimburses the board for the FFP they have already given the agency.
- **ODJFS Reject Codes** – A full list is available on the web. The most common reject codes are:
 1. 218 – According to JFS client has 3rd party insurance and no third party information was entered.
 2. 225/120 – Claim is over 365 days old
 3. 271 – Client is Medicaid eligible but not for this date of service



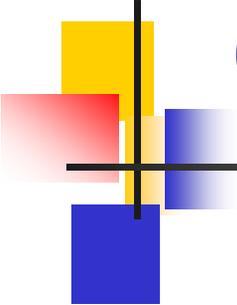
OHEXT Error Report Corrections

- It is the board's responsibility to make the necessary changes to correct the errors being reported on the OHEXT Error Report
 - These errors occur when claims are adjudicated and finalized in MACSIS as MCD, but are not being extracted for submission to ODJFS.
- Error Indication - Medicaid Number not Found or Invalid Medicaid Number
 - This message identifies a claim that has a Medicaid plan for that date of service, but no Medicaid number in the USERDEF field or the Medicaid number does not pass a check digit validation



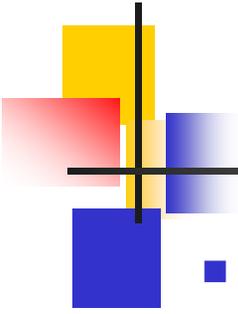
OHEXT Error Report Corrections (cont'd)

- Once you verify the client was Medicaid eligible on the date of service and you have a valid Medicaid ID:
 - Add the Medicaid ID to the appropriate member eligibility span in the USERDEF field
 - The claim will be extracted the next time the OHEXT process is run
- If the person was not Medicaid eligible on the date of service:
 - Reverse the original claim and enter the adjustment reason code – ADMBR
 - Correct the member's eligibility from MCD to non-MCD
 - Split the original claim, refresh the header, access the detail screen and enter the necessary information.



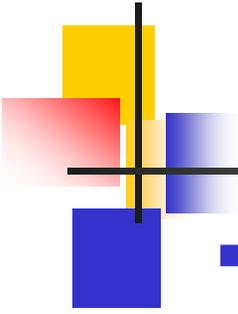
OHEXT Error Report Corrections (cont'd)

- If the claims were for a UCI number that has been EDUP'd because it is a duplicate put the Medicaid number in the USERDEF field of the appropriate eligibility span.
 - Do not put the Medicaid ID in the Medicaid field of the Other Identification ID section
 - Diamond does not allow a Medicaid ID to be in the Medicaid field of more than one UCI.
 - Per Medicaid these are valid claims and should be allowed to process through ODJFS as valid claims.
 - Claims are submitted to ODJFS by Medicaid number not UCI number.
- You should not be reversing these claims and having them resubmitted or entering them manually under the active UCI.



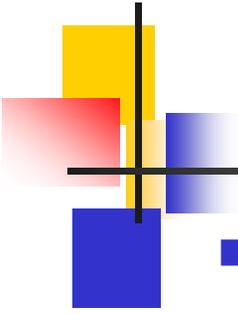
What are "F" claims?

- These are claims that have been through APUPD but have not completed CKPRT/ CKPST of the Accounts Payable Process.
 - Since CKPRT/CKPST is where the Proc Stat of "F" is changed to "P" and a check date is assigned these claims remain with no check date and a PROC STAT of "F"
 - "F" claims are caused because the total dollar amount for a provider is a negative amount or zero dollar amount.
- Prior to January 2002
 - "F" claims did not get reported on RA's
 - "F" claims did not get extracted to ODJFS
 - Since these claims could remain in "F" status for months by the time they did become paid claims (PROC STAT of "P") and get extracted to ODJFS they were too old and were getting reversed.



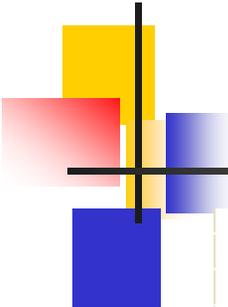
The Remedy for "F" Claims

- Since January of 2002, the State has made changes to the Accounts Payable Process and the OHEXT process to eliminate the problems caused by "F" claims.
 - 835's (RA/ERA's) are now created for claims with a PROC STAT of "F" or "P"
 - When extracting claims for ODJFS, the post date is now used instead of the check date
 - The "F" claims will have the check date field populated with the post date for ERA/RA purposes. This is being done so that it will not cause problems with importing (posting) the ERA/RA files into your local system. The check date is not reported on the 835
- In most cases "F" claims will become payable claims with a check date in Diamond, however the check date that shows up on the ERA/RA's for these claims will not be the same check date in Diamond.



Tracking Files

- Boards and providers can track the status of their files and remittance advices by routinely checking the reports available on the MACSIS website.
- These reports can be accessed either by going to the main MACSIS web page (<http://www.mh.state.oh.us/ois/macsis/macsis.index.html>) and then clicking on Reports, or by going directly to the Reports Index (<http://www.mh.state.oh.us/ois/macsis/mac.rpts.index.html>)



What reports are on the Reports page?

MACSIS Reports List

Reports List

[Spring 2005 FMG Reports Presentation \[PPT\]](#) [\[PDF\]](#)

APUPD

[Current Week](#)

[Previous Week](#)

Check Post

[Current Week](#)

[Previous 1](#)

[Previous 2](#)

[Previous 3](#)

Claims Billing

[Finalized Claims by Company \(Board\) & UPI \(Provider\)](#)

[Finalized Claims by UPI \(Provider\) & Company \(Board\)](#)

Claims Status Reports by Provider

Updated 1st Tuesday of the month

[Documentation of Reports](#)

[Provider List Sorted by Name](#)

[Provider List Sorted by MACSIS UPI \(Provider\)](#)

Claims Remittance Tracking Reports by Provider

Updated 1st Tuesday of the month

[Documentation of Reports](#)

[Provider List Sorted by Name](#)

[Provider List Sorted by MACSIS UPI \(Provider\)](#)

Weekly Claims File Submissions by Board

[Documentation of Reports](#)

[Current Week](#)

[Previous Week 1](#)

[Previous Week 2](#)

[Previous Week 3](#)

Weekly Claims File Submissions by Provider

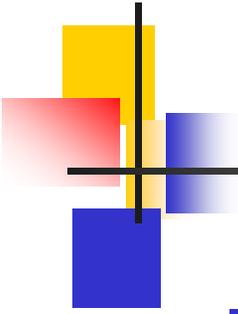
[Documentation of Reports](#)

[Current Week](#)

[Previous Week 1](#)

[Previous Week 2](#)

