

Below you'll find the three attachments mentioned in the original MACSIS Claims EDI Communication sent earlier this morning from ODMH-OIS. If you have any questions, please contact MACSIS Support.

MACSIS Support Desk

1-877-462-2747

1-614-466-1562

MacsisSupport@mh.ohio.gov

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Ohio Department of Mental Health
MACSIS SYSTEM PROCEDURE

Procedure: Submitting Test Claim EDI Files For Approval

Last Revised Date: 06/15/2011

Purpose:

This procedure outlines how test claim files should be submitted for MACSIS approval using the HIPAA-mandated format (837 Professional Claims Format, Version 4010A1 and 5010A1). The procedure indicates where files should be sent, any corresponding forms needed and how errors or approval will be communicated to the board and subsequently provider.

Related Policies

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

Provider Procedures:

1. Providers should thoroughly review Topics 40-45 of the Guidelines Pertaining to MACSIS under HIPAA prior to submitting test claim files.
 - ◆ Topic 41(B) “Becoming a Business Associate/Trading Partner” in the Guidelines Pertaining to MACSIS under HIPAA relates specifically to MACSIS EDI testing policy. The guideline will outline under what circumstances providers are required to submit test files, any pre-testing requirements, and what types of claim scenarios must be included in each test file.
2. The provider should make sure they have supplied the required Medicaid Uniform Cost Report and Rate Sheet(s) information to the ODMH and/or ODADAS Medicaid Policy staff prior to beginning EDI testing.
3. The provider should discuss with their main contracting board how they expect to receive and/or be notified of test files submissions. This procedure will vary by board depending on the file transfer arrangements they have made for their providers.
4. When ready to submit a test file, the provider should ensure that the test file is appropriately named as follows:
 - **For 837P v4010 files containing NPI:** XXXXXXX#.julyy (ex., X0010431.31411), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.
 - **For 837P v5010 files containing NPI:** TXXXXXX#.julyy (ex., T0010431.31411), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.
5. Upon submission of the test file, the provider should notify their Board that the test file is available per Board procedure..

Provider Procedure After Final Approval:

1. Once approved, providers may submit production 837P claim files using the following naming conventions:
 - **For 837P v4010 files containing NPI:** NXXXXXX#.julyy (ex., N0010431.31411), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.

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

- **For 837P v5010 files containing NPI:** Wxxxxxx#.julyy (ex., W0010431.31411), where xxxxxx is the submitter ID (formerly UPI), # is sequential submission number and julyy is the creation julian date and year.

Board Procedure For Test Files:

1. Once a test file is received by the board, the board should, at a minimum, verify the file follows the appropriate test file naming convention as noted under the provider procedures.
 - Boards have the option and are, in fact, encouraged to verify test files pass additional requirements by verifying HIPAA form, structure and syntax compliance as well as checking for the MACSIS-specific requirements outlined in the Guidelines Pertaining to MACSIS under HIPAA. If errors are found, the Board can communicate the errors to the provider prior to any involvement by the MACSIS staff, but they (Boards) are not encouraged to actually change the provider file before submitting it onto the MACSIS staff. This file level review is an optional step depending upon the capabilities of the Board.
 - If the Provider or the Board would like rates checked in MACSIS, the Board should complete the HIPAA Service Rate Forms(s) pertaining to the State Fiscal Year being tested for the Departments under which the provider will be submitting claims ([ODMH](#) and/or [ODADAS](#))
 - ◆ Boards should make sure they have entered/updated the provider's Non-Medicaid rates and contracts in MACSIS and/or the provider has supplied the required Medicaid Uniform Cost Report and Rate Sheet(s) to the Medicaid Policy staff before beginning testing
2. The board should FTP the file to the MACSIS mhhub server to the /county/<Board designation>/hipaa/test/ subdirectory. The board should then complete the [MACSIS EDI Claims Testing Form](#) and email it along with the HIPAA Service Rate Form(s) if rates are being checked to macsistesting@mh.state.oh.us.
 - It is very important for the boards to complete all requested information on the HIPAA Service Rate (if they are being checked) and EDI Claims Test forms and to submit them at the same time the test file is made available. Emailing the form is preferred; however, if the Board does not have MS Word, a [PDF version](#) of the form is available and can be faxed to 614-752-6474. If faxing, please make sure information is legible.
 - It is important to check the correct box in the Type of Test section according to the type of file being submitted, otherwise there is a risk the file could be rejected based on the incorrect information being submitted on the form.
3. Once received, the MACSIS staff will make sure the test environment is a current copy of Production and will attempt to run the test file through the Claims EDI process in the test environment.
 - ◆ The MACSIS staff will review the PREDI-Edit and Post reports to determine why records created critical or non-critical errors, why warnings were created, if the procedures priced as expected (if this was requested to be checked) and if all benefit rules were applied appropriately.
4. If the file meets the acceptance criteria as determined per the policy, the provider will be approved for submission of the type of claims file submitted either, 837P v4010A1 or 837P v5010A1 claim files for Production. A copy of the final Testing Request Form will then be emailed back to the Board indicating the provider has been approved for production claim submission.
 - If the file does not pass the acceptance criteria due to problems with the **source** file, the board should contact the provider, who will need to correct their file creation program and resubmit a new file beginning with step 1.
 - If the file does not pass the acceptance criteria due to problems with the **Diamond benefit, contract and pricing tables**, the board will need to follow appropriate change control procedures to correct the Diamond tables. Changes to PANEL, PLAN, BENEF,

and BRULE records should be submitted to the [MACSIS Support Desk](#). The board should then submit a new test form (when ready) to request the process begin starting at step 3.

