Procedure for Claim Corrections Within MACSIS

(For Claims with Dates of Service Beginning July 1, 2003)

General

- To ensure consistency across Provider and Board areas, both ODMH and ODADAS will allow the correction of both finalized and un-finalized Medicaid claims and finalized and un-finalized non-Medicaid claims.
- The procedure for correcting claims will vary depending on whether the claim has been finalized or is un-finalized.
- If a Board identifies a erroneous billed service, a **Claims Correction Form**[1] is to be completed and sent to the Provider.
- When a Provider identifies a claim that was erroneously billed, a **Claims Correction Form**[1] is to be completed and sent to the Board that is responsible for payment of the claim.
- With the roll-up of claims, there may be occasions when a same-day service comes in after the initial claim was submitted. This is a "straggler" claim. These claims will be denied as a duplicate claim. If these claims are identified before the original claim is finalized; follow the "Un-Finalized Claim Correction Procedures" for incorrect units of service billed. If the Provider identifies the "straggler" when it is reported on an 835 (denied as a duplicate claim), the "Finalized Claim Correction Procedures" for incorrect units would be followed to correct the claim.
- Refer to the "**Claim Corrections in MACSIS (For Claims with Dates of Service Beginning July 1, 2003")**, for the policy regarding claims correction.

I. Procedure For Correcting Claims Prior to Reimbursement Through MACSIS (Un-Finalized Claims)

Whether these claims are identified by the Board or the Provider the correction procedure is the same except if it is Board-identified, the Board should put the claim(s) on hold with the appropriate reason code.

1. Board Identified Claims

a. Using OPCLM, access the claim line in question and change the processing status to "H"(held) and enter one of the following Held Reason Codes:

- **MCDBA – Medicaid Billed Amount Correction**
- **NONBA – non-Medicaid Billed Amount Correction**
- **MCDDU – Medicaid Duplicate Claim Correction**
- **NONDU – non-Medicaid Duplicate Claim Correction**
- **MCDMO – Medicaid Modifier Correction**
- **NONMO – non-Medicaid Modifier Correction**
- **MCDPR – Medicaid Procedure Code Correction**
- **NONPR – non-Medicaid Procedure Code Correction**

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

- **MCDTP – Medicaid Third Party Amount Correction**
- **NONTP – non-Medicaid Third Party Amount Correction**
- **MCDUN – Medicaid Units of Service Correction**
- **NONUN – non-Medicaid Units of Service Correction**
- **MCDWC - Incorrect UCI Billed**
- **NONWC - Incorrect UCI Billed**
- **MCDWD - Incorrect Date of Service Billed**
- **NONWD - Incorrect Date of Service Billed**

Update (save) the claim detail.

- Claims identified by the Board as billed in error will be reported to the Provider on the **Claims Correction Form** within a week of being identified.
- Provider will have 30 days from receipt of the **Claims Correction Form** to provide written confirmation that the claim was or was not in fact billed in error. (If a Provider states a service was not billed in error, they must have the clinical documentation on file to support their claim.)
- Boards are permitted to keep a claim in question on hold for up to 30 days after the **Claims Correction Form** was mailed to the Provider. If there has been no response from the Provider after 30 days, the Board may deny the claim (see # 2-g. below).

2. Board and Provider-Identified Claims

Once the Board receives the written confirmation from the Provider that the service was or was not billed in error, or a **Claims Correction Form** is received from the Provider (Provider-identified billing error), claims must be corrected following one of the procedures below.

- **The Board must keep on file all written confirmations from Providers regarding the services in question (i.e., for both those services confirmed as erroneous and those which were confirmed as correct.)**
- **It is critical that the Boards include the not covered reason code when correcting claims.**

a. Claim Is a Duplicate

These claims have already been denied in Diamond as a duplicate (Claim Stat "D"), but have not been finalized (Proc Stat "U"). No action is to be taken on these claims in Diamond. They should be allowed to finalize as a denied claim. If this is a "straggler" claim, the original claim is the one that will need to be corrected following procedure b. (below) for correcting incorrect units of service.

b. Billed Amount, Units of Service, Procedure Code, Modifier, Place of Service or Third Party Amounts are Incorrect

Note: Only correct the place of service code if it is changing from 51 or 99, or to 51 or 99.