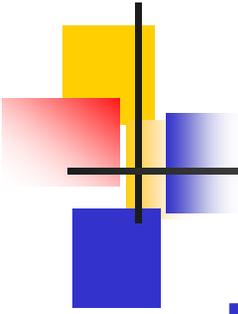
[Previous Week 3](#)



MACSIS Reports List

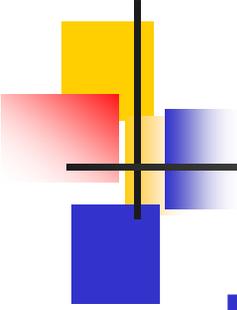
- MACSIS Reports List

- Listing of all paper and electronic reports that are created for boards and providers. This is a spreadsheet that contains:
 - Report/File name or description
 - Report Naming convention
 - Created By
 - Distributed
 - Frequency
 - Purpose
 - Board Action



Weekly Claims File Submissions by Board

- Weekly Claims File Submissions by Board
 - There are four separate reports: Current Week, Previous 1, Previous 2 and Previous 3.
 - This report can be used by boards to reconcile the files and claim lines they submitted to the State against what was received and processed by the State.
 - Boards can verify what files were submitted by a provider by, what files were accepted, file problem, the process date, the number of claims submitted in the file and the number of claims that made it into Diamond with that file name.



Weekly Claims File Submissions by Board (cont'd)

- This report contains the following information:
 - Report Header contains the report name, the processing dates and the board name and number.
 - Provider Name
 - Provider # (UPI number)
 - File Problem – will contain “ACCEPTED” if the file is okay or will list the problem if the file was bad.
 - File Name – Name of the file submitted
 - Process Date – Date the file was run through the “overnight” process.
 - # Claims Submitted in File
 - # Claims in Diamond with this File Name – number of claims accepted into Diamond for that board with that file name.

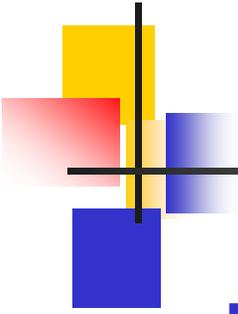
Note: Detailed documentation for these reports is posted on the Reports web page.

Weekly Claims File Submissions by Board (cont'd)

*Claim Files Submitted to Diamond by Board by Provider by File
Process Dates between April 1, 2007 - April 7, 2007
As of Extract Dated April 7, 2007*

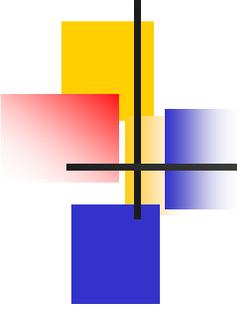
BOARD=Cuyahoga ADAS (18A)

Provider Name	Provider #	File Problem	File Name	Process Date	# Claims Submitted in File	# Claims In Diamond With This File Name
AIDS TASKFORCE	12186	ACCEPTABLE	A0121861.09207	04/03/2007	10	.
		ACCEPTABLE	A0121861.09307	04/05/2007	1	.
		ACCEPTABLE	A0121861.09407	04/06/2007	1	.
BRIDGEWAY-UNBAR	01090	ACCEPTABLE	A0010901.09207	04/03/2007	155	.
CLEVE HLTH SMIT	01073	ACCEPTABLE	A0010731.09507	04/07/2007	137	.
COMM ACTION	01116	ACCEPTABLE	N0011161.09407	04/05/2007	8,573	.
E CLEVE NEIGHOR	02435	ACCEPTABLE	A0024351.09407	04/05/2007	33	.
E SIDE CATH SHE	06989	ACCEPTABLE	A0069891.09407	04/05/2007	311	.
FRESH START VI	07158	ACCEPTABLE	N0071581.09507	04/06/2007	211	.
GOLDEN CIPHERS	12423	ACCEPTABLE	N0124231.09207	04/03/2007	87	.
HITCHCOCK CNTR	01100	ZERO BYTES IN FILE	A0011001.09607	04/07/2007	.	.
LUTHERAN MIN-25	01875	ACCEPTABLE	A0018751.09407	04/05/2007	45	.
MATT TALBOT	06848	ACCEPTABLE	N0068481.08907	04/03/2007	130	.
		ACCEPTABLE	N0068481.09207	04/04/2007	15	.
		ACCEPTABLE	N0068481.09307	04/04/2007	5	.
		ACCEPTABLE	N0068481.09407	04/06/2007	112	.
		ACCEPTABLE	N0068481.09507	04/06/2007	5	.
NEW VISIONS	11000	ACCEPTABLE	N0110001.09407	04/06/2007	16	.
NORTHERN OH REC	12379	ACCEPTABLE	A0123791.09407	04/05/2007	64	.
		ACCEPTABLE	A0123791.09507	04/06/2007	6	.
ORCA MEN-CUYA	01077	ACCEPTABLE	A0010771.09207	04/04/2007	95	.



Weekly Claims File Submissions by Provider

- Weekly Claims File Submissions by Provider
 - There are four separate reports: Current Week, Previous 1, Previous 2 and Previous 3.
 - This report can be used by providers to reconcile the files and claim lines they submitted to the board against what was received and processed by the State.
 - Providers can verify what files were submitted by board and by file name, what files were accepted, file problem, the process date, number of claims submitted in the file and the number of claims that made it into Diamond with that file



Weekly Claims File Submissions by Provider (cont'd)

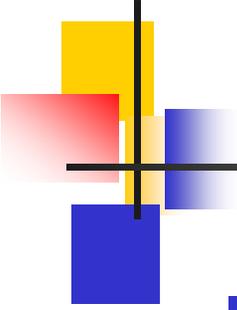
- This report contains the following information:
 - Report header contains the report name and the processing dates.
 - Provider Name
 - Provider # (UPI)
 - Board Name (board or consortium name)
 - Board # (board or consortium number)
 - File Problem – will contain “ACCEPTED” if the file is okay or will list the problem if the file was bad.
 - File Name – Name of the file submitted
 - Process Date – Date the file was run through the “overnight” process.
 - # Claims Submitted in File
 - # Claims in Diamond with this File Name – number of claims accepted into Diamond for that board with that file name

Note: Detailed documentation for these reports is posted on the Reports web page.