- ◆ The board is responsible for changes to the PROVC or PROCP records pertaining to the provider's non-Medicaid agreement.
- ◆ If changes need to be made to either Medicaid provider contracts or Medicaid PROCP records, the provider must contact Debbie Downs to make the needed updates before proceeding.
- Boards should wait three business days after the submission of a test file to the MACSIS staff before inquiring about the status (if they have not heard). Inquiries about test file status should be sent to the [MACSIS Support Desk](#).

MACSIS CLAIMS EDI TESTING REQUEST FORM

Boards: Please verify the form is complete and email to the Office of Information Services, Ohio Department of Mental Health at macsistesting@mh.state.oh.us, after the test file has been placed in the appropriate FTP directory. **All information is required to process request. DO NOT FAX THIS VERSION OF THE FORM.**

FILE SUBMISSION INFORMATION			
Test File Name	Date File FTP'd to State	Submitter ID (UPI)	NPI
Billing Provider Name		Provider Bills Other Payers (COB)?	
Provider Software Vendor		Provider Software Product/Version	
Board Name	Board Contact Name	Board Phone #	
Board Email	Board Fax #	Test File FTP Directory	
		/county/ /hipaa/test	
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"/> 4010 – NPI format	X0xxxxx#.julyy /county/(board)/hipaa/test <i>e.x. /county/02B/hipaa/test</i>	Required for any new provider to MACSIS or providers who are ready to submit NPI 4010-837 compliant files, have new software, undergoing major system upgrade or added new NPIs.
<input type="checkbox"/> 5010 – NPI format	T0xxxxx#.julyy /county/(board)/hipaa/test <i>e.x. /county/02B/hipaa/test</i>	Required for any new provider to MACSIS or providers who are ready to submit NPI 5010-837 compliant files, have new software, undergoing major system upgrade or added new NPIs.

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

Rate Requested/Sheet Received?	Y <input type="checkbox"/> / N <input type="checkbox"/>
Tax ID matches Diamond?	Y <input type="checkbox"/> / N <input type="checkbox"/>
Real Clients?	Y <input type="checkbox"/> / N <input type="checkbox"/>
POS HIPAA compliant?	Y <input type="checkbox"/> / N <input type="checkbox"/>

WHAT WE WANT TO SEE		WHAT'S IN THE FILE	
Weekly Expected Count:		Claims tested:	
MH Procedures:		MH Procedures tested	
AOD Procedures		AOD Procedures tested	
COB Needed:	Y <input type="checkbox"/> / N <input type="checkbox"/>	COB tested:	Y <input type="checkbox"/> / N <input type="checkbox"/>

MACSIS – New 837 Claims Testing Procedure

July 22, 2011

Background:

Effective August 5, 2011, the Ohio Department of Mental Health (ODMH) and the Ohio Department of Drug and Alcohol Services (ODADAS) are implementing a new streamlined testing procedure for the 837P V4010A1 and V5010A1 formats. The revised procedure combines what was commonly referred to as Tier 1 and Tier 2 testing into a single level of testing

837P V4010A1 Format

- ODMH will accept the new forms and follow the related procedure beginning August 5, 2011.

837P V5010A1 format

- ODMH will begin to test files not later than September 1, 2011 based on information contained in the previously distributed MACSIS 837 Professional Claim v5010 Informational Guide. ODMH has increased the number of resources to assist with testing as all providers will be required to go through this testing.

Attachments:

- MACSIS 837 Professional Claim v5010 Informational Guide
- MACSIS System Procedure for submitting test claim EDI Files (*New*)
- MACSIS Claims EDI Testing Request Form (*New*)

Boards – Action Required:

Boards responsibilities will be consistent with those required under Tier 2 testing. These include: Diamond builds should be in place and correct; the volume of claims represent a typical production file for that agency up to a maximum of 500 claims and file structure is correct. For all the existing providers, the rate sheet is no longer required UNLESS the board wants ODMH to test the Diamond rate build. This change in testing requires a new location for Boards to place test files on MHHUB. The location for the test files to be placed will be /county/XXX/hipaa/test. The current tier1test and tier2test directories will be removed. Please ensure that you place all test files into the new directory beginning August 5, 2011 so there is no risk that the test files will be accidentally removed when these old directories are deleted.

Providers – Action Required:

837P V4010A1 format

Providers are required to submit test 4010 test files if they have not previously submitted 837 claims to MACSIS, have new software, undergoing major system upgrade or added new UPI and/or NPIs. For all the existing providers, the rate sheet is no longer required UNLESS the provider wants ODMH to test the Diamond rate build. If rates will be tested, then all funded procedure codes should be included in the file and COB is coded if needed. For all new providers, ODMH will still request rate sheets, using the same HIPAA rate sheet templates on the web.

837P V5010A1 format

All providers will be required to go through this testing. For all the existing providers, the rate sheet is no longer required UNLESS the provider wants ODMH to test the Diamond rate build. If rates will be tested, then all funded procedure codes should be included in the file and COB is coded if needed. For all new providers, ODMH will still request rate sheets, using the same HIPAA rate sheet templates on the web.

