State of Ohio
MACSIS SYSTEM POLICY

Policy: HIPAA EDI Claims File Testing and Approval **Last Revised Date**: 1/27/05

Purpose:

This document outlines the methodology and policies related to the testing and approval of electronic claim files from providers or clearinghouses for the purpose of submitting claim files in a production MACSIS environment. There are four sets of constituents who have responsibilities during the testing phase:

- Providers
- Clearinghouses (Value-Added-Networks or VANs)
- County Boards or Board Consortiums
- MACSIS Operations Management Staff (MOM)

Required Reading:

There are three minimum sets of documents all parties should read and understand before beginning the MACSIS claims testing process. They include:

- National Standard HIPAA EDI Implementation Guides for 837P and 835 Files – Copies can be downloaded from the Washington Publishing Company website (www.wpc-edi.com). Please be sure to download the 837 Professional, not Institutional, Claims Format (Version 4010) and related addenda.
- MACSIS HIPAA EDI Documents – There are several MACSIS-specific documents available to guide providers and boards regarding the requirements to successfully adjudicate claims in MACSIS under HIPAA. These documents are available at http://www.mh.state.oh.us/ois/macsis/mac.claims.index.html and should be thoroughly reviewed prior to test file creation.
- WEDI's Strategic National Implementation Planning (SNIP) Committee's "Transaction Compliance and Certification" White Paper - This is a document created by a sub-committee of the Workgroup For Electronic Data Interchange (WEDI). It explains and recommends the types of testing which should be done prior to approval of data for production submission. This MACSIS policy has been designed to adhere to the recommendations of the white paper, which can be retrieved via www.wedi.org/snip/public/articles/testing_whitepaper082602.pdf .

Constituent Responsibilities:

I. Providers

A. Approval Policy

Each provider who intends to bill for services under MACSIS will be required to submit test 837P files for approval prior to being granted permission to submit production claims.

Note: Each provider must be approved at the "MACSIS UPI" level, not just at the "MACSIS Vendor" level. If a clearinghouse or main provider office creates the billing file for multiple UPI's from the same system and location, then it is still required that the clearinghouse or provider submit one UPI per Tier 1 and 2 test file. This is so each UPI's structure can be thoroughly evaluated. (Note: Loop 2010AA and 2010AB can still be different within the file.) Once approved for both Tiers, then the clearinghouse or provider would submit a "combined" test file (i.e., all UPI's submitting to the same BOARD as expected in Production) to ensure the proper combined structure is in place. Please note that a clearinghouse and/or provider must create separate billing files for UPI's sent to different boards.

If a provider chooses to use a clearinghouse, it is the provider's responsibility, not the State or County Board, to resolve any issues, bugs, problems identified with the files during the testing phase, as well as issues which might occur in the production environment.

The final Tier 2 File Analysis Report returned to the provider will indicate if they have approval to submit claims in the production environment.

Although we encourage software vendors to work through their providers to submit test files via the boards, it is possible for software vendors to submit an initial test file directly to the MACSIS staff to determine how close their file formats fit the basic MACSIS requirements. The latter will be managed by the MACSIS Support Desk (macsissupport@mh.state.oh.us) via an independent process and the test file must contain no real client data. However, approval for production submission will not be granted at a software vendor level, only at a provider level.

Providers are required to be re-approved through Tier 1 and Tier 2 testing, if they change software vendors and/or apply a significant upgrade to their existing system. Although not required, it is recommended that Tier 2 testing be re-done if there is a significant change in the provider's benefit or contract (i.e., pricing, etc.) structure in MACSIS.

B. Pre-Testing Requirements

As noted in the White Paper mentioned above (see Required Reading), SNIP recommends covered entities perform up to seven different types of tests on a file to ensure HIPAA transaction compliance. These "types" as noted in the White Paper can be reviewed independent of one another and do not necessarily need to be conducted in any specific order.