Weekly Claims File Submissions by Provider (cont'd)

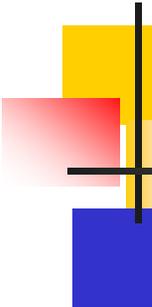
*Claim Files Submitted to Diamond by Provider by Board by File
Process Dates between April 1, 2007 - April 7, 2007
As of Extract Dated April 7, 2007*

Provider Name	Provider #	Board Name	Board #	File Problem	File Name	Process Date	# Claims Submitted in File	# Claims In Diamond With This File Name
				ACCEPTABLE	N0013813.08707	04/04/2007	241	241
				ACCEPTABLE	N0013814.08707	04/04/2007	8	8
				ACCEPTABLE	N0013815.08707	04/04/2007	9	9
				ACCEPTABLE	N0013816.08707	04/04/2007	101	100
				ACCEPTABLE	N0013817.08807	04/04/2007	486	486
				ACCEPTABLE	N0013818.08807	04/04/2007	124	124
COUNSELING CNTR	10038	Stark MH	76B	ACCEPTABLE	N0100381.09507	04/06/2007	2,208	.
COUNSELING-COLU	01051	Stark MH	76B	ACCEPTABLE	N0010511.09407	04/06/2007	1,276	.
				ACCEPTABLE	N0010512.09407	04/06/2007	316	.
COVA	10001	Central/PPS	23B	DUP FROM 24MAR07	A0100013.07907	04/04/2007	.	.
		Franklin	25B	ACCEPTABLE	N0100011.09307	04/04/2007	152	145
CRISIS CENTER	01492	Stark MH	76B	ACCEPTABLE	N0014921.09507	04/07/2007	715	.
				ACCEPTABLE	N0014922.09507	04/07/2007	581	.
				ACCEPTABLE	N0014923.09507	04/07/2007	107	.
				ACCEPTABLE	N0014924.09507	04/07/2007	83	.
CROSSROADS-BELM	01118	Belmont-Harrison-Monroe	07B	ACCEPTABLE	A0011182.09407	04/05/2007	1,386	.
CROSSROADS-LAKE	01318	Lake	43B	ACCEPTABLE	N0013181.09207	04/04/2007	2,120	2,118
CUYA CTY MH BD	00413	Cuyahoga MH	18M	ACCEPTABLE	A0004131.09107	04/03/2007	163	163
				ACCEPTABLE	A0004131.09207	04/03/2007	156	156
D V EDNA BROOKS	10167	Athens-Hocking-Vinton	05B	ACCEPTABLE	N0101671.08607	04/03/2007	17	17
DARKE CNTY RECV	02546	Miami-Darke Shelby	55B	ACCEPTABLE	N0025461.09207	04/05/2007	140	.
DELAWARE-RECOV	01144	Central/PPS	23B	ACCEPTABLE	A0011441.08707	04/04/2007	105	105



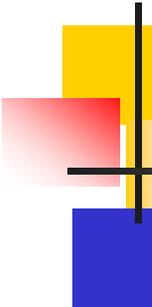
Claims Remittance Tracking Reports by Provider

- Claims Remittance Tracking Reports by Provider
 - This report displays the number of claims and associated dollar amounts that have been reported on either a paper and/or electronic remittance advice.
 - This report contains claims that have a PROC STAT of "P" and "F".
 - This report can be used by providers to identify which boards "owe" them a remittance advice for a specific date range.
 - Reports are updated the first Tuesday of the month.



Claims Remittance Tracking Reports by Provider (cont'd)

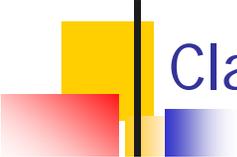
- There are two ways to find the report for a particular provider:
 - Search by provider name – ***Provider List Sorted by Name***
 - Search by UPI (provider number) – ***Provider List Sorted by MACSIS UPI***
 - Both searches produce the exact same reports, just different ways to locate the provider information you are looking for.



Claims Remittance Tracking Reports by Provider (cont'd)

- The information is reported by fiscal year and by funding stream (Medicaid and Non-Medicaid).
 - The report includes the following information under each funding stream:
 - The board (company code)
 - APDATE – date the claim processed through APUPD
 - Claims – number of claim lines remitted by the board on the designated AP date
 - Remit Amt. – summary of the net amount remitted for those claims included on the report

Note: Detailed documentation for these reports is posted on the Reports web page.



Claims Remittance Tracking Reports by Provider (cont'd)

Access to Remittance Tracking Reports: Provider Name Order

PROVIDER NAME	MONTH 1	MONTH 2	MONTH 3
ACCESS OHIO (12607)	JAN.2007	FEB.2007	MAR.2007
ACHIEVEMENT CENTERS FOR CHILDREN (10360)	JAN.2007	FEB.2007	MAR.2007
ACHIEVEMENT CENTERS FOR CHILDREN (10361)	JAN.2007	FEB.2007	MAR.2007
ACHIEVEMENT CENTERS FOR CHILDREN (11178)	JAN.2007	FEB.2007	MAR.2007
ADDICTION PROGRAM OF MAHONING COUNTY (989)	JAN.2007	FEB.2007	MAR.2007
ADELANTE (6816)	JAN.2007	FEB.2007	MAR.2007
ADRIEL SCHOOL INC (12467)	JAN.2007	FEB.2007	MAR.2007
ADVANCED INJURY MANAGEMENT (12408)	JAN.2007	FEB.2007	MAR.2007
AFRICENTRIC PERSONAL DEVELOPMENT SHOP (2915)	JAN.2007	FEB.2007	MAR.2007
AIDS TASKFORCE OF GREATER CLEVELAND (12186)	JAN.2007	FEB.2007	MAR.2007
AKRON HEALTH DEPARTMENT COUNSELING SERVICES (1498)	JAN.2007	FEB.2007	MAR.2007
AKRON URBAN MINORITY ALCOHOLIS DRUG ABUSE OUTREACH PROGRAM (6838)	JAN.2007	FEB.2007	MAR.2007
ALCOHOL AND DRUG FREEDOM CENTER OF KNOX COUNTY (1311)	JAN.2007	FEB.2007	MAR.2007
ALCOHOL AND DRUG SERVICES OF GUERSNEY COUNTY (1234)	JAN.2007	FEB.2007	MAR.2007
ALCOHOLISM COUNCIL OF BUTLER COUNTY OHIO INC (1032)	JAN.2007	FEB.2007	MAR.2007
ALCOHOLISM COUNCIL OF THE CINCINNATI AREA NCADD (1267)	JAN.2007	FEB.2007	MAR.2007
ALLIANCE FOR THE MENTALLY ILL OF FRANKLIN COUNTY (10004)	JAN.2007	FEB.2007	MAR.2007
ALTERNATIVE PATHS INC (1997)	JAN.2007	FEB.2007	MAR.2007

