Instructions For Completing MACSIS Claims Correction Form
DRAFT
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I. Purpose

This form should be completed whenever an error in a claim, which was previously submitted to MACSIS, has been identified. The following is a list of scenarios under which a provider or board may initiate this form:

- Billed Amount Was Incorrect
- Units of Service Were Incorrect
- Billed Procedure Code Was Incorrect
- Billed Modifier(s) Was Incorrect
- Third Party COB Amount Was Incorrect
- Service Was Billed Under Wrong UCI (Unique Client Identifier)
- Service Was Billed Under Wrong Date of Service
- Service Was Billed Under Wrong Place of Service
- Service is "Straggler" Claim[1]

II. Related Policies and Procedures

This form was developed in conjunction with the Claims Correction Policy and Procedure for MACSIS Under HIPAA. Please refer to the policy and procedure for a full explanation of when and how this form should be used.

III. General Instructions

1. Fields highlighted in **BLUE** must be completed by the sender**.**

2. If the form is initiated by the provider, the provider should sign and date the bottom of the form (see Provider Representative Signature).

3. Once complete, **the form should be sent to the receiver per the receiver's instructions (ex., mail, fax or in some instances, electronic submission).**

   - The method of sending the information is determined by the receiver, since this form does contain "protected health information (PHI) and, therefore, the receiver must determine its own submission policies to ensure the protection of information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

4. **If a board initiates the form**, **the provider has 30 days from receipt of the form to respond in writing (via the form) to the board that the claim was in fact billed in error**. Providers should be sure to sign and date the bottom of the form when responding. If no response within 30 days, the boards can deny or reverse payment on the claim(s).

   - If a provider responds that a service was not billed in error, they must have the clinical documentation on file to support their claim.

[1] The term "straggler" claim has often been used to describe the instance where the provider originally billed for a service and later discovered additional units of the same service were provided on the same day. This form should be used to report the correct total number of units, whether the original claim has been remitted or not.

- Boards should refer to the Claims Correction Policy and Procedure for specific rules around when Medicaid claims can and cannot be reversed.

5. **If a provider initiates the form, the board should review the information, take the necessary correction action and return the form with the actions noted in a timely manner.**

    - The Claims Correction Policy requires boards to process corrections with "little delay". Boards and Providers should be particularly sensitive to processing Medicaid claims corrections timely, so as to not exceed the ODJFS filing limits.

IV. Sending and Receiving Information

1. Sending Organization Name

Enter the name of the entity that is initiating the form, which could be either a provider agency name or county board name. This should be the entity that identified the error.

2. Receiving Organization Name

Enter the name of the entity to which the form will be sent. This could be either the provider agency name or the county board name. If this form is initiated by the provider, it should be sent to the county board responsible for payment of the claim.

3. Provider MACSIS Unique Provider Identified (UPI)

Enter the 5-digit provider identification number assigned by MACSIS to identify the provider agency whose claim contained the error. If the agency does not know its assigned MACSIS UPI Number, you can obtain the number via the MAC-Search feature available on the MACSIS website (http://www.mh.state.oh.us/ois/macsis/macsis.index.html) or you can contact your county board.

4. Date Received

This field is completed by the receiver and denotes the date the form was received.

5. Date Completed

This field is completed by the receiver. If the receiver is a board, this is the date the board corrected the claims in MACSIS. If the receiver is a provider, this is the date the provider provided the corrected claims information on the form and returned it to the board for correction in MACSIS.

V. Contact and Fiscal Year Information

1. Person Reporting Errors

This is the name of the individual at the organization who is initiating the form. This should be a person's name.

2. Phone Number

This is the phone number for the individual (reported above) who initiated the form.

3. Return Form to Attn

This is the person to whom the form should be returned once complete.

4. Errors Apply to Fiscal Year

This field should contain the State fiscal year under which the dates of service for the claims in error occurred. ODMH/ODADAS' fiscal year is July 1 through June 30. If the claims span more than one fiscal year, list all fiscal years pertaining to the claims.

VI. Erroneous and Corrected Claim Information

There are four rows of information which appear on this section of the form.

- The **first row should be used to report the original claim information** pertaining to the claim submitted in error.

- **The second row should be used to report the correct claim information** pertaining to the claim submitted in error.

  - You do not need to complete all information in the second row, "Corr'd Claim Information". Only the changed (i.e., corrected) claim information needs to be completed in the second row. That way the changed (corrected) information will "stand out".

- **The third row should be used to explain what was incorrect about the claim billed in error**. Providers should be a specific as possible when describing the reason for the error. (Do not just note "billed in error".) State "wrong UCI originally billed", "wrong date of service", "claim denied as duplicate" etc., and/or include the MACSIS Not Covered Reason Code reported on the original remittance transaction (See ERA, field 43) or the Claim Adjustment Reason Code reported on the 835 Health Care Claim Payment Advice (Loop 2110, CAS02). If the board is initiating the form, the board should be a specific as possible as to why they thought the claim was billed in error.