Please contact the MACSIS Help Desk if you have any questions

MACSIS 837 Professional Claim v5010 Information Guide

ASCX12N/005010X222-837 FILE SPECIFICATIONS - revised 6/2011						
IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
C.4	ISA	Interchange Control Header				Please note that the ISA control segment is a fixed length segment. It is the only fixed length segment in the 837P v5010 file.
	ISA01	Authorization Information Qualifier	00-No autho info present	ID 2/2	R	
	ISA02	Authorization Information	SPACES	AN 10/10	R	
	ISA03	Security Information Qualifier	00-No Security info present	ID 2/2	R	
	ISA04	Security Information	SPACES	AN 10/10	R	
	ISA05	Interchange ID Qualifier	ZZ- Mutually defined	ID 2/2	R	
	ISA06	Interchange Sender ID	MACSIS Submitter ID Right Justified, zero fill	AN 15/15	R	- For providers who do not use a value-added network (VAN), the submitter ID will be the provider's original MACSIS UPI. -For providers who do use a VAN, the submitter ID will be a MACSIS-assigned VAN ID.
	ISA07	Interchange ID Qualifier	ZZ- Mutually defined	ID 2/2	R	
	ISA08	Interchange Receiver ID	BOARD NUMBER and TYPE Left-justified, blank-fill	AN 15/15	R	This field should identify the board receiving the file (ex. 25B for Franklin County).
	ISA09	Interchange Date	YYMMDD	DT 6/6	R	
	ISA10	Interchange Time	HHMM	TM 4/4	R	
	ISA11	Interchange Control Standards ID	U	ID 1/1	R	
	ISA12	Interchange Control Version Number	00501	ID 5/5	R	
	ISA13	Interchange Control Number	same as in IEA02	N0 9/9	R	The interchange sender determines this value. Per the standard implementation guide, this field must match IEA02 or the file will fail ANSI validation edits.

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	ISA14	Acknowledgement Requested	0 - No Acknowledgement requested	ID 1/1	R	The receipt of an interchange acknowledgement is determined by the TPA. Per this document, the State will not be providing an acknowledgement transaction to the Boards. However, Boards may choose to negotiate this item in the TPAs with their providers if the board can and wants to create the acknowledgement transaction themselves.
	ISA15	Usage Indicator Indicator	P-Production T-Test	ID 1/1	R	This field will be referenced by MACSIS to determine if the file is a production or test file.
	ISA16	Component Element Separator	:	ID 1/1	R	To guarantee accurate evaluation and processing of the file, this field should be valued to :
C.7	GS	Functional Group Header				
	GS01	Functional Identifier Code	HC	ID 2/2	R	
	GS02	Application Sender's Code	MACSIS Submitter ID	AN 2/15	R	This field should equal the value in ISA06; however, since this segment is not required to be fixed-length, the leading zeros are not required. (Note: It is not a problem if they are provided.)
	GS03	Application Receiver's Code	BOARD NUMBER and TYPE	AN 2/15	R	This field should identify the entity receiving the claims contained in the functional group. This field should equal ISA08.
	GS04	Date	CCYYMMDD	DT 8/8	R	
	GS05	Time	HHMM	TM 4/8	R	
	GS06	Group Control Number	Same as GE02	N0 1/9	R	The application sender determines this value. Per the standard implementation guide, this field must match GE02 or the file will fail ANSI validation edits.
	GS07	Responsible Agency Code	X	ID 1/2	R	
	GS08	Version/Release Code	005010X222	AN 1/12	R	
	TABLE 1 - HEADER					

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
70	ST	Transaction Set Header			R	
	ST01	Transaction Set Identifier Code	837 - Health Care Claim	ID 3/3	R	
	ST02	Transaction Set Control Number	Transaction Set Control Number	AN 4/9	R	It must match the value in SE02, but it will not be stored in MACSIS.
	ST103	Implementation Convention Reference	005010222	AN 1/35	R	New element
71	BHT	Beginning of Hierarchical Transaction			R	
	BHT01	Hierarchical Structure Code	0019	ID 4/4	R	
	BHT02	Transaction Set Purpose Code	00-Original	ID 2/2	R	
	BHT03	Reference Identification Originator Application Transaction Identifier	Batch number assigned by application sender	AN 1/50	R	This number is determined by the application sender. It will not be stored in MACSIS.
	BHT04	Date Transaction Set Creation Date	CCYYMMDD	DT 8/8	R	
	BHT05	Time Transaction Set Creation Time	HHMM	TM 4/8	R	
	BHT06	Transaction Type Code Claim or Cencounter Identifier	CH-chargeable	ID 2/2	R	MACSIS will consider for payment "CH" transaction types only.
-- LOOP ID 1000A SUBMITTER NAME						
74	NM1	Submitter Name			R	
	NM101	Entity Identifier Code	41	ID 2/3	R	
	NM102	Entity Type Qualifier	2 - non-person entity	ID 1/1	R	
	NM103	Name Last or Organization Name Submitter Last or Organization Name	Submitter Name	AN 1/60	R	This should be the organization name associated with the MACSIS Submitter ID provided in ISA06 and GS02. Do not use "&" in the name.
	NM108	Identification Code Qualifier	46-ETIN	ID 1/2	R	
	NM109	Identification Code Submitter Identifier	MACSIS Submitter ID	AN 2/80	R	This field should equal the value in ISA06; however, since this segment is not required to be fixed-length, the leading zeros are not required. (Note: It is not a problem if they are provided.)
76	PER	Submitter EDI Contact Information			R	
	PER01	Contact Function Code	IC	ID 2/2	R	