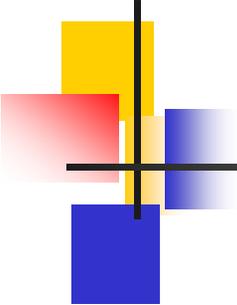
Claims Remittance Tracking Reports by Provider (cont'd)

This Remittance Report Tracking Report Pertains to ALCOHOL AND DRUG FREEDOM CENTER OF KNOX COUNTY (1311)

Notes:

- (1) This Report Produced on 10APR07 From a Master File Created 07APR07*
- (2) MACSIS APUPD/Posts Between 01MAR07 and 31MAR07 are included here.*

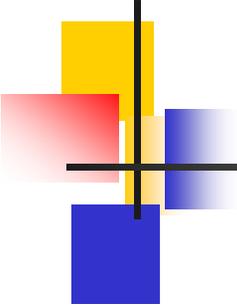
		Fiscal Year							
		2006				2007			
		Funding Stream				Funding Stream			
		Medicaid		Non-Medicaid		Medicaid		Non-Medicaid	
Board	APDATE	Claims	Remit Amt.	Claims	Remit Amt.	Claims	Remit Amt.	Claims	Remit Amt.
FRANB	2007-03-19	.	.	.	.	3	\$194.24	5	\$0.00
	2007-03-26	.	.	.	.	5	\$241.06	.	.
<i>FRANB</i>		.	.	.	.	8	<i>\$435.30</i>	5	<i>\$0.00</i>
LICKB	2007-03-12	.	.	.	.	2	\$-157.04	.	.
	2007-03-19	7	\$212.69	7	\$-214.37	16	\$1,085.32	16	\$-1,106.00
	2007-03-26	.	.	1	\$12.40	540	\$24,396.52	503	\$31,283.76
<i>LICKB</i>		7	<i>\$212.69</i>	8	<i>\$-201.97</i>	558	<i>\$25,324.80</i>	519	<i>\$30,177.76</i>
TUSCB	2007-03-19	.	.	.	.	.	.	3	\$0.00
<i>TUSCB</i>		.	.	.	.	.	.	3	<i>\$0.00</i>
<i>G.TOT</i>		7	<i>\$212.69</i>	8	<i>\$-201.97</i>	566	<i>\$25,760.10</i>	527	<i>\$30,177.76</i>



APUPD Report

- APUPD Report

- These reports are broken down into Current Week and Previous Week.
- The report is created from Diamond and contains claims that have completed the APUPD (accounts payable update) process
- These claims have not yet gone through CKPRT (check print) and CKPST (check post).
- All claims on this report have a PROC stat of "F".

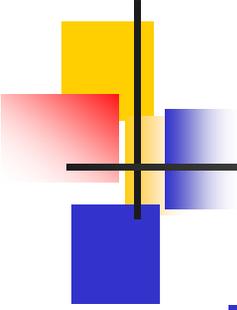


APUPD Report (cont'd)

- The information on these reports are summarized by company and gives the “thru date”, the number of claims and the dollar amount of the claims.
- The claims on the current report will be on next week’s remittance reports (RA, ERA, 835), while the claims reflected on the previous week report will be on this week’s remittance reports.
- This report can be used to give the boards an approximate dollar amount as to what is owed to providers once they show up on remittance reports.

APUPD Report (cont'd)

APUPD			
April 9, 2007			
COMPANY	Run Thru Date	HIPAA Claims	HIPAA Dollars
ALLEB	3/23/07	1,831	\$143,914.96
ASHLB	3/30/07	293	\$29,554.84
ASHTB	3/30/07	2,163	\$181,559.79
ATHEB	3/30/07	5,776	\$438,511.77
BELMB	3/23/07	781	\$19,153.86
BROWB	3/23/07	410	\$43,452.40
BUTLB	3/30/07	4,385	\$372,934.14
CHAMB	3/23/07	282	\$15,715.40
CLARB	3/30/07	8,138	\$589,977.81
CLERB	3/30/07	2,468	\$291,652.51
COLUB	3/30/07	2,446	\$162,671.36
CUYAA	3/23/07	9,476	\$406,596.02
CUYAM	3/30/07	20,712	\$1,809,635.23
DEFIB	3/30/07	508	\$22,965.18
DELAB	3/23/07	2,714	\$253,541.07
ERIEB	3/23/07	638	\$48,408.58
FAIRB	3/23/07	4,207	\$303,978.00
FRAN	3/30/07	30,741	\$1,539,722.43
GALLB	3/23/07	226	\$17,494.42
GEAUB	3/23/07	1,856	\$156,388.45
HAMIA	3/30/07	2,826	\$384,749.47
HAMIM	3/30/07	11,410	\$885,450.44



Check Post Report

■ Check Post Report

- This report provides the information on claims that have completed the Check Post process which changes the PROC stat from an “F” to a “P” and is broken down by provider.
- There are four separate reports: Current Week, Previous 1, Previous 2 and Previous 3.
- Boards can use this report as an estimate of what they will owe each provider.
- Providers can use this report as an estimate of what is owed them from the various boards.

Check Post Report (cont'd)