Using OPCLM, access the claim line in question and then access the claim detail screen. Correct the incorrect value and re-adjudicate the claim by pressing F6- B. This also removes the held reason code(s) (if the claim was on hold) and will change the processing status to "U"(Un-posted). Enter one of the following adjustment reason codes:

- **MCDBA – Medicaid Billed Amount Correction**
- **NONBA – NON-Medicaid Billed Amount Correction**
- **MCDMO – Medicaid Modifier Correction**
- **NONMO – non-Medicaid Modifier Correction**
- **MCDPR – Medicaid Procedure Code Correction**
- **NONPR – non-Medicaid Procedure Code Correction**
- **MCDTP – Medicaid Third Party Amount Correction**
- **NONTP – non-Medicaid Third Party Amount Correction**
- **MCDUN – Medicaid Units of Service Correction**
- **NONUN – non-Medicaid Units of Service Correction**
- **MCDPS - Medicaid Place of Service Correction**
- **NONPS - non-Medicaid Place of Service Correction**

Update (save) the claim detail.

c. <u>Incorrect Date of Service or Incorrect UCI billed</u>

Using OPCLM, access the claim in question and then access the claim detail screen. If the claim is on hold, access the 001 detail line and do an F6-C to take the claim off hold. This also removes the held reason code(s), updates the benefit accumulators and will also change the processing status to "U" (Un-posted). Enter the not covered amount (this should be equal to the allowed amount). This will automatically change the claim status to "D" (Denied). Enter one of the following not covered reason codes:

- **MCDWC - Confirmed Incorrect UCI Billed**
- **NONWC - Confirmed Incorrect UCI Billed**
- **MCDWD - Confirmed Incorrect Date of Service Billed**
- **NONWD - Confirmed Incorrect Date of Service Billed**

Update (save) the claim detail.

<u>Do not split the claim because it will carry the incorrect UCI and/or incorrect DOS forward.</u> The Board should manually enter a new claim with the correct information or, depending upon volume and ability, request the Provider submit the "correct" claim(s). **If a board chooses to manually enter the new claim, make sure that the primary header date and the date of service on the detail line match.**

d. <u>Claim Was Not Billed in Error Per Provider</u>

If a claim was put on hold due to a possible billing error and it is later determined that the claim was in fact billed correctly, the Board should take the claim off hold and remove the held reason code. Using OPCLM, access the claim in question and then access the claim detail screen. Make sure the detail line is 001 and do an F6-C to take the claim off hold. This also removes the held reason code(s), updates the benefit accumulators and changes the processing status to "U" (Un-posted). Update (save) the claim detail. Do not enter an adjustment reason code since no adjustment was made.

e. Claim Is Over 365 Days Old

If the date of service on a Medicaid claim is over 365 days old when it is received in MACSIS (based on the received date in Diamond), the Board may deny the claim (without having to hold and confirm with the provider first) or may allow the claim to be submitted to ODJFS for adjudication.

Using OPCLM, access the claim in question and then access the claim detail screen. Access detail line 001 and enter the not covered amount (this should be equal to the allowed amount). This will automatically change the claim status on the claim detail line to "D" (Denied). Enter the following not covered reason code:

- **MCDYO – Medicaid Claim More than a Year Old when Received**
- **NONYO – non-Medicaid Claim More than a Year Old when Rec'd**

Update (save) the claim detail.

f. Original Claim is Denied

i. If the original claim(s) was denied due to missing or invalid modifier or diagnosis code, Boards may require the Provider to resubmit the claim(s) electronically or may choose to correct the claim manually, depending on the volume. If the Board has the Provider electronically resubmit the claim(s), the original claim should be allowed to finalize. The resubmitted claim will not deny as a duplicate since the original claim was denied, not reversed. If the Board chooses to manually fix the claim, they would then correct/add the missing or invalid modifier or diagnosis code and re-adjudicate the claim so that it is now a payable claim.

ii. If the original claim(s) was denied due to Board error (e.g., missing PROCP), Boards cannot require the Provider to resubmit the claim(s) electronically, unless mutually agreed to.