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ASCX12N/005010X222-837 FILE SPECIFICATIONS - revised 6/2011						
IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	PER02	Name Submitter Contact Name	Contact Person	AN 1/60	S	This field should contain the name of the person who should be contacted if there is a technical problem with the file.
	PER03	Communication Number Qualifier	TE-Telephone	ID 2/2	R	
	PER04	Communication Number	Format: AAABBBCCCC, where AAA is the area code, BBB is the telephone number pre-fix and CCCC is the telephone number.	AN 1/256	R	The extension, when applicable, should be included immediately after the telephone number.
-- LOOP ID 1000B RECEIVER NAME						
79	NM1	Individual or Organizational Name			R	
	NM101	Entity Identifier Code	40	ID 2/3	R	Receiver Code
	NM102	Entity Type Qualifier	2 - non-person Entity	ID 1/1	R	
	NM103	Name Last or Organization Name Receiver Name	Board Name	AN 1/60	R	It is recommended this field contain the name of the board corresponding to the value in ISA08
	NM108	Identification Code Qualifier (ETIN)	46	ID 1/2	R	
	NM109	Identification Code Receiver Primary Identifier	BOARD NUMBER and TYPE	AN 2/80	R	It is recommended this field contain the same value as noted in ISA08.
	TABLE 2 - BI	BILLING PROVIDER HIERARCHICAL LEVEL				
-- LOOP ID 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL						Implied max of 5000
81	HL	Hierarchical Level			R	
	HL01	Hierarchical ID Number	start with 1, increment by 1	AN 1/12	R	
	HL03	Hierarchical Level Code	20	ID 1/2	R	
	HL04	Hierarchical Child Code	1	ID 1/1	R	
-- LOOP ID 2010AA BILLING PROVIDER NAME						
87	NM1	Individual or Organizational Name			R	
	NM101	Entity Identifier Code	85	ID 2/3	R	
	NM102	Entity Type Qualifier	2 - Non-Person Entity	ID 1/1	R	

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	NM103	Name Last or Organization Name Billing Provider Last or Organizational Name	Billing Provider Name D/B/A	AN 1/60	R	This field should contain the billing provider name under which the provider is doing business as noted on the provider's type-2 NPI application. If the provider applied for a subpart, this identifier must reflect the subpart who is billing for the service. Do not use & in the name.
	NM108	Identification Code Qualifier	XX- National Provider Identifier	ID 1/2	S	Required for providers with NPI. The value in this field must be "XX" or the file will be rejected. Required by MACSIS.
	NM109	Identification Code Billing Provider Identifier	Provider National Provider Identifier	AN 2/80	S	This field must contain the type-2 national provider identifier assigned to the organization or subpart who is billing for the service. All 10 digits of the NPI number are required. The claim file will be rejected for the following: - It is not a valid NPI number on file with MACSIS - The calculated self-check digit for the NPI number does not match the last digit of the NPI. Required by MACSIS.
91	N3	Billing Provider Address			R	
	N301	Address Information Billing Provider Address Line	Provider Primary Practice Location Address Line 1	AN 1/55	R	This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.
	N302	Address Information Billing Provider Address Line	Provider Primary Practice Location Address Line 2	AN 1/55	S	This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.
92	N4	Billing Provider City, State, Zip Code			R	

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	N401	City Name Billing Provider City Name	Provider Primary Practice City	AN 2/30	R	This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.
	N402	State or Province Code Billing Provider State or Province Code	Provider Primary Practice State	ID 2/2	S	Required if N401 is in U.S./U.S. Territories/Canada. This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.
	N403	Postal Code Billing Provider Postal Zone or Zip Code	Provider Primary Practice Zip Code	ID 3/15	S	Required if N401 is in U.S./U.S. Territories/Canada. This field should contain the primary practice location information associated with the type-2 national provider identifier assigned to the organization or subpart.
94	REF	Billing Provider Tax Identification	Billing Provider Name		R	This segment will be required to ensure proper adjudication of the claim in MACSIS.
	REF01	Reference Identification Qualifier	EI - Employer's Identification Number	ID 2/3	R	
	REF02	Reference Identification Billing Provider Tax Identification Number	Provider Tax ID Number No Hyphens	AN 1/50	R	This field must contain the Tax ID number associated with the provider's type-2 National Provider Identifier. The claim file will reject if the Tax ID number provided does not match the NPI provided in Loop 2010AA according to MACSIS provider enrollment records.
	REF01	Billing Provider UPIN/License Information	1G- Provider UPIN Number	ID 2/3	S	Submitters may provide a "1G" reference qualifier and corresponding UPI value. Required by MACSIS.

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ASCX12N/005010X222-837 FILE SPECIFICATIONS - revised 6/2011							
IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	
	REF02	Reference Identification Billing Provider License and/or UPIN Information	MACSIS-Assigned UPI Number 9 bytes with leading zeros	AN 1/50	S	If REF01 = 1G, this field must contain the MACSIS-Assigned UPI number. Please note the value must be 12 bytes in length and containing leading zeros. The claim file will reject if the UPI number provided does not match the NPI or Tax ID numbers provided in Loop 2010AA according to MACSIS provider enrollment records.	
98	PER	Billing Provider Contact Information			S	This segment is required if different than the submitter contact information in Loop 1000A, segment PER, but the information will not be used by MACSIS.	
	PER01	Contact Function Code	IC	ID 2/2	R		
	PER02	Name Billing Provider Contact Name	Provider Contact Person	AN 1/60	S	This field should contain the name of the provider contact person who should receive questions regarding the provider's NPI.	
	PER03	Communication Number Qualifier	TE -Telephone	ID 2/2	R		
	PER04	Communication Number	Provider Contact Telephone Number	AN 1/256	R	This information should match the information provided in Section 5 of the NPI Application.	
	-- LOOP ID 2010AB PAY-TO ADDRESS NAME						This loop is only required if the pay-to provider information is different than the billing provider information. It will not be used by MACSIS for payment purposes.
101	NM1	Individual or Organizational Name			R		
	NM101	Entity Identifier Code	87	ID 2/3	R	For MACSIS it is the Billing Provider	
	NM102	Entity Type Qualifier	2 - Non-Person Entity	ID 1/1	R		
103	N3	Pay-To Address Name			R		