JCKPST10.PGM

MHIPAA DIAMOND SYSTEM

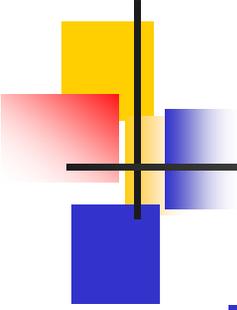
Page 1

Run on 04/09/07 @ 6:37 PM

Post Check Run

Audit Log

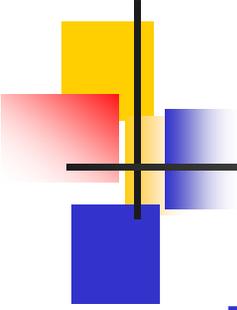
Bank Code	Check #	Check Date	Vendor #	Vendor Name	Ad dr	Amount	Vo id
ALLEB	98	04/09/2007	10065	BEN-EL	0	413.81	
ALLEB	190	04/09/2007	10178	OH YOUTH ADVOCA	0	1577.77	
ALLEB	272	04/09/2007	10277	WESTWOOD BHVRL	0	349.98	
ALLEB	276	04/09/2007	10279	MARSH FOUNDATIO	0	2174.58	
ALLEB	281	04/09/2007	10295	CHILD SERV-WOOD	0	180.00	
ALLEB	288	04/09/2007	10305	BEHAV CONNECTIO	0	1602.41	
ALLEB	300	04/09/2007	10332	SAFY OF OHIO	0	10230.78	
ALLEB	316	04/09/2007	10384	INTEGRATED SERV	0	191.30	
ALLEB	423	04/09/2007	11004	ASTOP INC	0	2700.72	
ALLEB	455	04/09/2007	11172	SHELBY CNTY CNS	0	130.43	
ALLEB	615	04/09/2007	12559	COMPASS-COLLING	0	3091.87	
ALLEB	646	04/09/2007	1345	LUTHERAN SS	0	67488.88	
ALLEB	674	04/09/2007	1381	COUNSEL-MARI	0	350.57	
ALLEB	684	04/09/2007	1387	GATEWAY OUTRECH	0	186.89	
ALLEB	695	04/09/2007	1446	RECOVERY-PIKE	0	599.41	
ALLEB	825	04/09/2007	3126	HARBOR	0	304.65	
ALLEB	836	04/09/2007	3153	BUCKEYE RANCH	0	1114.48	
ALLEB	870	04/09/2007	3340	UNISON BHG	0	78.96	
ALLEB	899	04/09/2007	3593	REH OF N CNTR	0	90.00	
ALLEB	919	04/09/2007	5004	UMADAOP-LIMA	0	3303.96	
ALLEB	927	04/09/2007	6370	FAMILY RESOURCE	0	30194.05	
ALLEB	969	04/09/2007	6846	COUNSELING-SCIO	0	11795.35	
ALLEB	1005	04/09/2007	6967	CORNELL ABRAXAS	0	4121.48	
ALLEB	1027	04/09/2007	7073	FOUNDATIONS B H	0	1642.63	
ALLEB						total check(s) amount:	143914.96



Claims Status Reports by Provider

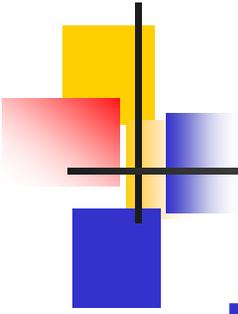
■ Claims Status Reports by Provider

- This report displays the number of claims and associated dollar amounts owed to a provider for claims received into MACSIS (either electronically or manually) for a calendar month.
- This report is a “snapshot” of the claims in Diamond as of the run date of the report.
- This report displays claims regardless of their current “payment” status.
- Reports are updated the first Tuesday of the month.



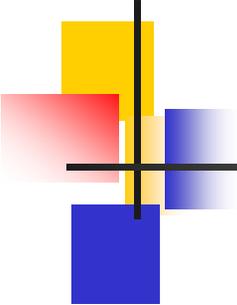
Claims Status Reports by Provider (cont'd)

- There are two ways to find the report for a particular provider:
 - Search by provider name – ***Provider List Sorted by Name***
 - Search by UPI (provider number) – ***Provider List Sorted by MACSIS UPI***
 - Both searches produce the exact same reports, just different ways to locate the provider information you are looking for.



Claims Status Reports by Provider (cont'd)

- This report can be used by a provider to ascertain the current status of claims received by MACSIS.
- The report includes the following information:
 - The board (company code)
 - Batch number claim was included on
 - CS (claim status) – “P”=payable, “D”=denied and “A”=adjustment
 - PS (processing status) – “P”=paid, “F”=finalized and “H”=held



Claims Status Reports by Provider (cont'd)

- Claims – number of claim lines
- Quantity – number of units billed
- Billed Amount – total billed amount for the claim lines reported
- Allowed Amount – total allowed amount for the claim lines reported
- Co-Pay Amount – total co-pay amount for the claim lines reported
- Withhold Amount – total withhold amount for the claim lines reported
- Net Amount – total net amount for the claim lines reported

Note: Detailed documentation for these reports is posted on the Reports web page.

Claims Status Reports by Provider (cont'd)

Access to Claim Status Reports: Provider Name Order

PROVIDER NAME	MONTH 1	MONTH 2	MONTH 3
ACCESS OHIO (12607)	JAN.2007	FEB.2007	MAR.2007
ACHIEVEMENT CENTERS FOR CHILDREN (10360)	JAN.2007	FEB.2007	MAR.2007
ACHIEVEMENT CENTERS FOR CHILDREN (10361)	JAN.2007	FEB.2007	MAR.2007
ACHIEVEMENT CENTERS FOR CHILDREN (11178)	JAN.2007	FEB.2007	MAR.2007
ADDICTION PROGRAM OF MAHONING COUNTY (989)	JAN.2007	FEB.2007	MAR.2007
ADELANTE (6816)	JAN.2007	FEB.2007	MAR.2007
ADRIEL SCHOOL INC (12467)	JAN.2007	FEB.2007	MAR.2007
ADVANCED INJURY MANAGEMENT (12408)	JAN.2007	FEB.2007	MAR.2007
AFRICENTRIC PERSONAL DEVELOPMENT SHOP (2915)	JAN.2007	FEB.2007	MAR.2007
AIDS TASKFORCE OF GREATER CLEVELAND (12186)	JAN.2007	FEB.2007	MAR.2007
AKRON HEALTH DEPARTMENT COUNSELING SERVICES (1498)	JAN.2007	FEB.2007	MAR.2007
AKRON URBAN MINORITY ALCOHOLIS DRUG ABUSE OUTREACH PROGRAM (6838)	JAN.2007	FEB.2007	MAR.2007
ALCOHOL AND DRUG FREEDOM CENTER OF KNOX COUNTY (1311)	JAN.2007	FEB.2007	MAR.2007
ALCOHOL AND DRUG SERVICES OF GUERSNEY COUNTY (1234)	JAN.2007	FEB.2007	MAR.2007
ALCOHOLISM COUNCIL OF BUTLER COUNTY OHIO INC (1032)	JAN.2007	FEB.2007	MAR.2007
ALCOHOLISM COUNCIL OF THE CINCINNATI AREA NCADD (1267)	JAN.2007	FEB.2007	MAR.2007
ALLIANCE FOR THE MENTALLY ILL OF FRANKLIN COUNTY (10004)	JAN.2007	FEB.2007	MAR.2007
ALTERNATIVE PATHS INC (1997)	JAN.2007	FEB.2007	MAR.2007

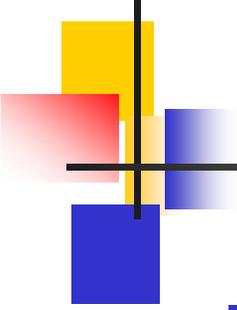
Claims Status Reports by Provider (cont'd)

This Report Pertains to ACHIEVEMENT CENTERS FOR CHILDREN (10360)

Notes:

- (1) Reporting for Claims Received from 01MAR07 thru 31MAR07*
- (2) This Report Produced on 10APR07 From Extract Created 07APR07*