Note: No other claims may be corrected by resubmission.

g. No Provider Response Within 30 Days

If a Board has not received written confirmation from the Provider that the service is or is not an erroneously billed claim, the Board may deny the claim using the denied reason code of NPR30 - No Provider Response within 30 Days of Notice.

Using OPCLM, access the claim in question and then access the claim detail screen. Make sure the detail line is 001 and do an F6-C to take the claim off hold. This also removes the held reason code(s), updates the benefit accumulators and will change the processing status to "U" (Un-posted). Enter the not covered amount (this should be equal to the allowed amount). This will automatically change the detail line status to "D" (Denied). Enter the following not covered reason code:

- **NPR30 - No Provider Response Within 30 Days**

Update (save) the claim detail.

h. Correcting OHIO Claims - MBRIN

Using OPCLM, access the claim in question and refresh the claim header (F6-F).

i. If there is a valid plan now in effect, press "END" and enter "A" to adjudicate the claim. Access the detail line 001 and press F6-B to price and adjudicate the claim. Press "END", then "Y" to update/save the claim. Press "HOME" to return to the Header screen and update/add the correct security code. Press "END", then "S" to update (save) the changes.

ii. If after refreshing the header there is still no valid plan in effect, press "END" and then enter "A" to adjudicate the claim. Type in the correct company code and the correct G/L Ref (usually DEF). Save/Update the claim. Press "HOME" to return to the Header screen. Add the security code; press "END" then "S" to save the changes.

i. Correcting Mismatch Claims

Mismatch claims occur when the EPLAN (eligibility plan in member for the date of service), CPLAN (the plan on the claim header), company (company on the claim detail) or security code do not match each other. How you correct the claims depends on the type of mismatch.

i. If the company code on the claim detail, the cplan on the claim header and the eplan (eligibility plan in the member record for that date of service) all match, but the security code does not match, correct the security code on the claim header.

ii. If the cplan on the claim header matches the eplan (eligibility plan in the member record for that date of service), but the company code on the claim detail does not match, access the claim detail line by pressing "END", then "A" to adjudicate. Access the 001 detail line and press F6-B to both re-price and re-adjudicate the claim detail. Press "END", then "Y" to update/save the claim detail. Press "HOME" to return to the header screen and add/correct the security code if necessary. Press "END" then "S" to save the changes.

iii. If the eplan (eligibility plan in the member record for that date of service) matches the company code on the claim detail, but the cplan on the claim header does not match, refresh the claim header by pressing F6-F. Add/correct the security code if necessary. Press "END" then "S" to save the changes.

iv. If the cplan on the claim header, the security code and the company code on the claim detail all match, but do not match the eplan from the member record covering that date of service you may need to investigate to find out if this is intentional. (For example, a client may have been Medicaid, the claim was reversed by ODJFS, and the Board wants to pay the claim as non-MCD. In order to do this the Board may have changed the client's eligibility span to non-MCD, re-adjudicated the claim and then changed the plan back to MCD. In this case the eplan would not match.)

If there was a retro-eligibility change made to the member record and the claim should be adjudicated based on that eligibility, then you will need to refresh the header, re-price and re-adjudicate the claim and add/change the security if necessary.

II. Procedure for Correcting Claims After Reimbursement Through MACSIS (Finalized Claims)

Whether the correction for a finalized claim (claim processing status of "P") comes in on a **Claims Correction Form** initiated by the Provider or whether the Board identifies the service as possibly being billed incorrectly, the procedures for correcting the claims are the same.

- Providers are permitted 30 days from the date of notification of the potential error to respond to the Board regarding the claim. If no response is received, the claim may be reversed by the Board.

- No action is to be taken on erroneously billed Medicaid claims that will be too old ***by the time they get extracted and sent to ODJFS for adjudication*** Adjustments will be handled in accordance with each department's ODJFS approved Medicaid Reconciliation Process.