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	N301	Address Information Pay-To Address Line	Pay-To Provider Address Line 1	AN 1/55	R	This field should contain the mailing address information associated with the NPI who should receive payment. It will not be used by MACSIS for payment purposes. Since Boards disburse payments, providers should verify with their main Board that they have the correct address for remittance information.
	N302	Address Information Pay-To Address Line	Pay-To Provider Address Line 2	AN 1/55	S	This field should contain the mailing address information associated with the NPI who should receive payment. It will not be used by MACSIS for payment purposes.
104	N4	Pay-To Address City, State, Zip Code			R	
	N401	City Name Pay-To Address City Name	Pay-To Provider City	AN 2/30	R	
	N402	State or Province Code Pay-To Address State Code	Pay-To Provider State	ID 2/2	S	Required when the address is in the U.S./U.S Territories/Canada.
	N403	Postal Code Pay-To Address Postal Zone or Zip Code	Pay-To Provider Zip Code	ID 3/15	S	Required when the address is in the U.S./U.S Territories/Canada.
TABLE 2 - SUBSCRIBER DETAIL						
-- LOOP ID 2000B SUBSCRIBER HIERARCHICAL LEVEL						Implied max of 5000
114	HL	Subscriber Hierarchical Level			R	
	HL01	Hierarchical ID Number	start with 1, increment by 1	AN 1/12	R	
	HL02	Hierarchical Parent ID Number	1-Subscribe self	AN 1/12	R	
	HL03	Hierarchical Level Code	22-Subscriber	ID 1/2	R	
	HL04	Hierarchical Child Code	0- No subordinate HL segment	ID 1/1	R	
116	SBR	Subscriber Information			R	
	SBR01	Payer Responsibility Sequence Number Code	P - Primary S - Secondary T - Tertiary U-Unknown	ID 1/1	R	
	SBR02	Individual Relationship Code	18 - Self	AN 1/30	S	

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ASCX12N/005010X222-837 FILE SPECIFICATIONS - revised 6/2011						
IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	SBR09	Claim Filing Indicator Code	ZZ- Mutually defined	ID 1/2	S	This code is required prior to the mandated use of a national plan ID code. It will not be used by MACSIS for adjudication purposes.
-- LOOP ID 2010BA SUBSCRIBER NAME						
121	NM1	Subscriber Name			R	
	NM101	Entity Identifier Code	IL-Insured or Subscriber	ID 2/3	R	
	NM102	Entity Type Qualifier	1-Person	ID 1/1	R	
	NM103	Name Last or Organization Name Subscriber Last Name	MACSIS Client Last Name	AN 1/60	R	
	NM104	Name First Subscriber First Name	MACSIS Client First Name	AN 1/35	S	Since all MACSIS clients are "person's", not "entities", first name should always be provided, even for pseudo-UCI's.
	NM105	Name Middle Subscriber Middle Name Or Initial	MACSIS Client Middle Initial	AN 1/25	S	
	NM107	Name Suffix Subscriber Name Suffix	MACSIS Client Suffix	AN 1/10	S	This field should contain the suffix of the client (ex. Jr, Sr, I, II, III). Do not value the suffix here and in NM103.
	NM108	Identification Code Qualifier	MI - Member ID Number	ID 1/2	R	
	NM109	Identification Code Subscriber Primary Identifier	MACSIS UCI Number	AN 2/80	R	
124	N3	Subscriber Address			S	This segment is situational but required if the patient is the subscriber (required by MACSIS). Will not be validated by MACSIS.
	N301	Address Information Subscriber Address Line	MACSIS Client/Enrollment Address 1	AN 1/55	R	
	N302	Address Information Subscriber Address Line	MACSIS Client/Enrollment Address 2	AN 1/55	S	Required when the address is in the U.S./U.S Territories/Canada.
125	N4	Subscriber City, State, Zip Code			R	This segment data is required, but will not be validated by MACSIS.
	N401	City Name Subscriber City Name	MACSIS Client City Name	AN 2/30	R	
	N402	State or Province Code Subscriber State Code	MACSIS Client State	ID 2/2	S	Required when the address is in the U.S./U.S Territories/Canada.
	N403	Postal Code	MACSIS Client Zip Code	ID 3/15	S	Required when the address is in the U.S./U.S Territories/Canada.

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
127	DMG	Subscriber Demographic Information			S	This segment will likely be used by MACSIS for matching the claim to an existing client.
	DMG01	Date Time Period Format Qualifier	D8	ID 2/3	R	
	DMG02	Date Time Period Subscriber Birth Date	MACSIS Client Date of Birth CCYYMMDD	AN 1/35	R	
	DMG03	Subscriber Gender	F-Female M-Male U-Unknown	ID 1/1	R	
129	REF	Subscriber Secondary Identification			S	
	REF01	Reference Identification Qualifier	SY-Social Security Number	ID 2/3	R	To ensure proper adjudication of the claim in MACSIS, the social security number of the client should be provided. It will be used to help link the incoming claim to the appropriate client's records in MACSIS.
	REF02	Reference Identification Subscriber Supplemental Identifier	MACSIS Client SSN	AN 1/50	R	Do not include dashes.
-- LOOP ID 2010BB PAYER NAME						
133	NM1	Payer Name			R	
	NM101	Entity Identifier Code	PR-Payer	ID 2/3	R	
	NM102	Entity Type Qualifier	2 - Non-Person Entity	ID 1/1	R	
	NM103	Name Last or Organization Name Payer Name	MACSIS	AN 1/60	R	
	NM108	Identification Code Qualifier	PI-Payer ID	ID 1/2	R	
	NM109	Identification Code Payer Identifier	MACSIS	AN 2/80	R	
-- LOOP ID 2300 CLAIM INFORMATION						
157	CLM	Claim Information			R	
	CLM01	Claim Submitter's Identifier Patient Control Number	Provider-assigned claim-level control number	AN 1/38	R	If this element is valued and returned on the 835 in Loop 2100. Alphanumeric values are permissible, but not special characters.