Providers should pre-test types 1-7 for their ASC X12N 837 Version 4010 Professional Claim Files ***prior to submitting files to their main contracting board to begin the MACSIS testing process***. This includes testing for basic HIPAA-compliant form, structure and syntax requirements at a minimum. In addition, **Appendix A** outlines examples of what to test and verify as it pertains to MACSIS-specific requirements.

Please note it is recommended per SNIP as well as MACSIS that providers use real data to the extent possible to complete testing; however, if test data is used, the provider should at a minimum ensure the same system parameters, product type and software versions are used to create the test data as established in ***the agency's*** current production environment.

C. Submitting Initial Test Files To Board for MACSIS Testing and Approval (Tier 1)

Once pre-testing is completed, providers will need to prepare their first test file for submission to their main contracting board to begin the MACSIS Testing and Approval Process. (See "Submitting Test HIPAA EDI Claim Files for Approval" http://www.mh.state.oh.us/ois/macsis/claims/procedure.submit.macsis.hipaa.edi.claim.file.pdf) for more information about the procedure for submitting test files.) Initial test files should include the following:

- A maximum of 100 claims per initial test file
- The test file must contain at least one scenario of each of the required testing scenarios noted in **Appendix B,** if the scenario could at all apply (even in the future) to the provider
- The test file may or may not use actual client or service data
- The test file name should comply with the file naming conventions as outlined in the Guidelines Pertaining to MACSIS, HIPAA EDI Policies and Procedures, Sections 42A and 43B. Please note that test files should begin with the character "J" instead of "A", so they can easily be distinguished.

When submitting test files to the board, providers must initiate the "MACSIS Claims Tier 1 Testing Form" (http://www.mh.state.oh.us/ois/macsis/claims/tier1.test.form.rev.pdf). In an effort to identify common problems across software vendors, providers will be asked to provide information about the software used to create the file on this form.

D. Submitting Final Test Files to Board for MACSIS Testing and Approval (Tier 2)

Once the initial test file(s) has been approved, providers will need to prepare their final test file for submission to their main contracting board to complete the MACSIS Testing and Approval Process. Final test files should include:

- The volume of claims representative of a typical production file submission for that agency up to a maximum of 500 claims in the file. If you are not sure what your average weekly claim volume is for MACSIS, see SFY03 (State Fiscal Year 2003) data available at http://www.mh.state.oh.us/ois/macsis/claims/prov_fy03_clms.XLS .
- All funded procedure codes are represented
- Real client data
- Claims for dates of service on or after July 1, 2003, must be demonstrated on the test file. Fictitious service data may be used, as long as all currently funded procedure codes and corresponding rates are represented. HIPAA-compliant procedure, modifier and place of service codes must be used.

- Provider Tax-ID information as stored in MACSIS exactly matches the information included on the 837P file. Since Tax-ID is private information, MACSIS-stored Tax-ID information is not available via the web. Providers must contact their Board to verify that the Tax-ID in MACSIS is correct.
- As in Tier 1, the test file name should comply with the file naming conventions as outlined in the Guidelines Pertaining to MACSIS, HIPAA EDI Policies and Procedures, Sections 42A and 43B.
- Although not required, it is highly recommended that the provider's address as stored in MACSIS match what the provider intends to submit on the 837P file both for Billing Provider information (Loop 2010AA) and the Pay-To Provider information (Loop 2010AB) if applicable.

When submitting the final test file for approval, providers must initiate the "MACSIS Claims Tier 2 Testing Form" (http://www.mh.state.oh.us/ois/macsis/claims/tier2.test.form.rev.pdf). They will be given the opportunity to request a return 835 Health Care Claim Payment/Advice file as a part of the testing process via this form.