1. Board and Provider-Identified Claims

Once a Board receives written confirmation from the Provider that the service was billed in error, or receives a **Claims Correction Form** initiated by the Provider, they will follow one of the correction procedures below.

- The Board will keep on file all written confirmations from Providers regarding the erroneously billed services in question (i.e., for both those services confirmed as erroneous and those which were not confirmed as erroneous.)
- **DO NOT** reverse Medicaid claims that have not come back from the Ohio Department of Job and Family Services (ODJFS). If ODJFS rejects the claim and a Board has already reversed the claim line in Diamond, the claim will have two reversal ACPAY records and the monies will be deducted from the Provider twice. The only way to check if claims have been extracted and sent to ODJFS is to use the claims extract file. If there is a date in the ODHSEXTD field, the claim has been extracted and sent to ODJFS. When there is a date in the DTPAID field and in the ODHSEXTD field, the claim has been extracted, sent to, and returned by ODJFS.

a. Claim Is a Duplicate

These claims have already been denied as a duplicate and no correction is to be done to a finalized, denied duplicate claim. You cannot un-deny a claim by reversing it. If this was a "straggler" claim, the original claim is the one that will need to be corrected. Follow procedure b. below (Units of Service are Incorrect).

b. Billed Amount, Units of Service, Procedure Code, Modifier, Place of Service or Third Party Amount are Incorrect

Note: Only correct the place of service code if it is changing from 51 or 99, or to 51 or 99.

- This correction procedure is also to be used to correct "straggler" claims.
- Do not reverse Medicaid claims that have not come back from ODJFS. If ODJFS rejects the claim and a Board has already reversed the claim line in Diamond, the claim will have two reversal ACPAY records and the monies will be deducted from the provider twice. The only way to check if claims have been extracted and sent to ODJFS is to use the claims extract file. If there is a date in the ODHSEXTD field, the claim has been extracted and sent to ODJFS. When there is a date in the DTPAID field and in the ODHSEXTD field, the claim has been extracted, sent to and returned by ODJFS.
- Currently ODJFS' adjudication deadline is 365 days from the date of service. Do not correct Medicaid claims if the date of service on the claim (MCD only) is such that when the correction is going to be made, reversing the claim will take the original payment back and the split claim

will get denied and reversed by ODJFS as being too old and the Provider will end up with no payment. DO NOT CORRECT THESE CLAIMS.

i. For those claims that should be corrected, using OPCLM access the claim line in question and enter a reversal line (001 R) and include one of the following adjustment reason codes:

- **MCDBA – Medicaid Billed Amount Correction**
- **NONBA – non-Medicaid Billed Amount Correction**
- **MCDMO – Medicaid Modifier Correction**
- **NONMO – non-Medicaid Modifier Correction**
- **MCDPR – Medicaid Procedure Code Correction**
- **NONPR – non-Medicaid Procedure Code Correction**
- **MCDTP – Medicaid Third Party Amount Correction**
- **NONTP – non-Medicaid Third Party Amount Correction**
- **MCDUN – Medicaid Units of Service Correction**
- **NONUN – non-Medicaid Units of Service Correction**
- **MCDPS - Medicaid Place of Service Correction**
- **NONPS - non-Medicaid Place of Service Correction**

Update (save) the claim detail.

ii. Access the claim header of the original claim, do an F6-S (split); all information on the claim header screen will be automatically filled in.

iii. Enter the correct amounts on the detail line of the split claim. No adjustment reason code should be entered on the split claim.

Note: It is important for Boards to enter a split claim when correcting paid (by ODJFS) claims so the claim can go back through the Double Loop. This is because the reversed line will "reclaim" the payment from the Provider and the split will go back through the double loop. ODMH will calculate how much FFP to withhold from a Boards future Medicaid reimbursement based upon claims, which were reversed after being paid by ODJFS.

c. <u>UCI or Date of Service are Incorrect</u>

Using OPCLM access the claim line in question, Boards will enter a reversal line (001 R) and one of the following adjustment reason codes:

- **MCDWC - Confirmed Incorrect UCI billed**
- **NONWC - Confirmed Incorrect UCI billed**
- **MCDWD - Confirmed Incorrect Date of Service**
- **NONWD - Confirmed Incorrect Date of Service**

Update (save) the claim detail.