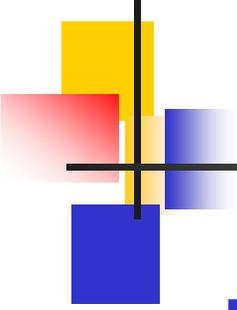
Board	Batch	CS	PS	Claims	Quantity	Billed Amount	Allowed Amount	Co-Pay Amount	Other Carrier Amount	Withhold Amount	Net Amount
CUYAM	A18M07066	D	P	3	11.3	\$393.99	\$168.99	\$0.00	\$0.00	\$0.00	\$0.00
		P	P	7	31.0	\$697.50	\$697.50	\$0.00	\$0.00	\$0.00	\$697.50
	A18M07073	D	P	11	35.6	\$1,402.95	\$867.96	\$0.00	\$0.00	\$0.00	\$0.00
		P	P	77	291.2	\$7,325.93	\$7,325.92	\$0.00	\$0.00	\$0.00	\$7,325.92
CUYAM				98	369.1	\$9,820.37	\$9,060.37	\$0.00	\$0.00	\$0.00	\$8,023.42
LORAM	A18M07066	P	P	1	4.0	\$90.00	\$90.00	\$0.00	\$0.00	\$0.00	\$90.00
	A18M07073	P	P	5	12.0	\$270.00	\$270.00	\$0.00	\$0.00	\$0.00	\$270.00
LORAM				6	16.0	\$360.00	\$360.00	\$0.00	\$0.00	\$0.00	\$360.00
G.TOT				104	385.1	\$10,180.37	\$9,420.37	\$0.00	\$0.00	\$0.00	\$8,383.42



Claims Billing Report

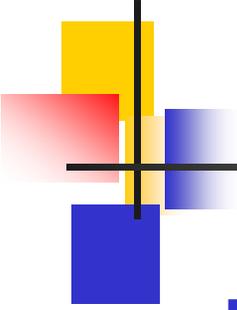
■ Claims Billing Report

- All totals on this report are year-to-date and the information reported is for fiscal year 2006 and 2007 Medicaid and non-Medicaid finalized claims.
- There are two versions of this report and the information is the same on each, except the way the information is summarized:
 - Finalized claims by Company (Board) & UPI (Provider)
 - Finalized claims by UPI (Provider) & Company (Board)



Claims Billing Report (cont'd)

- The information contained on the reports shows the number of finalized Medicaid and Non-Medicaid claims, as well as the net dollar amount of the claims for the current week and what those totals were four weeks prior and are broken out by fiscal year.
- Unlike the APUPD and Check Post reports, this report is created outside of Diamond and contains both “P” (paid) and “F” (finalized) claims.



Claims Billing Report (cont'd)

- Boards can use this report to see how much money they have (should have) paid to a particular provider.
- Providers can use the report to see how much money they have (should have) been paid by a particular board.
- By subtracting the “4 weeks prior” totals from the “current” totals boards and providers can tell how many claim lines and the net dollar amount of those claim lines were finalized for the four week period.

Claims Billing Report (cont'd)

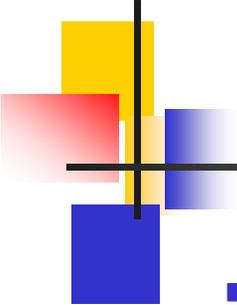
Program: billprgByCompUPI.sas

MACSIS - CLAIMS BILLING PROGRESS REPORT
CURRENT AND 4 WEEKS PRIOR
FOR FINALIZED CLAIMS BY COMPANY AND UPID

Run Date: April 10, 2007

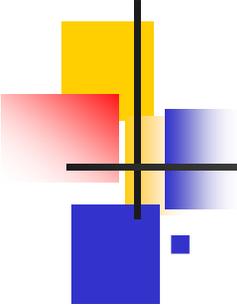
Page: 1

Company	UPID	Provider	Claims Entered Thru Date	SPY07				SPY06			
				Medicaid Claims	Medicaid Net Amount	Non-Medicaid Claims	Non-Medicaid Net Amount	Medicaid Claims	Medicaid Net Amount	Non-Medicaid Claims	Non-Medicaid Net Amount
ALLES	01007	ST RITA MEDICAL	Apr 07,2007 Mar 10,2007	0 0	\$0.00 \$0.00	1 1	\$0.00 \$0.00	0 0	\$0.00 \$0.00	48 48	\$5,860.00 \$5,860.00
ALLES	01018	TRI-CNTY MENTAL	Apr 07,2007 Mar 10,2007	7 7	\$783.36 \$783.36	0 0	\$0.00 \$0.00	31 31	\$2,912.95 \$2,912.95	0 0	\$0.00 \$0.00
ALLES	01140	FIVE COUNTY	Apr 07,2007 Mar 10,2007	20 9	\$996.33 \$608.20	0 0	\$0.00 \$0.00	212 212	\$11,537.09 \$11,537.09	16 16	\$0.00 \$0.00
ALLES	01144	DELAWARE-REDDY	Apr 07,2007 Mar 10,2007	0 0	\$0.00 \$0.00	0 0	\$0.00 \$0.00	0 0	\$0.00 \$0.00	27 27	\$95.24 \$95.24
ALLES	01184	ST VINC FAMILY	Apr 07,2007 Mar 10,2007	1 1	\$324.95 \$324.95	0 0	\$0.00 \$0.00	0 0	\$0.00 \$0.00	0 0	\$0.00 \$0.00
ALLES	01186	NORTH CMTY COUN	Apr 07,2007 Mar 10,2007	0 0	\$0.00 \$0.00	0 0	\$0.00 \$0.00	0 0	\$0.00 \$0.00	2 2	\$0.00 \$0.00
ALLES	01221	WOODLAND-GALL	Apr 07,2007 Mar 10,2007	13 12	\$1,321.76 \$1,231.76	0 0	\$0.00 \$0.00	3 3	\$322.43 \$322.43	0 0	\$0.00 \$0.00
ALLES	01248	ORCA MARY-CUYA	Apr 07,2007 Mar 10,2007	0 0	\$0.00 \$0.00	0 0	\$0.00 \$0.00	0 0	\$0.00 \$0.00	2 2	\$300.60 \$300.60
ALLES	01290	CENTURY-SOUTH	Apr 07,2007 Mar 10,2007	42 41	\$2,583.80 \$2,779.44	16 14	\$1,661.69 \$1,327.34	93 93	\$5,138.32 \$5,138.32	26 26	\$3,675.28 \$3,675.28
ALLES	01346	LUTHERAN SS	Apr 07,2007 Mar 10,2007	79 79	\$2,521.73 \$2,521.73	6 6	\$0.00 \$0.00	92 92	\$5,493.35 \$5,493.35	6 6	\$0.00 \$0.00
ALLES	01360	RESIDUE	Apr 07,2007 Mar 10,2007	11 11	\$1,622.42 \$1,622.42	19 14	\$1,123.37 \$226.63	2 2	\$176.30 \$176.30	2 2	\$92.61 \$92.61
ALLES	01369	COMPASS-LUCA	Apr 07,2007 Mar 10,2007	22 22	\$7,726.62 \$7,726.62	4 4	\$0.00 \$0.00	19 19	\$1,293.62 \$1,293.62	28 28	\$0.00 \$0.00
ALLES	01381	COUNSEL-MARI	Apr 07,2007 Mar 10,2007	27 23	\$4,222.91 \$4,200.37	17 17	\$462.63 \$462.63	59 59	\$2,978.71 \$2,978.71	9 9	\$1,487.91 \$1,487.91