II. Clearinghouses

Clearinghouses will be responsible for ensuring their contracting provider's outbound claim files (i.e., ASC X12N 837P Version 4010 Files) have successfully passed the testing requirements as noted above. They will also be responsible for ensuring policies and procedures related to the transmission of test or real claim files are adhered to. Policies and/or procedures related to the access of or exchange of EDI data between a clearinghouse, provider and board should be clearly outlined in any trading partner agreements between the provider and board and/or provider and clearinghouse.

III. County Boards or Board Consortiums

County Boards or Board Consortiums will be responsible for the following:

- Instructing their contracting providers on how to submit files for the purposes of testing to their attention
- Verifying the test file naming convention used is accurate
- Following the appropriate procedure to transfer the test files to the State to begin the testing process
- Completing the MACSIS Claims Testing Forms and faxing them to the State
- Verifying test files comply with HIPAA-mandated and MACSIS-specific EDI requirements under Tier 1
- Evaluating Error Reports resulting from Tier 1 and 2 testing to ensure valid codes are being submitted, pricing and adjudication decisions are accurate, all PROCP records exist and that benefit rules are functioning as planned.
- Updating the Diamond Support Tables within the board's control to correct errors resulting from Diamond "build" issues.
- Notifying the MACSIS staff via the Tier 2 form that a new copy of Production is necessary before re-testing, when applicable.

- Receiving and communicating results from the test process to the provider. This includes answering questions about format and value requirements under HIPAA. If the board is unsure of an answer, the Board, not the provider, should contact the MACSIS Support Desk for clarification.
- Monitoring and encouraging their contracting providers to begin the testing process if they have not already done so
- Training and maintaining staff knowledge of the EDI format and value requirements, testing policies, procedures, FTP and Unix Commands necessary for testing
- Submitting HIPAA Service Rate Forms with Tier 2 Test File Forms
- Initiating Medicaid Contract Agreements or Amendments per ODMH and/or ODADAS Medicaid Policy.
- Maintaining Non-Medicaid rates in MACSIS.

IV. MACSIS Operations Management

The MACSIS Operations Management Staff (MOM) will be responsible for the following:

- Providing and maintaining the appropriate test sub-directories for board use
- Supporting "testing" programs used by MOM
- Maintaining Test Environments
- Completing Tiers 1 and 2 of the MACSIS Testing and Approval Process (see below)
- Communicating results to the boards
- Disbursing any related MACSIS reports to the boards
- Final approval of the provider for production submission

V. Cross-Constituent Shared Responsibilities:

All constituents will be responsible for:

- Ensuring all transmitted data sent for testing purposes adheres to the HIPAA Privacy requirements with respect to the confidentiality of patient identifiable information. All precautions should be made to eliminate the possibility that patient information be exposed.
- In keeping with the above policy, no testing files should be emailed as attachments to the Boards.
- Ensuring file handling protocols are followed to ensure the proper translation of file end of line markers. See http://www.mh.state.oh.us/ois/macsis/mac.tech.revisited.EOL.issues.html for more information.

MACSIS Testing and Approval Methodology:

MACSIS will be using a two-tiered approach to test files received from providers via the boards. This approach allows the staff to identify simple, basic file problems in the first tier and then

focus on more complex problems which may only manifest themselves in a large, production-simulation environment in the second tier.

I. Tier 1 – Basic Form, Structure, Syntax Testing

The primary purpose of Tier 1 testing is to evaluate the form, structure and syntax of the claims EDI test file as it pertains to MACSIS-specific guidelines. The type of review includes but is not limited to:

- Conformance to file naming conventions
- Envelope Structure and Control Numbers
- Appropriate End-of-Line (EOL) marker and other delimiter definitions
- Appropriate use of sender and receiver identification numbers
- Appropriate use of provider identification numbers
- One-To-One Correspondence of Loops 2300 and 2400 (i.e., one service line per claim)
- Appropriate Segment Usage For MACSIS Adjudication Purposes as outlined in the MACSIS 837P Technical Information Guide

Tier 1 testing does not require information related to "real" clients, although the latter is preferable. These files can contain fictitious names, dates of birth, Unique Client Identifiers (UCI), etc. Segment, field and component usage will be examined, but no comparisons will be made between the EDI file and the MACSIS database content at this point in the testing process. Appendix A provides a list of the types of items examined in Tier 1 Testing by the MACSIS staff.