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	CLM02	Monetary Amount Total Claim Charge Amount		R 1/18	R	This amount should match the amount in Loop 2400, SV102. The addenda further clarified how decimal points should be used for Type "R" fields. If there are no "cents" involved in the amount (ex., \$100), then the value should not include the decimal point or subsequent decimal positions (ex., 100). If however, there are "cents" involved in the amount (ex., \$100.50), then the value must include the decimal point and subsequent decimal positions (ex. 100.50)
	CLM05	Health Care Service Location Information		ID 1/2	R	
	CLM05-1	Facility Code Value Place of Service Code	See http://www.cms.gov/states/podsdata.pdf for a complete list of codes.	AN 1/2	R	This information will be stored at the claim header level in MACSIS. If no information is provided in Loop 2400, SV105, then this code will default to the service location on the associated claim detail record(s) and will be used for adjudication purposes.
	CLM05-2	Facility Code Qualifier	B - Place of Service Codes for Professional Services	AN 1/2	R	
	CLM05-3	Claim Frequency Type Code	1-Original	ID 1/1	R	MACSIS will not use this information for adjudication purposes.
	CLM06	Provider Signature on File	Y-Yes N-No	ID 1/1	R	Must be a "Y" for MACSIS purposes.

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	CLM07	Provider Accept Assignment Code Assignment or Plan Participation Code	A-Assigned B-Assignment Accepted on Clinical Lab Services Only C-Not Assigned	ID 1/1	R	This information will not be used by MACSIS for adjudication purposes.
	CLM08	Yes/No Condition or Response Code Benefits Assignment Certification Indicator	N-No Y- Yes	ID 1/1	R	This information will not be used by MACSIS for adjudication purposes.
	CLM09	Release of Information Code	I-Informed Consent to Release Medical Info Y-Signed statement permitting release of data	ID 1/1	R	This information will not be used by MACSIS for adjudication purposes. Existing policies regarding obtaining appropriate release information still apply.
	CLM10	Patient Signature Source Code	P-Physician signed due to patient not present	ID 1/1	S	Not be used by MACSIS for adjudication purposes.
	CLM11	Related Causes Information	Composite field - see below	O	S	Although this information is required if the cause of the client's condition is related to other factors, it will not be used for adjudication purposes in MACSIS.
	CLM11-1	Related Causes Code	AA - Auto Accident EM - Employment OA - Other Accident	ID 2/3	R	
	CLM11-2	Related Causes Code	AA - Auto Accident EM - Employment OA - Other Accident	ID 2/3	S	
	CLM11-4	State of Province Code Auto Accident State or Province Code	State where accident occurred	ID 2/2	S	
	CLM11-5	Country Code	Country where accident occurred	ID 2/3	S	
	CLM12	Special Program Indicator	02 - Physically Handicapped Childrens' program 03 - Special Federal Funding 05 - Disability	ID 2/3	S	This information will not be used by MACSIS for adjudication purposes.
194	REF	Prior Authorization			S	Send only when an authorization number is assigned and the service on this claim was preauthorized

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	REF01	Reference Identification Qualifier	G1 - Prior Authorization Number	ID 2/3	R	
	REF02	Prior Authorization Number		AN 1/50	R	
226	HI	Health Care Diagnosis Code			R	
	HI01	Health Care Code Information			R	
	HI01-1	Code List Qualifier Code Diagnosis Type Code	BK-Principle Diagnosis ICD-9 Codes ABK-ICD-10-CM	ID 1/3	R	
	HI01-2	Industry Code Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	Only the principal diagnosis code will be sent to ODJFS for Medicaid eligible services to Medicaid eligible clients. Do not include decimal point.
	HI02	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI02-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI02-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI03	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI03-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI03-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI04	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI04-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI04-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI05	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI05-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI05-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI06	Health Care Code Information			S/R	Required if additional diagnosis code.

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	HI06-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI06-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI07	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI07-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI07-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI08	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI08-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI08-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI09	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI09-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI09-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI10	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI10-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI10-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI11	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI11-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	
	HI11-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	HI12	Health Care Code Information			S/R	Required if additional diagnosis code.
	HI12-1	Diagnosis Type Code	BF-Principle Diagnosis ICD-9 Codes ABF-ICD-10-CM	ID 1/3	R	