Once this is complete, the Board will either enter a new claim using the correct UCI or correct Date of Service or, depending upon volume, request the Provider to submit a new claim. **If a board**

chooses to manually enter the new claim, make sure that the primary header date and the date of service on the detail line match.

d. Original Claim is Denied

i. If the original claim(s) was denied due to missing or invalid modifier or diagnosis code, Boards may require that the Provider resubmit the claim(s) electronically or may choose to correct the claim manually, depending on the volume. The resubmitted claim will not deny as a duplicate.

ii. If the original claim(s) was denied due to Board error (e.g., missing PROCP), Boards cannot require the Provider to resubmit the claim(s) electronically, unless mutually agreed to.

e. No Response From the Provider Within 30 Days of Notification

Using OPCLM, access the claim in question and create a reversal line (001 R). Enter the following adjustment reason code:

- **NPR30 - No Provider Response Within 30 Days**

Update (save) the claim detail.

III. OHEXT Error Report Corrections (Claim and/or Member Eligibility Changes)

It is the Board's responsibility to make the necessary changes to correct the errors being reported on the OHEXT error report. These errors occur when claims are adjudicated and finalized in MACSIS as MCD (Medicaid) but are not being extracted for submission to ODJFS. The primary reason these claim lines are not being extracted is the OHEXT program cannot find a valid Medicaid ID number on the members eligibility span for the date of service to use to bill the record.

1. Error Indication: Medicaid Number Not Found or Invalid Medicaid Number

This message identifies a claim adjudicated in MACSIS when a Member's eligibility span that covers the date of service has a Medicaid plan but the Medicaid ID field (a.k.a. USERDEF1) in this span does not have a Medicaid ID number entered or the number entered does not pass a check digit validation routine in the program. To correct this error, a valid Medicaid ID must be entered on the appropriate span. If you do not know what the valid Medicaid ID is, the Board must use the MACSIS Member function "EXINQ"* to find the valid Medicaid ID for the eligibility span.

**Procedures on how to use the EXINQ keyword (also known as the "EEI" function) can be found in the Member Manual.*

a. Once you have the valid Medicaid ID, access the Members eligibility span by using the F6 "special functs" and then select "E" to "View/maintain Elig History". Select "C" to change and enter the appropriate span number. When the span appears, enter through the fields until you reach the Medicaid ID field (a.k.a. USERDEF1) and enter the valid Medicaid ID number. Press "ENTER" again, then press "END". Select "S" for Save and use the "HOME" function to get back to the main Member Screen.

b. If the person was not Medicaid eligible on the claim's date of service but the claim was adjudicated as MCD, then the method of correction requires the claim to be reversed **AND** the Member's eligibility span(s) to be corrected. There are three (3) steps to correcting these claims:

Step One: Reverse the existing claims by using OPCLM to access the claim line(s) in question and access the claim detail screen by pressing the "END" key and selecting A to Adjudicate. Manually enter a "001 R" detail line to reverse the claim. Enter the adjustment reason code "ADMBR" (Claim Adjusted due to Member Eligibility Change). Press "END", then "Y" to update.

Step Two: After all affected claim detail lines have been reversed; the Member's eligibility span(s) **MUST** be corrected before entering split claims.

Step Three: Enter "new" claims by splitting the existing claims. Using OPCLM, access the original claim(s). From the Claim Header Screen use the F6 function key and then enter S to split the claim. Use the F6 function key and then enter "F" to refresh the header. Access the claim detail screen by pressing the "END" key and selecting "A" to Adjudicate. Enter all necessary information from the original claim. Double check to see that it now has a NON-Medicaid MEDEF (Medical Definition). If this was done properly, the claim has been properly processed as non-Medicaid but remains "connected" to the original claim. This is apparent because the claim number is the same except the last character of the split claim number is now an alpha character. The resulting "split" claim will process during the next APUPD cycle.