II. Tier 2 – Production Simulation Testing

Tier 2 testing is the final stage before approval is granted to submit claims into the HIPAA-compliant Diamond Production Environment.

This level of testing will compare the test file to a copy of the MACSIS production environment to simulate as close as possible how claims will be processed in a live environment. Since Tier 2 testing is the first time the data in the test files is compared to the data in the Diamond environment, issues such as discrepancies in Tax-ID and/or provider addresses will become apparent in Tier 2 testing. Appendix C provides a list of the types of items examined in Tier 2 Testing by the MACSIS staff.

All files must be created by the provider's software and no manual (or other) corrections or adjustments should be performed (by Provider, Board, or State staff). Every effort should be made to emulate standard operating procedures.

- Exception: If a provider and/or clearinghouse plans to submit production 837P claim files with more than one UPI number represented on the file, they should initially submit Tier 2 test files containing just one UPI per file. Once the Tier 2 test files are

approved on a per-UPI basis, then a final combined Tier 2 test file (i.e., multiple UPIs) will be necessary to ensure the proper "combined" structure is in place.

The primary goal is to ensure that the provider software has created a standard, MACSIS-compliant ANSI X12 837P 4010 file; that provider contracts are in place (in the HIPAA compliant Diamond 725 database) and accurate for all lines of business and panels; that PROCP (procedure code pricing) records exists for all contracted services; G/L (general ledger) references are present and correct; and that all procedures that are expected to result in claims being denied or held as specified in the benefit rules are applied as intended.

The Tier 2 testing file should be large enough to approximate at least one-week worth of data (up to 500 claims) with all possible funded procedure codes from the provider before Tier 2 approval will be granted.

Clients for whom claims are submitted must have member records in the HIPAA- compliant Diamond 725 Production database. All claims-related tables must be present in the HIPAA-compliant Production database. When this level of testing is to be performed, MOM will create an exact copy of the production database and perform the new HIPAA-compliant EDI process.

Providers will have the option to request a simulated 835 Health Care Claim Payment/Advice file in return, if the final test file is processed successfully into the MACSIS test environment.

III. Test File Rejection

Test files submitted by providers via their boards may be rejected for the following reasons:

- HIPAA-mandated and/or ASC X12N requirements are not met
- MACSIS-specific billing requirements are not met, including having one claim loop per service loop or invalid tax ID submitted
- Fatal errors occur on the MACSIS Edit Reports
- Less than 90% of the claims pass MACSIS edits
- Duplicate claims contained on the file violate the Duplicate Claim Check Policy under HIPAA.