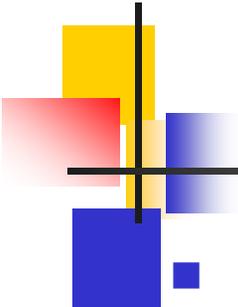
Report Summary

- All the reports covered are created by either ODMH or ODADAS.
- Some of the reports are created directly from Diamond while others are created from extracts with specific selection criteria.
- The intention of these reports is to provide the boards and providers with information regarding claims that have been submitted to MACSIS.
 - The information on these reports reflect the claim details (claims status, processing status, etc.) at the time the report was created.
 - Not all reports are generated using the same method or criteria.
- Some boards generate additional reports for their providers.
 - Questions about board generated reports should be directed to the board.



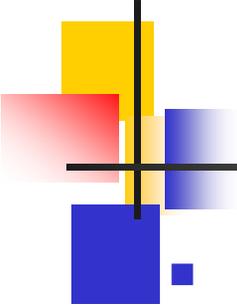
Claims Testing

- 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.
- There are two levels of testing; Tier 1 and Tier 2.
 - Tier 1 tests for basic form, structure and syntax and includes but is not limited to:
 - Conformance to file naming conventions
 - **For 837P v4010 files containing NPI:** Xxxxxxx#.julyy (ex. X0010431.31406) where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.
 - **For 837P v4010 files containing UPI only:** Jxxxxxx#julyy (ex. J0010431.31406)
 - 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.



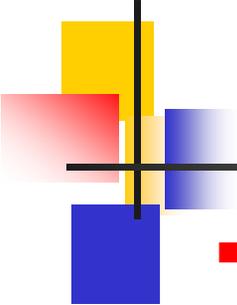
Claims Testing (cont'd)

- Tier 1 testing does not require information related to “real” clients, although the latter is preferable.
 - Refer to Topic 41, Appendix A of the Guidelines for a list of the types of items examined in Tier 1 Testing by the MACSIS staff.



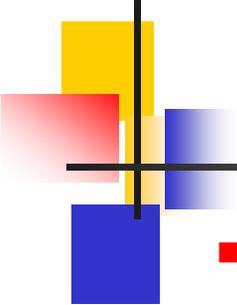
Claims Testing (cont'd)

- Tier 2 is 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. Topic 41, Appendix C in the Guidelines provides a list of the types of items examined in Tier 2 Testing by the MACSIS staff.



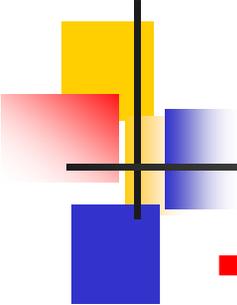
Claims Testing (cont'd)

- 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.



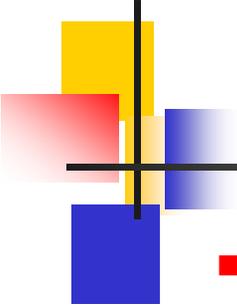
Claims Testing (cont'd)

- 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.



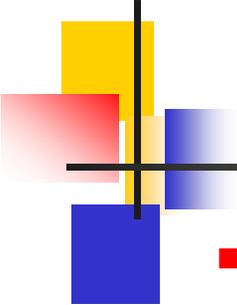
Claims Testing (cont'd)

- Previously approved providers who are submitting 837P files containing NPI are not required to go through Tier 1 testing unless:
 - Provider has changed software
 - Provider is testing a new UPI which was not previously approved
 - Provider has failed basic syntax/structure compliance with Tier 2 submission
 - Provider is submitting the first NPI format file produced from a vendor product/version which has never been tested, Tier 1 testing is highly recommended.



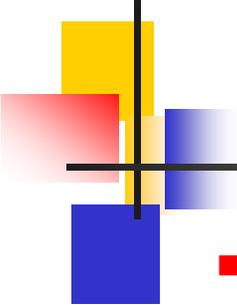
Claims Testing (cont'd)

- Once a Tier 1 test file is received by the board, the board should at a minimum, verify the file follows the appropriate test file naming convention.
 - Boards are encouraged to verify test files meet HIPAA form, structure and syntax compliance as well as the MACSIS specific requirements.
- Board FTP's the test file to the MHHUB server to their /county/<Board>/hipaa/test subdirectory.
- The board should then complete the MACSIS EDI Claims Testing Form and email (macsistesting@mh.state.oh.us) or fax (614-752-6474) to ODMH. (Email is preferred)



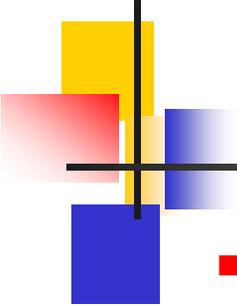
Claims Testing (cont'd)

- Once received, the MACSIS staff will analyze the test file and return a Test Analysis Form denoting the approval status and/or any errors detected to the board.
 - Testing is usually completed within 24 hours, boards should wait three business days after submission of a test file before making inquiries to the MACSIS Support Desk.
- The board is then responsible for providing and reviewing the results with the provider.
- If not approved, provider will need to repeat Tier 1 before initiating Tier 2.
 - Boards should assist the provider in understanding what corrections are needed to submit a subsequent test file.



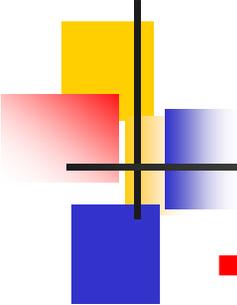
Claims Testing (cont'd)

- Once a Tier 2 test file is received by the board the board should verify the file follows the appropriate test file naming convention.
- Board completes the HIPAA Service Rate Forms pertaining to the fiscal year being tested.
 - There are separate rate forms for ODMH and ODADAS.
 - Boards should make sure they have entered/updated the provider's Non-Medicaid rates and contracts in MACSIS and/or the provider has supplied the required Medicaid Uniform Cost Report and Rate Sheets to the Medicaid Policy staff before beginning Tier 2 testing.
- Board ftp's the file to the MHHUB server to the /county/<Board>/hipaa/tier2test/ subdirectory.



