WEEKLY MACSIS PERFORMANCE OVERVIEW - BY BOARDS
DOCUMENTATION

The purpose of the report is to provide board-level benchmark statistics regarding claims processed in MACSIS, so boards can monitor their claim volumes against their peers and identify potential problem areas.

The **Performance Overview** report is distributed on Monday mornings, based on a snapshot of MACSIS (Diamond data) created on Saturday.

⇒ **Please remember that the figures on the Performance Overview are based on the status of the claims on Saturday when the claims extract is created. Actual volumes may vary from the report due to processing (manual or electronic) that occurs between the time the extract is created and the time the report is distributed.**

The report is divided into five areas. It is important to monitor each area to ensure claims are efficiently being processed. Each area is described below:

A. Valid Claims

These are claims that have been properly identified within MACSIS as being assigned to a specific board (i.e., that contain valid company codes in MACSIS). Claims without a company code or with a company code of OHIO are not included.

- **Total # of Claims_04** - The total number of valid (finalized and un-finalized) claim lines for Fiscal Year 2004.
- **Total $ of Claims_04** - The total board cost of valid claims for Fiscal Year 2004 (net paid amount plus withhold amount).
- **% of MCD Claims_04** – The percentage of the **Total # of Claims_04** that are Medicaid reimbursable.
- **Total # of Claims_03** - The total number of valid claim lines for Fiscal Year 2003.
- **Total $ of Claims_03** - The total board cost of valid claims for Fiscal Year 2003 (net amount plus withhold amount).
- **% of MCD Claims_03** – The percentage of the **Total # of Claims_03** that are Medicaid reimbursable.

B. Retro MCD to Fix

Retroactive Medicaid claims to fix are claims with a date of service within the last 330 days 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 will result in additional money for the board (FFP) and could mean more money for the provider.

The number of Retro Medicaid claims does not reflect claim lines from a TASC provider. Even though clients who have received services are Medicaid eligible, the services provided by the TACS provider are not Medicaid reimbursable.

- **# of Retro MCD** – The total number of retroactive Medicaid claim lines that if corrected could be billed to Medicaid.
- **$ of Retro MCD** – The total dollar amount of the retroactive Medicaid claim lines that if corrected could be billed to Medicaid.

C. Held Claims

These are claims that have been placed on hold automatically via a statewide MACSIS-defined or Board-defined benefit rule or manually by board staff. This number includes held claims with a denied or payable claims status. Held claims must be worked in a timely manner to comply with Medicaid policy and to minimize the possibility of duplicate claims being submitted by the provider (due to lack of response) and potentially being erroneously paid.

- **Total # of Held Claims** - The total number of claim lines that are on hold in MACSIS.
- **Claims Held Over 90 Days** – The total number of claim lines in MACSIS that have been on hold for 90 days or more. These claims need to be taken off hold per the **Claims Correction Policy** that states, "Boards are permitted to place claims in question on hold for no more than 30 days after entered into Diamond".

D. # of Ohio Claims

The total number of claim lines in MACSIS with "OHIO" as the company code. OHIO claims are caused when the client does not have an eligibility span in Diamond that covers the date of service (denied due to MBRIN) or the provider does not have a contract in Diamond for the date of service (denied due to PRVIN).

These claims are assigned a denied claim status and do not finalize through the MACSIS accounts payable update (APUPD) process. Once these claims are corrected, they will finalize in Diamond and appear on an electronic remittance advice (ERA/835). This is the only way providers are notified that the claims were denied.

In the MACSIS HIPAA environment (MHHIPAA), electronically submitted claims where the member is ineligible (MBRIN) receive a critical error and do not make it into Diamond. In MHHIPAA, some MBRIN OHIO claims may still occur if the member's eligibility has been changed by board staff to make the member ineligible and the payable claim is re-adjudicated.

E. Mismatch Claims

These are claims where the eligibility plan for a member for the date of service (EPLAN), the plan on the claim header (CPLAN), company code on the claim detail or the security code does not match each other.

Mismatch claims occur when changes are made to a member's eligibility plan after claims have already been receive, but board staff does not correct or improperly corrects the claim(s).

One common example of this would be when a county board is notified of a retroactive change in residency of a client after claims for that client have already been received and assigned to the original board of residency. These mismatch claims can be avoided if timely communication and proper claim handling occurs between the board notified of the change and the board assigned existing claims.

- **Claims with your security** – These are un-finalized mismatch claims in MACSIS that contain your security code but have another board's EPLAN, CPLAN, or Company code. These claims need to be fixed so that the appropriate board has access/ownership of the claim (see "**Claims Correction Procedure**" for the proper way to correct these claims).
- **Claims with your Co./other sec.** – These are un-finalized mismatch claims in MACSIS that contain your company code but another board's security code. You cannot view these claims until the security code is corrected. You cannot do anything to correct these claims. The board whose security is on the claims must make the correction.

NOTE: These statistics include mismatch claims that were un-finalized at the time the claims extract was run. Some of these claims may have become finalized after the Monday morning APUPD run; some may have already been corrected and are no longer mismatches. Any mismatches that have been finalized will not appear on next week's report.