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	HI12-2	Diagnosis Code	ICD-9 Code ICD-10-CM	AN 1/30	R	
	-- LOOP ID 2310B RENDERING PROVIDER NAME					Required if different than billing provider noted in Loop 2010AA. However, this segment will not be used by MACSIS for adjudication purposes.
262	NM1	Referring Provider Name			S	
	NM101	Entity Identifier Code Rendering Provider	82 - Rendering Provider		R	
	NM102	Entity Type Qualifier	2 -Non-Person Entity	ID 1/1	R	
	NM103	Name Last or Organization Name Rendering Provider Last or Organization Name	Rendering Provider Organization Name	AN 1/60	R	Do not use "&" in the name.
	NM108	Identification Code Qualifier	XX-National Provider Identifier	ID 1/2	S	
	NM109	Identification Code Rendering Provider Identifier	Rendering Provider ID	AN 2/80	S	
	-- LOOP ID 2320 OTHER SUBSCRIBER INFORMATION (CLAIM LEVEL ADJUSTMENTS)					This loop is required to be sent by the provider when another payer has adjudicated the claim. MACSIS plans on using only the first iteration of the segments noted below for adjudication purposes.
295	SBR	Other Subscriber Information			S	
	SBR01	Payer Responsibility Sequence Number Code	P - Primary S - Secondary T - Tertiary	ID 1/1	R	
	SBR02	Individual Relationship Code	See guide for valid values	ID 2/2	R	
	SBR05	Insurance Type Code	See guide for valid values	ID 1/3	S	
	SBR09	Claim Filing Indicator Code	ZZ - Mutually Defined	ID 1/2	S	This code is required prior to the mandated use of a national plan ID code. It will not be used by MACSIS for adjudication purposes.

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments	
305	AMT	Coordination of Benefits (COB) Payer Paid Amount			S	Payments from another payer should be reported in this segment. MACSIS will reference this segment for adjudication purposes. Please note MACSIS will not use prior payor paid amounts reported in Loop 2430, SVD Segment for adjudication purposes.	
	AMT01	Amount Qualifier Code Payer Paid Amount	D- Payer Amount Paid	ID 1/3	R	MACSIS plans to only use COB amount reported as "D" - Payer Amount Paid for adjudication purposes.	
	AMT02	Monetary Amount Payer Paid Amount	Payer Amount Paid	R 1/18	R	Report the amount paid by the prior payer in this field. Do not include any amounts paid or due from the patient including provider-determined sliding fee amounts here. If the payer denied the claim or adjudicated the claim payment as zero, enter zero. Include decimal points.	
308	OI	Other Insurance Coverage Information			R	This information will not be used by MACSIS for adjudication purposes.	
	OI03	Yes/No Condition or Response Code Benefits Assignment Certification Indicator	N-No Y-Yes	ID 1/1	R		
	OI06	Release of Information Code	I - Informed Consent to Release Medical Information Y-Provider has a signed permission the release	ID 1/1	R		
		-- LOOP ID 2330A OTHER SUBSCRIBER NAME					This loop is required when Loop 2320 is used.
313	NM1	Other Subscriber Name			R		
	NM101	Entity Identifier Code	IL - Insured or Subscriber	ID 2/3	R		
	NM102	Entity Type Qualifier	1-Person	ID 1/1	R		
	NM103	Name Last or Organization Name Other Insured Last Name	Other Subscriber Last Name	AN 1/60	R		
	NM104	Name First Other Insured First Name	Other Subscriber First Name	AN 1/35	S		

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	NM105	Name Middle Other Insured Middle Name	Other Subscriber Middle Name	AN 1/25	S	Required when NM102=1 and is needed to identify the individual.
	NM107	Name Suffix Other Insured Name Suffix	Other Subscriber Name Suffix	AN 1/10	S	Required when NM102=1 and is needed to identify the individual.
	NM108	Identification Code Qualifier	MI-Member ID Number	ID 1/2	R	
	NM109	Identification Code Other Insured Identifier	Other Subscriber Member ID Number	AN 2/80	R	
	-- LOOP ID 2330B OTHER PAYER NAME					Although required when Loop 2320 is used, this loop will not be used for adjudication purposes in MACSIS.
320	NM1	Other Payer Name			R	
	NM101	Entity Identifier Code	PR-Payer	ID 2/3	R	
	NM102	Entity Type Qualifier	2-Non-Person Entity	ID 1/1	R	
	NM103	Name Last or Organization Name Other Payer Organization Name	Other Payer Name	AN 1/60	R	
	NM108	Identification Code Qualifier	PI-Payer ID	ID 1/2	R	
	NM109	Identification Code Other Payer Primary Identifier	Other Payer ID Number	AN 2/80	R	
325	DTP	Claim Check or Remittance Date			S	Although required if claim was previously adjudicated and a service level adjudication date is not reported in Loop 2430, this information will not be used by MACSIS for adjudication purposes.
	DTP01	Date/Time Qualifier	573-Date Claim Paid	ID 3/3	R	
	DTP02	Date Time Period Format Qualifier	D8	ID 2/3	R	
	DTP03	Date Time Period Adjudication or Payment Date	Date claim adjudicated by other payer	AN 1/35	R	
	REF	Other Payer Secondary Identifier			S	MACSIS will need ths for populating the other carrier indicator.
	REF01	Reference Identification Qualifier	2U - Payer Identification Number	ID 2/3	S	

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	REF02	Reference Identification	2 – Blue Cross/Blue Shield 3 – A private carrier 4 – Employer or Union 5 – Public Agency (Medicare, Worker's Comp) 6 – Other carrier R – No response from carrier P – No coverage for this recipient number F – No coverage for all recipient numbers L – Disputed or contest liability S – Non-covered service E – Insurance benefits exhausted X – Non-cooperative member.	AN 1/50	R	Required if REF01 is valued and the amount must be provided in Loop 2320, field AMT02 (COB Amount) and AMT01 must equal "D" (Payer Amount Paid).
-- LOOP ID 2400 - SERVICE LINE NUMBER						
350	LX	Service Line Number- repeat >=1			R	
	LX01	Assigned Number	Line Counter - Incremented by 1 for each service line	NO 1/6	R	
351	SV1	Professional Service			R	
	SV101	Composite Medical Procedure Identifier				
	SV101-1	Product/Service ID Qualifier	HC-HCPCS (incl. CPT, for Healthcare) ER -For claims which are not covered under HIPAA, i.e., Non HeathCare Service	ID 2/2	R	
	SV101-2	Procedure/Service ID Procedure Code	HCPCS/CPT/Non-Healthcare Procedure Code	AN 1/48	R	See http://www.mh.state.oh.us/ois/macsis/mac.codes.index.html for a list of valid procedure codes which will be considered for payment in MACSIS.