- **The fourth row should be used by the board to indicate what action was taken to correct the claim in MACSIS**. If no action was taken in MACSIS (ex., claim was Medicaid and over 365-days old), boards should indicate how reconciliation of the claim will be handled.

If the form is initiated by a provider, the provider should complete the first three rows of information. If the form is initiated by a board, the board will initially complete the first row of information and the provider who receives the form must complete the second row. Upon correction in MACSIS, the board would then complete the fourth row.

1. UCI

This column should contain the Unique Client Identifier (UCI) Number assigned to the client in MACSIS. This number is assigned to the client by the board upon enrollment in MACSIS.

2. DOS

This column should contain the date of service pertaining to the claim.

3. MACSIS Claim

This column should contain the MACSIS Claim Number. This number is assigned to the claim upon entry into the MACSIS system. The number appears on the MACSIS Electronic Remittance Advice (ERA - field 18), and on the 835 Health Care Claim Payment Advice (Loop 2100, CLP07). **Do not enter the provider-assigned claim control number in this column.**

- When reporting straggler claims[1], if the original claim has not been remitted, the provider may not know the MACSIS Claim Number. In this case, the MACSIS Claim Number can be left blank.

4. Billed Amount

This column should contain the amount billed for the service.

- When reporting straggler claims[1], providers should indicate the total correct amount billed on the second row, not just the additional amount billed.

5. Procedure Code

This column should contain the MACSIS/HIPAA procedure code for the service. For a list of procedure codes considered for payment under HIPAA see http://www.mh.state.oh.us/ois/macsis/codes/macsis.mh.hipaa.proc.code.table.pdf or http://www.mh.state.oh.us/ois/macsis/codes/macsis.aod.hipaa.proc.code.table.pdf . **Do not report the internal provider-assigned service code here.**

- Providers and Boards should verify that the procedure code noted is a contracted service for which the provider is licensed and certified to provide.

6. Mod 1-4

These columns should contain the MACSIS/HIPAA modifiers applicable to the service. For a list of modifiers considered for payment under HIPAA, see http://www.mh.state.oh.us/ois/macsis/codes/mh.hipaa.modifier.code.table.pdf or http://www.mh.state.oh.us/ois/macsis/codes/aod.hipaa.modifier.code.table.pdf .

7. Units

This column should contain the units of service. Do not report service minutes here, just units of service. Be sure to report **whole units** of service for procedures defined under HIPAA to be billed in **"15-minute" service increments** and for **day-based services** (ex., 1, 2, 3)**.** You may report "partial" units of service (ex., .5,.6,.7) for procedures defined to be billed in "60-minute" service increments (i.e., hourly-based services).

Services should be rounded according to the tables and instructions outlined in the "Guidelines Pertaining to MACSIS, HIPAA EDI Policies and Procedures" (http://www.mh.state.oh.us/ois/macsis/policies/macsis.hipaa.edi.guidelines.pdf), Section 44C1.

- When denoting "correct" units of service, the provider should double-check their service records and make sure they have summed the service minutes and then rounded according to the MACSIS tables correctly.

- When reporting straggler claims[1], providers should indicate the total correct number of units on the second row, not just the additional units of service.

8. POS

This column should contain the HIPAA Place of Service Code pertaining to the service. For a list of allowable place of service codes under HIPAA, see http://www.mh.state.oh.us/ois/macsis/mac.codes.macsis.pos.codes.html .

- Please note that you only need to "correct" a claim for place of service, when the "corrected" place of service code affects the adjudication of the claim in MACSIS (i.e., when the place of service code changes from or to "51" – IMD or "99" – Penal System).

9. COB Amount

This column should contain the amount paid by another payer toward the service. The amount can be zero, if the other payer did not respond and/or denied the claim. If this column is completed, the initiator must provider the "COB Indicator" in the next column. Please note this column **should not** contain any amounts paid by the client.

10. COB Ind (Indicator)

This column should contain one of the acceptable ODJFS COB Indicators noted below:

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.

If two or more payers (other than MACSIS) previously adjudicated the claim, use the COB indicator pertaining to the payer who actually made a payment toward the claim.

11. Prov Pt Control

This column should contain the control number assigned by the provider to track this service. This is the number which was or will be used to report related remittance transactions. It is recommended that this number be a service-level control number, not a claim or patient level control number.

- The term "patient control number" is widely used within the industry, as well as within the 837 Professional Claim implementation guide, to refer to the provider-assigned control number related to a service line. Therefore, it is a misnomer. It really should be "service control number".