Note: Claims originally adjudicated as Non-Medicaid, which are later identified as being Medicaid eligible, are referred to as Retroactively Eligible Claims. These claims are not listed on the OHEXT Error Report because the claim was posted with a Non-Medicaid line of business. Reference the topic below "Claims Affected by Retroactive Medicaid Eligibility" for the processes related to correcting and re-billing these claims.

Note 2: Claims that were originally paid in MACSIS with a Medicaid line of business, billed, and paid by ODJFS then subsequently lost Medicaid eligibility are known as Medicaid Retroactive Eligibility Terminations. At this time since ODJFS does not pursue repayment when they retroactively terminate eligibility, those Medicaid claims will not need to be reversed or re-adjudicated as non-Medicaid.

2. Error Indication: DOS not Equal to Primary Date

This message identifies a claim adjudicated in MACSIS as Medicaid but the claim has a date of service on the claim detail line (DOS) that is different from the date of service on the claim header (Primary Date). These claims can not be reversed in Diamond by the OBREV process so therefore are not extracted and sent to ODJFS.

The OBREV process uses the date of service on the claim detail line to post reversals back to Diamond. Since the date of service on the detail line is not the same as the date of service on the claim header, the claim can not be found and therefore, not reversed. The OHEXT process excludes these claims from being extracted.

The only way to correct these claims is:

a. Reverse the claim in Diamond using an adjustment code of MCDWD (Confirmed Incorrect Date of Service).

b. If the date of service is correct on the header, split the claim and enter the correct information on the claim detail making sure the date of service on the claim detail is the same as the date of service on the claim header.

c. If the date of service is incorrect on the claim header DO NOT SPLIT THE CLAIM. You must enter a new claim making sure the same date of service is on the claim header and the claim detail.

NOTE: The only way for the date of service on the header and detail to be different is by manual entry/corrections made by the board.

IV. Claims Affected by Retroactive Medicaid Eligibility

1. Identifying Claims and Members

In accordance with the "Guidelines Pertaining to the Implementation of MACSIS" "Topic 19: Retroactive Medicaid Eligibility" **Boards are required to make the claim adjustments/corrections in this section**.

Reports of claims originally adjudicated as non-Medicaid, which are later identified as likely to be eligible to be reimbursed by Medicaid are produced every month by the ODMH MACSIS Member and Eligibility Maintenance Section. A simplified explanation of the process is:

- Compares claims to Medicaid eligibility to locate members who have not been fixed in Diamond.
- Locates claims that have cplan/eplan mismatches.
- Takes into consideration those claims that have already been reversed and split
- Takes into consideration claims that have been denied and re-billed
- Denied claims with certain reason codes have now been included

Three files created and placed in your /county/extracts directory. The files are as follows:

a. mondd.ret.clm.group_bd (ex: jul20.ret.clm.group_25b)

This file is in claims extract format and Boards can begin fixing claims immediately. To do this you would reverse the original claim, split the claim, and refresh the header to make it Medicaid billable. (This would mean additional funds for Board if claims are payable by Medicaid). This file contains records for which the eligibility has already been changed in Diamond.

b. mondd.ret.mbr.group_bd (ex: jul20.ret.mbr.group_25b)

- This file is in a tilde-delimited file with seven fields. These members need to have their eligibility fixed first in order to then fix their associated claims in the next file.
- There is a field called has_claims that contains a Y or N and you can utilize this to determine who has claims and needs their eligibility fixed immediately.
- The format for this file will be contained on MHHUB in /county/common.

Note: this file contains member records that need to be fixed so that you can fix the claims records in the file listed below.

c. <u>mondd.ret.clmfxmbr.group_bd</u> (ex: jul20.clmfxmbr.group_25b)

This files is in claims extract format and Boards can begin fixing claims once the member is fixed from the mondd.ret.mbr.group_bd file. Then you can reverse the original claim, split the claim, and refresh the header to make it Medicaid billable. (This would mean additional funds for Board if claims are payable by Medicaid).

Note: YOU MUST FIX THE MEMBER ELIGIBILITY RECORD BEFORE YOU FIX THESE RECORDS!