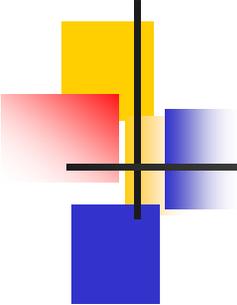
Claims Testing (cont'd)

- The board should then complete the MACSIS EDI Claims Testing Form and email (macsistesting@mh.state.oh.us) or fax (614-752-6474) to ODMH (Email is preferred) along with the HIPAA Service Rate Forms.
 - Make sure all of the relevant information is completed on the MACSIS EDI Claims Testing Form.
- Once received, the MACSIS staff will make sure the test environment is a current copy of production and will attempt to run the Tier 2 test file through the PREDI-Edit process.



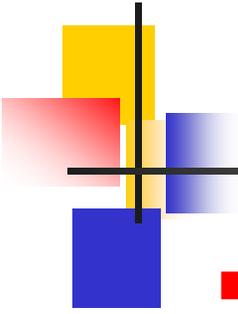
Claims Testing (cont'd)

- MACSIS staff will review the PREDI-Edit and Post reports to evaluate whether the benefit, contract and pricing rules in production are indeed intact and working as expected..
 - Boards should wait three business days after submission of a test file before making inquiries to the MACSIS Support Desk.
- A copy of the final Tier 2 Testing Analysis Form will be emailed back to the board indicating whether the provider had been approved.
 - If approved the provider can now begin submitting production files.



Claims Testing (cont'd)

- If not approved due to problems with the source file, the board should contact the provider with the information needed to correct their file creation program before submitting a new Tier 2 Test file.
- If not approved due to problems with Diamond benefit, contract and pricing tables, the board will need to follow the appropriate change control process to correct the Diamond tables.
 - The board is responsible for changes/corrections to the Non-Medicaid PROVC and PROCP records.
 - Providers should notify Margie Herrel (ODMH) or Doug Day (ODADAS) for corrections/changes to Medicaid PROVC or PROCP records.



Claims Testing (cont'd)

- Note: Previously approved agencies should refer to NPI EDI Claims Checklist (step #6) for submission requirements.
 - This document is located on the web at:
http://www.mh.state.oh.us/ois/macsis/claims/npi_edi_checklist.pdf

Claims Testing (cont'd)

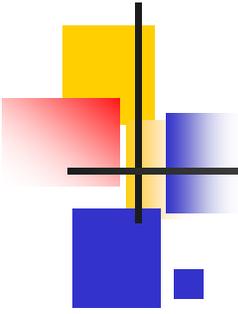
MACSIS EDI CLAIMS TESTING REQUEST FORM

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

FILE SUBMISSION INFORMATION			
Test File Name	Date File FTP'd to State	Submitter ID (UPI)	NPI
Billing Provider Name		Provider Bills Other Payers (COB)?	
Provider Software Vendor		Provider Software Product/Version	
Board Name	Board Contact Name	Board Phone #	
Board Email	Board Fax #	Test File FTP Directory	
		/county/	/hipaa/test (Tier 1)
		/county/	/hipaa/tier2test (Tier 2)
Comments			

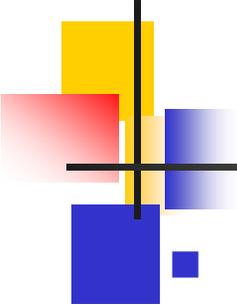
TYPE OF TEST (CHECK ONE)		
Scenario	File Name Format Board FTP Directory	Comments (One test file per UPI/NPI required for all scenarios)
<input type="checkbox"/> Tier 1 – UPI format	J0xxxxx#.julyy /county/(board)/hipaa/test e.x. /county/02B/hipaa/test	Required for providers who are not ready to submit NPI-compliant files, but who are new to MACSIS, have new software, undergoing major system upgrade and/or adding new UPIs.
<input type="checkbox"/> Tier 2 – UPI format	J0xxxxx#.julyy /county/(board)/hipaa/tier2test e.x. /county/02B/hipaa/tier2test	Required for providers who are not ready to submit NPI-compliant files, but who have passed Tier 1, are new to MACSIS, have new software, undergoing major system upgrade and/or adding new UPIs
<input type="checkbox"/> Tier 1 – NPI format	X0xxxxx#.julyy /county/(board)/hipaa/test e.x. /county/02B/hipaa/test	Required for providers who are ready to submit NPI-compliant files and who are new to MACSIS, have new software, undergoing major system upgrade, added new NPIs or significantly failed Tier 2 NPI testing.
<input type="checkbox"/> Tier 2 – NPI format	X0xxxxx#.julyy /county/(board)/hipaa/tier2test e.x. /county/02B/hipaa/tier2test	Required for previously approved providers who are ready to submit NPI-compliant files for previously approved UPIs and/or for providers who passed Tier 1 NPI testing for the reasons noted above.
<input type="checkbox"/> Previously approved agency ¹		
<input type="checkbox"/> New agency (or major upgrade)		

TESTING STATUS (COMPLETED BY STATE STAFF)			
Date Tested	Tested By	File Passed?	Results Attached?



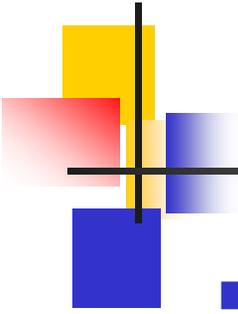
Summary

- Follow the recommended procedures outlined in the Claims Manual
- Submit files in a timely manner
- Track files through the entire process
- Reconcile what was submitted with what was processed and paid
- Work your reports regularly
- Correct claims in a timely manner



Summary

- Retrieve reports in a timely manner and save them locally
 - Any reports, files, etc. are deleted after 30 days
 - Some reports (i.e., ARA files) get overwritten
 - State does not keep backup copies of all the files, reports, etc.
- Become familiar with the reports on the web.
- Review the claims testing procedures before submitting test files.



Where to Get More Information

- MACSIS web site
- Claims Section of the Board Operations Manual
- Guidelines Pertaining to the Implementation of MACSIS under HIPAA
- MACSIS Support Desk
- Attend the Claims User Group Meetings
- Participate in the monthly POP bridge calls