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APPENDIX A
MACSIS HIPAA EDI TESTING CHECKLIST FOR TIER 1

#	*Requirement*	*MACSIS Guideline*	*Loop/Segment /Element*	*SNIP Type*
	FILE NAMING CONVENTION			
O1	Proper file naming convention is used (Jxxxxxx#.julyy)	42A	N/a	7
	CONTROL SEGMENT USAGE			
C1	Expected segment, field and component delimiters used as outlined in Guidelines	40D6	ISA	7
C2	ISA envelope is a fixed length of 105 bytes	N/A	ISA	7
C3	ISA-06 and ISA-08 are properly coded	41A2	ISA	7
C4	ISA-13 matches IEA-02 (Interchange Control Numbers)	N/A	ISA and IEA	7
C5	GS-02 and GS-03 (Application Sender and Receiver Codes) are properly coded	N/A	GS	7
C5	SE02 (Trans Set Control #) equals the total number of lines in the file minus four	N/A	SE	7
	SUBMITTER/RECEIVER Ids			
S1	Submitter ID equals valid MACSIS UPI number, MACSIS Vendor number or MACSIS-Assigned VAN ID	41A2	1000A/NM109	7
S2	Receiver ID is valid Board Number and Type	41A2	1000B/NM109	7
S3	Receiver Name is valid Board Name	41A2	1000B/NM103	7
	PROVIDER INFORMATION			
P1	Agency Tax-ID is valued and is in the correct format (ex., with hyphen is present)	N/A	2010AA/NM109	7
P2	Agency UPI number is present; 12 bytes, leading zeros	N/A	2010AA/REF02	7
P3	If Pay-To Provider information is applicable, tax-id is provided with hyphen	N/A	2010AB/NM109	7
P4	If Pay-To Provider information is applicable, the MACSIS-assigned vendor number is provided in a 15-byte, leading zero format.	N/A	2010AB/REF02	7
P5	If rendering provider information is sent (i.e., not used for MACSIS adjudication purposes), then it is coded correctly	N/A	Loop 2310B	7
	SUBSCRIBER INFORMATION			
B1	Claim Filing Indicator Code equals “ZZ”	N/A	2000B/SBR09	7
B2	Client First and Last Name are provided	N/A	2010BA/NM103 and NM104	7
B3	Client suffix is provided in EITHER NM107 or NM103	N/A	2010BA/NM107 or NM103	7
B4	Valid date or birth and gender code is provided		2010BA/DMG02 and DMG03	7
B6	Client SSN is provided (without hyphens)	N/A	2010BA/ REF02	7
B7	Destination Payer Name and ID is MACSIS	N/A	2010BB/NM103 and NM109	7
	CLAIM INFORMATION			
M1	Patient Control Number contains expected value per provider’s system needs (see Guidelines for specific AOD prevention requirements).	44B	2300/CLM01	7
M2	Total claim charge amount and corresponding	N/A	2300/CLM02	7

#	*Requirement*	*MACSIS Guideline*	*Loop/Segment /Element*	*SNIP Type*
	decimal point usage (implied or explicit) is correct			
M3	ICD-9-CM diagnosis code is present when required for procedure, billable under MACSIS and does not contain a period	44E	2300/HI segment	7
	OTHER PROVIDER INFORMATION			
X1	Rendering Provider Information, if provided, is properly coded. (Note: Not required for MACSIS)	N/A	Loop 2310B	7
	OTHER PAYER INFORMATION (IF APPLICABLE)			
R1	If other payer involved with claim, other payer paid amount is provided and logically corresponds to the ODJFS Coordination of Benefits (COB) Indicator value in Loop 2330A/REF02. The amount is correct given decimal point usage (implied or explicit).	44F	2320/AMT02	7
R2	For Medicaid eligible services to Medicaid eligible clients, Other Subscriber Secondary ID is valued to ODJFS COB Indicator.	N/A	2330A/REF02	7
R3	For Medicaid eligible services to Medicaid eligible clients, other payer paid amount is valued correctly when ODJFS COB indicator is present	N/A	2320/AMT02	7
	SERVICE INFORMATION			
L1	One service loop per claim loop is provided	44A1	2400 Loop	7
L2	Proper "product/service qualifier" is used for the procedure being billed (i.e., HC for HCPCS and ZZ for non-healthcare procedure codes)	N/A	2400/SV101-1	7
L3	Service code is valid for date of service	N/A	2400/SV101-2	7
L4	Modifier 1 is always present	N/A	2400/SV101-3	7
L5	Unit or Basis for Measurement Code is valued to "UN"	N/A	2400/SV103	7
L6	Units of service were accurately calculated per rounding tables and do not exceed a one-tenth decimal place.	44C1	2400/SV104	7
L6	Emergency Indicator is "null" or "N"	N/A	2400/SV109	7
L7	Date/Time Qualifier is "472" for Service Date	N/A	2400/DTP01	7