2. Correcting Retroactive Medicaid Eligibility and Claims

These reports list all information necessary to correct the member eligibility and correct the claims.

There are several things about this process that needs to be highlighted:

- Correcting these claims will result in additional reimbursement to the Board. The Board should obtain the Federal Financial Participation as reimbursement from ODJFS for claims that are re-processed and found to have Medicaid eligibility. Therefore, it is a Board's responsibility to correct these claims per the correction process outlined below.

- There may have been some claims that were denied because they were for an out-of-county client and the services were non-crisis. In these cases the Provider never received payment for these services. These claims must be corrected so that the Provider can be paid.

- When the "corrections" are made, the Boards must communicate these corrections to the Providers. The Provider will encounter a negative claim that will be generated by this process on their reports and an offsetting positive claim, which they did not submit on one of their claim files.

a. Correct Member Eligibility (mondd.ret.mbr.group_bd)

Access the member's record. Do an F6-E (View/maintain Elig History) to access the eligibility maintenance screen. Do "C" to change and select the appropriate span. Change the member's plan to a Medicaid plan. Enter the Medicaid number in the USERDEF field in the bottom left-hand corner.

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

b. Correct the Claims that Should have been Billed as Medicaid

i. Un-Finalized Claims paid as non-Medicaid

- Using OPCLM, access the claim header screen and do an F6-F to refresh the member eligibility so you will have the updated member eligibility information. Access the claim detail screen by hitting "END", then "A" to adjudicate. Enter 001 to access the detail line and press F6-B to price and adjudicate the claim. Update (save) the claim detail.

ii. Finalized Claims paid as non-Medicaid

- Using OPCLM, access the claim line in question and access the claim detail screen by hitting "END" and selecting "A" to adjudicate. Enter a 001 R reversal line using the adjustment reason code of "ADMBR" (Claim Adjusted Due to Member Eligibility Change). Update (save) the claim detail.

- Return to the claim header screen and do F6-S (Split Claim) to split the claim. Refresh the claim header by doing F6-F (refresh member eligibility) so you will have the updated member eligibility information. Enter all necessary information from the original claim (either make a screen shot or write down all the information from the original claim) and verify the claim now has the appropriate Medicaid MEDEF. Update (save) the claim detail.

  If the original claim contained other carrier information (other carrier amount and other carrier reason code), make sure they are entered on the split claim.

  These are two separate claims, but by splitting the claim, the original and split claim will remain linked because the split claim number will be identical to the original except the last character (usually a zero) will be replaced with an alpha character (starting with A).

  Once the split claim is finalized, it will be extracted and submitted to ODJFS for payment the next time OHEXT is run. Do not reverse and split claims that will not make it to ODJFS within the ODJFS adjudication time limit.

iii. Denied Claims

- Using OPCLM, access the claim header screen and do F6-S (Split) to split the claim. Refresh the claim header by doing F6-F (refresh member eligibility) so you will have the updated member eligibility information.
- Access the claim detail screen by hitting "END" and selecting "A" to adjudicate. Enter all necessary information from the original claim (either make a screen shot or write down all the information from the original claim) and verify the claim now has the appropriate Medicaid MEDEF.
- Update (save) the claim detail.

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

V. Department Reporting Procedures

The State will produce the following reports as needed:

- Reversed Medicaid Claims in MACSIS – This report will list the claims (by Board and Provider), which were reversed by the Board after payment had been made to the Provider. It will be used to determine the amount of FFP a Board owes the state.

- Held Medicaid Claims in MACSIS – This report will list the potentially erroneous claims. For example, non-Medicaid claims reversed using the Medicaid-specific reason codes or claims that have been held over 60 days with no action by the Board or Provider. It will be used to identify when Boards may not be following this procedure.

- Board Denied Medicaid Claims in MACSIS – This report will list the MH and AOD claims by Board and Provider, which were "denied" due to erroneous billing before payment having been made to the Provider (un-finalized claims).

Boards are encouraged to produce local versions of these reports for their use in monitoring claim correction activity.