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	SV101-3	Procedure Modifier	HCPCS/CPT Modifiers	AN 2/2	S	See http://www.mh.state.oh.us/ois/macsis/mac.codes.index.html for a list of valid modifier codes which will be considered for payment in MACSIS.
	SV101-4	Procedure Modifier	HCPCS/CPT Modifiers	AN 2/2	S	See http://www.mh.state.oh.us/ois/macsis/mac.codes.index.html for a list of valid modifier codes which will be considered for payment in MACSIS.
	SV101-5	Procedure Modifier	HCPCS/CPT Modifiers	AN 2/2	S	See http://www.mh.state.oh.us/ois/macsis/mac.codes.index.html for a list of valid modifier codes which will be considered for payment in MACSIS.
	SV101-6	Procedure Modifier	HCPCS/CPT Modifiers	AN 2/2	S	See http://www.mh.state.oh.us/ois/macsis/mac.codes.index.html for a list of valid modifier codes which will be considered for payment in MACSIS.
	SV102	Monetary Amount Line Item Charge Amount	Amount billed for service	R 1/18	R	This amount should match the amount in Loop 2300, CLM02. The addenda clarifies how decimal points should be used for Type "R" fields. If there are no "cents" involved in the amount (ex., \$100), then the value should not include the decimal point or subsequent decimal positions (ex., 100). If however, there are "cents" involved in the amount (ex., \$100.50), then the value must include the decimal point and subsequent decimal positions (ex. 100.50).
	SV103	Unit or Basis for Measurement Code	UN-Unit	ID 2/2	R	

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	SV104	Quantity Service Unit Count	Units of Service	R 1/15	R	Must be greater than 0. To report partial units, include the decimal and only one tenth decimal position to assure proper adjudication in MACSIS (ex., 15.6). Refer to addenda for clarification as to how Type "R" fields should be reported (in terms of including or excluding the decimal point). Services must be "summed and rounded" according to the MACSIS guidelines and reported as one service line.
	SV105	Facility Code Value Place of Service Code	See http://www.cms.gov/states/podsdata.pdf for a complete list of codes.	AN 1/2	S	Required for MACSIS. Must be same value reported in Loop 2300, CLM05-1.
	SV107	Composite Diagnosis Code Pointer			R	
	SV107-1	Diagnosis Code Pointer		N0 1/2	R	Only SV107-1 will be used by MACSIS for adjudication purposes.
	SV107-2	Diagnosis Code Pointer		N0 1/2	S	Only SV107-1 will be used by MACSIS for adjudication purposes.
	SV107-3	Diagnosis Code Pointer		N0 1/2	S	Only SV107-1 will be used by MACSIS for adjudication purposes.
	SV107-4	Diagnosis Code Pointer		N0 1/2	S	Only SV107-1 will be used by MACSIS for adjudication purposes.
	SV109	Yes/No Condition or Response Code Emergency Indicator	Y-Yes	ID 1/1	S	Do not value the data element if it does not apply. Even if valued, MACSIS will not use it for adjudication purposes.
380	DTP	Date - Service Date			R	
	DTP01	Date/Time Qualifier	472-Service	ID 3/3	R	
	DTP02	Date Time Period Format Qualifier	D8	ID 2/3	R	Per Medicaid Policy, a range of dates of service (i.e., RD8) is not permissible for behavioral health services. For services administered over range of dates, only a single start date of service should be provided.

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IG PAGE	REF. DES	NAME Implementation Name	PROPOSED VALUE / FORMAT	DATA TYPE/ LENGTH	USAGE	MACSIS Comments
	DTP03	Date Time Period Service Date	CCYYMMDD	AN 1/35	R	
401	REF	Line Item Control Number			S	
	REF01	Reference Identification Qualifier Provider Control Number	6R	ID 2/3	R	
	REF02	Reference Identification Line Item Control Number	Provider-assigned line item control number	AN 1/50	R	f this field is valued, MACSIS will store this as well as the value sent in Loop 2300, CLM01. Both will be returned on the 835 file in Loop 2100. Alphanumeric values are permissible, but not special characters. See guidelines for specific requirements for AOD prevention services.
496	SE	TRANSACTION SET TRAILER			R	
	SE01	Number of Included Segments Transaction Segment Count	Total number of segments including SE and ST	N0 1/10	R	
	SE02	Transaction Set Control Number	Same as in ST02	AN 4/9	R	This value must equal the value in ST02, but it will not be stored in MACSIS.
C.9	GE	Functional Group Trailer			R	
	GE01	Number of Transaction Sets included	# of STs	N0 1/6	R	
	GE02	Group Control Number	Same as in GS06	N0 1/9	R	The application sender determines this value. Per the standard implementation guide, this field must match GS06 or the file will fail ANSI validation edits.
C.10	IEA	Interchange Control Trailer			R	
	IEA01	Number of Included Functional Groups	# of GS	N0 1/5	R	
	IEA02	Interchange Control Number	same as in ISA13	N0 9/9	R	The interchange sender determines this value. Per the standard implementation guide, this field must match ISA13 or the file will fail ANSI validation edits.