Certain items beyond those noted above may be reported in the Tier 1 Test results as "Notes". These are items which will not prevent Tier 1 approval, however, offer further explanation or clarification so the submitter can assess if/how the data should be provided. Examples of "notes" are below:

- Loop 2010BB (Payer Name), N3 and N4 (Payer Address) are not required; however, if sent, the values should be "30 E. Broad Street, Columbus, OH 43215-3430".
- All PRV segments are no longer required per the October 2002 addenda.
- If both Loop 2300, CLM01 and Loop 2400, REF02 (where REF01 = 6R) are provided, MACSIS will only return Loop 2400, REF02 on the 835 remittance file.

APPENDIX B
MACSIS HIPAA EDI SCENARIOS FOR TIER 1 TESTING

#	***Test Scenario***	***Used to Verify***
1	• Other payer is involved with the claim • Client is Medicaid Eligible • Service is Medicaid Eligible	• Provider system can properly generate the Loops related to Other Payer Information (2320, 2330A and 2330B)
2	• Other payer is involved with the claim • Service is not Medicaid Eligible	• Provider system can properly generate the Loops related to Other Payer Information (2320 and 2330B)
3	• Date of service is after July 1, 2003 • Billed service uses "new" MACSIS procedure, modifier codes and place of service codes	• Provider system is using "new" MACSIS procedure, modifier and place of service codes for dates of service on or after July 1, 2003.
4	• Same-day services (for dates of service on or after July 1, 2003) are "summed" per the MACSIS same-day service policies under HIPAA.	• Provider system is "summing" same-day services appropriately. • Refer to MH Duplicate Claim Check Roll-Up Category Matrix for more information.

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APPENDIX C
MACSIS HIPAA EDI TESTING CHECKLIST FOR TIER 2

#	Requirement	Loop/Segment/Element
1	Non-Medicaid rate changes have been updated by the board.	N/A
2	Current Medicaid Agreements have been submitted to Medicaid Policy Staff (ODMH and/or ODADAS).	N/A
3	• HIPAA Service Rate Forms (Medicaid and Non-Medicaid) have been faxed along with the Tier 2 Test form. • The rates as represented on the HIPAA Service Rate Form must match the rates as stored in Diamond (MHHIPAA). Additionally, the rates as provided on the Tier 2 Test file[1] must not be less than the rates on the HIPAA Service Rate Form and in Diamond.	N/A
4	The number of claims on the file represents a typical weekly submission for the provider, but does not exceed 500 claims[2].	N/A
5	Real Tax-ID is used on the test file	Loop 2010AA and/or Loop 2010AB, NM109
6	Although not required, it is highly recommended that the Billing Provider address match the address associated with the "UPI" number in MACSIS[3].	Loop 2010AA, N3/N4 segments
7	Although not required, it is highly recommended that the Pay-To Provider address match the address associated with the MACSIS Vendor Number[3].	Loop 2010AB, N3/N4 segments
8	Real client data is used on the test file for all services.	Loop 2010BA
9	Valid place of services under HIPAA are used	Loop 2300, CLM05-1 and Loop 2400, SV105
10	At least one claim includes ODJFS COB (coordination of benefits) information, if provider submitted COB information in SFY03	Loop 2320, AMT02 and Loop 2330A, REF02
11	All current contracted services are represented on file with correct HIPAA procedure, modifier and place of service code combinations as well as the correct rate.	Loop 2400/Segment SV1

[1] Once approved, it is not required that providers submit billed amounts that do not exceed their contracted Medicaid or Non-Medicaid rate in the production environment. It is only necessary during the testing phase so that it is clear that the provider and board have the same understanding about what the contracted rate is.

[2] See http://www.mh.state.oh.us/ois/macsis/claims/prov_fy03_clms.XLS for information about your average weekly volume of claim submission in FY03.

[3] See http://www.mh.state.oh.us/ois/macsis/mac.provf.top.html to verify address information as stored in MACSIS.